



Orthopaedic Institute of Ohio Demographic Information

Date: _____

Patient Name	Age	Date of Birth	Marital Status	Sex
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Mailing Address (include PO Box and apt #)	Social Security Number
City, State, & Zip	Home Phone Cell Phone

Employer's Name	Employer's Address	Employer's Phone
Referring Doctor	Family Doctor	
Phone	Phone	
Pharmacy	Location	Phone

CONTACT PERSON – Not Living at the Same Location

Name	Relationship	Phone
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SPOUSE/PARENT/GUARDIAN INFORMATION (Please Circle which one)

Name	Social Security Number
Address	Date of Birth
City, State	Zip Marital Status
Employer's Name	Relationship to Patient
Employer's Address	Employer's Phone

INSURANCE INFORMATION (Please present your insurance cards so that we may obtain a copy for our records).

Primary Insurance Company	Secondary Insurance Company
Policy Holder's Name Social Security Number	Policy Holder's Name Social Security #
Date of Birth Co-Pay	Date of Birth Co-Pay
Relationship to Patient	Relationship to Patient
Policy Holder's Address	Policy Holder's Address
Policy Holder's Employer	Policy Holder's Employer
If BWC: Date of Injury	



Orthopaedic Institute of Ohio
 801 Medical Drive Suite A Phone: (419) 222-6622
 Lima, OH 45804

Release of Medical Information

Federal and state law direct when the Practice may disclose a patient's Protected Health Information to persons involved in a patient's care. This form allows a patient to designate family members, friends or other individuals to whom the practice may release Protected Health Information.

Date: _____

I, _____ (print patient name) hereby agree that the following person (s) involved in my care may receive medical information about me (friends or family members, not physicians).

 (Name)

 (Relationship to patient)

 (Name)

 (Relationship to patient)

 (Name)

 (Relationship to patient)

This form is not intended as a full authorization to release all of your Protected Health Information. The individuals listed above will only receive Protected Health Information directly relevant to such individual's involvement in your care or payment related to your care.

You may cancel or alter this designation at any time by informing OIO in writing of such change/ alteration. Any cancellation or alteration can only apply to future disclosures or actions regarding your Protected Health Information and cannot cancel actions taken or disclosures made while the designation was in effect.

Contact Information

Our office may need to contact you by telephone to remind you of appointments and to give you test results or other information related to you medical care. Please indicate in the order of how you would like to be contacted. All telephone numbers must be listed (work, cell, family, etc.) in order for us to comply with this request.

Number

Location

1. _____

2. _____

3. _____

Signature: _____

Date: _____



Orthopaedic Institute of Ohio

801 Medical Drive Suite A
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Phone: (419) 222-6622

PATIENT AUTHORIZATION

I hereby authorize Orthopaedic Institute of Ohio, to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I also authorize the release of any necessary information, including medical information if requested by the above named insurance company. I permit a copy of this authorization to be used in such instances.

By signing below, I agree to pay all charges for services rendered by OIO which are not covered by the above referenced insurance coverage. If it becomes necessary for OIO to seek judicial action to enforce the above agreement, I agree to pay all collection fees and all attorneys' fees of OIO for such action.

REFERRALS

I understand that I am responsible for obtaining a valid referral from my primary care physician if required by my insurance company.

PRE-CERTIFICATION

I understand that OIO will attempt to obtain a pre-certification as a courtesy for me. I understand that OIO is not obligated to obtain pre-certification for me and it is my responsibility to obtain or to make sure any required pre-certification has been obtained for me prior to my procedure. I agree to advise and confirm with OIO that a pre-certification has been obtained for me. I understand in the event pre-certification is not obtained by me, I will be responsible for any amounts not paid, reduced or denied by my insurance company.

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

I agree to promptly pay all charges when billed for medical services rendered. As a parent or guardian, I agree legal responsibility for all charges incurred by the patient named on the previous page.

POLICY CONCERNING MEDICAL RECORDS

I hereby authorize OIO to release my medical information as I have directed. I understand that OIO does not copy records and that such record copying services are performed by the independent records copying company. Therefore, such record copying may be subject to a copying charge. I also understand that since OIO does not copy records that records must be requested at least two weeks in advance of desired receipt date. If there is a charge for copying my records, I understand that I will be billed by the independent records copying company based upon allowable charges under current Ohio law for copying medical records. Patients or other parties authorized by the patient to request medical records for legal issues, insurance, disability (not workman's compensation), physician change, or relocation from the area are subject to a copying charge. There will be no charge for copying records for a referral to another physician made by an OIO physician, or workman's compensation issues or any other situations covered by Ohio law.

PHOTOGRAPHY CONSENT

I give OIO permission to photograph my child for security purposes. I understand the picture will be retained in their medical record and used for identification purposes only.

