Patient Information

ORTHOPAEDIC ASSOCIATES, LLP

❑ Dr. Gregory Harvey ❑ Dr. Vivek Kushwaha ❑ Dr. Alan Rechter ❑ Dr. Navin Subramanian ❑ Dr. David Lin ❑ Dr. Amy Riedel ❑ Dr. Justin Chronister

PATIENT NAME (First Name, Middle Initial, Last Name) PATIENT ID (Office Use Only)		Office ( ) -	Home ( ) -	THIRD PHONE (MOBILE) ( ) -
ADDRESS DATE OF BIRTH		SOCIAL SECURITY NUMBER	SEX (M OR F) ❑ M ❑ F	MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ OTHER
CITY, STATE, ZIP AGE		EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER		OCCUPATION	PATIENT EMAIL ADDRESS	
REFERRING DOCTOR NAME AND ADDRESS				
PRIMARY CARE DOCTOR NAME AND ADDRESS				
RACE		ETHNICITY		
PHARMACY NAME		ZIP CODE	PHARMACY PHONE NUMBER	
NAME OF AUTHORIZED PARTIES THAT MAY DISCUSS MEDICAL CARE			CONTACT NUMBER	
Is it okay to leave test results on voice mail? ❑ YES ❑ NO				

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)	Office ( ) -	Home ( ) -	THIRD PHONE (MOBILE) ( ) -
ADDRESS		DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		SEX (M OR F) ❑ M ❑ F	PATIENT'S RELATION TO RESP
EMPLOYER		OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE):
❑ Patient (same as above) ❑ Responsible Party (same as above) ❑ Other (complete below)

INSURANCE COMPANY NAME CO-PAY AMOUNT		INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M OR F) ❑ M ❑ F	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE):
❑ Patient (same as above) ❑ Responsible Party (same as above) ❑ Other (complete below)

INSURANCE COMPANY NAME CO-PAY AMOUNT		INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M OR F) ❑ M ❑ F	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Responsible Party

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize ORTHOPAEDIC ASSOCIATES, LLP to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

Signature of Patient / Parent / Guardian _____ Printed Name _____ Date _____

I / We authorize direct payment to be made to ORTHOPAEDIC ASSOCIATES, LLP for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified. I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian _____ Printed Name _____ Date _____

ORTHOPAEDIC ASSOCIATES, L.L.P

NAVIN SUBRAMANIAN, M.D.

New Patient Questionnaire

Date: _____

Patient name: _____ Date of birth: _____
Primary Care Physician: _____
Referring Physician: _____
Height: _____ Weight: _____

Reason for appointment: _____
_____

When did problem begin? Month: _____Year: _____
Is this problem a result of a work injury? Y/N Date of injury: _____ Attorney: Y/N
Is this problem a result of an auto accident? Y/N Date: _____ Attorney: Y/N
Does one side of your neck/back hurt worse? Right _____ Left _____
Do you have difficulty with sitting/standing/walking? _____
Do you have muscle spasms, insomnia, stiffness, or numbness/tingling? _____
Do you have difficulty with daily activities and/or loss of quality of life? _____
Do you have bowel problems: _____ Do you have bladder problems:_____
Have you had physical therapy, epidural steroid injections: _____ How many: _____
Prior surgery on neck or back? _____
Do you use any topical creams or patches, TENS unit, heat or ice? _____

Occupation:
Physical requirements of job: _____
Last day worked:_____ Retired: Y/N Disabled: Y/N

Past Medical History:

Heart Attack	Blood Clot	High Blood Pressure	
Diabetes	COPD/Emphysema	Asthma	Stroke
Thyroid	Osteopenia/Osteoporosis	Ulcers	Reflux/Heartburn
Cancer	Kidney Disorder/Failure	Cirrhosis	HIV/Hepatitis A/B/C
Lupus	Rheumatoid Arthritis	Osteoarthritis	Depression
Seizures	Congestive Heart Failure	Gout	Bleeding Disorders
Tuberculosis			

Other: _____

Past Surgical History:
_____
_____
_____
_____
_____

Patient: _____
Date: _____

NP
N. Subramanian, MD

Current Medication: (List all medications including over the counter medications)

