MEDICATION SHEET

NAME: _____ DOB: _____

HOME PHONE NUMBER: _____

PHARMACY / TOWN: _____ PHARMACY PHONE#: _____

MEDICATION	STRENGTH & QUANTITY	DIRECTIONS

SHORE ORTHOPAEDIC GROUP – DR. RATHI INTAKE FORM

DATE: _____ **PATIENT NAME:** _____ **AGE:** _____

WHAT PROBLEM / ISSUES BRING YOU HERE TODAY? _____

DATE OF ACCIDENT: _____

WHAT MAKES IS WORSE? ☐WALKING ☐SITTING ☐STANDING ☐LYING DOWN ☐NOTHING ☐SIT → STAND ☐OTHER _____

WHAT MAKES IT BETTER? ☐WALKING ☐SITTING ☐STANDING ☐LYING DOWN ☐NOTHING ☐SIT → STAND ☐OTHER _____

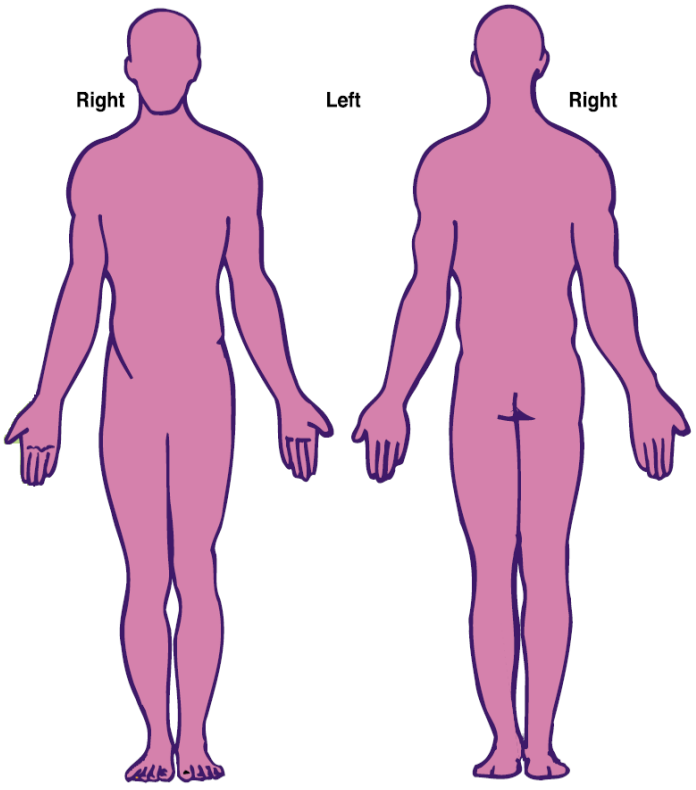
WHAT DO YOU WANT TO ACCOMPLISH FROM TODAY'S VISIT?
☐DIAGNOSIS ☐TREATMENT OPTIONS ☐XRAY RX ☐MRI RX ☐MED RX ☐REVIEW TEST ☐INJECTION RX

WHAT DIAGNOSTIC TESTS HAVE YOU HAD FOR THIS PROBLEM? ☐NONE ☐XRAY ☐MRI ☐CTSCAN ☐ORTHO CONSULT ☐EMG

WHAT TREATMENTS HAVE YOU HAD? ☐NONE ☐MEDS ☐INJECTIONS ☐PHYSICAL THERAPY ☐PSYCHOTHERAPY ☐CHIROPRACTIC

PLEASE INDICATE THE LEVEL OF DISCOMFORT YOU HAVE TODAY

NO PAIN										WORST PAIN EVER
0	1	2	3	4	5	6	7	8	9	10



PLEASE DESCRIBE WHAT THE PAIN FEELS LIKE: ACHY, BURNING, CRAMPING, STABBING, STIFF, TINGLING, NUMBNESS, DULL, TIGHT, PULLING

PLEASE DESCRIBE THE TIME COURSE OF YOUR PAIN: CONSTANT, GETTING WORSE, COMES & GOES, GETTING BETTER, STAYING THE SAME

PLEASE LIST ALL MEDICAL PROBLEMS: ☐DIABETES ☐HIGH BLOOD PRESSURE ☐CANCER ☐ARTHRITIS ☐OSTEOPOROSIS ☐HEART CONDITION ☐PACEMAKER ☐OTHER: _____