PATIENT RIGHT TO PRIVACY/CONFIDENTIALITY

Orthopaedic Institute of Ohio is committed to patient privacy and confidentiality. In our Patient Bill of Rights, we state that our patients have a right to privacy and confidentiality. Therefore, you will be asked for your permission prior to the release of your records. Your medical information will be kept confidential to the degree required under existing law and regulation. However, from time to time we may need to contact you at home or work. If we need to contact you, may we have your permission to leave a message with regards to your care, any lab results, and appointment information, if you are unavailable or do not answer the phone?

DURABLE MEDICAL EQUIPMENT (DME)

I authorize OIO to submit a claim for the product(s) on my behalf and I assign the benefits payable by my insurer for such product(s) to the Orthopaedic Institute of Ohio. I authorize my Health Care Provider to release any medical information required for my insurer to process the claim. I understand that I am responsible for, and I agree to pay, any portion of the amount due for such product not paid by my insurer, whether resulting from deductibles, co-pays, or otherwise.

I authorize/ request OIO to (please initial your choice)

Leave a message at work _____ Yes _____ No

Leave a message at home _____ Yes _____ No

Date

Patient/ Parent or Guardian Signature



Orthopaedic Institute of Ohio

801 Medical Drive, Suite A

Lima, Ohio 45804

(419)222-6622 or (800) 225-3921

Fax: (419)238-3941

Please make sure when completing the attached form to darken the circles completely.

LIKE THIS



Thank you for your cooperation.

The staff at the Orthopaedic Institute of Ohio.

Patient Name: _____ **Date:** _____

DOB: _____ **Referring Doc:** _____ **Family Doc:** _____

I. Have you seen another doctor in this practice within the last 3 years? Yes No

If yes, which doctor? _____

II. Which side is affected? Right Left Bilateral

III. Joint or part(s) that you are being seen for today:

Back Neck Foot/Toes Hip Elbow

Ankle Shoulder Wrist/Hand Knee(s)

IV. Date of Injury: _____

V: Start of Pain/Cause of Pain? _____

How did the pain occur? Injury Chronic Spontaneous

Is this work related? Yes No

Is this the result of a motor vehicle accident? Yes No

Is there a Third Party responsible for payment? Yes No

If accident, where did the accident occur? _____

VI. Pain Description

Quality of your pain? Mild Moderate Severe

Type of pain? Sharp Dull Other: _____

Medical History, Do you have or have you had:

Asthma/ COPD Yes No Hepatitis Yes No

Cancer Yes No High Blood Pressure Yes No

Diabetes Yes No Lung Disease Yes No

Drug Allergies Yes No Seizures Yes No

Heart Attack Yes No Stroke Yes No

Problems w/Anesthesia Yes No Blood Clots Yes No

Latex Allergy Yes No

Do you have a pacemaker or AICD? (automatic internal cardiac defibrillator) Yes No

Social History

Do you smoke? Yes No

Do you consume alcohol? Yes No

Do you exercise regularly? Yes No

Family History

Arthritis Father Mother Siblings Grandparents

Cancer Father Mother Siblings Grandparents

Diabetes Father Mother Siblings Grandparents

Red Flag:
Identity Theft
Prevention



**DO YOU KNOW
ABOUT THE
“RED FLAG”
RULES TO FIGHT
IDENTITY THEFT?**

Identity Theft is a national and global issue, and each of us must protect our identity. The Federal Trade Commission adopted new rules for every creditor – including this facility – to implement by December 21, 2010. They are called the “Red Flag” Rules, and we are protecting YOUR identity by watching for the Red Flags of Identity Theft.

EFFECTIVE December 21, 2010, EVERY ADULT PATIENT REGISTERING FOR SERVICES MUST SHOW A PHOTO I.D. AND PROOF OF ADDRESS, UNLESS PAYING IN CASH, IN FULL, IN ADVANCE. IF THE PATIENT IS A MINOR, THE ADULT GUARANTOR’S IDENTIFICATION WILL BE CHECKED.

ACCEPTABLE PHOTO I.D. INCLUDES:

- PHOTO DRIVERS LICENSE OR STATE PHOTO I.D.
- PASSPORT, COLLEGE I.D. OR EMPLOYER I.D.
- VALID IMMIGRANT VISA or “GREEN CARD”

*IF THE ADDRESS ON YOUR DRIVER’S LICENSE IS NOT ACCURATE – PLEASE BRING IN A UTILITY BILL, PAYCHECK STUB OR GOVERNMENTAL CORRESPONDENCE SHOWING CURRENT RESIDENCE.

**PLEASE REMEMBER THE DAY OF SURGERY TO BRING
YOUR INSURANCE CARD, PHOTO ID
AND PROOF OF ADDRESS.**