Atlantic ORTHOPAEDICS & SPORTS MEDICINE™

Excellence • Innovation • Compassion

1900 Lafayette Road Portsmouth, NH 03801
p: (603) 431-1121 f: (603) 431-9147

16 Hospital Drive Suite B York, ME 03909
p: (207) 363-3490 f: (603) 431-9147

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New Patient Form, Section 1 of 4

HIPAA Confidential Communication Request
Notice of Privacy Practices — Acknowledgment of Receipt

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have the right to request that communication concerning your protected health information be made through confidential channels.

I, _____, hereby request the use of confidential channels for information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential communications.

Please select your preferred method of contact for discussions related to your personal health, treatment and payment for treatment at Atlantic Orthopaedics & Sports Medicine™.

- ◯ Home Telephone Number
  - ◯ Okay to leave detailed message
  - ◯ Leave a call back number only
- ◯ Work Telephone Number
  - ◯ Okay to leave detailed message
  - ◯ Leave a call back number only
- ◯ Cell Phone Number
  - ◯ Okay to leave detailed message
  - ◯ Leave a call back number only
- ◯ Other Method of Communication

Please list the name, relationship, and telephone number of the person with whom you authorize us to discuss information involving your protected health information.

Authorized Person/Phone Number _____

◯ Spouse ◯ Significant Other ◯ Parent ◯ Family Member ◯ Friend ◯ Other

◯ I do not authorize the disclosure of my protected health information to anyone other than myself. Information for Quality Reporting (Required)

1. Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

2. Race: ◯ White ◯ Black or African American ◯ Asian ◯ American Indian or Alaska Native ◯ Native Hawaiian or Other Pacific Islander

3. Preferred Language: ◯ English ◯ French ◯ Spanish ◯ Vietnamese ◯ Sign Language ◯ Arabic ◯ Chinese ◯ German ◯ Greek ◯ Italian ◯ Japanese ◯ Other

I understand and acknowledge that Atlantic Orthopaedics & Sports Medicine is obligated to keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, or for the internal operations of the Practice, such as improving care and treatment services. I understand that a detailed list of permissible uses and disclosures is included in Atlantic Orthopaedics & Sports Medicine's Notice of Privacy Practices, which I have been offered. I also acknowledge that I have had an opportunity to ask questions about the practice's Notice of Privacy Practices. I have:

- ◯ Accepted
- ◯ Refused/Declined copy of Atlantic Orthopaedics & Sports Medicine's Notice of Privacy Practices.

_____ _____

Signature of Patient or Authorized Representative **Date**

Patient Name: _____ Patient DOB: _____

Guarantor Name: _____

Patient Payment Policies

Acknowledgment of Responsibility for Payment: By signing below, I understand and acknowledge that I am financially responsible for paying all costs associated with the health care services I receive from Atlantic Orthopaedics & Sports Medicine (Sports Medicine Atlantic Orthopaedics PA). I understand that I may be financially responsible for such costs even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy. I understand that I am also financially responsible for charges not covered by my health insurance policy. I understand that I am also financially responsible for charges not covered by my health insurance, including deductibles and copayments.

· Office visit copayments (for specialist) are due at the time of my appointment.
· Payment for all services rendered is due within (30) days after insurance processing.

Release of Information: By signing below, I understand that health information about me, including (if applicable) information related to HIV/AIDS, substance abuse, and mental health treatment, may be shared with my health insurance carrier(s) or other third party payors responsible for paying for my health care. I understand that I may choose to pay privately in full for particular services if I do not wish certain sensitive health information to be disclosed to my third party payor(s).

Assignment of Benefits: By signing below, I authorize health insurers or other third party payors (including Medicare, Medicaid, and TRICARE) to pay the costs associated with my health care services directly to Atlantic Orthopaedics & Sports Medicine (Sports Medicine Atlantic Orthopaedics PA).

Other Patient-Specific Financial Policies:

Returned Checks: A $25.00 processing fee will be charged for any personal checks returned by the bank.