PLEASE LIST ALL SURGERIES: _____

_____

_____

LIST ALL ALLERGIES: _____

_____

TOBACCO USE: ☐CURRENT ☐QUIT ☐ NEVER

NUMBER OF ALCOHOLIC BEVERAGES PER WEEK? _____

OCCUPATION: _____

EMPLOYMENT STATUS: ☐FULL TIME ☐PART TIME ☐LIGHT DUTY ☐OFF DUTY DUE TO INJURY ☐FULL TIME PARENT ☐ NOT WORKING ☐ RETIRED

PHYSICAL REQUIREMENTS: ☐PROLONGED SITTING ☐PROLONGED STANDING ☐LIFTING ☐TRAVEL ☐DRIVING ☐COMPUTER ☐PHONE ☐ CHILDCARE

FEVERS, UNINTENTIONAL WEIGHT CHANGE?	☐YES ☐NO	**NEW RASHES OR SKIN LESIONS?**	☐YES ☐NO
DIFFICULTY SWALLOWING, HEADACHES?	☐YES ☐NO	**DIZZINESS, WEAKNESS, NUMBNESS, TINGLING?**	☐YES ☐NO
CHEST PAIN, PALPITATIONS?	☐YES ☐NO	**DEPRESSED MOOD, SLEEP PROBLEMS, ANXIETY?**	☐YES ☐NO
SHORTNESS OF BREATH, WHEEZING?	☐YES ☐NO	**CURRENT JOINT SWELLING OR MUSCLE PAIN?**	☐YES ☐NO
NAUSEA, VOMITING, BLACK STOOLS, LOSS OF CONTROL OF STOOLS?	☐YES ☐NO		
LOSS OF CONTROL OF URINE, URINARY FREQUENCY OR URGENCY?	☐YES ☐NO		

ARE YOU: PREGNANT ☐YES ☐NO **TRYING TO GET PREGNANT** ☐YES ☐NO **BREASTFEEDING** ☐YES ☐NO

PATIENT'S SIGNATURE: _____ **MD INITIALS / DATE**: _____

SHORE ORTHOPAEDIC GROUP – NEW PATIENT INFORMATION FORM

DATE: _____

LAST NAME: _____ **FIRST NAME (LEGAL):** _____ **M.I.** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____ **AGE:** _____

HOME#: _____ **CELL#:** _____

WORK #: _____ **EMAIL:** _____

SEX: ☐ **M** ☐ **F** **MARITAL STATUS:** ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ **SEPARATED**

RACE: _____ **ETHNICITY:** _____ **PREF LANGUAGE:** _____

EMERGENCY CONTACT

NAME: _____ **RELATIONSHIP:** _____ **PHONE#:** _____

IF PATIENT IS A MINOR – PARENT'S SOCIAL SEC# _____

REFERRED BY: ☐ **PRIMARY PHYSICIAN** ☐ **OTHER PHYSICIAN** ☐ **FRIEND** ☐ **OTHER** _____

YOUR PRIMARY CARE PHYSICIAN: _____ **CITY:** _____ **STATE:** _____

REFERRING PHYSICIAN: _____ **ADDRESS:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____ **PHONE#:** _____

EMPLOYER INFORMATION

NAME: _____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP CODE:** _____ **PHONE#:** _____

OCCUPATION: _____

CURRENT PROBLEM

PLEASE BRIEFLY DESCRIBE: _____

_____

IS PROBLEM ON YOUR: ☐ **RIGHT SIDE** ☐ **LEFT SIDE** **DATE OF ONSET:** _____

HEALTH INSURANCE INFORMATION

PRIMARY

CARRIER: _____ **NAME OF INSURED (POLICY HOLDER):** _____

ADDRESS: _____ **ID NUMBER:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

INSURED'S EMPLOYER: _____ **SS#:** _____ **DOB (MM/DD/YEAR):** _____

SECONDARY

CARRIER: _____ **ID NUMBER:** _____

NAME OF INSURED (POLICY HOLDER): _____ **SS#:** _____ **DOB (MM/DD/YEAR):** _____

INSURED'S EMPLOYER: _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

SHORE ORTHOPAEDIC GROUP L.L.C

www.shoreortho.com

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Sports Medicine
Scoliosis
Spinal Reconstruction Surgery
Total Joint Replacement and Revision
Foot and Ankle Surgery
Laser Surgery
Shoulder & Elbow Surgery
Interventional Pain Medicine
Electrodiagnostic Testing

