NORTHWEST
ORTHOPAEDICS
& SPORTS MEDICINE

24 Hour Cancellation & "No Show" Fee Policy

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, the Physicians' of Northwest Orthopaedic Associates reserves the right to charge a fee of $25.00 for each missed (No Show) appointment, which is, absent for a compelling reason, and is not cancelled within a 24 hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "No Shows" in any 12 month period will result in termination from our practice.

Thank you for you anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy

____
Printed, Last Name, First   Date

____
Signature

NORTHWEST ORTHOPAEDICS and SPORTS MEDICINE

PRIVACY STATEMENT FOR PATIENTS

Welcome to our practice. In accordance with the Health Insurance Portability and Accountability Act of 1996, our practice is publishing our privacy and security policies for your reference. Your personal information is protected here at Northwest Orthopaedic Associates, Ltd.

Under the law, your protected personal health information may be released to designated health plans or other health care providers without specific authorization in accordance with the law to treat you, obtain payment and conduct normal practice operations. This is called a CONSENT form. We will ask you to sign our consent form for treatment here at Northwest Orthopaedic Associates, Ltd. This consent is valid for all treatment and related operational activity. If you wish to release your protected health information for any other purpose, such as a disability, a life insurance company or a physician not associated with your treatment, you will need to sign a specific authorization.

OUR PRIVACY POLICY

1. Northwest Orthopaedic Associates, Ltd will take all reasonable steps that the minimum necessary amount of information is disclosed to accomplish practice operations, obtain payment for your services and render treatment to you. Such operations include the sending of claims and records to obtain payments, the dictation, typing and filing of medical office notes. Discussion with insurance companies to obtain payment, discussion with collection agencies, i.e., radiologists, laboratory, and other physicians.

2. Your entire medical record will never be released to anyone, unless specifically authorized by you, in writing. You have a right to restrict to whom you allow a portion or all of your record released to. Your records, may, however be released without an authorization in the course of legal investigations by state or federal agencies. Should you need to restrict to whom your records are released, please call or see the Director of Operations.

3. You have a right to inspect your medical records, with reasonable notice to the Director of Operations. You will then be allowed to inspect the records, with the Director present. You have a right to ask that your medical records be amended, however, that is only a request, and the physician is not obligated to comply. You may address a request to the treating physician. Your request will be evaluated and a written response sent to you. The request and reply will be kept in your medical record. If you disagree with the decision of the treating physician, you may request that the President of the Practice evaluate the request. His reply shall be sent to you in writing.

4. If you choose to receive a copy of your medical records, the cost of this will be quoted.

5. We keep a list of all medical record releases here at the practice. You have a right to inspect to whom and when your personal health information is sent to.

6. Our staff and physicians are trained in the policies and procedures concerning the release of protected health information. Each of our staff has signed a Confidentiality Agreement here at Northwest Orthopaedic Associates, Ltd.

7. All complaints regarding the safeguarding of your personal protected health information can be directed to the Director of Operations. You will receive a written reply to any concerns.

8. If there are any changes to this policy statement, it will be posted in our office.

If you need assistance or have questions, please contact our Account Specialists **between 8:30 a.m. and 4:30 p.m., Monday through Friday at 773-631-7898.**

NORTHWEST ORTHOPAEDICS & SPORTS MEDICINE FINANCIAL POLICY

We want to thank you for choosing our practice for Orthopaedic care. We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our Financial Policy. Please contact the office if you have any questions or concerns.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE:
Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Northwest Orthopaedics accepts cash, cashier's check, VISA, MasterCard, Discover, and American Express. There is a service charge of $25.00 for returned checks.

Patients with an outstanding balance of 90 days or more must make arrangements for payment prior to scheduling appointments.

*****Collections: In the event that your account is forwarded to collections from Northwest Orthopaedics, there will be a 10% charge of your balance for the expenses incurred by the agency. *****

REFUNDS:
Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for a refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

INSURANCE:
It is the patient's responsibility to provide their current insurance card and or referral at the time of service. If you fail to provide your current insurance/referral information, it may be necessary to reschedule your appointment. We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payments from your insurance company or if the payments are denied within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

Please note your insurance plan determines your co-pay/co-insurance/deductible; they also determine what codes they cover and do not cover. Your EOB (Explanation of Benefits) should outline this information.

We do not bill third party insurance companies.

MANAGED CARE:
If you are enrolled in a managed care insurance plan (i.e., RPPG, HMO, etc.), you must receive a referral from your primary care physician before seeing a specialist. Retroactive referrals are not always guaranteed.