Referrals: I understand that if my insurance plan requires a referral for services provided at AOSM that I am responsible for obtaining the referral from the primary care physician listed with the insurance carrier. I will be asked to sign a waiver at each appointment, accepting responsibility for the payment of services not covered due to incorrect referral information or failure to obtain a referral.

Motor Vehicle Accidents or Third Party Liability Claims: I understand that I must pay AOSM at the time of service if I choose to not use my medical insurance for coverage, and seek reimbursement from third party.

Health Sharing Networks: AOSM does not participate in Health Sharing Networks. If I am a member of such a network, I agree to be considered a self-pay patient and I can pursue reimbursement from my network.

No Insurance: I understand that if I do not have insurance coverage or cannot provide sufficient information for AOSM to submit insurance claims, a deposit of $400.00 is required at check-in prior to my appointment. Actual charges will be calculated at check-out and any additional amount will be collected. A prompt payment discount of 25% for charges paid-in-full at the time of service, for patients who do not have insurance will be extended. This discount cannot be applied to medical insurance copayments, deductibles, or co-insurances which are contractually fixed by specific insurance plans.

Time of Service Discount for Patients with No Insurance: AOSM will provide a prompt payment discount of 25% for charges paid-in-full at the time of service, for patients who do not have insurance. This discount cannot be applied to medical insurance copayments and deductibles, which are contractually fixed by specific insurance plans.

Workers' Compensation (WC): I accept full financial responsibility in the event that workers' compensation denies my claim, and I understand that my health insurance will be billed for any claims denied by the WC carrier. I further understand that I am ultimately responsible for payment for all services not paid in full by WC or health insurances. I understand that WC injuries and unrelated orthopaedic issues must be evaluated at separate office appointments, as WC will likely deny claims for combined services.

Collections Agency: AOSM refers all accounts in arrears, (90 days from date of invoice) including those that are in dispute with a third party, are in litigation and/or are managed or represented by legal counsel to a collections agency for further action. AOSM does not provide additional payment extensions for accounts involving third party liability. Once an account has been transferred to collections, it is subject to credit bureau reporting if not paid in full 30 days from the date of transfer.

No Show/Cancellation Fee: A fee of $50.00 will be charged for "no show" appointments and appointments which are cancelled with less than 24 hours' notice.

X_____

Signature of Patient or Authorized Representative (Annual Authorization) **Date**

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New Patient Form, Section 2 of 4

Patient Review of Registration Information
Please review and update the information we have about you.

Account Number: _____

Name: _____

Nickname: _____

Date of Birth: _____

Social Security Number: _____

Marital Status: _____

Mailing Address: _____

Residence (if other than Mailing): _____

City: _____

State: _____ Zip: _____

Home (or best contact) Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Email: _____

PCP or Referring Physician: _____

Patient's Employer: _____

Employer Address: _____

Employer City: _____

Employer State: _____

Employer Zip: _____

Who should we contact in the event of an emergency?

Emergency Contact: _____

What is this person's relationship to you? _____

Emergency Home Phone #: _____

Emergency Cell Phone #: _____

Medical Insurance Information
Please present your insurance card(s) at Check-in

Primary Plan: _____
ID & Group #s: _____
Subscriber's Name: _____
Subscriber's Birth Date & Relationship: _____

Secondary Plan: _____
ID & Group #s: _____
Subscriber's Name: _____
Subscriber's Birth Date & Relationship: _____

If your medical problem the result of a Workers' Compensation injury? ◯ Yes ◯ No
If "yes" you will be asked to complete an additional form at Check-in.

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New Patient Form, Section 3 of 4

Medical History

Patient Name: _____ Date: _____

Review of Systems: If you have any of the following, please place mark inside circles.

