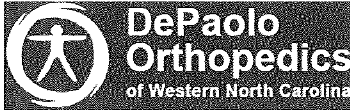

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Patient Name: ______________________________ Patient SSN: ____________________

Patient Address: ______________________________ City: ____________ State: ________ Zip: ________

Sex: M/F Birth date: __________________ Marital Status: □ S □ M □ D □ W

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ______________

Accept text messages? Yes No Email: ________________________________

Is the patient a minor? **Y/N IF SO: Guarantor Name: ____________________________

Guarantor SS# and Date of Birth ________________________

How did you hear about our practice? (Circle one) Website-Magazine-Physician-word of mouth-Hospital-Other______

Race: □ American Indian/Alaskan Native □Asian □African American □Pacific Islander □White □Unknown □Declined

Ethnicity: □Hispanic/Latino □Non-Hispanic/Latino □Unknown □Declined Preferred Language:____________

Employment Status: (circle one) Full-Time Part-Time Unemployed Self-employed Retired Student None

Name of Employer: ____________________

Primary Care Physician: ________________________ Referring Physician: ________________________

Pharmacy name/address/phone#: ____

INSURANCE INFORMATION

PRIMARY Insurance Company: ____

Insurance Address: ____

(Street Address) (City, State, Zip Code)

Subscriber's Name: ______________________________ Subscriber's Sex: M/F

Subscriber's SSN: ______________________________ Subscriber's Birth date: ____________________

Relationship to Patient: □ self □ spouse □ parent

Subscriber's Employer: ____________________ ID Number: ____________________ Group Number: __________

SECONDARY Insurance Company: ____

Insurance Address: ____

(Street Address) (City, State, Zip Code)

Subscriber's Name: ______________________________ Subscriber's Sex: M/F

Subscriber's SSN: ______________________________ Subscriber's Birth date: ____________________

Relationship to Patient: □ self □ spouse □ parent

CONSENT SECTION:

I consent to medical treatment and procedures by Charles J. DePaolo, MD, PA and his staff. I have read and agree to the policy sheet included in the new patient package. I am responsible for all charges incurred at Charles J. DePaolo, MD, PA and authorize payment of insurance benefits (Medicare, Medicaid, or commercial insurance) directly to this practice. I authorize the release and transmission of pertinent medical information for research purposes and/ or medical information necessary to determine insurance benefits. I am responsible for payment of all charges not covered by insurance contracts, including co-payments, deductibles, non-covered services, and those determined by the insurance company, where there is no contract with Charles J. DePaolo, MD, PA to be above their usual and customary.

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. Please list the family members or other persons, if any, whom we may inform about your appointments, labs, x-ray results and/ or other healthcare information. **PLEASE NOTE THAT THE FIRST PERSON LISTED SHOULD ALSO BE YOUR EMERGENCY CONTACT.**

NAME	RELATIONSHIP	PHONE NUMBER

Can confidential messages including appointment reminders, labs, x-ray results, and/ or other health care information be left on your home answering machine or voicemail? (PLEASE CHECK ONE) □ YES □ NO

IF NO, PLEASE LIST THE PHONE NUMBER, IF ANY, WHERE YOU WANT TO RECEIVE THIS INFORMATION:______________________________

I understand that I may revoke or change this authorization at any time by notifying the office of Charles J. DePaolo, MD, PA in writing. I understand and agree that Charles J. DePaolo, MD, PA has THIRTY (30) days from the receipt of the written revocation to update this information in the system.

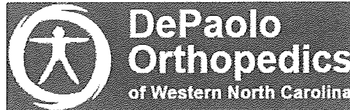
However, the revocation will not be valid if:

1. Charles J. DePaolo, MD, PA has taken action in reliance on the above authorization.
2. This authorization is obtained as a condition for obtaining insurance coverage. Other laws provide the insurer with the right to contest a claim under the policy or the policy itself.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received a copy of the Notice of Privacy Practice for the above-named practice. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by writing to the Privacy Officer, 3B McDowell Street, Asheville, NC 28801 or by requesting one in person at the office located at the same address.

