ORTHONOW

Bret R. Sokoloff, MD, MBA

Today's date: _____

First Name: _____Middle:_____Last:_____

Home Address:_____City:_____State:____Zip_____

Social Security Number:_____Date of Birth_____ Male ☐ Female ☐

Home Phone:_____Cell Phone:_____Work Phone:_____

E-mail: _____

Primary Care Physician:_____Referring Physician:_____

Referring Physician Phone:_____

Emergency Contact:_____Phone:_____

Responsible Party:_____Relationship to Patient:_____

Name of Pharmacy to which you would like your prescriptions sent:_____

Pharmacy Phone:_____

Insurance: We will file your insurance, however, you will receive monthly statements. At each visit you will be responsible for paying co-pays, deductibles and balance due after insurance. You are responsible for promptly responding to all insurance inquiries.

Primary	Secondary
Insurance Company(1)_____	Insurance Company(2)_____
Phone#:_____	Phone#:_____
Policy#:_____	Policy#:_____
Group/Plan#:_____	Group/Plan#:_____
Policy Holder:_____	Policy Holder:_____
Policy Holder's DOB:_____Male ☐ Female ☐	Policy Holder's DOB:_____ Male ☐ Female ☐
Policy Holder's SSN:_____	Policy Holder's SSN:_____

In consideration of the medical services rendered and/or to be rendered, I/we agree to pay OrthoNow, PLLC and/or it's physician(s) the regular charge for said services. I/We further agree to pay any court costs and reasonable attorney's fees in the event that this account has to be referred to an attorney for collection. I/We understand that I/We are responsible for all charges not paid by insurance. I/We certify that I/We have read the above or had it explained to me/us and agree to all of it's terms and as evidence of this fact sign my/our name below:

Patient Signature: _____

Responsible Party Signature: _____

PAST SURGICAL HISTORY

Have you ever had any prior surgeries (from birth to current)? Yes ☐ (please check all that apply) No ☐

☐ Appendectomy	☐ Heart Stent	☐ Shoulder Scope
☐ Arterial Bypass	☐ Heart Bypass	☐ Rotator Cuff Repair
☐ Back Surgery	☐ Hip Replacement	☐ Shoulder Replacement
☐ Bowel Surgery	☐ Knee Replacement	☐ Ankle Replacement
☐ Defibrillator	☐ Knee Scope	☐ Ankle Scope
☐ Dialysis shunt	☐ Neck Surgery	☐ Thyroid Surgery
☐ Fracture Surgery	☐ Nerve Surgery/Release	☐ Foot Surgery
☐ Gallbladder Surgery	☐ Pacemaker Implantation	☐ Prostate Surgery
☐ Hysterectomy	☐ Transplant surgery	☐ Other _____

MEDICATIONS

Have you received narcotics/pain medicine from another physician in the past 30 days? ☐ Yes ☐ No

LIST ALL PRESCRIPTIONS, OVER THE COUNTER DRUGS, AND VITAMINS

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

***Please attach extra medication list if necessary**

ALLERGIES

Do you have any allergies to medicines? ☐ Yes ☐ No

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____

Do you have an allergy to LATEX? ☐ Yes ☐ No
Do you have any allergies to food? ☐ Yes ☐ No

1. _____ Reaction: _____
2. _____ Reaction: _____

Signature: _____ ***Date:*** _____

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CURRENT ORTHOPEDIC ISSUE(S)

Have you ever been treated for your present condition? ☐ Yes ☐ No
If yes, please list names of Doctor(s): _____
Have you had an X-RAY for this condition? ☐ Yes Location _____ ☐ No
Have you had an MRI for this condition? ☐ Yes Location _____ ☐ No
Have you had a CT scan for this condition? ☐ Yes Location _____ ☐ No
Have you had an EMG for this condition? ☐ Yes Location _____ ☐ No
Do you have an attorney you have consulted or a lawsuit in regard to this condition? ☐ Yes ☐ No
If yes, please give the name of the attorney _____
Is your condition related to a motor vehicle accident? ☐ Yes ☐ No
Is this a work-related injury? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Bones/Joints:
☐ Arthritis (degenerative)
☐ Rheumatoid Arthritis
☐ Lupus
☐ Psoriasis
☐ Lyme Disease
☐ Degenerative Spine
☐ Herniated Discs
☐ Fractures
☐ Fibromyalgia
☐ Osteoporosis
☐ Spinal Stenosis

Cancer:
☐ Bone Cancer
☐ Lung Cancer
☐ Prostate Cancer
☐ Breast Cancer
☐ Thyroid Cancer
☐ Paget's Disease
☐ Lymphoma
☐ Leukemia
☐ Other Cancer

Gastrointestinal
☐ Colitis/Crohn's
☐ Reflux Disease
☐ Stomach Ulcers

Heart:
☐ High Blood Pressure
☐ Coronary Artery Disease
☐ Heart Attack
☐ Irregular Heart Beat
☐ Heart Murmur

Lungs:
☐ Asthma
☐ Chronic Bronchitis
☐ COPD/Lung Disease
☐ Pulmonary Embolism
☐ Sleep apnea