Constitutional
- ◯ Weight Loss/Gain
- ◯ Weakness
- ◯ Fatigue
- ◯ Fever

Cardiovascular
- ◯ High Blood Pressure
- ◯ Chest Pain
- ◯ Rheumatic Fever
- ◯ Palpitations
- ◯ Has Pacemaker

Musculoskeletal
- ◯ Joint Pain
- ◯ Arthritis
- ◯ Muscular Weakness
- ◯ Stiffness
- ◯ Muscular Pain

Eyes
- ◯ Glasses or Contacts
- ◯ Blurred Vision
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Excessive Tearing

Skin
- ◯ Rashes
- ◯ Sores
- ◯ Lumps
- ◯ Dryness
- ◯ Itching

Blood or Lymph
- ◯ Anemia
- ◯ Easy Bruising
- ◯ Easy Bleeding
- ◯ Swollen Glands

Ear Nose Mouth Throat
- ◯ Ears Ringing
- ◯ Earaches
- ◯ Hearing Aid
- ◯ Frequent Colds
- ◯ Nasal Discharge
- ◯ Hay Fever
- ◯ Nosebleeds
- ◯ Dentures
- ◯ Bleeding Gums
- ◯ Frequent Sore Throats

Neurological
- ◯ Headache
- ◯ Dizziness
- ◯ Seizures
- ◯ Loss of Sensation
- ◯ Vertigo

Respiratory
- ◯ Shortness of Breath
- ◯ Cough
- ◯ Wheezing
- ◯ Asthma
- ◯ Bronchitis

Gastrointestinal
- ◯ Heart Burn
- ◯ Rectal Bleeding
- ◯ Abdominal Pain
- ◯ Gallbladder trouble
- ◯ Hepatitis

Genitourinary
- ◯ Blood in Urine
- ◯ Urinary Infections
- ◯ Kidney Stones
- ◯ Burning Urination
- ◯ Sexual Disease

Endocrine
- ◯ Thyroid Trouble
- ◯ Excessive Sweating
- ◯ Excessive thirst

Immunologic
- ◯ Reactions to Drugs
- ◯ Skin Rashes
- ◯ Reactions to Foods

Psychological
- ◯ Nervousness
- ◯ Depression
- ◯ Mood Changes

Medical Disorders: If you have any of the following, please place mark inside circles.

- ◯ No Medical History
- ◯ AIDS/HIV
- ◯ Alcoholism
- ◯ Alzheimer's
- ◯ Anemia
- ◯ Rheumatoid Arthritis
- ◯ Asthma
- ◯ Blood Clot Leg
- ◯ Clood Clot Lung
- ◯ Other Disease (list below)
- ◯ Stroke
- ◯ Cancer Breast
- ◯ Cancer Colon
- ◯ Cancer Lung
- ◯ Cancer Prostate
- ◯ COPD
- ◯ Depression
- ◯ Diabetes
- ◯ Drug Abuse
- ◯ Blood thinners (Coumadin, Plavix, aspirin, etc)
- ◯ Sleep Apnea
- ◯ Gout
- ◯ Heart Attack
- ◯ High Blood Pressure
- ◯ Hepatitis
- ◯ Kidney Disease
- ◯ Osteoarthritis
- ◯ Seizures
- ◯ Ulcers, Bleeding

Surgical History: If you have had any of the following. please place mark inside circles.

- ◯ No Surgical History Reported
- ◯ Carpal Tunnel Left Wrist
- ◯ Arthroscopy Left Elbow
- ◯ Arthroscopy Left Shoulder
- ◯ Arthroscopy Left Ankle
- ◯ Arthroscopy Left Knee
- ◯ Arthroscopy Left Hip
- ◯ Left Hip Replacement
- ◯ Left Knee Replacement
- ◯ Spinal Fusion
- ◯ Other Surgery (list below)
- ◯ Cardiac (Heart)
- ◯ Carpal Tunnel Right Wrist
- ◯ Arthroscopy Right Elbow
- ◯ Arthroscopy Right Shoulder
- ◯ Arthroscopy Right Ankle
- ◯ Arthroscopy Right Knee
- ◯ Arthroscopy Right Hip
- ◯ Right Hip Replacement
- ◯ Right Knee Replacement
- ◯ Laminectomy
- ◯ Fracture Surgery

Social History: Please respond to the following by placing mark inside circles.