Patient Signature: ______________________________ Date Signed: ______________

Notice of Privacy Practices



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

The privacy of your medical information is important to us. We are required by federal and state law to protect the privacy of your medical information. We are also required to give you this Notice about our privacy practices, or legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect June 1, 2005, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of out Notice is effective for all medical information that we maintain, including medical information we creased or received before we made the change. Before we make a significant change in our privacy practices we will change this Notice and make a new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose medical information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your medical information to a physician other healthcare providers involved in your care including your referring physician, or provider and other physicians or providers consulted in your care, or to whom you may be referred, including physicians, providers, and healthcare facilities such as a hospital or medical laboratory.

Payment: We may use and disclose your medical information to receive payment for services provided to you.

Healthcare Operations: We may use and disclose your healthcare information during normal healthcare operations. Healthcare operations include such things as quality assessment and improvement, training programs, accreditation, certification, licensing and /or credentialing of our physicians, providers, and facilities.

Your Authorization: In addition to our use of your medical information for treatment, payment, and healthcare operations you may give us written authorization to use or disclose your healthcare information to anyone for any purpose. This authorization may be revoked by you, in writing, at any time but will not affect any use or disclosure of medical information during the time the authorization was in effect. Without written authorization we cannot use or disclose your medical information for any reason not covered in this Notice.

Persons Involved In Your Care: We may use or disclose your medical information to notify a family member, your personal representative or another person responsible for your care, of your location and your general condition. If you are present we will provide you an opportunity to object to such use or disclosure. In the case of an emergency or if you are incapacitated for any reason, we will use our professional judgment in determining if such use or disclosure is necessary and in your best interest. We will also use our professional judgment in allowing a person other than you, to pick up prescriptions, medical supplies, or other similar forms of healthcare information or material.

Appointment Reminders: We may use or disclose your medical information to provide you with appointment reminders including answering machine messages, post cards, or mailings unless you specifically object to receiving these reminders in writing.

Abuse or Neglect: We may use or disclose your medical information to appropriate authorities if we reasonably believe you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your medical information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Required by Law: We may use or disclose your medical information in certain circumstances when we are required to do so by state or federal law. If you are a member of the Armed Forces we may disclose your medical information to military authorities. We may disclose medical information to correctional institutions or law enforcement representatives if you are in their lawful custody.

PATIENT RIGHTS

Access: You have the right to look at or get a copy of your medical information if requested in writing. We will charge you a reasonable cost based fee for expenses such as photocopies and staff time. We will charge $0.20 cents per page for photocopies and $15 per hour for staff time to locate and copy your medical information, and postage if you want the copies mailed to you. Once we receive a request for review we will estimate the cost and provide that to you.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, healthcare operations, or those specifically authorized by you with in the last six years but not prior to June 1, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost based fee for responding to these additional requests.

Notice of Privacy Practices

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your medical information. We are not required to agree with these additional restrictions, but if so, we will abide by our agreement.
Confidential Communications: You have the right to request that we communicate with you about confidential medical information by alternative means or to an alternate location. The request must be made in writing and specify the nature of the alternative means or the alternate locations and provide a satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your medical information. Your request must be made in writing and it must state the information to be amended and explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns please contact us. If you are concerned that we may have violate your privacy rights or if you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative locations, you may complain to us at the time of the incident or you may use the contact information listed at the end of this Notice. You may also submit a written complaint with the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request. We support your right to privacy for your medical information and will not retaliate in any way if you choose to file a complaint with us, or with the US Department of Health and Human Services.

Privacy officer: Deborah Scott
Telephone: 828-225-1920
Fax: 828-225-1924
Address: 3B McDowell St. Asheville NC 28801

I have read and acknowledge receipt of Notice of Privacy Practices for DePaolo Orthopedics.