AUTOMOBILE ACCIDENTS/PERSONAL INJURY CLAIMS:
Northwest Orthopaedics cannot get involved in third party liability; it is the insurance company's responsibility to determine damages. Patients shall be financially responsible for medical services related to an MVA and Personal Injury. It is also the patient's responsibility to notify Northwest Orthopaedics if the service is due to such incidents.

We will need a claim number, adjustor's name, address, telephone and fax number and/or attorney information for personal injury or workers' compensation.

DISABILITY /FMLA/INSURANCE FORMS:
A $25.00 flat fee, pre-payment will be charged for 3 or more pages. Please allow 7-10 business days for them to be completed.

I have read and understand the Financial Policy of Northwest Orthopaedics & Sports Medicine. I agree to assign insurance benefits to Northwest Orthopaedics whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections as mentioned above.

____ _________________________

Signature of insured or authorized representative **Date**

NORTHWEST ORTHOPAEDICS & SPORTS MEDICINE

PATIENT CONSENT FOR TREATMENT AND RELEASE OF PERSONAL INFORMATION

I have been given a copy of the privacy policy and consent to treatment at Northwest Orthopaedic Associates, Ltd. I understand that information about me may be used or disclosed in, the context of normal practice operations, including all treatment, filing of claims, and the receiving of payments for services provided. I understand that information for any other purpose may not be released to anyone without my specific authorization. I may revoke this consent at any time, but it will not have any effect on any actions taken prior to my revoking the consent.

Patient Name ______________________________________ Date ____________________
Please Print

Patient Signature __________________________________

If patient unable to sign:

Patient Representative _______________________________ Date ________________
Please Print

Patient Representative Signature ______________________________

Relation to Patient ____

I have no objection to the physician discussing my medical or surgical care and treatment with the following persons.

Name: _________________________ Relationship: _______________ Phone: _____________
(Please Print)

Name: _________________________ Relationship: _______________ Phone: _____________
(Please Print)

Name: _________________________ Relationship: _______________ Phone: _____________
(Please Print)

Initial Medical History Form
Patient Information

Date	Dr.				Referred by
First Name	Middle Initial	Last Name			Email address
Street Address					Unit/Apt #
City	State				Zip Code
Home Number	Cell Number				Work Number
Social Security Number	Age	Birthdate	Marital Status M S D W		☐ Male ☐ Female
Primary Physician			Phone Number		
Name of Responsible Party			Address (if different than patient)		
Name of relative/friend (in case we are unable to reach you)			Relation	Phone Number	
Pharmacy	Address			Phone Number	

History of Present Illness:

Reason for today's visit: ____________________

Date of injury or onset: ____________________

Problem due to: ☐car accident ☐work related ☐sports injury ☐fall ☐arthritis ☐other ________

If injured, where did injury occur? : ☐home ☐work ☐school ☐other ________

If yes, last day worked or went to school ____________________

Employer Name		School Name (if patient is minor)
Address		Phone Number
City	State	Zip
Complete the section below only if your injury is work related		
Workmen's Compensation Claim Number		
Company Name		Contact Name
Address	Phone Number	Fax Number
City	State	Zip Code

______________________________ ______________________________
Last Name First Name

Dominance: ☐ Right Handed or ☐ Left Handed

Height _______ Weight _______ BP _______ Temp ________

Location of pain: ___________________ if the problem is related to a limb is it: ☐right ☐left ☐both

Have you fallen within the past year? ☐Yes ☐ No
Did this result in an injury? ☐ Yes ☐ No

Indicate the characteristics that describe your problem: ***(Please Circle)***

Pain	**Onset**	**Frequency**	**Context**	
sharp	sudden	intermittent	standing	sitting
dull	slowly	constant	kneeling	lying down
throbbing	**Severity**	**Timing**	down stairs	up stairs
aching	minor	am or pm	walking	running
burning	moderate	while sleeping	coughing	lifting heavy objects
other	severe	after activity		
		during activity	straining with a bowel movement	

Associated Symptoms: ***(Please Circle)***
Do you notice any sensation listed below that occurs due to injury or at the site?

weakness	stiffness	locking	popping
visible swelling	discoloration	numbness	tingling
fever	crunching	chills	
discharge or blood at site		other _______________	

On a scale from 1-10 please rate your pain with 1 being barely noticeable _______
Is your pain intermittent or constant? ___________ Sharp stabbing or dull throbbing? __________
What makes the pain worse? ____

Is this the first time you have had a problem with this area? ☐ Yes ☐ No
Describe prior problem: ____

For this problem, have you had any of these tests done?
☐X-ray ☐MRI ☐CT Scan ☐Ultrasound ☐Bone Scan ☐EMG ☐Nerve Study

If yes, where? __________________________
Did you bring them with you? ☐ Yes ☐ No

Prior treatment for the current problem:

☐oral medication __________	☐ injection – how many? _____	
☐chiropractor	☐ heat	☐ cold
☐brace – type? ___________	☐ crutch	☐ walker
☐wheelchair	☐ elevation	☐ other__________

☐Physical Therapy – how long? _________ Where? ____________

Previous Treating Physician and Phone Number ________________________
Has a physician recommended that you have surgery for this problem? ☐Yes ☐ No

______________________________ ______________________________
Last Name First Name

Past Medical History:

Have you or any family member had any of the following medical problems?