Substance Use:

Do you:

Use Tobacco?	◯ Yes	◯ No	Former
Use Alcohol?	◯ Yes	◯ No	
Use Caffeine?	◯ Yes	◯ No	
Use Illicit Drugs?	◯ Yes	◯ No	

◯ I do not use any of the above

Hand Dominance ◯ Right Handed ◯ Left Handed

Females Only
Could you be pregnant? ◯ Yes ◯ No

Allergies: Do you have allergies to any of the following medications or substances:

◯ No Known Allergies	◯ Aspirin	◯ Tegretol
◯ Penicillin	◯ Amoxil	◯ Bactrim
◯ Codeines	◯ Keflex	◯ Pediazole
◯ Sulpha Drugs	◯ Cefzil	◯ Dilantin
◯ Iodine/Shellfish	◯ Ceftin	◯ Novacaine
◯ Ampicillin	◯ Suprax	◯ Insulin
◯ Vantin	◯ Septra	◯ Lidocaine
◯ Depakene	◯ Lamictal	

Other Allergies:

◯ Latex ◯ IVP/X-Ray Dye Metal ◯ Egg/Avian (Bird)

List any other allergies in this box

Family History: If any family member below has any of the following history, please mark inside circles.

Father Medical History

- ◯ AIDS/HIV
- ◯ Anemia
- ◯ Blood Clots
- ◯ Cancer
- ◯ Coronary Artery Disease
- ◯ Diabetes
- ◯ Gout
- ◯ Heart Attack
- ◯ Hemophilia
- ◯ Hypertension
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Muscle Disease
- ◯ Osteoporosis
- ◯ Rheumatoid Arthritis
- ◯ Osteoarthritis

Mother Medical History

- ◯ AIDS/HIV
- ◯ Anemia
- ◯ Blood Clots
- ◯ Cancer
- ◯ Coronary Artery Disease
- ◯ Diabetes
- ◯ Gout
- ◯ Heart Attack
- ◯ Hemophilia
- ◯ Hypertension
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Muscle Disease
- ◯ Osteoporosis
- ◯ Rheumatoid Arthritis
- ◯ Osteoarthritis

Sibling Medical History

- ◯ AIDS/HIV
- ◯ Anemia
- ◯ Blood Clots
- ◯ Cancer
- ◯ Coronary Artery Disease
- ◯ Diabetes
- ◯ Gout
- ◯ Heart Attack
- ◯ Hemophilia
- ◯ Hypertension
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Muscle Disease
- ◯ Osteoporosis
- ◯ Rheumatoid Arthritis
- ◯ Osteoarthritis

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New Patient Form, Section 4 of 4

Medical History

Today's Date: _____

Name: _____ DOB: _____

Height: _____ Pharmacy: _____

Weight: _____ Primary Care Doctor: _____

Allergies: ◯ **No Known Drug Allergies**

Please check any drugs or substances you are allergic to.

Medication:	Reaction:	Medication:	Reaction:
◯ Amoxicillin		◯ Keflex	
◯ Ampicillin Sodium		◯ Lamictal	
◯ Aspirin		◯ Latex	
◯ Bactrim DS		◯ Lidocaine HCL Viscous	
◯ Ceftin		◯ Metal	
◯ Cefzil		◯ Novocain	
◯ Codeine Sulfate		◯ Pediazole	
◯ Dapakene		◯ Penicillin V Potassium	
◯ Dilantin		◯ Septra	
◯ Egg/Avian		◯ Sulfa Drugs	
◯ Insulin		◯ Suprax	
◯ Iodine		◯ Tegretol	
◯ IVP/X-Ray Dye		◯ Vantin	

Medications: ◯ **No Current Medications**

Medication	**Dose**

Are you participating in any pain management programs?

◯ No ◯ Yes, where?