____

Patient Name

____

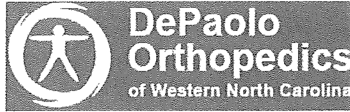
Patient or Legal Representative Signature

____

Relationship to Patient

____

Date



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Medication History Authority

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medications that we or other doctors have recently prescribed to you.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and mental health conditions, such as depression. This information will become part of your medical record.

I hereby authorize DePaolo Orthopedics of WNC to access my medication history without limitation or exclusion as is required and/or reasonably advised to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

If you call our office for a prescription refill, please allow 24 hours for the prescription to be refilled. Our office will only process prescription refills during office hours Monday thru Thursday. Requests received on Friday will not be filled until Monday.

____

Primary Pharmacy & Location

____

Patient Name -- **(PRINT)**

____

Patient Signature

PATIENT SERVICES FINANCIAL AGREEMENT

Insurance

If you have health insurance, we will assist you in receiving your maximum allowable benefits. In order for us to achieve this objective, we need your assistance and your understanding of our payment policy.

Insurance Cards and Personal Information

Please provide your insurance card at time of check-in for ***each visit to our office.*** Timely payment by your insurance company is dependent on our billing office having the correct demographic and billing information. You should make certain that all personal and insurance information is correct at each visit.

Permission to Release Personal Information

Federal law requires that you provide your signature for perm1ss10n to release information to your insurance carrier or other healthcare providers. Our failure to obtain this information could result in criminal/civil penalties and/or expulsion from your insurance plan. Please assist us in complying with these requirements.

Filing Your Insurance for Covered Services

We will gladly submit charges for our services to your insurance company; however, we require payment at the time of service.

It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is correct and current. If you give the wrong insurance information and a referral is required, you will be responsible for the charges. We will assist you to ensure that all plan requirements are met.

Responsibility for Services Not Covered by Your Insurance

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date services are rendered.

Payment for Services

Payments for services, including insurance co-payments, deductibles, or self-pay balance amounts, are due at the time services are rendered unless a Patient Financial Plan has been approved in advance by the Practice Administrator. We accept exact cash, checks, MasterCard, VISA and Discover. **A $40.00 service charge for checks returned due to insufficient funds will be added to your account. No services will be provided until the returned check and service charge have been paid in full.**

Surgical Claims

You will be responsible to pay your deductible, and/or co-insurance prior to your surgery as per your surgical benefits. You will receive separate billing statements from the surgery facility and anesthesiologist for your surgery.

Workers Compensation

Written verification from your employer is required. If the injury is denied as a Worker's Compensation Patient Services injury. All charges incurred are your responsibility.

Costs for Completion of Certain Forms

We require pre-payment of $25.00 for completion of the following forms: Disability, FMLA, and Insurance Forms Other than Primary Insurance.

General Information

We will discuss gladly your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance in managing your account.

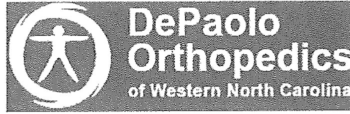
Financial Plan for Services Owed by Patient

If necessary, we will discuss a Financial Plan with the patient and/or guarantor for any services that are not covered by insurance. This Financial Plan must be completed before the scheduling of any surgical procedures.

I have read and understand the insurance/financial policy as outlined above for Charles J. DePaolo, M.D., P.A.

Printed Patient's Name:
Signature of Patient and/or Guarantor: ______________________

Health History & Vitals



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Today's Date: ______________ **Pharmacy (Name and Location):**______________________________

Patient Name: ______________________________**DOB:**________________ **Age:** ____________

Referring Physician: ______________________________ **Family Physician:** ______________________________

Who referred you to us (phone book, Ad, Referring Physician, Radio, other)? ______________________________

Chief Complaint (what are we seeing you for today?) **CIRCLE- LEFT OR RIGHT**______________________________

Was this a Work-Related Injury? Yes/No **Date of Injury/Onset of Pain:** ______________________________

Past Medical History (Please list any medical conditions you have had or currently have, ex: hypertension, diabetes):