Kidneys:
☐ Urinary Tract Infections
☐ Kidney Stones
☐ Kidney Failure
☐ Dialysis

Head:
☐ Migraines
☐ Seizures

Psychiatric/Addiction:
☐ Alcoholism
☐ Prescription Drug Addiction
☐ Illicit Drug Addiction
☐ Dementia/Alzheimer
☐ Anxiety
☐ Depression
☐ Bipolar Disorder
☐ Schizophrenia
☐ Other Psychiatric

Vascular:
☐ Vascular Disease
☐ Blood Clots/DVT
☐ Edema
☐ Phlebitis
☐ Stroke

Endocrine/Blood:
☐ Diabetes
☐ Thyroid Disease
☐ Sickle Cell Disease
☐ High Cholesterol
☐ Bleeding disorder
☐ Anemia
☐ HIV/AIDS
☐ Hepatitis A, B, C (circle)
☐ Obesity

Signature: _____ ***Date:*** _____

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SOCIAL HISTORY

Highest education: ☐ Grade school ☐ High School ☐ College ☐ Graduate

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you employed? ☐ Yes ☐ No ☐ Retired

Occupation: _____

Are you disabled: ☐ Yes ☐ No Reason: _____

Ambulation: ☐ Independent ☐ Brace ☐ Cane ☐Walker ☐Wheelchair ☐Crutches ☐ Scooter

Who do you live with? ☐ Alone ☐ Others ☐Who? _____

Are you or have you been treated by a pain management clinic? ☐ Yes ☐ No

Are you or have you been in a drug or alcohol program in the past? ☐ Yes ☐ No

Do you smoke? ☐ Never ☐ Former ☐ Current

How much do you smoke? ☐ ¼ PPD ☐ ½ PPD ☐ 1 PPD ☐ 2 PPD

How many years have you smoked? ☐ 1-5 ☐ 5-10 ☐ 10-15 ☐ 15-20 ☐ >20

How much alcohol do you drink? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Drinks per week: _____

What type of alcohol? ☐ Beer ☐ Wine ☐ Liquor

Do you use illicit drugs? ☐ Yes (CIRCLE: Crack/Cocaine, Marijuana, Heroin, Other) ☐ No

How has your health been recently? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Exercise level? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

FAMILY HISTORY

NONE KNOWN ☐

Father alive ☐ Yes ☐ No Age of death? _____
Mother alive ☐ Yes ☐ No Age of death? _____

(Circle Mother/Father)

Arthritis M F Hypertension M F Psychiatric M F Diabetes M F Kidney Disease M F
Alcoholism M F Heart Disease M F

Signature: _____ ***Date:*** _____

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REVIEW OF SYSTEMS

What symptoms are you having today or regularly? ☐ NONE

☐ Fever > 100	☐ Shortness of Breath	☐ Weakness
☐ Weight Loss	☐ Abdominal Pain	☐ Numbness
☐ Ear Pain	☐ Vomiting	☐ Dizziness
☐ Frequent Nose Bleeds	☐ Diarrhea	☐ Headaches
☐ Sinus Problems	☐ Blood in Stool	☐ Fatigue
☐ Mouth Ulcer	☐ Bowel Incontinence	☐ Swollen Glands
☐ Tooth Infection	☐ Urinary Incontinence	☐ Easy Bruising
☐ Chest Pain	☐ Blood in Urine	☐ Exposure to HIV
☐ Cough	☐ Pain in Joints	
☐ Wheezing	☐ Rash	

Patient Name: _____ Date: _____

I may restrict the individuals or organizations to which my health care information is given and I may revoke my authorization to you at any time. This revocation must be given to OrthoNow in writing and sent to their address.

In the event we cannot contact you, please list family members or other persons if any, whom we may inform about your general medical condition and diagnosis:

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____ DATE: _____

May we leave messages regarding your treatment, billing, insurance, or other aspects associated with your care on your home answering machine or voicemail? ☐ Yes ☐ No

SIGNATURE OF PATIENT/GUARDIAN: _____DATE: _____
(MUST BE 18 YEARS OR OLDER TO SIGN)

Bret R. Sokoloff, MD, MBA

Patient Name: _____ Date: _____

We appreciate the opportunity to serve you and desire to provide you with the best service/care possible. The information provided below is intended to insure that you are aware of certain treatment, financial and privacy policies. If you have any questions, please inform the receptionist.

Consent for Medical Treatment

I authorize OrthoNow physicians and their health care team to render the evaluation and medical treatment needed. I further authorize the use of X-rays, injections, casting or bracing or other diagnostic tests and treatment as determined necessary by my health care provider.

