COASTAL ORTHOPEDIC Associates

Last Name: _____ First:_____ MI: _____ DOB:_____ Age: _____

Primary Care Physician:_____ Dominant hand: Right ☐ Left ☐

I was referred by: _____ Height: _____ Weight:_____

*Pharmacy: _____ Address:_____ City: _____

Reason for today's visit: ☐ Left ☐ Right _____

Date problem began?_____

Date of injury?_____ ☐Work Injury ☐Motor Vehicle Accident

Things that make the problem worse: _____

Things that make the problem better: _____

What has been done for your problem? _____

☐ X-ray ☐ Ultrasound ☐ MRI ☐ CT ☐ Bone Scan ☐ Physical Therapy ☐Injection(s)

Medications – name: _____

PLEASE LIST ALL ALLERGIC REACTIONS TO MEDICATION (include latex, adhesive tape, etc.) ☐ **NONE**

PLEASE LIST ALL MEDICATIONS, DOSE & FREQUENCY (including herbs and vitamins) ☐ **NONE**

Medication Name	Dose	Frequency	Reason for Taking

PATIENTS AGE 12 AND OLDER

Tobacco & Other: ☐ never smoked

☐ current smoker How many per day? ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐31+

☐ former smoker How long has it been? ☐ <1 mo ☐1-3 mo ☐3-6 mo ☐1-5yr ☐5-10yr ☐>10yr

Alcohol: ☐ Never ☐ 1x month ☐2-4x month ☐2-3x week ☐ More than 3x week

Substance Abuse: ☐ No ☐ Yes – please explain: _____

Special Diet: ☐ No ☐ Yes – please explain: _____

Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children: ☐ No ☐ Yes – ages: _____

PLEASE FILL OUT YOUR COMPLETE MEDICAL HISTORY:

High blood pressure?	Y___ N___	Ulcers? Gastrointestinal?	Y___ N___
Diabetes?	Y___ N___	Cancer?	Y___ N___
Heart disease?	Y___ N___	Other (Cholesterol, thyroid?)	Y___ N___
Asthma? COPD?	Y___ N___	Sleep apnea?	Y___ N___
Blood clot? Pulmonary embolus?	Y___ N___	Pregnant?	Y___ N___
Blood disorders (hepatitis, HIV)?	Y___ N___	Please explain: _____	
Other?	Y___ N___	Please explain: _____	

PLEASE FILL OUT YOUR FAMILY HISTORY ☐ **NONE**

Mother:	☐ Alive	☐ Deceased – cause: _____
Father:	☐ Alive	☐ Deceased – cause: _____
Sister/Brother:	☐ Alive	☐ Deceased – cause: _____

Other pertinent family medical history: _____

PLEASE LIST ALL PAST SURGERIES (i.e. tonsils, appendix, screws, plates, joint replacements, etc.) ☐ **NONE**

PATIENTS AGE 65 AND OLDER

Fall Risk:	Have you had a fall in the last 12 months?	☐ No falls	☐ 1 fall with injury
		☐ 1 fall without injury	☐ 2+ falls with injury
		☐ 2+ falls without injury	
Osteoporosis:	Have you ever had a bone density scan?	☐ Yes ☐ No	
	Have you been diagnosed with Osteoporosis?	☐ Yes ☐ No	

REVIEW OF SYSTEMS – *Please check all that currently apply to you*

☐ Weight Loss	☐ Fevers	☐ Chills	☐Sweats
☐ Dry eyes	☐ Red eyes	☐ Sore throat	☐Dental problems
☐ Shortness of breath	☐ Wheezing	☐ Productive cough	☐Coughing up blood
☐ Chest pain	☐ Irregular heartbeats	☐ Leg swelling	☐ Abdominal pain
☐ Nausea / Vomiting	☐ Diarrhea	☐ Constipation	☐Heartburn
☐ Burning with urination	☐ Blood in urine	☐ Discharge	☐ Unusual menstrual bleeding
☐ Headache	☐ Dizziness	☐ Balance	☐ Numbness
☐ Bowel/bladder dysfunction	☐ Weakness	☐ Tingling	☐ Joint stiffness
☐ Swollen joints	☐ Warm/red joints	☐ Neck pain	☐ Back pain
☐ Arthritis	☐ Bruising	☐ Bleeding	☐ Skin changes
☐ Heat/cold intolerance	☐ Hair changes	☐ Poor healing	☐ Rashes
☐ Wounds	☐ Anxiety	☐ Depression	

Patient Signature **Date**

Acknowledgement of Awareness of Notice of Privacy Practices

By signing this form, I acknowledge that I have been informed of Coastal Orthopedic Associates' Note of Privacy Practices. A copy of the notice is posted in the office and is available to me upon request. The notice provides me with detailed information about how Coastal Orthopedics Associates may use and disclose my protected information for the purposes of treatment, payment and health care operations.

