THE ORTHOPAEDIC INSTITUTE
SOUTHERN ILLINOIS
WESTERN KENTUCKY

Today's Date: ___/___/_____

Patient Demographics:

Last Name: _____ First Name: _____ Middle: _____ Date of Birth: _____ **Age:** ____

Height: _____ Weight: _____ Sex: Male Female SSN: _____ Hand Dominance: Left Right

Address: _____ City: _____ State: ____ Zip: _____ **Email:** _____

Primary #/Cell #: _____ Secondary #: _____

Emergency Contact Name: _____ Emergency Contact #: _____

Who can we speak with regarding your care: _____ _____

Primary Physician: _____ Referring Physician: _____

Have you previously been seen by any of our OI providers: *(circle)* *Other:* _____

OISI: M. Davis JT Davis Golz JWood Barr Miller Morgan Brown Young Jones Lee

OIWK: Jackson DeWeese Patel Hill Romine Strenge Beck Adams Ruxer Kern Lindenberg Patton

Have you seen any other physician regarding this condition prior to coming to our office: Yes No *If yes complete below*

Physician Name: _____ When: _____ Treatment: _____ Results: _____

Chief Complaint/Details of Injury:

Chief Complaint: _____

What Body Part: _____ Left Right Both

When did the symptoms begin/Date of onset: _____

Where did this happen: Home School Work MVA/Auto Sports Other: _____

How did this happen: _____

****If you are over 55, have you had an Osteoporosis screening visit within the last 2 years? Yes No**

History of Present Illness: *circle when applicable*

Previous similar problems or complaints: _____

Severity of your pain: 1 (mild) 2 3 4 5 6 7 8 9 10 (severe)

Character of your pain: Dull Sharp Achy Piercing Burning Stabbing Throbbing Other _____

What makes your symptoms worse: Time of day Daily Activity Driving Sitting Standing Lifting Other _____

How long does the pain last: _____

Associated symptoms: Swelling Giving Way Fatigue Numbness Radiating pain Joint Pain Other _____

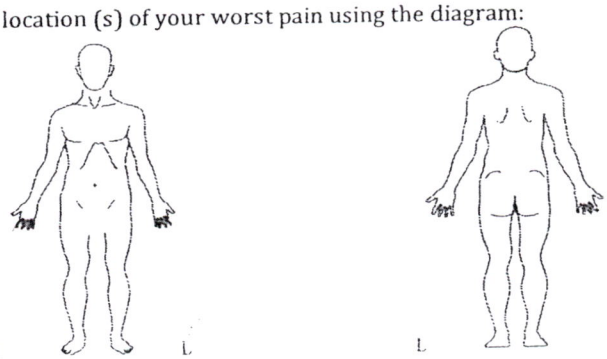
What makes your symptoms better: No movement Heat Ice Sitting Standing Rest Other _____

Previous treatment for the problem: (medications, therapy, injections, bracing) _____

Any special diagnostic tests or studies done: X-rays MRI NCS Labs Other: _____ Where: _____

Similar complaints on the opposite side: _____

PAIN DRAWING Place x's at the location (s) of your worst pain using the diagram:



Past Medical History: *Applies to the patient*

Medical Condition	YES	NO	Explanation
Arthritis			
Heart Disease			
High Blood Pressure/Hypertension			
Elevated Cholesterol			
Lung Disease			
Do you require Oxygen?			
Sleep Apnea			
Diabetes *(circle)* Type 1 or Type 2			
Thyroid Problem			
Kidney/Liver Disease			
Cancer Type? _____			
Ulcer Disease (Peptic)			
Stroke			
Hepatitis			
AIDS/ Immune Deficiency			
Blood Clots/Pulmonary Embolism			
Osteoporosis			
Bone Density Test			
Date menopause or LMP			
Other Orthopedic Conditions			
Living Will?			

Current Medications: ***Include ALL medications and dosage including over the counter drugs & supplements***

Medication & Dosage	Medication & Dosage

If taking, date you began using NSAIDS (Motrin, ibuprofen, naproxen)? _____

Preferred Pharmacy: _____ Location: _____

Allergies: ☐ *No Known Allergies*

Latex: Yes No Reaction: _____ **Metal:** Yes No Reaction: _____ **Food:** Yes No Reaction: _____

Medication Allergy (specify)	Adverse Reaction

Prior Surgeries: *applies to the patient*

Do you have a Pacemaker or other implants? Yes No What Type: _____

Prior Transfusion? Yes No

Type of Surgery	Date	Provider/Where	Any Complications

Social History: *circle when applicable*

Marital Status: Single Married Divorced Widowed Life Partner Other:_____ Number of Children: _____

Occupation: _____ Employer: _____

Work Status: Working Unemployed Disabled Homemaker Laid off On Leave Retired Date of Retirement: _____

Have you been off work from this current injury: Yes No Date last worked: _____

Is this a: Workman's Compensation Claim: Yes No Liability Claim: Yes No Auto Accident: Yes No

Have you ever used tobacco: No/Never Yes Type: Cigarettes Chew/Dip Cigar Other How often: ____ Quit/when: ____

Do you drink alcohol: Yes No Formerly Frequency: Daily Monthly Occasionally Rarely Socially Amount: _____

Recreational Drug Use: Yes No Type: _____ Frequency: _____

Do you have any specific hobbies/recreational pursuits: Yes No Describe:_____

Do you participate in any organized sports: Yes No Describe: _____

Family History: *Do any of your immediate relatives (mother, father, brother, sister) have any of the following?*

Illness	Yes	No	Explain
Cancer			
Heart Disease			
Diabetes			
Other:			

Review of Systems: *Applies to the patient for Today's Visit. Please explain positive answers.*

