

NEW PATIENT REGISTRATION

Date of Visit: _____/_____/_____

Office Use Only: Account #: _____

Full Name: _____ Date of Birth: _____/_____/_____

Social Security #: _____ - _____ - _____ Gender: Male Female Hand Dominance: Left Right

Marital Status: Single Married Divorced Widowed Life Partner

Race: African American Asian Caucasian
 American Indian or Alaska Native Native Hawaiian or other Pacific Islander
 Other: _____

Ethnicity: Hispanic Not Hispanic or Latino Other: _____

Employer: _____ Occupation: _____

Primary Care Physician: _____

Who referred you to us? Physician _____ Friend _____

Hospital—Please indicates which one: _____ Other _____

CONTACT INFORMATION

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Primary Contact Phone: _____ Secondary Contact Phone: _____

E-Mail: _____

Preferred Method of Contact: Patient Portal E-Mail Mail Mobile Phone

Would you like to receive e-mails on events our office may have? Yes No

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone #: _____ Mobile #: _____

***Information below must be filled out completely and accurately in order for qualified RXs to be prescribed:**

Pharmacy Name: _____ Phone #: _____

Address (If phone # is not supplied): _____

SMS/Text Message Consent

I authorize **Coastal Orthopaedic & Sports Medicine Center** to send text messages to me at the phone number I provided for purposes including appointment reminders, scheduling updates, care instructions, billing notices, or other healthcare communications. I understand that text messaging may not be a fully secure method of communication. I may opt out at any time by replying **STOP** to any message or by contacting the office directly. Standard messaging rates may apply. Phone number for text messaging: _____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES PERMISSION TO SHARE HEALTH INFORMATION

Patient Name: _____

I have **received a copy** of Coastal Orthopaedic & Sports Medicine Center's "Notice of Privacy Practices" on this day (posted in office). I hereby **authorize** Coastal Orthopaedic & Sports Medicine Center to disclose my health information to the following person(s):

NAME	RELATIONSHIP TO PATIENT

I hereby request the following **restrictions** on the use and disclosure of my health information. The practice is not required to agree with my requests.

By my signature below, I affirm the above information.

Patient's Signature

Date

DO YOU HAVE AN ADVANCED DIRECTIVE? YES NO

DO YOU WANT TO PROVIDE A COPY OF THE ADVANCED DIRECTIVE? YES NO

DO YOU WANT TO DISCUSS YOUR ADVANCED DIRECTIVE? YES NO

WHO IS YOUR POWER OF ATTORNEY? NAME _____ PHONE _____

INSURANCE INFORMATION

Patient Name: _____ Today's Date: _____

If your visit is related to an injury **of any kind** please complete the below questions. Please answer all questions in detail if possible. Enter "N/A" if not applicable.

Worker's Compensation Auto Accident Other Type of Accident Not an Accident

Please answer the following questions in order to provide your insurance company information to process claims for benefit for all types of accidents. If this form is not completely filled out, you may be responsible for any accrued balances. If your injury is due to an auto or workers compensation injury, this must be billed thorough auto or w/c insurance. Please stop and see receptionist if you have not provided us with this information yet.

1. Brief description of accident: (Please be specific as to the exact date, time and place if possible.)

Date of accident:

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Policy #: _____

Policyholder's Name: _____ Policy Holder DOB: ____/____/____

Relationship to patient: Self Spouse Child Other

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Policy #: _____

Policyholder's Name: _____ Policy Holder DOB: ____/____/____

Relationship to patient: Self Spouse Child Other

By my signature below, I affirm the above information.