Name Dosage Frequency for what condition

_____
_____
_____
_____

Medication Allergies:

_____

FAMILY Medical History:

Blood Clot	High Blood Pressure	Heart Attack	
Diabetes	COPD/Emphysema	Asthma	Stroke
Thyroid	Osteopenia/Osteoporosis	Ulcers	Reflux/Heartburn
Cancer	Kidney Disorder/Failure	Cirrhosis	Hepatitis A/B/C
Lupus	Rheumatoid Arthritis	Osteoarthritis	Depression
Seizures	Congestive Heart Failure	Gout	Bleeding Disorders
Tuberculosis			

Other: _____

Social:

Tobacco: Yes No How much? _____ How long? _____ Quit? _____
Alcohol: Yes No How much? _____ How long? _____ Quit? _____
Illicit Drugs: Yes No Which drug? _____ How long? _____ Quit? _____
History of substance abuse? Yes No How long sober? _____

Review of Systems: (please circle all that apply)

Headache	Change in Vision	Weight Loss	Pain at Night
Fever	Hoarseness	Dizziness	Numbness/Tingling
Cough	Shortness of Breath	Chest Pain	Palpitations
Heartburn	Bowel Incontinence	Psychiatric Illness	Irregular Heart Beat
Pain with Urination	Bladder Incontinence	Bruise Easily	

QUESTIONARIO DE HISTORIA MEDICA

NOMBRE: _____ FECHA: _____
FECHE DE NACIMIENTO: _____ EDAD: _____
FECHA DE LESION O INICIO DE PROBLEMA: _____
TYPO DE LESION/ENFERMEDAD: _____
_____
_____

FUE LESIONADO EN EL TRABAJO? (SI) (NO)
ESTAS TRABAJANDO ACTUALEMNTE/ (SI) (NO)
CUAL ES SU DESCRIPCION/RESPONSIBILIDADES DEL TRABAJO? _____
_____

HISTORIA DE LA LESION/ENFERMEDAD ACTUAL _____
_____
_____
_____
_____

HAS TENIDO ALGUN TRATAMIENTO O EXAMENES ANTERIOR? (SI) (NO)
POR FAVOR INDIQUE CUAL EXAMEN O TRATAMIENTO:
_____
_____
_____
_____

TIENE PROBLEMAS MEDICOS? (SI) (NO)
POR FAVOR INDIQUE PROBLEMAS MEDICOS:
_____
_____
_____
_____

ALGUNA VEZ HA TENIDO CIRUGIA? (SI) (NO)
POR FAVOR INDIQUE QUE TIPO DE CIRUGIA Y CUANDO
_____
_____
_____
_____

ESTA TOMANDO ALGUN MEDICAMENTO? (SI) (NO)
POR FAVOR INDIQUE MEDICAMENTO Y DOSIS
_____
_____
_____
_____

ERES ALERGICO A ALGUN MEDICAMENTO? (SI) (NO)
POR FAVOR INDIQUE ALERGIA Y TIPO DE REACCION
_____
_____
_____
_____

FUMAS? (SI) (NO) CUANTO? _____
TOMAS ALCOHOL? (SI) (NO) CUANTO? _____
USA DROGAS ILICITAS? (SI) (NO)