Consent for Financial Responsibility

I acknowledge full financial responsibility for services rendered by OrthoNow. I assign and authorize payments of medical insurance benefits to OrthoNow directly and release of any medical information necessary to process insurance claims. Additionally, I understand that I am responsible for expenses that may be incurred in collection of my account to include attorney's fees, court costs and collection agency costs in the event of default of payment of my charges. It is my responsibility to contact my insurance company and/or employer to verify that the physicians of OrthoNow are participants in my insurance plan prior to treatment. OrthoNow does not accept third party liability such as automobile insurance, pending litigation and other indirect insurance products, and I am responsible for the full payment of services at the time they are rendered.
If my insurance plan requires a referral in order to be treated by a specialist, it is my responsibility to obtain the referral prior to being treated at OrthoNow. If a referral is required and I fail to obtain one, I will be financially responsible for any services that are provided to me.
OrthoNow will submit a claim to my insurance company but will require payment of any unpaid deductible, co-payments and co-insurance for the services provided in the office at the time they are rendered. If I am without verified health insurance or am a member of a plan in which OrthoNow does not participate, I am required to pay in full at the time medical services are rendered to me. In the event my insurance company denies my claim or pays my claim as "out of network", I am aware that I will be responsible for the balance due.
Some insurance companies claim that certain Orthopedic supplies that physicians prescribe for the patient's treatment of their condition(s) are not covered. I agree to pay for these supplies in the event my insurance company denies coverage.

OrthoNow accepts cash, checks, credit and debit cards. Returned checks are subject to a $35.00 processing fee.

Consent For Release Of Medical Information

I understand that I have certain rights regarding the use of my Protected Health information (PHI). These rights are governed by the Health Insurance Prtability and Accountability Act of 1996 (HIPAA). My signature below indicates that I have been given the opportunity to read the OrthoNow notice of Privacy Practices for PHI and I further understand that I can obtain a copy of this policy upon request.

I hereby authorize the release and disclosure of my PHI for treatment, payment or health care operations. I understand that any records containing my personal and medical history are the confidential property of OrthoNow. I consent to allowing OrthoNow to communicate with and exchange medical information with my primary care physician and any referrals/specialists that are, or may become involved in my care. This will remain in effect until I notify OrthoNow in writing of my desire to withdraw such authorization.

Signature: _____ ***Date:*** _____

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Office Policies

Welcome to OrthoNow. We respect your time and will make every attempt to remain prompt in providing the best care for you. The following information should help to answer most of your questions, and will enable us to provide you with the best care possible. If you still have any questions, please feel free to ask one of our staff members to help you.

Please inform one of our staff members if you have had ANY recent changes to your insurance coverage. Please bring your new insurance cards with you to your appointment so that we may record the changes in your account and help prevent you from receiving additional charges on your bill.

Please make certain that we have your correct and current contact information, including your address and phone numbers. An emergency number is also helpful in case we have difficulty contacting you.

We will not discuss your care with any other party without your expressed written permission. We will send a copy of your office notes to your primary care physician or referring provider to keep them apprised of your treatment and progress. Let us know if you do not wish your medical doctor to receive your information.

Please notify our staff of any medication changes or newly diagnosed allergies at each office visit. For your safety, we recommend always keeping a current medication list in your purse or wallet.

If any new medical problems should arise, please inform one of our staff or physicians so that we may update the information in our records. Please also notify us if you have had any recent surgical procedures.

All medication/refill requests must be received by 4:00pm Monday through Friday, and will be addressed within 24 hours of the request. No prescriptions will be called in on evenings or weekends, as our physicians may not have access to your records and wish to avoid any medication related complications. Please plan accordingly.

If you have been scheduled for any test or procedure (MRI, CT, X-ray, bone density, lab tests, spinal block, nerve conduction studies, PT, etc.), please make sure that you attend the appointment as directed. If you are unable to attend your test, please call in advance to reschedule. If you were not given an appointment time for your test or procedure while in the office and have not heard from our staff or the facility that you were referred to within 3 days, please call our office so that we may resolve the issue. Please be aware that all testing is different, and some may take longer to schedule based on your insurance.

Signature: _____ ***Date:*** _____

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If you are unable to keep your scheduled appointment, please notify our office more than 24 hours in advance so that another patient can occupy your appointment time. A $10 no-show fee will be applied to your account for all missed appointments. If you wish to cancel your scheduled surgery, please notify our office more than 24 hours in advance. A $100 no-show fee will be applied to your account for any missed surgical appointments. These fees are not covered by insurance and will be your responsibility. You may not be seen for subsequent appointments before you clear any remaining balance on your account.

If you are being seen for a motor vehicle accident or a worker's compensation injury, you MUST let the front desk know before you see our physicians. If you do not do so, you may be responsible for any or all charges incurred by your office visit.

Dr. Sokoloff and Dr. Tucker will not prescribe any chronic pain medication. Such medication should be prescribed by a pain management physician. Please ask your primary care doctor for a referral. If you are taking long-term narcotic medications through our office, you may be subjected to random drug testing. Narcotic medication must be prescribed by a single physician. Any drug-seeking, doctor shopping, selling of medications or falsification of prescription medications will be reported to the DEA and similar law enforcement agencies.

Dr. Sokoloff and Dr. Tucker believe that YOU are an important team member in the provision of your care and overall health. They will personally review the results of all your testing and will explain your diagnosis and all related treatment options available to you. If you EVER have any questions, please ask our staff. Dr. Sokoloff and Dr. Tucker believe that it is of the utmost importance for you to thoroughly understand your diagnosis and treatment options.

We believe it is an honor to serve you and will work diligently on your behalf.

Signature: _____ **Date:** _____