_____

PATIENT'S NAME (PLEASE PRINT)

Shore Orthopaedic Group may leave messages at my home/cell. _____
Initials

I do not wish to have messages left at my home/cell. _____
Initials

An alternative number to reach me at is: _____ _____
Initials

Shore Orthopaedic Group may call me at my work/office. _____
Initials

I authorize the following person(s) to speak to Shore Orthopaedic Group on my behalf:

_____ _____
Initials

Shore Orthopaedic Group may speak to my spouse. _____
Initials

_____ _____
Patient's Signature Date

* Fellow of the American Board of Orthopaedic Surgeons
+ Clinical Assistant Professor of Orthopaedic Surgery Drexel University

(messages HT)

SHORE ORTHOPAEDIC GROUP - OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you read and sign prior to any treatment.

All patients must complete our information form in its entirety before seeing the doctor.

IF WE ARE NOT PARTICIPATING WITH YOUR INSURANCE PLAN, FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, OR ATM/CREDIT CARDS.

REGARDING YOUR INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance policy. In the event that we do accept assignment of benefits, we require that you provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to your responsibility. Please be aware that some and perhaps all of the services that are provided may be uncovered services, and not considered reasonable and necessary under the Medicare program and/or other medical insurance if doctor is non-participating with the insurance company. I authorize the insurance company to forward payment directly to the physician. Should payment be sent directly to me, it is my responsibility to forward payment directly to physician. This office does not accept any and all medicaid insurances. By signing this waiver you are aware that you are responsible.

I AUTHORIZE MY INSURANCE CARRIER TO FORWARD PAYMENT TO MY PHYSICIAN'S OFFICE.

A CURRENT REFERRAL IS REQUIRED FOR OUR MANAGED CARE PATIENTS AT TIME OF SERVICE.

Insurance plans, where we are a participating provider, co-payments are due prior to treatment. You will be billed for any deductible and co-insurance amounts. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Patients involved in worker's compensation or motor vehicle injuries must provide this office with an open claim number, name and address of insurance company, adjuster's name and phone number, in addition to your health insurance information. In the event that your claim is denied, you will be held responsible for all charges incurred. In accordance to New Jersey state laws, patients involved in motor vehicle accidents are responsible for their deductible and co-insurance amounts which may vary depending on your policy. Please refer to the above paragraph concerning your health insurance coverage for any outstanding balances.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult patients are responsible for full payment according to their plan at the time of service.

MINOR PATIENTS

A minor must be accompanied by a parent or guardian. The adult accompanying the minor is responsible for full payment. Unfortunately we cannot get involved in divorce and custody matters.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, we reserve the right to charge at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

I HAVE READ THE FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THESE TERMS.

_____	_____	_____
Please Print Name	Signature of patient or responsible party	Date

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Scoliosis
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Laser Surgery
Shoulder & Elbow Surgery
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Electrodiagnostic Testing

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

* Fellow of the American Board of Orthopaedic Surgeons
+ Clinical Assistant Professor of Orthopaedic Surgery Drexel University

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Dear Patient:

In accordance with Federal Regulations and the Public Law of the State of New Jersey, it is mandated that a physician, podiatrist, chiropractor, and all other licensees of the Board of Medical Examiners must inform his/her patients of any significant financial interest he/she may have in a health care service.

Therefore, please note that the physician who will be performing your procedure/surgery has a financial interest in the **Lakewood Surgery Center, LLC** for which you are being referred.

Of course, you may seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

You have the right to make informed decisions regarding your care. This includes the right to accept, refuse, or choose alternatives in your medical and/or surgical treatment.

You have the right to enter into an advance directive, which can include a Living Will and Durable Power of Attorney. Please note that the **Lakewood Surgery Center, LLC** is an outpatient facility where only elective surgery/procedures are performed. If a life-threatening situation should occur, all emergency measures will be taken and may include transportation to a higher level of care.

You have a right to receive a copy of the Patient's Rights and Responsibilities.

In addition, depending upon your health insurance coverage, any services or facility fees associated with a referral to **Lakewood Surgery Center, LLC** will be considered to be "out-of-network" and will be reimbursed at an "out-of-network" rate by your insurance carrier or other third party payer.