FIRMA DE PACIENTE: _____

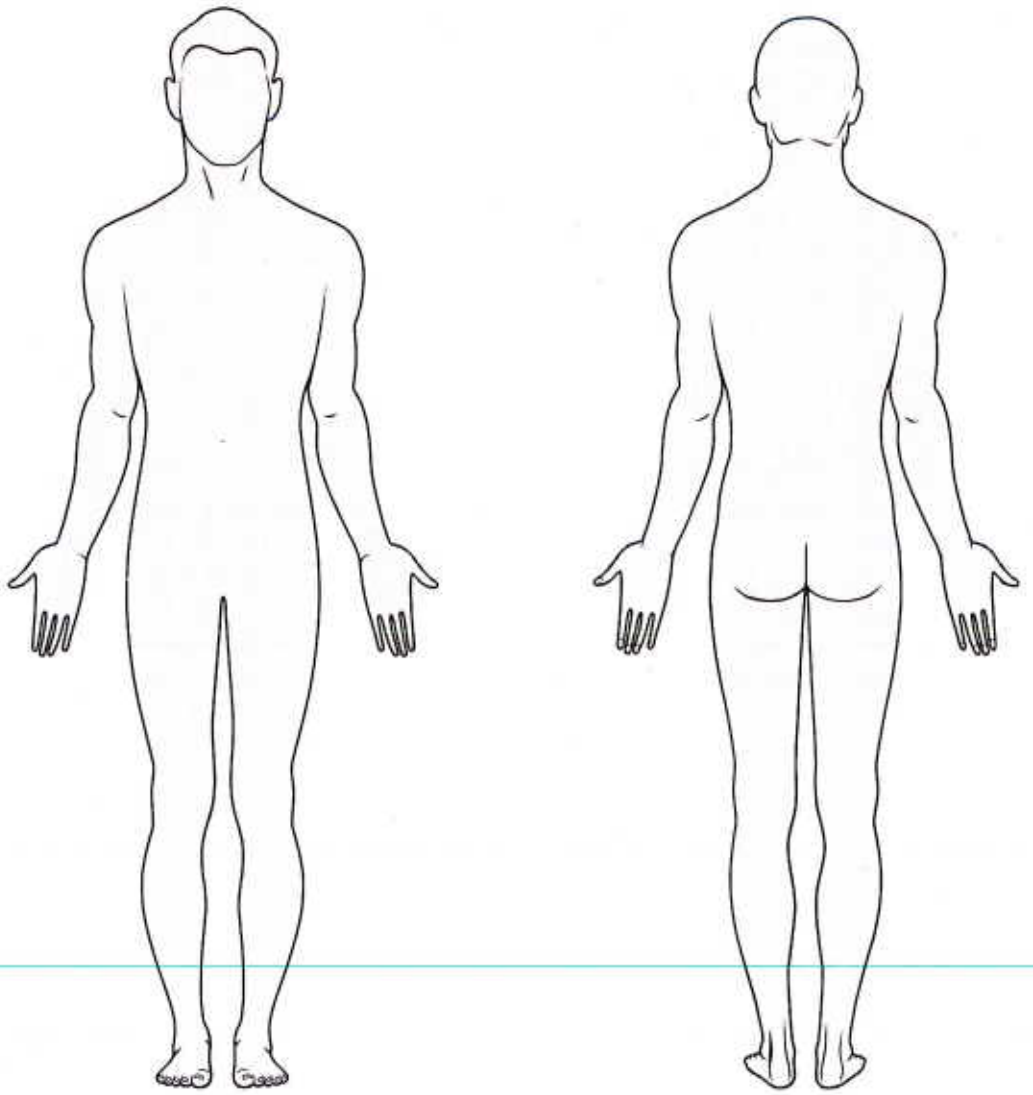
ORTHOPAEDIC ASSOCIATES, L.L.P.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

PATIENT PAIN DRAWING

Name _____ Date _____

- Where is your pain now?
- Using the symbols below, mark the areas on the body diagram where you feel the sensations described
- Mark the areas of radiation.
- Include all affected areas.

ACHING ▲▲▲▲ NUMBNESS ●●●● PINS & NEEDLES ○○○○ BURNING ❑❑❑❑ STABBING ■■■■



- How bad is your pain?
- Please mark with an X on the body form where the pain is the worse
- Please mark on the line how bad your pain is now.
- No Pain _____ Worst Possible Pain

QUADRUPLE VISUAL ANALOGUE SCALE

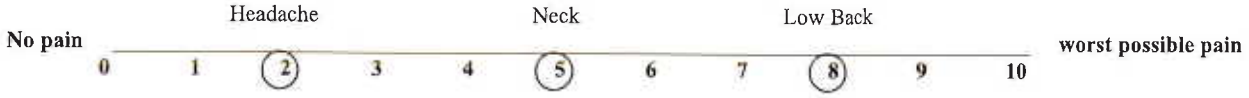
Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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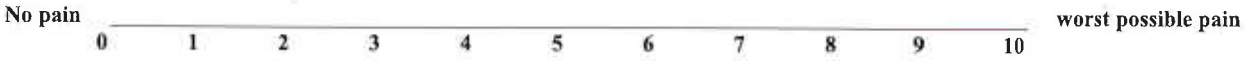
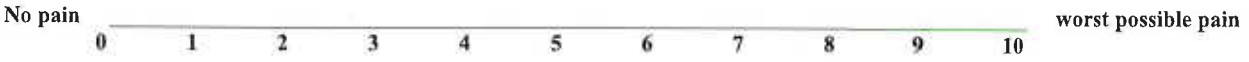
1 – What is your pain RIGHT NOW?

