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ORTHOPEDIC INSTITUTE

Patient Name:_____ SSN:_____ Date of Birth:_____

Address:_____ City:_____ Zip Code:_____

Cell Phone:_____ Work Phone:_____ Email Address:_____

Sex: Male Female Referred by:_____ Preferred Language:_____

Patient Race: Hispanic Caucasian Asian Black/African American Chinese Multi-racial Other

My condition is related to:_____Work Accident _____Car Accident _____Other

Is the patient responsible for payment of this bill? ___yes ____no,please provide information below:

Guarantor Name:_____ Address:_____

Phone Number:_____ DOB:_____ SSN:_____

Relationship to Patient:_____ Sex:_____

Occupation:_____ Employer:_____

Insurance Coverage Information

Please present your insurance card so we can obtain the correct filling information

Primary Insurance:_____ Phone:_____

Group ID No.:_____ Individual ID:_____

Policy Holder Info.

Name:_____ SSN:_____ DOB:_____

Relationship to Patient: _____

Secondary Insurance:_____ Phone:_____ Group ID No.:_____

Employer:_____ Individual ID:_____

Policy Holder Info.

Name:_____ SSN:_____ DOB:_____

Relationship to Patient: _____

If your insurance changes you are responsible for notifying our office prior to your appointment. Please present your new insurance card so we can obtain the correct filling information.

The information provided about is true and correct to the best of my knowledge. I understand that no guarantees have been made as to the result of such treatments and examinations. I acknowledge that I am responsible for notifying our office if my insurance has changed.

Signed:_____ Date:_____

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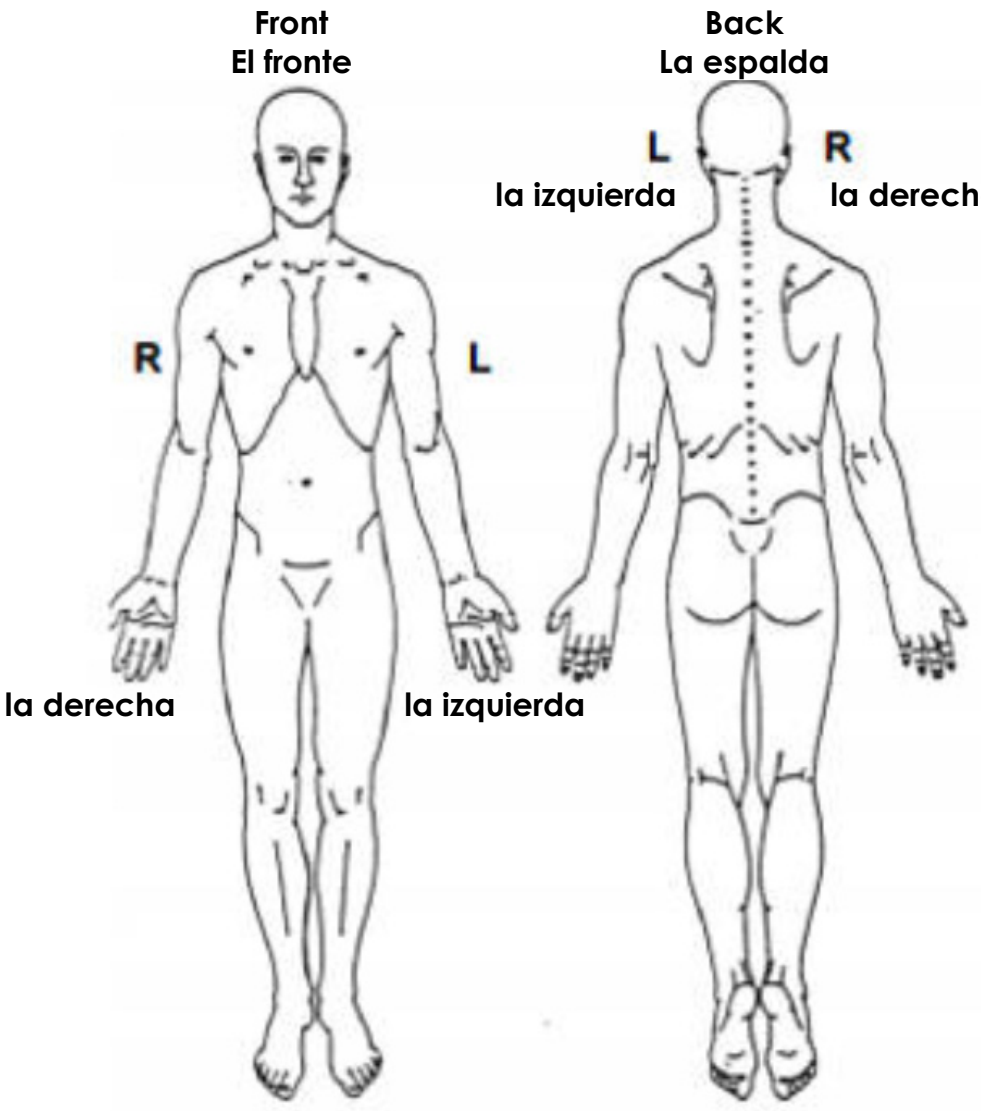
Patient Pain Diagram
(This will become part of your chart)