By signing this disclosure, you or your legal representative acknowledge that: (1) you are receiving this notice prior to the date of the procedure/surgery; (2) you have been informed of the financial interests of the practitioners in this office; (3) you voluntarily desire to have your procedure/surgery performed at the **Lakewood Surgery Center, LLC**; (4) you have the right to make an informed decision regarding your care; (5) you have the right to enter into an advanced directive; and (6) you have received a copy of the Patient's Rights and Responsibilities.

Understood and agreed:

_____	_____
Patient's Signature	Witness
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date

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I, _____agree that Dr. Sandeep Rathi will be the only physician prescribing controlled substances/medication for me and that I will obtain all of my prescriptions for controlled substances at one pharmacy. I will not seek controlled substances from another physician.

- I will not take controlled substances in larger amounts or more frequently than is prescribed.
- I will not give or sell my medication to anyone else, including family members; nor will I accept any controlled substances from anyone else. I agree to be responsible for the secure storage of my medication at all times. I understand that lost or stolen medication will not be replaced.
- I will not use over-the-counter codeine containing medications such as Tylenol®.
- I will attend all reasonable appointments, treatments and consultations as requested by my physician.
- I understand that the long-term use of controlled substances to treat chronic pain may result in physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of controlled substances withdrawal. I understand that controlled substances withdrawal is uncomfortable but not life threatening.
- I understand that there is a small risk that I may become addicted to the controlled substances I am being prescribed.
- I understand that my physician may, at any time, require that I have additional blood or urine monitoring and/or see a specialist in addiction medicine should a concern about addiction arise during my treatment. I will comply with all requests for laboratory tests including random urine monitoring ordered by my physician.
- I understand that the use of any mood altering substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician and I agree that this information may be shared.
- I consent to open communication between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc.
- I understand that if I break this agreement, my physician reserves the right to stop prescribing controlled substances and I may be discharged from this practice.
- I will comply with requests by my physician to go to the office for a pill count between scheduled visits.
- I understand narcotic medication will not be prescribed over the phone by my doctor; and understand I cannot receive weekend refills.
- If I violate this contract I authorize communication to my other treating doctors and case manager.

Patient's signature:_____Date:_____

Physician's signature:_____

Legal Assignment of Benefits & Designation of Authorized Representative

I, _____ represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Shore Orthopaedic Group, LLC (the "provider(s)"), as my Statutory Derivative Beneficiary (SDB), commonly known as a Designated Authorized Representative, and a Claimant under the "patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including but not limited to, (1) obtaining information about the claim to the same extent as the assigner; (2) submitting evidence; (3) making statements about factors or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including if necessary, to bring suit by the provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured/Guardian Date

_____

Please Print name of Insured/Guardian

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MEDICAL RECORDS RELEASE FORM

Patient Name: _____ ***Date of Birth:***_____

Home Phone:_____ **Cell or Daytime#:**_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my complete medical record, or a summary or narrative of my protected health information (including but not limited to mental health records, hospital records, and records pertaining to drug or alcohol abuse) to the person(s) or entity listed here.

HIV/AIDS: I **DO ____, or DO NOT ____** consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initials: _____ Date:_____

Release my protected health information to the following person(s)/entity:

Sandeep Rathi, MD
35 Gilbert Street South
Tinton Falls, NJ 07712
732-530-1515 Fax: 732-704-9956

I do_____ do NOT_____ give permission for these records to be faxed to the above entity.

_____ _____
Patient Signature (or parent, guardian, or legal representative) Date

* Fellow of the American Board of Orthopaedic Surgeons
+ Clinical Assistant Professor of Orthopaedic Surgery Drexel University

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Please complete the following information to help expedite your check-in process

Patient Name: _____

Date of Birth: _____

Pharmacy: _____

Pharmacy Address/Town: _____

Pharmacy Phone #: _____

Height: _____

Weight: _____

Smoking Status

Tobacco Usage: Never _____ Current Smoker_____ Former _____

Type: Cigarettes _____ Cigars_____ Chewing ____ Other _____

Years Used: _____

Frequency: Daily_____ Packs per Day_____ Occasionally _____

Do you have a family history of any of the following?

	Mother	Father	Sister	Brother
Arthritis	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Cardiac Disease	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____