

**MIDWEST ORTHOPAEDIC CONSULTANTS**

Please complete this entire form, and present your insurance cards for billing purposes.

**PATIENT INFORMATION SHEET**

Patient Name: \_\_\_\_\_  
Last First MI

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

City, State, Zip: \_\_\_\_\_

Sex: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

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

Emergency Contact  
 Name & Phone: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Location: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_  
Last First

Office Location: \_\_\_\_\_

Referring Physician: \_\_\_\_\_  
Last First

Office Location: \_\_\_\_\_

**WORK-COMP**

Adjuster/RN Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Is your visit due to a work related incident? Yes No  
 If you answered yes to the questions above, please provide the date,  
 and a brief description of the accident and your injury:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PRIMARY INSURANCE CARRIER:**

Ins. Co. Name: \_\_\_\_\_

(if PPO or HMO please identify Plan) \_\_\_\_\_

**Policy Holder Information:**

Name: \_\_\_\_\_  
Last First MI

Policy Holder Sex: M  F  Birth Date: \_\_\_\_\_

Policy Holder Social Security #: \_\_\_\_\_

Policy Holder relationship to patient:  Self  Spouse  Parent

Insurance ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Employer: \_\_\_\_\_  
(of Ins Policy Holder)

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

City, State, Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

**SECONDARY INSURANCE CARRIER:**

Ins. Co. Name: \_\_\_\_\_

(if PPO or HMO please identify Plan) \_\_\_\_\_

**Policy Holder Information:**

Name: \_\_\_\_\_  
Last First MI

Policy Holder Sex:  M  F Birth Date: \_\_\_\_\_

Policy Holder Social Security #: \_\_\_\_\_

Policy Holder relationship to patient:  Self  Spouse  Parent

Insurance ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Employer: \_\_\_\_\_  
(of Ins Policy Holder)

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

City, State, Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

I authorize the release of all medical information necessary to process my insurance claim. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Midwest Orthopaedic Consultants. I understand that regardless of my insurance, I am financially responsible for the fees for services rendered and all collection and attorney fees if applicable. A photocopy of this assignment is considered as valid as the original. This assignment will remain in effect until revoked by me in writing. If the balance is not paid at the time of service, for whatever reason, it is agreed that our office is extending credit to you as a courtesy. If credit is extended, you authorize our office and/or our agents to access your consumer credit report.

Patient Signature: \_\_\_\_\_  
 (Parent/Guardian) \_\_\_\_\_ Date: \_\_\_\_\_

## Release of Medical Information

My Medical Care may be discussed with:

Name: \_\_\_\_\_

Yes       No

DOB: \_\_\_\_\_

Relation: \_\_\_\_\_

Name: \_\_\_\_\_

Yes       No

DOB: \_\_\_\_\_

Relation: \_\_\_\_\_

\*I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance upon the authorization.

Test Results may be left on my answering machine/voice mail.

Yes       No

Appointment information may be left on my answering machine/voicemail.

Yes       No

**If Applicable, for personal representative:**

Print name of Personal Representative: \_\_\_\_\_

Describe Personal Representative relationship: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

\*Please note we do require documentation for personal representatives.