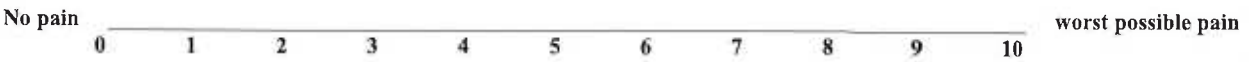
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

_____

_____

_____
Examiner

ORTHOPAEDIC ASSOCIATES, L.L.P.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

UNIVERSAL CONDITION, INJURY/ACCIDENT STATEMENT FORM

ALL BOXES MUST BE COMPLETED BEFORE SEEING A PHYSICIAN

PATIENT NAME: _____ ***TODAY'S DATE:*** _____/_____/_____

PLEASE COMPLETE THE FOLLOWING STATEMENTS. MOST INSURANCE COMPANIES REQUEST ACCIDENT DETAILS. THIS INFORMATION MAY BE FORWARDED WITH YOUR INSURANCE CLAIM OR PROVIDED TO AN ADJUSTER TO COMPLETE YOUR CLAIM. WE MUST HAVE "*BOX 1: CONDITION OR DATE OF INJURY*" COMPLETED TO FILE YOUR CLAIM.

1. Please check: ☐ CONDITION ☐ INJURY INJURY DATE: _____/_____/_____ (ON OR ABOUT)
   THIS DATE IS REQUIRED FOR INSURANCE FILING

How did the injury or pain occur, what were you doing? (Brief Summary)_____

_____

2. Did the injury occur during work? ☐ YES ☐ NO
3. Were you clocked in? ☐ YES ☐ NO
4. Were you at lunch? ☐ YES ☐ NO

THIRD PARTY LIABILITY

5. Is there a possible third party liability? ☐ YES ☐ NO
   (INJURY OCCURRED SOMEWHERE OTHER THAN HOME OR WORK? SUCH AS AUTO, HOMEOWNER'S PROPERTY, ETC.?)

IF YES, A letter of subrogation should be provided before seeing the physician. Your health insurance may deny the claim if the letter is not obtained.

I certify that this information to be true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury or condition and the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a **"non-covered"** service and may make me personally liable for the charges incurred.

SIGNATURE: _____ ***TODAY'S DATE:*** _____/_____/_____
(RESPONSIBLE PARTY)

ORTHOPAEDIC ASSOCIATES, LLP • FINANCIAL POLICY

WELCOME, and thank you for choosing Orthopaedic Associates, L.L.P. for your medical care. We are committed to providing you with quality medical care. Our professional fees have been determined through careful consideration and we believe are reasonable and in line with other area physician charges.

INSURANCE: The patient or their guarantor is responsible for payment for services provided by Orthopaedic Associates, L.L.P. at the time of service. O.A. will file claims directly with your insurance carrier for services verified under your plan. Verification does not guarantee your insurance will pay for services. Payments of co-pays, co-insurance, deductibles or fees for non-covered services are required at the time of service.

HMO/ PPO OR CONTRACTED INSURANCE PLANS: Each time you make an appointment with an O.A. physician, it is your responsibility to make sure that the physician is currently contracted with your plan and that you have obtained the necessary referrals. We will bill your plan and allow 45 days for payment. If the services are not paid the balance will become your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, pre-existing conditions, or "reasonable and customary" charges.

IF YOU DON'T HAVE MEDICAL INSURANCE: We request payment at the time of service or satisfactory payment arrangements made prior to service. If you are unable to pay for non-emergent services and do not have insurance, the service or treatment may be delayed until acceptable payment arrangements can be made. If you have any questions about your account balance, please call our billing office at 888-330-1737 between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday.

