Fulcrum Orthopaedics Patient Registration Packet

v.90 | 18.07.2019

Patient Information

Name (LAST, FIRST) ..... Gender ..... Age .....

Date of Birth ..... SSN .....

Street Address .....

City, State, ZIP .....

Mobile Phone ..... Home Phone .....

Email Address (REQUIRED) .....

ETHNICITY:

- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Non-Latino
- ☐ Other

RACE:

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Middle-Eastern or North African
- ☐ White
- ☐ Other

SMOKING STATUS:

- ☐ I Never Used Tobacco
- ☐ I Quit Using Tobacco
  - Former Frequency: ..... Year of last use: .....
- ☐ I Currently Use Tobacco
  - Frequency/Packs per day, etc: .....
  - ☐ Cigarettes
  - ☐ Cigar/Pipe
  - ☐ Chewing Tobacco/Snuff
  - ☐ Other

SPOUSE / GUARDIAN / OTHER CONTACT INFORMATION

Name (LAST, FIRST) ..... Gender ..... Age .....

Date of Birth ..... SSN .....

Street Address .....

City, State, ZIP .....

Mobile Phone ..... Work Phone .....

Email Address .....

PATIENT EMPLOYER INFORMATION

Employer Name ..... Contact Person .....

Street Address .....

City, State, ZIP .....

Email Address .....

Primary Phone ..... Direct Phone .....

PHARMACY INFORMATION (SO WE CAN SEND YOUR PRESCRIPTIONS ELECTRONICALLY WHEN AVAILABLE)

Pharmacy .....

Address .....

Pharmacy Phone ..... Fax .....

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PATIENT INFORMATION (PLEASE REPEAT)

Last Name ..... First ..... Date .....

INSURANCE COMPANY INFORMATION

Primary Insurance	Secondary Insurance .....
Street Address	Street Address .....
City	City .....
State, Zip	State, Zip .....
Phone	Phone .....
Patient ID No.	Patient ID No. .....
Group No. & Name	Group No. & Name .....

PRIMARY INSURED ☐ self ☐ other (please describe below)

Name (LAST, FIRST) ..... Relationship .....

Date of Birth ..... SSN .....

Street Address .....

City, State, Zip .....

Mobile Phone ..... Work Phone .....

Email Address .....

EMAIL AND TEXT POLICY

I agree to permit the Practice and their authorized representatives to communicate with me by email and text message with respect to my appointments, the medical claims submitted to my health plan, and with respect to any balances not covered by my health plan, coinsurance, deductibles, or any other balance as deemed patient responsibility.

I understand that I have the option to receive communication by paper or non-electronic form. In such case, I will notify the Practice in writing of this request. I understand that my consent is continuous. However, I understand further that I may terminate my consent to email and text message communication in writing to the Practice.

I understand the Practice and their authorized representatives will not sell, share, or rent my email address, phone number, or any other personal information collected on this consent.

ATTESTATION

I attest, to the extent of my knowledge, that all of the information I have supplied is accurate and complete.

SIGNATURE REQUIRED:

....

Printed Name of Patient | Printed Name of Legal Guardian, if applicable

....

Signature of Patient or Legal Guardian | Date

PATIENT INFORMATION (PLEASE REPEAT)

Last Name ..... First ..... Date .....

Description of Present Injury

Date of injury? .....

Rate your current pain level from your injury. 0 (NONE) 1 2 3 4 5 6 7 8 9 10 (WORST)

What part(s) of the body is injured? Right or left? .....

Describe your Injury. .....

Describe your symptoms. .....

What makes your symptoms worse? .....

What makes your symptoms better? .....

What treatment, if any, have you previously received for this injury? .....

WAS THE INJURY WORK-RELATED? ☐ yes ☐ no

List the name and contact information for any law firm that is representing you for the injury.

Firm .....

Attorney .....

Phone .....

Address .....

.....

.....

WAS THE INJURY RELATED TO AN AUTOMOBILE / MOTORCYCLE ACCIDENT? ☐ yes ☐ no

List the name and contact information for any law firm that is representing you for the injury.

Firm .....

Attorney .....

Phone .....

Address .....

.....

.....

List the name, contact information, claim number, and address of your automobile/PIP insurer.

Insurer .....

Claim # .....

Phone .....

Address .....

.....

.....

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PATIENT INFORMATION (PLEASE REPEAT)

Last Name ..... First ..... Date .....

Medical History

Attach additional sheet if necessary.

ALL CURRENT MEDICATIONS OR HERBALS	DOSE/FREQUENCY
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

ALLERGIES ☐ no ☐ yes (please list)

.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

CURRENT MEDICAL PROBLEMS

.....
.....
.....
.....
.....

Previous Surgeries

DATE	TYPE	SURGEON NAME	HOSPITAL	COMPLICATIONS
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....