Symptom	Yes	No	Explain	Symptom	Yes	No	Explain
Fever				Urinary Problems			
Chills				Urinary Incontinence			
Night Sweats				Cold Intolerant			
Weight Loss (last 6 months)				Heat intolerant			
Weight Gain (last 6 months)				Difficulty Walking			
Blurred Vision				Muscle Weakness			
Headache				Depression/Psychiatric Concerns			
Hearing Loss				Rash			
Cough				Skin Lesions			
Shortness of Breath (Dyspnea)				Bleeding			
Chest Pain				Bruising			
Irregular Heart Beat				Back or Neck Problems			
Abdominal Pain				Numbness/Tingling			
Heartburn				Weakness/Paralysis			
Bloody or Black Tarry Stools				Other:			

Other:

Have you EVER had a Pneumonia Vaccine? Yes No Approx. Date: _____

Have you had your yearly Flu Shot? Yes No Date: _____

Are you currently under contract with Pain Management: Yes No Name of provider: _____

Are you a patient at a skilled nursing facility: Yes No Which facility:_____ Phone: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

The Orthopaedic Institute of Western Kentucky

Billing Information, Financial Policy, Information Release

Billing Information

An insurance claim for fracture care will typically appear as follows, as it is considered **Surgery**:

1. **Exam** at the documented level for diagnosis/decisions about the best treatment options
2. An **x-ray** is often used to diagnose the fracture and/or a post fracture treatment x-ray to ensure proper alignment.
3. A Fracture Code will be assigned based on the site, type of fracture, and whether the treatment is *closed* or *open*. Open treatment is most often performed in an operating room at a surgery center or hospital. Closed treatment is often done at the emergency room or in the office. **However, all fracture treatment is considered "Major Surgery" and will often times be reported as surgery on your insurance company Explanation of Benefits (EOB).**
4. The **Cast Application** for the initial work of applying the cast is included in the above Fracture Code at no charge. Subsequent applications are separately reported and billable.
5. **Cast Supplies** are reported separately and billable.
6. **Subsequent Fracture Care:** Most "routine" fractures will require several post operative visits which are included at no charge in the fracture/surgical fee if related to the same diagnosis for 90 days. Subsequent xrays, cast applications and supplies are separately billable. Some fractures may need additional surgery, procedures, or physical therapy that are not included in the fracture fee. There are special rules our office required to use to report those services.

This office is required by Federal compliance law to report the services provided based on the documentation in the medical record. As a matter of policy, we cannot improperly alter a claim for the purpose of obtaining payment. If you discover a bona fide billing error, duplicate charge, or other posting error, we would greatly appreciate you bringing the matter to the attention of our business office staff for further investigation, upon which further, corrective action may be taken. If you receive a questionnaire from your insurance asking how your injury occurred, please complete the form, and return to them promptly. Your insurance company will not pay until the form is returned to them.

Insurance coverage and payment amounts vary greatly by payer. If you have any questions about your particular coverage, it is best to inquire with your insurance company's representative. Our business office staff is happy to assist in the claims filing process for prompt adjudication and payment of your insurance claim.

Financial Policy

Contracted Insurances: Medicare, Railroad Medicare, Kentucky Medicaid, Health Alliance HMO, Health Alliance PPO, Healthlink HMO (Tier I), & Healthlink PPO (Tier II), Aetna, Wexford, Corvel, Group Health Plan, Anthem BC/BS, Federal BC/BS Plan, UMWA H&R Fund, Harmony Health, and United Healthcare. Any Co-Payments assigned by your specific insurance plan are due at the time of service.

Private Insurance: We will submit your claim to your insurance company for payment. You are responsible for paying all balances not paid by your insurance company. Your insurance policy is a contract is a contract between you and your insurance company – we are not a party to that contract. If your insurance company does not remit payment within 90 days, you are ultimately responsible for your balance due.

No Insurance: Full payment is due at the time of service unless you have made prior arrangements with a member of our billing department by calling 270-450-7224. We gladly accept payment via cash, check, VISA, MasterCard, or Discover.

Workers' Compensation: Charges will be submitted for you IF all information has been fully furnished and agreed to by your employer. You are required to provide us the claim number, name, address, and contact information of your compensation carrier. IF all information is not provided, we assume and expect payment from you. "I authorize any treating physician or provider to communicate orally, or in writing, with my employer or its insurance company, claims administrator, medical management consultant, case manager, field nurse case manager, and/or attorneys as to the treatment provided associated with my assumed work related injury, and do hereby waive my physician-patient privilege."

Authorization: "I authorize Drs. S. Jackson, T. DeWeese, S. Patel, B. Kern, B. Strenge, C. Hill, W. Adams, S. Romine, R. Beck, and/or J. Patton to release records pertaining to my health to insurance companies, referring physicians, attorneys, employer, employer's insurance company, case manager, field nurse case manager, claims administrator, and/or my other responsible party. I authorize release of my x-rays to above said persons. I request payment under the medical insurance program to be made directly to appropriate above said physicians. Should my account become delinquent and referred to collection, I shall pay all reasonable collection expenses, court costs, and attorney fees associated.

"I have read and understand the billing information, financial policy, and information release, and agree to the contents."

Patient Signature:_____ Date:_____

Signature of other
Responsible Party:_____ Date:_____

Notice of Privacy Practices

I, _____, have read the notice of privacy practices, and authorize the Orthopaedic Institute of Western Kentucky to disclose the identified information to the persons and for the purpose described herein. I understand that by signing this document, I release the Orthopaedic Institute of Western Kentucky harmless for any release made pursuant to this authorization.

_____ Date:_____

Signature of Patient or Legal Representative

_____

Description of Legal Representative's Authority

4/22/19 JP