MIDWEST ORTHOPAEDIC
MOC
CONSULTANTS

MEDICAL HISTORY FORM

(Please answer all questions)

Name: _____ Age: _____ Date of Birth: _____

Occupation (if retired, previous occupation): _____ Height: _____ Weight: _____

Primary Care Physician: _____

Reason for your visit/Area affected (e.g., right hand, left knee): _____

_____ Hand Dominance: ☐ R ☐ L

Date of Injury? _____ Type of Injury? ☐ home ☐ work ☐ auto ☐ other: _____

How long have you had this present condition? _____

Have you had any previous treatment for this condition? _____

_____

PAST MEDICAL and FAMILY HISTORY:

Have you or a family member had problems with any of the following? Please indicate "Yes" with an X and indicate which family member.

DISEASE/CONDITION	Self	Family
High Blood Pressure	☐	☐
Diabetes Mellitus	☐	☐
High Cholesterol	☐	☐
Angina/MI/Cardiomyopathy	☐	☐
Heart Valve Problem/Rhythm Problem	☐	☐
Stroke/TIA/Seizures	☐	☐
Asthma/COPD/Emphysema	☐	☐
GERD/Ulcers/Colitis	☐	☐
Hepatitis/Liver/Gallbladder	☐	☐
Kidney Failure/Stones	☐	☐
Urinary Tract Infections/BPH	☐	☐
Cancer	☐	☐
Arthritis/Osteoporosis	☐	☐
Bleeding/Clotting Disorder	☐	☐
Anemia/Sickle Cell Anemia	☐	☐
Thyroid/Endocrine Problem	☐	☐
HIV/AIDS	☐	☐
Tuberculosis	☐	☐
Psychiatric/Mental Disorder	☐	☐
Psoriasis/Eczema	☐	☐
Other	☐	☐

Describe all "Yes" responses

_____

PAST ORTHOPAEDIC SURGICAL HISTORY:

Procedure: _____ Surgeon _____ Year _____

Procedure: _____ Surgeon _____ Year _____

OTHER SURGICAL HISTORY:

Procedure: _____ Year _____

Procedure: _____ Year _____

MEDICATIONS: Please list the names of the medications you are currently taking (prescription/non-prescription/herbal supplements/vitamins/other):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: Please list type of allergy (medications, latex, tape, food, etc.) and type of reaction you experience:

_____

SOCIAL HISTORY:

Smoking Status: ☐ Never a smoker ☐ Currently smoke every day ☐ Currently smoke occasionally
☐ Former smoker ☐ Unknown smoking status

How many alcoholic beverages do you drink per week? _____

Marital status: ☐ single ☐ married ☐ divorced ☐ widowed Who do you live with? _____
Are you pregnant? ☐ yes ☐ no ☐ unknown Breastfeeding? ☐ yes ☐ no

REVIEW OF SYSTEMS:

Have you ever experienced or do you currently have any of the following signs or symptoms? If "Yes", please describe:

SYMPTOMS	Yes	No	Describe all "Yes" responses
Eyes (e.g. blurred vision, double vision, loss of vision)	☐	☐	_____
Ears, Nose, Throat (e.g. sore throat, earache, ringing)	☐	☐	_____
Cardiovascular (e.g. chest pain, palpitations, ankle swelling)	☐	☐	_____
Respiratory (e.g. shortness of breath, cough, snore)	☐	☐	_____
Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)	☐	☐	_____
Genitourinary (e.g., burning, bleeding or difficulty urinating)	☐	☐	_____
Musculoskeletal (e.g., joint, muscle, back or neck pain)	☐	☐	_____
Skin (e.g. delayed healing, rash, acne, cellulitis, psoriasis)	☐	☐	_____
Neurological (e.g. numbness, tingling, weakness)	☐	☐	_____
Mental Health (e.g. depression, anxiety, memory loss)	☐	☐	_____
Endocrine (e.g. weight gain/loss, excess thirst or urination)	☐	☐	_____
Hematologic (e.g. bruising, bleeding or clotting disorder)	☐	☐	_____
Allergic/Immunologic (e.g. rash, swelling, wheezing)	☐	☐	_____

I have reviewed the above information.
Patient's Signature: _____ Date: _____

Follow-up Patient Statement:
☐ I have reviewed the above information and have made updates to the original form. ☐ There are no changes.
Date: _____ Initials: _____

OFFICE USEONLY

Provider Statement: I have reviewed the above information.

Provider's Signature: _____ Date: _____

Follow-up Provider Statement: I have reviewed the above information and have noted updates if applicable.

Provider's Signature: _____ Date: _____

MIDWEST ORTHOPAEDIC MOC CONSULTANTS

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:** _____

MIDWEST ORTHOPAEDIC MOC CONSULTANTS

10719 West 160th Street • Orland Park, Illinois 60467 • (708) 226-3300 • Fax (708) 226-3500
4220 West 95th Street • Oak Lawn, Illinois 60453 • (708) 226-3300 • Fax (708) 226-3500

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.

MIDWEST ORTHOPAEDIC
MOC
CONSULTANTS

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)

MIDWEST ORTHOPAEDIC MOC CONSULTANTS

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:** _____

MIDWEST ORTHOPAEDIC CONSULTANTS

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