MEDICARE: If, you are a Medicare patient, we ask that you pay the Medicare deductible at the time of service only if you have not met the deductible and your 20% Co-insurance. If you have a supplemental policy, then you will only be required to pay the Medicare deductible. As a courtesy to you, Orthopaedic Associates, L.L.P. will file Medicare and any supplemental insurance claims to your insurance carrier(s).

I have read all of the information above and agree that, regardless of my insurance status, I understand I am responsible for the balance on my account for any professional services rendered.

Patient Signature_____ Date_____

INSURANCE ASSIGNMENT & AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ORTHOPAEDIC ASSOCIATES, L.L.P. to release any information acquired in the course of my treatment that may be necessary to process my claim. (I permit a copy of this authorization to be used in place of the original.) In consideration of services rendered, I authorize payment to be made directly to ORTHOPAEDIC ASSOCIATES, L.L.P.

Patient Signature_____ Date_____

ANESTHESIA AND HOSPITAL BILLS

You may also receive separate bills from one or other physician's offices. These bills may cover such expenses as physician services and/or professional interpretation of tests and X-rays. Questions concerning such bills should be directed to the office of the physician who sent the bill.

Patient Signature_____ Date_____

USE OF A PHYSICIAN ASSISTANT OR CO-SURGEON

As deemed necessary by your physician, a physician assistant or co-surgeon may be necessary to provide the highest level of care during a surgical procedure. For such circumstances, you may be required to provide a surgery deposit for this individual in addition to your physician.

Patient Signature_____ Date_____

MEDICARE PATIENTS

I hereby acknowledge that I am not a member of any Medicare HMO plan.

Patient Signature_____ Date_____

ORTHOPAEDIC ASSOCIATES, L.L.P.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

GREGORY P. HARVEY, M.D.
VIVEK P. KUSHWAHA, M.D.
ALAN J. RECHTER, M.D.
NAVIN SUBRAMANIAN, M.D.
DAVID L. LIN, M.D.
AMY E. RIEDEL, D.P.M
JUSTIN CHRONISTER, M.D.

KATHRYN P. HARRISON
ADMINISTRATOR

NOTICE OF PRIVACY PRACTICES

I have reviewed ORTHOPAEDIC ASSOCIATES, L.L.P.'s Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Patient Signature_____ Date_____

I hereby give authorization to Orthopaedic Associates, L.L.P. to release any or all of my information regarding my medical records to a designation of my choice:

Name_____ Relationship to Patient_____

MEDICARE PATIENTS

I hereby acknowledge that I am not a member of any Medicare HMO plan.

Patient Signature_____ Date_____

As your Physician, I believe that you are entitled to make informed decisions regarding your medical care. To assist you in making an informed decision, I have provided notification that I hold partial ownership interest in:

St. Joseph Hospital
Houston Orthopedic & Spine Hospital
Houston Metro Ortho and Spine Surgical Center
Houston Methodist Hospital
Grand Texas Surgery Center, PLLC and HHS Joint Venture
Kingwood Medical Center
Oak Bend Medical Center

By my signature below, I hereby acknowledge that I have received notification of Dr. Subramanian's ownership interests.

Patient Signature_____ Date_____

Orthopaedic Associates, L.L.P

Contract for Opioid Therapy

Our policy regarding the prescription of opioids for nonmalignant pain is strict and non -- negotiable. Narcotics should only be used as an adjunct to other therapies and as a last resort after other treatment modalities have failed.

Our objective when prescribing narcotics are:

- To provide adequate analgesia with the least dose possible.
- To minimize side effects.
- To allow you to become more functional.
- To avoid abuse and addiction.

Please read the following 20 statements listed below

1. The goal of my medication plan is to discontinue the use of short action opioids (Vicodin, Lortab, Lorcet, and Norco) for chronic pain conditions.

2. Prescription refills will be done on an as needed basis, but no sooner than 10 (ten) days.

3. No refills will be made after clinic hours and on weekends or holidays.

4. I will use my medication only as prescribed. I will not take more than the amount indicated. Any evidence of such may result in termination of patient-physician relationship in OA.

5. I will not share my medications with anyone.

6. If I lose my medication, my prescription will not be replaced. Only in the event of extraordinary circumstances an exception will be made (i.e. your house burns down or you have a police report).