____

____

History of Blood Clot: Yes No If "yes": _____Deep Vein Thrombosis (DVT) ____Pulmonary Embolism (PE) DATE:__________

Past Surgical History____

____

Family History (Past or current medical condition of family member) Mother______________________________
Father______________________________Siblings______________________________

Social History: Single_____ Married_____ Divorced_____ Separated_____ Widowed____ Domestic Partner_____
Tobacco Use: Cigarettes (packs per day) _____ Chew/Snuff ______ Pipe/Cigar ______
Alcohol Use: (drinks per day) ___________ Illicit drug use: (marijuana, etc.) ___________

Any Known Allergies (medicine and non-medicine):

____

Medications (please list all medications you are currently taking including supplements. Also dosages and frequency)

____

____

Immunizations: Last Tetanus:______________________________ Last Flu shot:______________________________

VITALS (office to complete)

Height__________ **Weight**__________ **BP**______________ **Temp**___________

Pulse____________ **Pulse Ox**_________ **Resp**____________

History of Present Illness

PLEASE CIRCLE AND FILL IN ALL QUESTIONS TO HELP US SERVE YOU MORE QUICKLY

PATIENT NAME: ______________________________ **DATE OF BIRTH:** ____________________

LOCATION

LEFT RIGHT BILATERAL FRONT BACK MIDDLE SIDE DEEP CLOSE TO THE SURFACE

QUALITY

ACHING BURNING GNAWING STABBING THROBBING SHARP DULL

SUPERFICIAL DEEP OCCASIONAL FREQUENT CONSTANT WORSENING IMPROVING

NOT CHANGING

SEVERITY

NO PAIN MILD MODERATE SEVERE PAIN LEVEL ____ / 10 WORST PAIN ____ / 10

DURATION

DATE OF ONSET: _______ DAYS ______ WEEKS ______ MONTHS ______ YEARS

_______ CONTINUOUS SINCE ONSET

TIMING

CANNOT IDENTIFY ACUTE CHRONIC ABRUPT GRADUAL MORNING DAYTIME

NIGHTTIME RECURRENT RARE OCCASIONAL INTERMITTENT EPISODES LASTING: ______

CONTEXT

CANNOT IDENTIFY FALL BENDING LIFTING TWISTING SPORTS INJURY WORK INJURY

MVA ASSAULT OVERUSE ATRAUMATIC LACERATION

ALLEVIATING FACTORS

NOTHING HELPS SITTING STANDING LYING DOWN POSITION CHANGE HEAT ICE REST

ELEVATION EXERCISE STRETCHING LIMITED WEIGHT BEARING PT/OT CHIROPRACTIC CARE ESI

OTC MEDICATION NARCOTICS NSAIDS CORTISONE INJECTION VISCOSUPPLEMENT INJECTIONS

ORTHOTICS PREVIOUS SURGERY BRACE CRUTCHES CANE WHEELCHAIR WALKER

History of Present Illness

PLEASE CIRCLE AND FILL IN ALL QUESTIONS TO HELP US SERVE YOU MORE QUICKLY

PATIENT NAME: ______________________ **DATE OF BIRTH:** ______________

AGGRAVATING FACTORS

CANNOT IDENTIFY SITTING STANDING LYING DOWN WALKING LIFTING CARRYING