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PATIENT INFORMATION (PLEASE REPEAT)

Last Name ..... First ..... Date .....

Have you or your family had any of the following?

	SELF	FATHER	MOTHER	SIBLING	GRANDPARENTS	OTHER
Diabetes						
Arthritis						
Hemophilia						
Hypertension						
Heart Disease						
Heart Attack						
Stroke						
Cancer						
Thyroid Disease						

Social History

OCCUPATION .....

.....

MARITAL STATUS (CHECK ONE) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

	Y	N		
Tobacco Use	☐	☐	If yes, number of years?	Number of packs a day? .....
Alcohol Use	☐	☐	If yes, how much?	How frequent? .....
Illicit Drugs	☐	☐	If yes, what drugs?	Date of last use? .....
Tattoos	☐	☐	If yes, date of last tattoo?	

Referral

WHO REFERRED YOU TO OUR OFFICE?

Name .....

Address .....

Address (CONT.) .....

City, State, ZIP .....

Phone .....

WHO IS YOUR PRIMARY CARE DOCTOR?

Physician .....

Name of Group .....

Address .....

City, State, ZIP .....

Phone .....

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PATIENT INFORMATION (PLEASE REPEAT)

Last Name ..... First ..... Date .....

Review of Systems

HAVE YOU BEEN DIAGNOSED OR RECEIVED TREATMENT FOR ANY OF THE FOLLOWING? PLEASE PROVIDE DETAILS.

CONSTITUTIONAL	Y	N	
Fever	☐	☐	.....
Unusual Weight Loss / Gain	☐	☐	.....
Unusual Fatigue	☐	☐	.....

EYES	Y	N	
Poor Vision	☐	☐	.....
Eye Pain	☐	☐	.....
Tearing	☐	☐	.....
Redness	☐	☐	.....

EARS, NOSE, THROAT	Y	N	
Hard of Hearing	☐	☐	.....
Stuffy Nose	☐	☐	.....
Cough	☐	☐	.....

CARDIOVASCULAR	Y	N	
High Blood Pressure	☐	☐	.....
Racing Pulse	☐	☐	.....
Chest Pain	☐	☐	.....

RESPIRATORY	Y	N	
Congestion	☐	☐	.....
Wheezing	☐	☐	.....
Shortness of Breath	☐	☐	.....

GASTROINTESTINAL	Y	N	
Stomach Upset	☐	☐	.....
Diarrhea	☐	☐	.....
Constipation	☐	☐	.....
Ulcers	☐	☐	.....

FEMALES	Y	N	
Pregnant or Nursing	☐	☐	.....

MUSCLES, BONES, JOINTS	Y	N	
Joint Pain	☐	☐	.....
Stiffness	☐	☐	.....
Swelling	☐	☐	.....
Cramps	☐	☐	.....

SKIN	Y	N	
Wounds	☐	☐	.....
Rash	☐	☐	.....
Pimples	☐	☐	.....

NEUROLOGICAL	Y	N	
Numbness	☐	☐	.....
Paralysis	☐	☐	.....
Seizures	☐	☐	.....

PSYCHIATRIC	Y	N	
Anxiety	☐	☐	.....
Depression	☐	☐	.....
Insomnia	☐	☐	.....

ENDOCRINE	Y	N	
Diabetes	☐	☐	.....
Hypothyroidism	☐	☐	.....

BLOOD / LYMPH	Y	N	
Bleeding	☐	☐	.....
Anemia	☐	☐	.....
Transfusion-Related Problems	☐	☐	.....
High Cholesterol	☐	☐	.....

ALLERGY / IMMUNOLOGIC	Y	N	
Hives	☐	☐	.....
Itching	☐	☐	.....
Sneezing	☐	☐	.....
Lupus	☐	☐	.....

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Financial Policy

FINANCIAL RESPONSIBILITY POLICY:

The patient (or patient's guardian) is ultimately responsible for the payment for treatment and care. Patients (or patient's guardian) are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan. Charges for medical services are due and payable at the time services are rendered. For your convenience we accept cash, check and most major credit cards at our office. If a check is returned, a $25.00 returned check fee will be charged and an alternate form of payment will be required. As a courtesy to our patients, we file your insurance claim and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill regardless of the status of your insurance claim. If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our Patient Account Representative. This will avoid misunderstandings and enable us to keep your account in good standing. Charges for medical care rendered by this practice will be through this practice exclusively and should not be confused with charges for care received in the hospital or surgery center.

