

 Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Height:\_\_\_\_\_ Weight:\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Practice Name:\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Name and Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/Member ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| Briefly describe your problem: |
| --- |
|  |
| Pain Level 1-10 (Ten being the worst pain): |
| Accident/Injury Related? YES ☐ NO ☐  | If yes, was it work related? YES ☐ NO ☐  | Date of Injury:  |
| Pending Litigation? YES ☐ NO ☐ | Pain Contract? YES ☐ NO ☐ DR? |
| **Medical History:** Are you or have you ever been treated for the following:  |
| ☐ Arthritis Type:  | ☐ Extremity Injury/ Deformity  | ☐ High Cholesterol  | ☐ Neuropathy  |
| ☐ Asthma  | ☐ Foot / Leg Ulcer  | ☐ Thyroid Disease | ☐ Osteoporosis / Low Vit D |
| ☐ Gout | ☐ DVT / Blood Clots | ☐ Kidney Disease  | ☐ Peripheral vascular disease  |
| ☐ Cancer Type:  | ☐ Hepatitis | ☐ Liver Disease  | ☐ Seizures  |
| ☐ Heart Attack  | ☐ Stroke | ☐ Migraines  | ☐ Sleep Apnea  |
| ☐ Coronary Artery Disease  | ☐ High Blood Pressure | ☐ MRSA  | ☐  |
| ☐ Diabetes Type 1 / Type 2 Last A1C? | ☐ Other:  |
| **Medication** ☐ **NONE**  | **DOSE**  | **Times/day?**  | **Allergies** ☐ **NONE**  |
| 1)  |   |   | ☐ Latex ☐ Tape ☐ Anesthetic ☐ Metal  |
| 2)  |   |   |  |
| 3)  |   |   | **Drug Allergies**  | **Reaction**  |
| 4)  |   |   | 1)  |   |
| 5)  |   |   | 2)  |   |
| 6)  |   |   | 3)  |   |
| 7)  |   |   | 4)  |   |
| **Past Surgeries** ☐ **NONE**  | **Year**  | **Complication?**  | **Social History**  |
| 1)  |  |  | ☐ Single☐ Married☐ Divorced☐ Widowed |
| 2)  |  |  | Occupation:  |
| 3)  |  |  | Alcohol: YES ☐ NO ☐ How Much?  |
| 4)  |  |  | Recreational DrugsType:  |
| 5)  |  |  | Tobacco/Nicotine: YES ☐ NO ☐ Packs/day:  |
| 6)  |  |  | If quit, when did you do so?  |
| **Review of Treatments:** Have you recently had any of the following treatments?  |
| Physical Therapy: ☐ 2 weeks ☐ 4 weeks ☐ 6 weeks **+**  | Steroid Injection: YES ☐ NO ☐ When?  |
| Visco/ Stem Cell Injection: YES ☐ NO ☐ When?  | Bracing: YES ☐ NO ☐ Type?  |
| Referred By? | Imaging? ☐ Xray ☐ MRI ☐ Nerve Conduction Study Where? |
| **Family History:**  **Please indicate**: **GF**=Grandfather **GM**=Grandmother **F**=Father **M**=Mother **S**=Sibling  |
| ☐ Father Deceased Cause: ☐ Mother Deceased Cause:  |
| Cancer: Type:  | Heart Attack:  | Bleeding Disorder:  |
| Diabetes:  | Foot Problems:  | Birth Defects:  |
| High Blood Pressure:  | Lung Disease:  | Stroke:  |
|  |
| **Review of Systems:** Have you recently had any of the following symptoms? ( Blank indicates "No Problem")  |
| General: ☐ Wt. Loss ☐ Wt. Gain ☐ Fever ☐ Night Sweats  | Skin: ☐Rash ☐ Itching ☐ Open sores Where:  |
| Eyes/Ears: ☐ Vision Loss ☐Double Vision ☐Hearing Loss  | Neuro: ☐ Numbness/Tingling ☐ Frequent Headaches  |
| Nose/Throat: ☐ Sinus Problems ☐ Nasal Drainage ☐ Sore Throat  | Endocrine: ☐ Cold intolerance ☐ Excessive hunger/thirst  |
| Heart: ☐ Chest Pain ☐ Palpitations ☐ Murmur ☐ Failure | M/S: ☐ Pain: ☐ Muscles ☐ Neck ☐ Back ☐ Hips ☐ Knees  |
| Lungs: ☐ Shortness of Breath ☐ Cough ☐ Wheezing  |  ☐ Cramping ☐ Stiffness ☐ Weakness  |
| GI: ☐Stomach Pain ☐Constipation ☐Diarrhea ☐Vomiting  | Psych: ☐ Anxiety ☐ Depression ☐ Memory Loss  |
| GU: ☐Frequent urination ☐ Painful urin. ☐ Difficult urin.  | Hematology: ☐ Anemia ☐ Excessive Bleeding ☐ DVT  |
| Signature: Date:  |

 **CONSENT FOR TREATMENT**

**Consent for treatment**: I voluntarily consent to receive care at BlackRock Orthopedics, its’ employees and contractors as well as members of the medical staff who are independent practitioners and not employees or contractors of BlackRock Orthopedics. Such care includes but is not limited to routine x-rays, injections, laboratory and other diagnostic procedures, medical treatment and other medical services as necessary in the treating physicians (or designees) judgment and normally provided by BlackRock Orthopedics. I am aware the practice of medicine is not a complete science and I understand that no guarantees have been made to me regarding the results of treatments or examinations.

**Consent for student/vendor**: As a patient, I understand that individuals being trained in healthcare may participate in my care. I also understand that healthcare vendors may be present during my care. I consent to their presence and assistance under general supervision.