I understand that if Coastal Orthopedics Associates amends its Notice of Privacy Practices as copy of the revised notice may be obtained by contacting us at 978-927-3040. Patients will be informed of any amendments to this notice upon registering for an appointment.

I have the right to request, in writing, that Coastal Orthopedics Associates restricts how they use and disclose my protected health information for the purpose of treatment, payment of health care operations and that the practice is not required by law to grant my request. If the practice does decide to grant my request, the practice must adhere to the approved restrictions unless it is an emergency situation or it is in direct conflict with state or federal laws and regulations.

Statement of Financial Responsibility

Coastal Orthopedics Associates appreciates the confidence you have shown in choosing us to provide for your health care needs. The service that you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees.

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service, including pre-determined deposits for elective surgical cases based on the allowed amount per you medical coverage. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any allowable amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for the cost of the service.

If a referral from your primary care physician is required by your insurance and a referral is not on file at the time of your visit, you may be asked to reschedule. If you are not rescheduled, per your request, you acknowledge by signing below that you may responsible for the full amount of your visit.

We reserve the right to submit delinquent accounts to a collection agency and/or terminate you as a patient for non-payment. If the balance due is more than 45 days delinquent, we will assess a one-time fee of $15.00 added to your balance. If your account is referred to a collection agency we reserve the right to assess additional collection fees added to your balance to compensate our practice for the costs associated collection. We reserve the right to assess a "no call – no show" fee should you miss a scheduled appointment without notifying us. If a fee is assessed, it will be $50.00, and must be paid before a subsequent appointment can be scheduled. Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected that you will pay your co-pay prior to the service being rendered and that you will pay your required co-pays at each visit associated with the care.

Consent to Treatment

I present for treatment and consent to my physician and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include but not limited to diagnostic procedures, x-rays, injections, casting and splinting and other treatments and procedures considered advisable in the diagnosis and treatment of my condition. I realize the practice of medicine and surgery is not an exact science. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examination.

I have read the above policies regarding consent to treatment and financial responsibility to Coastal Orthopedics Associates for providing orthopedic services to me or the named patient. I certify that the information that I have provided regarding my insurance coverage is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Coastal Orthopedics Associates, the full and entire amount of the bill incurred by me or the above named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

Patient Signature	Patient Name	Date

Signature of Legal Representative	Print Name	Date

Medication and Narcotic Policy

Thank you for choosing Coastal Orthopedic Associates for your orthopedic needs. As part of your treatment plan we may prescribe narcotic pain medication for certain acute injuries and postoperative care. Narcotics are considered safe when used appropriately, but side effects may occur, including the development of an addictive disorder.

Narcotics are highly addictive pain medications and can cause side effects, such as: lethargy, dizziness, lightheadedness, fainting, altered consciousness, sedation, slowed reflexes, slowing of respiratory rate, physical dependence, constipation and addiction. Abrupt discontinuation of these medications can result in withdrawal symptoms. Due to these potential side effects, you should not drive or operate heavy machinery, operate a motor vehicle, work in hazardous areas or be responsible for care for another individual who is unable to care for him/herself while taking these medications. You could cause harm to yourself or others.

We will manage your acute medication needs during your course of treatment with our office for your specific orthopedic issue. We will not continue to manage your medication needs beyond your active treatment with our office. Routine medication needs are to be managed by your primary care physician or pain management physician.

We are required by Massachusetts Law to run each patient's information through the Massachusetts Prescription Monitoring Program database. It is important that you are honest and forthcoming with us regarding any medications that you take, including narcotics. Accurate information will help us provide you with the best care and support possible.

The following conditions must be met:

- You must maintain the dosing schedule prescribed by our office. Any changes to the dosing schedule must have prior approval from your provider.
- You must notify us if you are receiving narcotic medication from any other physician.
- You understand that prescriptions that are lost, stolen, accidentally disposed of, or consumed before the appropriate date will NOT BE REFILLED.
- We will NOT provide prescriptions after office hours or on weekends. NO EXCEPTIONS.

You further understand that you will be discharged from the practice at the discretion of the physician if:

- You use more medication than prescribed (run out early)
- You received pain medication from any other person or physician no authorized by your Coastal Orthopedic Associates physician.
- You use the medication in a manner that it was not prescribed.
- You exhibit deceitful behavior or provide false information.
- You make repeated telephone calls to the office or after hours to obtain medication.
- You sell or give your medications to another person.
- You alter a prescription.
- You use multiple pharmacies without your physician's knowledge.

I have read the Medications and Narcotic Policy of Coastal Orthopedic Associates and I agree to comply with these rules. I understand that failure to follow these rules will result in my being discharged from the practice and risk prosecution, as directed, by state and federal laws.

Patient Signature	Patient Name	Date

Signature of Legal Representative	Print Name	Date