Patient's Signature

Date

HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION

For office use only: To be completed every 6 months

Patient's Full Name: _____ Account # _____

DOB: _____ Height: _____ Weight: _____

CHIEF COMPLAINT: _____ RIGHT LEFT BILATERAL

Have you been treated for this problem before: Yes No

If yes, by whom? _____ Date of treatment: _____

PLEASE LIST ALLERGIES TO MEDICATION **NONE**

MEDICATION _____ REACTION: _____

PLEASE LIST ANY ALLERGIES TO METALS INCLUDING ANY JEWELRY AND/OR IMPLANTS

METAL _____ REACTION: _____

METAL _____ REACTION: _____

METAL _____ REACTION: _____

METAL _____ REACTION: _____

PAST MEDICAL HISTORY (Please check) **NONE**

<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Constipation	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Pressure Ulcer
<input type="checkbox"/> Addiction	<input type="checkbox"/> Coronary Artery Bypass	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Prior Anesthesia Complications
<input type="checkbox"/> Alzheimer's Disease	Graft (CABG)	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Amputation	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Angina	(CAD)	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Defibrillator	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Dementia	<input type="checkbox"/> Lupus	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Back/Neck Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Urinary Frequency
<input type="checkbox"/> Blood Clot _ RT _ LT	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Migraines	<input type="checkbox"/> Urinary Tract Infection (UTI)
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Edema	<input type="checkbox"/> MRSA	<input type="checkbox"/> Urinary Retention
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> Valve Replacement
Reaction	<input type="checkbox"/> Endometriosis	(MI)	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Bowel disease	<input type="checkbox"/> Enlarged Prostate	<input type="checkbox"/> Neck/back disorder	<input type="checkbox"/> Weakness
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Other:
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pacemaker	
Type: _____	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Paralysis	
Current Treatment: _____	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Parkinson's	
Past Treatment: _____	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Peripheral Vascular	
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hernia	Disease (PWD)	
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Phlebitis	
<input type="checkbox"/> Chronic Obstructive	<input type="checkbox"/> History of VRE	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Pulmonary Disease			
(COPD)			
<input type="checkbox"/> Congestive Heart Failure			

FAMILY HISTORY (Please check)

Please indicate which family member has any of the following conditions: **NONE**

(i.e. Mother, Father, Brother, Sister)

<input type="checkbox"/> Addiction: _____	<input type="checkbox"/> Alcoholism: _____	<input type="checkbox"/> Rheumatoid Arthritis: _____
<input type="checkbox"/> Bleeding DisOrder Radiology: _____	<input type="checkbox"/> Heart Disease: _____	<input type="checkbox"/> HIV/AIDS: _____
<input type="checkbox"/> Hypertension: _____	<input type="checkbox"/> Kidney Disease: _____	<input type="checkbox"/> Mental Illness: _____
<input type="checkbox"/> Stroke: _____	<input type="checkbox"/> Arthritis: _____	<input type="checkbox"/> Kidney Stones: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Unknown	<input type="checkbox"/> Adopted

SMOKING STATUS

Never Smoked Former Smoker Occasional Smoker
 Light -1-9 cigs/day Moderate - 10-19- cigs/day Heavy -20-39 cigs/day Very Heavy - 40+ cigs/day
Do you use: Cigarettes Chewing Tobacco

SOCIAL HISTORY

Living Status: Lives Alone With Spouse Skilled Nursing With Other Family—Who? _____

Do you use alcohol? Never Occasional Moderate Heavy Past Abuse

History of drug abuse? Yes No

Do you Exercise? Less than 3 times a week More than 3 times a week Never

Employment Status: Full Time Part Time Homemaker Retired Student Unemployed Disabled

If female, are you pregnant? Yes No

SURGICAL HISTORY

<input type="checkbox"/> Appendix	<input type="checkbox"/> Fracture	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Back/Lumbar	<input type="checkbox"/> Gallbladder	*Prior Orthopaedic Surgeries: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hysterectomy	If yes, please specify body part and year of surgery: _____
<input type="checkbox"/> Cervical	<input type="checkbox"/> Prostate	_____

MEDICATIONS

Please correctly spell the names of medications you are currently taking, or you may provide a list on a separate sheet of paper

Name of Drug

Strength

Frequency Taken

****I attest that the information provided above is complete & accurate as it will be utilized as a part of my care and treatment plan. ****

Patients Name (Please Print)

Date

Patient's Signature (Parent's Signature if Minor)

WELCOME TO OUR PRACTICE

Please review a few of our office policies. If you would like a copy of this, please notify the receptionist:

PRESCRIPTION REFILLS

Refill request made after 12:00 p.m. will not be filled until the next business day. Additionally, by signing below you are authorizing Coastal Orthopaedic & Sports Medicine Center to electronically receive and review any prescription history available to the electronic health record.

It is our office policy that written prescriptions are only released to authorized individuals listed on the patient information sheet. If any other person (not listed) picks up a written prescription, we must have a signed consent from the patient notifying us of this. Copy of a picture ID is necessary in order to release the prescription.

WE WILL NOT RELEASE THE PRESCRIPTION WITHOUT WRITTEN CONSENT!

The on-call physician will not call in prescriptions on weekends, please call in advance for all refill requests. **Do not wait until you are completely out of medication.**

PAYMENT POLICY

Payment is expected at time of service unless prior arrangements have been made in advance.

Patients are responsible for paying their annual deductible, co-insurance payments and any non-covered service charges at the time of the visit. The office accepts MasterCard, Visa, Discover and American Express with a 3.99% surcharge.

HMO OR MEDICARE REPLACEMENT PLANS

If you are enrolled in a HMO or Medicare Replacement Plan, it is your responsibility to notify the office staff before treatment. It is the responsibility of the patient to assure that the office staff has a referral/authorization on file for your visit and participates with the plan as a provider. Your signature below indicates you understand you may be financial responsibility for any claims rejected by the insurance carrier for reasons such as non-provider, no authorization, etc.