Name:_____ **Age:**_____ **Sex:**_____

Please mark where your pain is located, front and back
Favor de marcar por enfrente y atras la area de dolor

X - Pain (Dolar) ✓ - **Burning (Ardiente)** **O - Numbness (Dormido)**



Patient Signature:_____ Date:_____

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Notice of Privacy Practices
Patient Acknowledgement

I acknowledge that I have provided a copy of the notice of privacy practices for Orthopedic Surgery Center (OSC) to review. I understand that OSC will administer out patients records in a confidential matter and in compliance with the Health Inusrance Portability and Accountability Act. A separate authorization must be executed for non-routine release of Protected Heath Information. Patient information shall not be sold to any outside marketing forms and will not be included in any medical studies without the explicit and separate authorization of the patient.

Requests:

☐ I wish to file a "Request of Restricition" of my Protected Health Information"

☐ I wish to file a "Request for Alternative Communications" of my Protected Health Information

☐ I wish to object to the following in the Notice of Privacy Practices and I understand the practice is not required to honor these objections.

_____

_____

Permission:

☐ I don't grant permission for OSC to utilize texting or email in order to inform me of my appointments.

☐ I grant permission for OSC to utilize calls, texting or email in order to inform me of my appointments.

Signed:_____ Date:_____

Print Name:_____

☐ I grant permission to the following 3 people to call on my behalf

Authorized Person 1

Name:_____ Relationship to patient:_____
Date:_____

Authorized Person 2

Name:_____ Relationship to patient:_____
Date:_____

Authorized Person 3

Name:_____ Relationship to patient:_____
Date:_____

**********FOR OFFICE USE ONLY**********

Recieved by:_____ Date:_____

Good faith effort to obtain receipt (descrbe):_____

_____

_____

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Disclosure of Physician Ownership in Hospital

Dr. Raul Marquez [and/or an immediate family member (if applicable)] has an ownership interest in Cornerstone Regional Hospital. This disclosure was made at the time of my/my family member's referral for inpatient or outpatient services at Cornerstone Regional Hospital. Dr. Raul Marquez has advised me that I or my family member may receive care at another health care facility in which he does not have ownership interest. I understand that another physician may need to care for me or my family member if I choose another health care facility and Dr. Raul Marquez does not privileges at that facility.

_____ _____

Name of Patient/Legal Representative (print) Relationship if not signed by the patient

_____ _____

Signature Date Signed

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Accident Report
(Report de Accidente)

Name:_____

Date of Birth:_____

Work Related?_____
(accidente de trabajo)

Auto Accident?_____
(accidente automovilístico)

School Injury?_____
(accidente de escuela)

Other_____
(otro tipo de accidente)

Date of Accident:_____
(fecha de accidente)

History of Accident: (in your own words state when, where and how the accident happened) Historia del Accidente: (en sus propias palabras describa cuando, donde y como occurrio el accidente)

_____

_____

_____

_____

_____

I verify, to the best of my knowledge, that the information above is true and accurate. (Al firmar significa que la información

Signed:_____
(firma de persona responsable)

Date:_____
(fecha)

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Patient Name:_____

DOB:_____
SSN:_____

Consent for Treatment/Privacy Policy/Assignment of Benefits

The undersigned, being the patient and/or guaranteeing party to the above named account hereby acknowledges and agrees to the following:

I. CONSENT FOR TREATMENT: I hereby consent to the evaluation and management services provided by Dr. _____ of Orthopedic Surgery Center within this facility. Services may include diagnostic radiology. I understand that my consent may be revoked, in writing, at any time. However, such revocation does not release, any financial obligation for services already rendered.

Signed:_____ Date:_____

II. RELEASE/OBTAIN INFORMATION: The undersigned understands that Orthopedic Surgery Center may release to any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's health care bill, such information as is deemed minimally necessary for the proper and accurate processing of such healthcare claims. Further, the undersigned understands that Orthopedic Surgery Center may provide to outside healthcare providers/services such information as is necessary to facilitate proper healthcare, limited only to which is deemed minimally necessary on behalf of the patient.