## HEALTH CARE CONSENT

1. **To Treat.** I, for myself (or the patient named below), hereby consent to such diagnostic procedures and medical treatment as necessary and appropriate for my condition or illness in a department of Midwest Orthopaedic Consultants, hospital or for a course of outpatient treatment in the judgment of my physician(s), to be performed by Midwest Orthopaedic Consultants' physicians, nurses and other healthcare providers/staff. I understand that the physicians, nurses and other healthcare providers in training may, under the supervision of appropriate personnel, participate in my treatment and I consent to such involvement in my care.
2. **Responsibility for Payment.** In consideration of services to be rendered by/at Midwest Orthopaedic Consultants, the undersigned agrees, as patient or guarantor for patient, to pay Midwest Orthopaedic Consultants for all services, facilities and supplies provided to me or the patient at the established rates, including any deductible, copayment or charges not covered by third party payors. I accept responsibility for any costs, including attorneys' fees, incurred in the collection of these charges. I understand that if I do not consent to release of records or later revoke such consent, I am fully responsible for payment of all charges for diagnosis and treatment received. I certify that the information given by me for purposes of payment for this treatment is, to the best of my knowledge, complete and accurate. I understand that if I am having difficulty in meeting my payment responsibilities to Midwest Orthopaedic Consultants, financial contract arrangements are available upon request.
3. **Assignment of Benefits.** In consideration of services rendered at/by Midwest Orthopaedic Consultants, I hereby assign and authorize direct payment to Midwest Orthopaedic Consultants, any insurance, health plan, or third party payor benefits otherwise payable to me or on my behalf for these services.
4. **Medicare Payment & Assignment of Benefits (if applicable).** I request that payment of authorized Medicare benefits be made on my behalf for services furnished to me at Midwest Orthopaedic Consultants and I assign such benefits to Midwest Orthopaedic Consultants. I certify that the information given by me in applying for such benefits is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed for payments of such benefits. I authorized Social Security Administration to release information about my entitlement to benefits to Midwest Orthopaedic Consultants providing services to me.
5. **Release of Medical Information for Payment.**
  - A. **General Release for Payment.** I hereby authorize Midwest Orthopaedic Consultants to release any and all pertinent information obtained in my medical records including HIV, mental health, and/or substance abuse to third party payers responsible for payment of patient charges including, but not limited to, insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above.
  - B. By initialing in the space below, I do not consent to the release of medical information concerning HIV, mental health, substance abuse diagnoses or treatment, if any, to third party payers and understand that I am personally responsible for payment for services. HIV \_\_\_\_\_ Mental Health \_\_\_\_\_ Substance Abuse \_\_\_\_\_
6. **Duration & Revocation of Authorization for release of information for billing.** This authorization to release information related to payment expires upon satisfactory payment of the bill. This authorization (or the refusal under paragraph 5B) may be revoked at any time by written notice to the Medical Records Department (with no effect on prior disclosures). If I revoke this authorization prior to satisfactory payment, I understand and accept that I am personally responsible for payment of all outstanding charges.
7. **Personal Belongings.** I assume full responsibility for all items of personal property including, but not limited to, eyeglasses, hearing aids, dentures, jewelry, currency and all other valuables. I hereby release Midwest Orthopaedic Consultants of responsibility and liability for those valuables and items of personal property.
8. **Credit Card Payment Authorization.** I hereby authorize Midwest Orthopaedic Consultants to use my credit card for copays, co-insurance, non-covered services, or other balances that are my financial responsibility if not paid within 45 days of service.  
Credit Card Type \_\_\_\_\_ # \_\_\_\_\_ Expiration \_\_\_\_\_
9. **Interest.** 1.5% interest will be accrued, per month, on balances due as described above after the aforementioned 45 days.

**I have read and understand the above terms of treatment and confirm that I am the patient or authorized to sign on the patient's behalf.**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Witness Signature \_\_\_\_\_  
(or patient/legal guardian/personal representative) (If not signed by patient)

**PATIENT ACKNOWLEDGEMENT OF RECEIPT  
OF THE NOTICE OF PRIVACY PRACTICES**

By signing this form, I am acknowledging the right to review the Notice of Privacy Practices of Midwest Orthopaedic Consultants. A copy of the Privacy Practices is available in the lobby for the patient review. Copies are available upon request.

**E-PRESCRIBING**

MIDWEST ORTHOPAEDIC CONSULTANTS is in the process of implementing e-Prescribing in each of our offices. E-Prescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011. E-Prescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. E-Prescribing software also lets your doctor see important information – like drug interactions and your prescription history.