**Photo Release:** As a patient, I understand that video and photography will be used for documentation, education, research, publicizing and other lawful purposes. If a photo or video is taken you will be asked for you permission each time and you will have the right to refuse any photo or video being taken. I hereby grant BlackRock Orthopedics permission to use my likeness in a photograph in any and all of its publications, including but not limited to all of BlackRock Orthopedics printed and digital publications. I understand and agree that any photograph using my likeness will become property of BlackRock Orthopedics and will not be returned.

I acknowledge that since my participation with BlackRock Orthopedics is voluntary, I will receive no financial compensation.

I hereby irrevocably authorize BlackRock Orthopedics to edit, alter, copy, exhibit, publish or distribute this photo/video for purposes of publicizing, educating, research, and documentation of BlackRock Orthopedics’ programs or for any other related, lawful purpose. In addition, I waive the right to inspect, or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation related to the use of the photograph.

I hereby hold harmless and release and forever discharge BlackRock Orthopedics from all claims, demands, and causes of action which I, my heirs, representatives executors, administrators, or and other persons acting on my behalf of on behalf of my estate have or may have by reason of this authorization.

**Health Insurance**: For your benefit, we are contracted with several insurance carriers. It is your responsibility to know your insurance policy and be familiar with your coverage and benefits. Each insurance company has its own rules for determining how much they will pay on each item/service. Your insurance policy is a contract between you and your insurance company. If you have any questions regarding coverage or payment of your services, we recommend that you contact your insurance company. We do perform insurance eligibility verification and prior authorizations as necessary prior to performing services. However, this process does not guarantee your plan will cover the services rendered. In the event your insurance carrier determines a service or supply is “not covered” based on your health plan, you (the patient) are responsible for the complete charge for that service. With this agreement, you authorize the payment of insurance benefits to Blackrock Orthopedic Specialists, LLC and understand that you are financially responsible for all charges regardless of your insurance. In addition, you authorize the release of any information acquired during examination or treatment, to and from any medical facilities, physicians, and/or your insurance company.

**No Insurance Policy:** Patients with no insurance coverage are expected to pay the full amount toward their service on the day of clinic service. Patient who needs surgery who do not have insurance coverages are expected to pay the full amount at the time they are scheduled for surgery.

**Canceled/No show Appointment:** Please understand that when a patient does not cancel an appointment, he or she is unable to keep, it may prevent other patients from receiving care they need. Therefore, a fee of $50 for appointments not cancelled within at least 24 hours will be charged. A patient who fails to keep three or more appointments in a twelve-month period—without prior notice of cancellation—may be discharged from BlackRock Orthopedics at the discretion of the patient’s physician and group.

**Financial Obligation, Payment Terms & Options**: It is our policy that you pay any co-payments, co-insurance, deductibles, equipment fees, non covered surgery fees or self-pay fees at the time of service. You have a legal right to opt out of using your insurance for services and instead choose to pay our self-pay rates. If you do not have proof of insurance or opt to pay cash for services, you will be expected to pay in FULL at the time of service. To avoid incurring additional charges, account balances must be paid in full within 90 days of date of service. If you are unable to pay your account balance in full within 90 days, please contact our billing department to set up a payment plan. Your account will be turned over to collections if you fail to pay your account in full or set up a payment plan with our billing department within 90 days of date of service. If your account is transferred to collections, you will need to pay the balance in full before scheduling another appointment. There will be a $75 charge for any checks returned to us for non-payment.

**Assignment of benefits**: I authorize assignment of insurance benefits to be paid directly to BlackRock Orthopedics for all medical services rendered.

**Prescription history consent**: I hereby give consent to BlackRock Orthopedics and its’ employees to obtain my prescription history from any pharmacy that has dispensed any medication to me for the purpose of establishing my treatment history.

**Patient Signature:** I acknowledge that I have received notice of BlackRock Orthopedics financial Policy and agree to pay for said medical services according to such terms.

This signature or electronic confirmation represent that I have read and agreed to the above policy. Failure to sign or accept electronically this authorization would result in BlackRock Orthopedics being unable to provide services for me.

**FMLA, Disability & Other Forms** Please allow up to 5-7 business days for the completion of any forms, prior authorizations, or letters. Certain forms may require a processing fee of $50 that is required at the time of pickup of said form(s).

**Medical Records** In accordance with the Health Information Portability and Accountability Act (HIPAA), we will not release any information pertaining to your medical records without your written consent. You may fill out an Authorization to Release Medical Records to facilities and person(s) of your choice. This form is available in our office at your request. This is an agreement between Blackrock Orthopedic Specialists and the patient named below. By signing this agreement, you are acknowledging that you understand and agree to all our policies. I have read, understand, and agree to comply with these policies. A photocopy of this agreement shall be as valid as the original.

**Billing/Coding**: Each procedure that your doctor performs has a billing code. Your provider codes your services according to guidelines and must use the correct codes for the procedures done. Providers use these codes when they submit claims to insurance companies. If your insurance company does not cover some or all the charges, you will be billed for any outstanding balance not covered under your policy. Billing errors can be fixed but it’s fraudulent for your provider to manipulate the coding system to satisfy payer or patient coverage rules.

Please contact your employer or insurance company if you have questions about coverage.

I acknowledge that a copy of the Notice of Privacy Practices for Blackrock Orthopedic Specialists is available at my request.

Thank you.

**Acknowledgement of Receipt of Privacy Notice**

I have been presented with a copy of BlackRock Orthopedics **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

Please circle one.

Are you willing to have photos and videos posted on social media? Yes No



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SIGN DATE



Internal Use Only:

If patient or patient’s representative refuses to sign acknowledgement of receipt of notice, please Document the date the time the notice was presented to patient and sign.

8/12/2022