

Valley Orthopaedic Specialists

www.vosct.com

Medical Intake Form

Patient Name: _____ Date: _____

Address: _____

Date of Birth: _____ Phone: _____ Cell: _____

Parent/Spouse: _____

Emergency Contact: _____

Social History

Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Occupation	<input type="checkbox"/> Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Disabled	
Children	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How many:	_____
Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Occupants:	_____
Substance abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How often:	_____
Tobacco	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How long:	_____
Drink alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How often:	_____

Chief Complaint: _____

What is the reason for your visit today?

Is your current problem the result of (check): Car Accident Work Accident Sports Injury Other Accident

What was the date of injury: _____

Briefly describe how the injury or accident occurred:

Do you have an attorney for this injury/accident? If so, please provide our office with the contact information.

Name: _____ Address _____

Treatment thus far (if, yes provide date, location & extent of treatment):

Emergency Facility Evaluation _____

X-rays/MRI/Radiology _____

Physical Therapy/Chiropractic _____

Pain medications _____

Current Medications	Dosage	Times a day
<i>Please feel free to provide us with a list of your medications</i>		

Are you taking any herbal or diet supplements? Yes No If yes, please specify _____

Allergies: _____ None

Medical and Injury History

Describe your Pain:

Aches Throbbing Stabbing Numbness Burns Tingles Other _____

Rate your pain on a scale of 1 to 10, with 1 being pain free and 10 being the worst pain imaginable (circle).

Please mark these drawings with an "X" according to location of your pain

Current pain

+++++
1 2 3 4 5 6 7 8 9 10

Best pain gets

+++++
1 2 3 4 5 6 7 8 9 10

Worst pain gets

+++++
1 2 3 4 5 6 7 8 9 10



FRONT



BACK

What makes your pain worse? _____

What makes your pain better? _____

Are you currently having or have you had problems with (circle):

Describe all circled responses

Ears Nose, Throat Lungs Breathing _____

Digestion Bowel movement Bladder problem _____

Diabetes High blood pressure Bleeding problems _____

Balance problems Numbness/tingling Blackout/fainting _____

Psychological problems _____

AIDS Cancer Polio _____

Other _____

Do you or anyone in your family have a history of (circle):

Diabetes Cancer Heart disease Bleeding disorders Anesthesia problems

Other _____

If so, who? _____

Patient Name _____

Signed _____

Physician signature & date



Valley Orthopaedic Specialists

Experience you can trust

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I AUTHORIZE Valley Orthopaedic Specialists, LLC to release my health insurance companies and its agents any medical information needed to process my medical claim and release medical information to participating providers as needed. I understand that my records may contain information regarding diagnosis or treatment of specific diseases including psychiatric, drug / or alcohol abuse, sexually transmitted diseases, HIV test results, and related information. I give my specific authorization for these records to be released.

_____Initials

CONSENT FOR TREATMENT

I consent for medical treatment for myself or for the patient who I am a parent or legal guardian. I also understand that if the patient is a minor (under the age of 18 yrs old), a parent or a legal guardian must attend all appointments.

_____Initials

ASSIGNMENT OF MEDICAL BENEFITS / GUARANTEE OF FINANCIAL RESPONSIBILITY

I request that payment of authorized medical benefits be made directly to VALLEY ORTHOPEDIC SPECIALISTS, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I AM FINANCIALLY RESPONSIBLE for all charges whether or not paid for by said insurance. In the event that I fail to pay charges due, and VALLEY ORTHOPEDIC SPECIALISTS, LLC refers my account to collection, I agree to pay costs of collection including a reasonable attorney fee.

_____Initials

For MEDICARE PATIENTS this applies to the SOCIAL SECURITY ADMINISTRATION, THE CENTER for MEDICARE and MEDICAID SERVICES or its intermediaries or carriers.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

_____Initials

Patient /Parent or legal Guardian (please print)

Date

Patient /Parent or legal Guardian Signature

Date

Financial Policy

Thank you for choosing VOS as your health care provider. We are committed to the successful treatment of your condition. Payment of your bill is considered part of your treatment and a clear understanding of our financial policy is important to our professional relationship.

We will bill your insurance as a courtesy to you with a copy of your current insurance card. If you do not have your insurance card, full payment is due at the time of service. We accept cash, check, credit, and debit cards. There will be a \$25 charge for returned checks. If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility.

Medicare: We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance we will bill it for you. Any remaining balance will be billed to you.

HMO/PPO/Commercial: All co-payments are due at the time of service, we are members of most, but not all plans. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan.

Workers Compensation: If you are here as a result of work related injury, we will require information regarding both health insurance and your employers Workers Compensation insurance. We will require a letter or statement authorizing your treatment from your employer or WC carrier. The letter should include the claim number, address, adjusters name and phone number. Your employer's human resource office should be able to assist you with obtaining this information. If payment is not received, the balance is your responsibility.

Accident Claims: If you are here as a result of an auto related injury, we will require information regarding both health insurance and your auto insurance. We will require a letter or statement authorizing your treatment from your auto insurance. The letter should include the claim number, address, adjusters name and phone number. Your auto insurance agent should be able to assist you with obtaining this information. If payment is not received, the balance is your responsibility.

UCR (USUAL AND CUSTOMARY RATE): We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR rates.

Self Pay: A minimum deposit of \$200 or the actual charges, whichever is less, is due at the time of service for all self-pay patients. Currently VOS offers a 20% prompt pay discount on charges paid in full at time services are rendered. Any subsequent visit charges will be due at time of service. If you cannot pay in full, you will need to set up and adhere to a payment plan with our billing department. We accept Visa, Master Card, Discover, American Express, Checks and Cash.

Delinquent accounts: Delinquent accounts may be assigned to a collection agency. All collection costs will be added to your outstanding balance. We cannot be involved in negotiating payment for divorce orders for medical bills. Whichever parent brings the minor child in for treatment will be responsible for payment of the bill regardless of your divorce decree.

Forms Completion/Medical Records Requests: From time to time various forms including but not limited to disability and FMLA forms need to be filled out. There will be a \$10.00 charge to complete these forms. There is a nominal fee for copying medical records in accordance with the state allowance. There is a \$5.00 per film charge to copy x-rays.

Consent for Medical Treatment: I authorize physicians and personnel to render medical treatment and evaluation if needed for this appointment and all future appointments. I further authorize X-rays, injections, casting, or other diagnostic tests and treatments that may be necessary.

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with VOS and have provided to the best of my ability the information requested accurately and completely.

Signed (patient, parent or authorized individual)

Date