The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescription filled

**Patient Consent:**

Approve Authorization

Decline

**CANCELLATION/NO-SHOW POLICY**

MIDWEST ORTHOPAEDIC CONSULTANTS makes every attempt to provide prompt medical service to our patients. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. We require a 24-hour advance notification for the cancellation of a scheduled appointment, EMG or MRI. Failed office appointments or "No-Shows" will be assessed a \$30.00 administration fee not covered by your insurance. Failed EMG or MRI appointments or "No-Shows" will be assessed a \$100.00 administration fee not covered by your insurance. Fees are subject to change without prior notice.

**AUTHORIZATION TO ACCESS THE PATIENT PORTAL**

Our patient portal grants the patient or the guardian of the patient access to the health records of the patient. This also allows you to send a message to the doctors through the portal. After consenting, you will receive an e-mail with a link that will bring you to the setup of the patient portal. An e-mail is required in order to gain access to the patient portal; if no e-mail is given your access will be declined.

Approve Authorization

Decline

Patients Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

## Prescription Refill Policy

Patient Name: \_\_\_\_\_

MR#: \_\_\_\_\_

At Midwest Orthopaedic Consultants we specialize in the diagnosis and treatment of Orthopaedic conditions. During your treatment, a broad range of medications may be prescribed to help relieve your pain. The providers of this office may prescribe controlled substances for acute injury conditions such as fracture, or during the postoperative period, etc. If used properly, these medications or controlled substances are extremely effective; however, if used in excess, they have the potential for serious adverse side effects such as altered consciousness, impaired judgments, constipation, lethargy, organ damage, and even death.

It is the policy of our practice, in accordance with federal law, to minimize the use of these controlled substances due to their addictive nature. Our providers may prescribe controlled substances for up to a 90-day period that begins with your first narcotic prescription or the first day after surgery. After the 90-day period, if your condition still requires these controlled medications, you will be referred to either your primary care physician or a pain management specialist. It is in your best interest that your future requirements of these medications be prescribed and monitored by a specialist in pain control.

Narcotic/non-narcotic medications this policy covers include: Hydromorphone, Hydrocodone, Lortab, Lorcet, Morphine, MS Contin, Oxycodone, Percocet, Vicodin, Tramadol, Tylenol 3 & 4, Ultram, Ultracet, and other potentially addictive medications such as diazepam, Valium, Xanax and Soma, etc.

*As a patient of MOC, I acknowledge and accept the following standards of MOC:*

- 1. As a patient, I am responsible for my controlled substance medication. A prescription will only be used by me and taken as prescribed. It will not be replaced if it is lost, stolen, misplaced or depleted sooner than prescribed.*
- 2. I will not operate a motor vehicle, use heavy equipment, or consume alcohol when medicated.*
- 3. I will keep all scheduled appointments related to my condition.*
- 4. I understand that it may take up to 48 hours for any narcotic/non-narcotic refill. I will not call for medications after 3 p.m. weekdays, or during weekends and holidays. I understand that the physician or physician assistant will need to review my file prior to renewing my prescription and those records are not available after hours, on weekends and holidays. I will call for refills at least 2 days before running out of my medication.*
- 5. I understand that certain medication refills may not be refilled over the phone and that written prescriptions in those cases are required.*
- 6. I understand that a doctor's prescription may never be altered or changed or I will immediately be dismissed from the practice and reported to law enforcement. I will not seek or receive any pain medications from other physicians while under MOC care. (Unless in a hospital).*
- 7. I understand and agree that if I violate any part of this agreement that I may be discharged from the practice immediately. I have been informed of the inherent risks of using these types of medications that can include dependency (withdrawal if eliminated abruptly), addiction (psychological dependence), and physiological dependence (the use and need of more or stronger dosed medication due to tolerance to regain adequate pain relief).*

Signature of Patient/Guardian \_\_\_\_\_

Date: \_\_\_\_\_ policy 6132017