7. If my prescription is not refilled, I might experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening. I may choose to seek medical attention at an emergency room.

8. While being a patient at OA, I will not receive prescriptions for opioids or other sedatives from any other licensed physician, unless it is authorized by OA. Any evidence of such will result in termination of the patient-physician relationship in OA.

9. I will not alter nor forge my prescriptions. Any evidence of such will result in termination of patient-physician relationship in OA.

10. I will use only **1 (one)** pharmacy to fill my medication.

11. I agree to provide a sample of my urine, and in some cases blood, for drug screening at my physician's request. Failure to do so will result in termination of the patient-physician relationship in OA.

12. Findings of other non-prescribed drugs in my urine or blood will result in termination of the patient-physician relationship in OA.

13. I am aware that **addiction** is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medication is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest drug history and that of my family to the best of my knowledge.

14. I understand that physical **dependence** is normal and expected result of using medicines for a long time. Dependence is not the same as addiction. I am aware physical dependence means that if pain medicine use is markedly decreased, stopped, or reversed by some agents (nalpuphine, buprenorphine, or stadol) I will experience withdrawal symptoms.

15. I am aware that **tolerance** to analgesia means that I may require more medicine to get the same amount of pain relief. Tolerance does not seem to be a big problem for most patients. If it occurs, increasing doses may not always help and may cause unacceptable side effects. This may cause my doctor to switch to another opioid or choose another form of treatment.

16. I am aware that the use of opioids has been associated with the following side effects:

    - Sleepiness and drowsiness
    - Nausea
    - Vomiting
    - Constipation
    - Urinary retention
    - Dizziness
    - Itching
    - Allergic reaction
    - Slow breathing/Slow reflexes and reaction times
    - Low testosterone levels in males

17. If the medications cause dizziness, sedation, or drowsiness, I understand I must not drive a motor vehicle or operate machinery that could put my life or someone else's in jeopardy.

18. Overdose of this medication may cause **death** by stopping my breathing.

19. I have read this contract or had it read to me. I understand all of it. I have had the chance to have all of my questions regarding this statement answered to my satisfaction. By signing this form voluntarily, I give ORTHOPAEDIC ASSOCIATES, L.L.P. my consent for the treatment of pain with opioid medications.

20. If I violate this agreement, my doctor will discontinue this form of treatment.

Patients Name: _____

Patients Signature: _____ Date Signed: _____

Pharmacy: _____ Phone #: _____

ORTHOPAEDIC ASSOCIATES, L.L.P.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

Dear Patient,

You are receiving this letter as notification of our prescriptive practices and compliance monitoring program regarding Schedule II medications.

The Drug Enforcement Administration (DEA) published a final rule of scheduling hydrocodone combination products from Schedule III to Schedule II on August 22, 2014. This rule will go into effect *October 6, 2014*. This ruling greatly restricts the ability of providers to prescribe hydrocodone products (Lortab, Norco, and Vicodin). This ruling will change our ability to prescribe hydrocodone products and provide refills. We have no control over many of the changes our practice is required to make that may unfortunately affect your postoperative care.

The DEA also strongly recommends the institution of a Medication Monitoring compliance program to ensure adequate protection of our patient's health and decrease drug related mortality and potential abuse or misuse.

The following changes will be put into effect in our practice due to the increased restrictions that accompany this schedule change:

- Schedule II medications (Norco, Vicodin, Lortab, Percocet) prescriptions must be written on an official prescription form. This means that we will no longer be able to call in prescriptions for this medication. The prescription must be physically picked up from our office.
- **We cannot legally provide phone refills on hydrocodone/oxycodone prescriptions.** Patients will be prescribed an adequate supply according to a schedule that will last until their next appointment. No refills will be given between appointments. If a refill is needed an appointment must be made Monday through Friday.
- **No "last minute" appointments for refills will be made on Fridays, no exceptions will be made.**
- If your prescription is lost or stolen, we will be unable to provide you with another prescription until your next scheduled appointment.
- You should expect that narcotic based medications will not be given any longer than six weeks after your last surgery. We will continue to try and treat your pain with non-narcotic modalities after six weeks. If you believe you will require hydrocodone/oxycodone beyond six weeks, it is advised that you establish care with a chronic pain or primary care physician as soon as possible and notify our clinic that another physician will be assuming care of your pain.
- You may be required to submit to a Medication Monitoring screening during appointments.
- Oral DNA samples may be required to evaluate patient susceptibility to medications.
- If you have a chronic pain physician, it is advised that you make an appointment as soon as possible, as you will not be able to receive the medication from multiple physicians. We will defer to your chronic pain physician for any postoperative narcotic prescription.