Signed:_____ Date:_____

III. PRIVACY STATEMENT: The undersigned hereby acknowledges that he/she has received a copy of the Notice of Privacy Practices. Orthopedic Surgery Center will administer our patients records in a confidential manner and in compliance with the Health Insurance Portability and Accountability Act. A separate authorization must by executed for the non-routine release of Protected Health Information. Patient information shall not be sold to any outside marketing firms, and will not included in any medical studies without the explicit and separate authorization of the patient. I acknowledge and accept the terms and conditions set forth in Sections II and III of the policy statement:

Signed:_____ Date:_____

IV: STATEMENT OF FINANCIAL RESPONSBILITY: In considerate of medical treatment and service provided to the above named patient, the patient or the undersigned guarantor, unconditionally guarantees payment in full to Orthopedic Surgery Center. Orthopedic Surgery Center agrees to abide by the terms ND conditions set forth in individual managed care contracts with which the patient and physician both participate. Patients covered by insurance that do not have a managed care contract with Orthopedic Surgery Center understand that Orthopedic Surgery Center will submit claims for processing. However, the patient/guarantor is ultimately responsible for payment of the entire account balance regardless of insurance coverage or insurance benefit determination. Should an insurance carrier not pay on a claim within the mandatory 45-day state limit, the balance due will be the responsibility of the patient/guarantor. All co-pays are due at the time of service. Patients are ultimately responsible for providing timely and accurate insurance information. Failure to modify this office of changes in coverage may result in claims not being paid. Patients will be billed directly for any claims not paid due to the failure of the patient to provide accurate and timely information.

V. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned hereby authorizes any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's healthcare bill, including personal injury protection or medical payment coverage, to pay directly to Orthopedic Surgery Center.

I acknowledge and accept the terms and conditions set forth in Sections IV and V of this policy statement:

Signed:_____ Date:_____

Relationship to Patient:_____

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Medication List/ Lista de Medicamentos

Please list all your current medications you are currently taking:
(prescriptions and over-the-counter medications)

(Espanol)
Enumere los medicamentos que esta tomando actualmente:
(prescripciones and medicamentos de ventana libre)

NAME/ NOMBRE:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

_____ _____

Signature (Firma del paciente) Date (Fecha)

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Raul A. Marquez, M.D.
Daniel A. Romanelli, M.D.
(956)668-0060
2402 Cornerstone Blvd. 78539

Injections
(Inyecciones)

Date: _____
(Fecha)

Patient's Name: _____ DOB: _____
(Nombre de Paciente) (Fecha de nacimiento)

Any history of Diabetes: _____Yes/Si or _____No
(Historia de diabetes)

Risk and Benefits for Injection:

Benefits of this procedure includes reduced pain and increased flexibility. Hematoma, infections, no improvement of the symptoms, an allergic reaction, discoloration of the skin and or indenting of injection site. Please know there are no guaranteed for this procedure.

(Espanol)
(Riesgos y beneficios de la inyeccion)

Los beneficios de este procedimiento incluyen reducción del dolor y mayor flexibilidad. Hematoma, infecciones, sin mejoría de los síntomas, reacción alérgica, decoloración de la piel o sangría en el lugar de la inyección. Tenga en cuenta que no hay garantía para este procedimiento.
Post-op Injection Instructions:

- Soreness – Please rest (Dolor - por favor descansa)
- Ice injection site (aplicar hielo en el lugar de la inyección)
- 10 – 15 minutes
- Allow 2-3 days for full effect of the injection (Espere 2-3 días para que la inyección tenga pleno efecto)

_____
Patient's signature/ Firma del paciente

Please call our office if you have any concerns or persistent pain (956)668-0060.
Llame a nuestra oficina si tiene alguna inquietud o dolor persistente

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Knee Survey

Instructions: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to do your usual activities. Answer every question by selecting the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Stiffness

The following question concerns the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?

☐ None (4) ☐ Mild (3) ☐ Moderate (2) ☐ Severe (1) ☐ Extreme (0)

Pain

What amount of knee pain have you experienced the **last week** during the following activities?

2. Twisting/pivoting on your knee

☐ None (4) ☐ Mild (3) ☐ Moderate (2) ☐ Severe (1) ☐ Extreme (0)

3. Straightening knee fully

☐ None (4) ☐ Mild (3) ☐ Moderate (2) ☐ Severe (1) ☐ Extreme (0)

4. Going up or down stairs

☐ None (4) ☐ Mild (3) ☐ Moderate (2) ☐ Severe (1) ☐ Extreme (0)

5. Standing upright

☐ None (4) ☐ Mild (3) ☐ Moderate (2) ☐ Severe (1) ☐ Extreme (0)

Function, daily living

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

6. Rising from sitting

☐ None (4) ☐ Mild (3) ☐ Moderate (2) ☐ Severe (1) ☐ Extreme (0)

7. Bending to floor/pick up an object

☐ None (4) ☐ Mild (3) ☐ Moderate (2) ☐ Severe (1) ☐ Extreme (0)

Knee Score = _____