SIGNATURE REQUIRED:

Printed Name of Patient

Printed Name of Legal Guardian, if applicable

Signature of Patient or Legal Guardian

Date

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Assignment of Benefits and Authorizations

ASSIGNMENT OF INSURANCE BENEFITS / APPOINTMENT AS LEGAL AUTHORIZED REPRESENTATIVE:

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Fulcrum Orthopaedics (the "Practice") and I appoint them as my authorized representative with the power to: (1) File medical claims and communicate with the health plan administrator and employer; (2) File appeals and grievances with the health plan administrator and employer and pursue all appeals/settlement options available to me; (3) File employer appeals and grievances in the name of the patient. Such appeals can contain health information such as medical records. I specifically authorize such appeals and this is considered a valid and enforceable HIPAA Authorization; (4) Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan administrator and employer; (5) Obtain copies of my health plan benefits, Master Plan Document and Summary Plan Description from my health plan or their administrator or plan sponsor.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the Practice to: (1) Perform all of the above referenced actions as specifically listed above; (2) Release any information necessary to my health benefit plan (or its administrator) regarding my medical condition and treatments; (3) Process insurance claims generated in the course of examination or treatment. This order will remain in effect until revoked by me in writing.

ERISA AUTHORIZATION:

I hereby designate, authorize, and convey to the Practice to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) The right and ability to act as My Authorized Representatives in connection with any claim, right, or cause of action including litigation against my health plan that I may have under such insurance policy and/or benefit plan; (2) The right and ability to act as My Authorized Representatives to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as My Authorized Representatives with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from the Practice and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines).
I authorize communication with the Practice by email. I understand I can revoke this authorization in writing at any time.

My email address is: .....

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

SIGNATURE REQUIRED:

....
Printed Name of Patient | Printed Name of Legal Guardian, if applicable

....
Signature of Patient or Legal Guardian | Date

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes:

TREATMENT

This means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

PAYMENT

This means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

HEALTH CARE OPERATIONS

This includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Notice of Privacy Practices continued on next page:

Notice of Privacy Practices continued:

You have the following rights with respect to your Protected Health Information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of Protected Health Information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information from us by alternative means or at alternate locations.
- The right to inspect and copy your Protected Health Information.
- The right to amend your Protected Health Information.
- The right to receive an accounting of disclosures of Protected Health Information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your Protected Health Information and to provide you with notice of our legal duties and privacy practices with respect to Protected Health Information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all Protected Health Information that we maintain. We will post and you may request a copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information.

For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

SIGNATURE REQUIRED:

Printed Name of Patient

Printed Name of Legal Guardian, if applicable

Signature of Patient or Legal Guardian

Date

Protected Health Information

I consent to the use and/or disclosure of my Protected Health Information by Fulcrum Orthopaedics for the purpose of Treatment, Payment, and Healthcare Operations as explained by the Notice of Privacy Practices (see page 10).

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing which will apply to disclosures and uses made subsequent to the revocation date.

I approve the release of my electronic medication history to Fulcrum Orthopaedics for their records, understanding that the information is considered patient data and will be kept confidential.

I,....., hereby authorize Fulcrum Orthopaedics to use and/or disclose my Protected Health Information (PHI) to the following persons:

....., Relationship: .....

....., Relationship: .....

....., Relationship: .....

This PHI is being used or disclosed for the following purposes:

- *Providing appointment reminders*
- *Describing or recommending treatment alternatives*
- *Providing information about health-related benefits and services that may be of interest to the individual*

I understand that I have the right to revoke this authorization at any time by submitting a written request and that a revocation is not effective prior to the revocation date. Furthermore, I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

SIGNATURE REQUIRED:

....

Printed Name of Patient | Printed Name of Legal Guardian, if applicable

....

Signature of Patient or Legal Guardian | Date

Medical Records Release Request

RECORDS REQUESTED BY FULCRUM ORTHOPAEDICS:

☐ Complete Records

☐ Records of Care from (Health Care Provider): .....

☐ Records of Care concerning the following medical condition only:

.....

.....

.....

REASON FOR RELEASE:

.....

.....

.....

HIV/AIDS CONSENT:

I give consent to release any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, along with the rest of my Medical Records.

SIGNATURE REQUIRED:

....

Printed Name of Patient | Printed Name of Legal Guardian, if applicable

....

Signature of Patient or Legal Guardian | Date

SEND RECORDS TO:

Fulcrum Orthopaedics
7715 San Jacinto Place, Suite 200
Plano TX 75024-3215
Fax: 972.618.4444

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Patient Authorization to Obtain Summary Plan Description and 5500 Form

I, the patient or patient's legal guardian, hereby direct you to send to Fulcrum Orthopaedics the following governing plan documents for the purpose of applicability of compliance with PPACA:

1. Summary Plan Description (SPD)
2. 5500 Form (Plan Annual Report)
3. Certified Copy of Certificate for PPACA Grandfathered Plan

Please send to the below address immediately:

Fulcrum Orthopaedics
P.O. Box 250328
Plano TX 75025-0328

SIGNATURE REQUIRED:

Printed Name of Patient

Printed Name of Legal Guardian, if applicable

Signature of Patient or Legal Guardian

Date

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