COPY REQUEST

Your records are the property of Coastal Orthopaedic & Sports Medicine Center. This includes X-rays or MRI's performed within our practice. However, we will be happy to provide you with a copy of your X-rays/MRI at a cost. The office requires a 24-hour advance notice if you need copies of medical records, x-rays or MRI's. **Please note our office has outsourced the request for all medical records to Diversified Medical Record Service. When requesting medical records all patients will work directly with a representative from DMRS. Should you need to speak to DMRS concerning your request for medical records please contact them at 800-359-8520.**

FORMS

Forms can be submitted to the office for completion. This is an additional service that is provided for our patients. Therefore, there is an additional charge of \$10 up to \$25 depending on the form. Payment must be made in full before the form can be completed. Please allow adequate time for completion.

INSURANCE VERIFICATION

As a courtesy to you our staff will verify your benefits for your insurance/s for services provided at our office. Verification of benefits is not a guarantee of payment nor accurate benefits, only an estimate. It is the responsibility of the patient (parent if minor) to contact their insurance company directly to verify that all information provided to our office is accurate.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Coastal Orthopaedic and Sports Medicine Center, Inc. (herein after referred to as the "practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations.

I understand diagnosis or treatment of me by my treating physician may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment for healthcare operations of the practice. The practice agrees to a restriction that I request, the restriction is binding on Coastal Orthopaedic and Sports Medicine Center, Inc. and My Treating Physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that My Treating Physician and Coastal Orthopaedic and Sports Medicine Center, Inc. have taken action in reliance on this consent.

My "protected health information" means health information including demographic information, collected from me and created or received by physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or if there is a reasonable basis to believe that information may identify me.

I understand I have a right to review the practices Notice of Privacy Practices prior to signing this document. By signing this document, I acknowledge that the practices Notice of Privacy Practices has been provided to me and that I have had the opportunity to read, ask questions, get answers and get a copy to take with me if I so desire. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the practice. The Notice of Privacy Practices also describes my right and the practice duties with respect to my protected health information.

I understand that the Physical Therapy performed at Coastal Orthopaedic and Sports Medicine Center, Inc. is generally performed in an open room. If I find the openness uncomfortable, the practice is happy to accommodate my request to be treated in a curtained area.

The practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a copy to be sent by mail or given at my next appointment.

I understand the above terms of the Office Policy and consent to use or disclose information of my protected health information.

Patient Name:

Signature of Patient or Parent (if Minor): _____

Office Use Only: Front Office: _____

ASSIGNMENT OF BENEFITS AND REPRESENTATION

1. Assignment of Benefits

I hereby assign and transfer to **COASTAL ORTHOPAEDIC & SPORTS MEDICINE CENTER** ("Representative") all rights, title, and interest to any and all insurance benefits, reimbursement claims, or monetary proceeds payable to me for services rendered, including but not limited to health insurance, disability insurance, workers' compensation, personal injury protection (PIP), medical payments coverage, or any other applicable benefits. This assignment is provided for the purpose of securing payment for services performed by the Representative on my behalf.

2. Authorization for Direct Payment

I authorize and direct any insurance carrier, claims administrator, governmental agency, plan administrator, or other responsible entity to release and remit payment directly to the Representative for any benefits or proceeds assigned herein. I understand that any payments made directly to me for services covered by this assignment must be promptly forwarded to the Representative.

3. Appointment of Representative

I hereby appoint the Representative as my authorized agent for the purpose of pursuing, negotiating, appealing, or otherwise administering any claim for benefits related to services rendered. This includes, without limitation, the authority to request records, submit claims, communicate with insurers or agencies, and take any action necessary to secure payment.

4. Authorization to Release Information

I authorize the release of any medical, legal, financial, or claim-related information necessary to process or administer claims for benefits or payments assigned under this agreement. Such information may be released to the Representative, insurers, benefit plans, or any other relevant entity.

5. Non-Revocation After Services Rendered

I understand that this assignment may not be revoked with respect to services already rendered. Any revocation must be made in writing and shall apply prospectively only.

6. No Guarantee of Payment

I acknowledge that this assignment does not guarantee that the insurer or benefit provider will approve or pay any claim. I remain financially responsible for any amounts not covered or paid.

7. Governing Law

This assignment shall be interpreted and enforced in accordance with the laws of the state or jurisdiction where services are rendered, unless otherwise required by applicable law.

8. Acknowledgment

By signing below, I acknowledge that I have read, understand, and voluntarily agree to the terms of this Assignment of Representation and Benefits.

Client/Claimant Signature: _____

Printed Name: _____

Date: _____

Parent or Guardian Signature (if Minor): _____