Should you have any questions or concerns, please contact your Physician or Nurse.

Sincerely,
Navin Subramanian, M.D.

Please sign below to acknowledge receipt of information.

Patient signature: _____ Date: _____

ORTHOPAEDIC ASSOCIATES, L.L.P.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE
HIPAA

GREGORY P. HARVEY, M.D.
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JUSTIN CHRONISTER, M.D.

FRACTURE CARE

In the event that our orthopaedic surgeon diagnoses you or your child with a fracture, the treatment of a fracture includes the clinical exam, reading of x-rays, casting/splinting, and following this injury until it has healed.

The charges associated with the care of a fracture (closed treatment of a fracture) are listed as a single charge. The code number and charges associated with this were developed by Medicare guidelines and your insurance company, not by our office. Your explanation of the benefits may describe it as a "surgery", but in reality it is not a surgery, but a closed (non surgical) treatment of the fracture.

The charge for this injury is a single charge that includes 90 days for follow up care, also known as the global period. It does not include charges for x-rays or casting materials. You will not be charged for an office visit every time you visit the doctor since this is included in your initial fracture care exam and fees.

_____ _____

Patient/Guarantor Signature Date

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KATHERINE HARRISON
ADMINISTRATOR

CONSENT FOR RADIOGRAPHS/INJECTION

I, _____ hereby authorize Orthopaedic Associates and staff to perform radiographs of my _____.

I, _____ hereby authorize Orthopaedic Associates and staff to give an injection in my _____.

Signed _____ Date _____

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KATHERINE HARRISON
ADMINISTRATOR

CONSENT FOR TREATMENT

This facility has on staff a physician in the deliver of medical (Orthopaedic) care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic disease as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the Supervising physician, but rather overseeing the activities of an accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/hers education, training and experience. The services may include:

A. Obtaining histories and performing physical exams
B. Ordering and/or performing diagnosis and therapeutic procedure
C. Formulating a working diagnosis
D. Developing and implementing a treatment plan
E. Monitoring the effectiveness of therapeutic interventions
F. Assisting at surgery
G. Offering counseling and education
H. Supplying sample medications and writing prescriptions (where allowed by law)
L. Making appropriate referrals

I have read the above, and hereby consent to the services of a physicians assistant for my health care needs.

I understand that at any time I can refuse to see the physicians assistant and request to see a physician.

Name (please print) _____

Signed _____ Date _____

ORTHOPAEDIC ASSOCIATES, L.L.P.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

GREGORY P. HARVEY, M.D.
VIVEK P. KUSHWAHA, M.D.
ALAN J. RECHTER, M.D.
NAVIN SUBRAMANIAN, M.D.
DAVID L. LIN, M.D.
AMY E. RIEDEL, D.P.M.
JUSTIN CHRONISTER, M.D.

KATHERINE HARRISON
ADMINISTRATOR

Orthopaedic Associates, L.L.P.

I understand_____may require a Physician Assistant to assist in my surgery, and in consideration for receiving medical services provided pursuant to my health insurance policy, I assign payment of my insurance benefits directly to Orthopaedic Associates, L.L.P. for the surgical assist services provided.

In the event that my health insurance plan refuses to pay for Physician Assistant surgical assist services, I also assign all my ERISA* rights to a full and fair review process to Orthopaedic Associates, L.L.P. for any and all paid, partially paid or denied surgical assist claims.

I give consent to release medical information to Orthopaedic Associates, L.L.P. or its designated representative. I give consent to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to release medical information to Orthopaedic Associates, L.L.P. or its designated representative to send medical information, as necessary, to my insurance plan.

**ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed insurance claims according to ERISA regulations.*

Patient / Guardian printed name: _____

Patient / Guardian signature: _____

Date: _____