You	Family		You	Family		You	Family	
☐	☐	Anemia	☐	☐	Emphysema	☐	☐	Nervous Disorder
☐	☐	Anesthesia Problems	☐	☐	Endocrine disorders	☐	☐	Phlebitis
☐	☐	Atrial fibrillation/irregular heartbeat	☐	☐	Heart trouble	☐	☐	Rheumatoid Arthritis
☐	☐	Bleeding disorder	☐	☐	Hepatitis	☐	☐	Osteoporosis
☐	☐	Blood clots/pulmonary embolism	☐	☐	High blood pressure	☐	☐	Osteoarthritis
☐	☐	Colitis	☐	☐	High cholesterol	☐	☐	Reflux
☐	☐	Depression	☐	☐	HIV/AIDS	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Kidney Stones	☐	☐	Tuberculosis
☐	☐	None of the above	☐	☐	Lyme	☐	☐	Ulcers
☐	☐	Other ______________________						

Family Medical History: If your parents, grandparents, siblings, or children have any of the medical problems listed above, please explain:

____

____

Prescription/Non-prescription Medications: *(Including herbal supplements & vitamins)*

Name	Dose	Taken per day	Name	Dose	Taken per day

Allergies

☐ None	☐ Codeine	☐ Shellfish	☐ Metal/Jewelry
☐ Penicillin	☐ Iodine	☐ Food___________	☐ Aspirin
☐ Local anesthetic	☐ Lidocaine	☐ Contrast	☐ Sulfa
☐ Novocain		☐ Latex	☐ Other ____________

Are you pregnant? ☐Yes ☐ No **Breastfeeding?** ☐Yes ☐ No

Past Surgical History:

Type of surgery _______________ Year ________ Type of surgery _______________Year ________
Type of surgery _______________ Year ________ Type of surgery _______________ Year________
Type of surgery _______________ Year ________ Type of surgery _______________ Year________

Social History

Occupation ________________________________ Working now? ________________________________
Do you use tobacco? ☐No ☐Yes - packs/day _________ If you quit how long ago? ______________
Alcohol use: ☐ No ☐Yes ☐Rarely ☐ Occasionally ☐ Daily ☐Heavy
History of Alcoholism? ☐No ☐ Yes History of recreational drug use? ☐ No ☐Yes
Do you live alone? ☐No ☐ Yes If no, who do you live with? ___________________
Type(s) of exercise/sports activity: ____
How often _____________ per week?

______________________________ ______________________________

Last Name First Name

Review of Systems:
Are you currently having problems with any of the following?

Genitourinary	**Constitutional**	**Respiratory**	**Endocrine**
☐ blood in urine	☐ fatigue	☐ Short of breath	☐ excessive urination
☐ kidney stones	☐ fever	☐ cough	☐ hormone/metabolic disorder
☐ testicle pain	☐ weight change	☐ bronchitis	☐ thyroid disease
Skin	**Gastrointestinal**	**Hematologic**	
☐ rash/itching	☐ nausea	☐ bruise easily	
☐ dry skin	☐ rectal bleeding	☐ slow to heal	
☐ non-healing sores	☐ constipation	☐ enlarged glands	
☐ temperature sensitivity	☐ diarrhea		
Ears/Nose/Mouth/Throat	**Eyes**	**Musculoskeletal**	
☐ hearing loss/ringing	☐ glasses/contacts	☐ pain/cramps	
☐ sinus problem	☐ glaucoma	☐ joint pain	
☐ sore throat	☐ blurred vision	☐ joint swelling	
☐ nose bleeds	☐ eye disease	☐ trouble walking	
Cardiovascular	**Neurological**	**Psychiatric**	
☐ cardiac disorder	☐ headaches	☐ insomnia	
☐ palpitations	☐ tremors	☐ confusion	
☐ swollen ankles	☐ seizures	☐ depression	
	☐ numbness/neuropathy		

Patient/Guardian Statement:

To the best of my knowledge, the above information is accurate and complete.

______________________________________ ________________________

Patient/Guardian Signature *Date*

***Patient forms are updated yearly. These forms will be reviewed on an annual bases and signed.*