TWISTING BENDING/SQUATTING PUSHING/PULLING ROM WEIGHT BEARING EXERCISE

PREVIOUS SURGERY CHANGING CLOTHES GETTING OUT OF BED GOING FROM SIT TO STAND UPSTAIRS

DOWNSTAIRS MORNING DAYTIME NIGHTTIME COLD WEATHER DAMP WEATHER

____

ASSOCIATED SYMPTOMS

WEAKNESS NUMBNESS TINGLING SWELLING REDNESS WARMTH ECCHYMOSIS

CATCHING/LOCKING POPPING/CLICKING BUCKLING GRINDING INSTABILITY RADIATION DOWN LEG

DRAINAGE FEVER CHILLS WEIGHT LOSS CHANGE IN BOWEL/BLADDER HABITS

____

PREVIOUS SURGERY NONE SURGICAL PROCEDURE DATE

____

PRIOR IMAGING NONE NO RECENT STUDIES X-RAY MRI CT SCAN BONE SCAN EMG

____

PREVIOUS INJECTIONS

NONE DID NOT HELP HELPED A LITTLE HELPED TEMPORARILY HELPED SIGNIFICANTLY

____

PREVIOUS PT

NONE DID NOT HELP HELPED A LITTLE HELPED TEMPORARILY HELPED SIGNIFICANTLY

____

WORK RELATED NO YES

____

WORKING NO REGULAR DUTY MODIFIED DUTY

Past Medical History/Review of Systems

PLEASE CIRCLE ANY CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST

PATIENT NAME: ______________________ **DATE OF BIRTH:** ______________

AIDS/HIV
ALLERGIES
ALZHEIMER DISEASE
ANEMIA
ANXIETY DISORDER
ANXIETY/DEPRESSION
ARTHRITIS
ASTHMA
ATRIAL FIBRILLATION
ATTENTION DEFICIT DISORDER
AVASCULAR NECROSIS
BIPOLAR DISORDER
BLEEDING DISORDERS
BLOOD CLOT
BLOOD IN STOOL
BLOOD PRESSURE
BREAST CANCER
BREATHING DIFFICULTY
COPD
CANCER
CARPAL TUNNEL SYNDROME
CERVICAL CANCER
CERVICAL DISC DEGENERATION
COLON CANCER
CORONARY ARTERY DISEASE
CHOHN'S DISEASE
DEMENTIA

DENTAL PROBLEMS
DEPRESSION
DIABETES
DIVERTICULOSIS
EMPHYSEMA
EPILEPSY
FEVER
FIBROMYALGIA
GERD
GLAUCOMA
GOUT
HEAD TRAUMA/INJURY
HEADACHES/MIGRAINES
HEARING CHANGES
HEART ATTACK (MI)
HEART DISEASE
HEART FAILURE
HEMOCHROMATOSIS
HEPATITIS
HERNIA
HERPES
HIGH CHOLESTEROL
HYPERTENSION
HYPERTHYROIDISM
HYPOTHYROIDISM
INFECTIONS / RASH
IRRITABLE BOWEL SYNDROME
KIDNEY DISEASE
LEG OR FOOT ULCERS

LESIONS
LIVER DISEASE
LUMBAR DISC DEGENERATION
LUNG DISEASE
MIGRAINES
MULTIPLE SCLEROSIS
MUSCLE, JOINT, OR BONE PROBLEMS
NAUSEA/VOMITING
NECK INJURY
NEUROLOGIC DISORDER
NEUROPATHY
NUMBNESS / TINGLING
OBESITY
ORGAN TRANSPLANT
ORTHOTICS
OSTEOARTHRITIS
OSTEOPENIA
OSTEOPOROSIS
PTSD
PACEMAKER
PARALYSIS
PARKINSON DISEASE
PERIPHERAL VASCULAR DISEASE
PNEUMONIA
PNEUMOTHORAX
PROSTATE CANCER
PULMONARY EMBOLISM
REFLUX/GERD

REITERS SYNDROME
RESTLESS LEG SYNDROME
RHEUMATOID ARTHRITIS
SCIATICA
SEIZURES/EPILEPSY
SERIOUS ILLNESS OR INJURIES
SHORTNESS OF BREATH
SINUS PROBLEMS
SKIN CANCER
SLEEP APNEA
STROKE
SWALLOWING DIFFICULTY
THYROID PROBLEMS
TUBERCULOSIS
ULCERS
URINARY INCONTINENCE
URINARY TRACT INFECTIONS
VERTIGO
VISUAL CHANGES/DOUBLE VISION
WEIGHT CHANGE