Elite Orthopaedics of North Hills
Dr. Thomas Carrell

Thank you for choosing us to be your healthcare provider.

How did you hear about us?

1. _____ Primary Care Physician: Dr. _____.
2. _____ Friend. Who can we thank? _____.
3. _____ Website: _____.
4. Magazine. Which one? _____.
5. Newspaper
6. Radio
7. Television
8. Insurance

Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

Address Line 2 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

Address Line 2 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

Address Line 2 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

ELITE ORTHOPAEDICS OF NORTH HILLS PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name**:** _____

Date of Birth: _____

_____ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members
DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient Initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.
____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:
Name: _____ Date: _____
Name: _____ Date: _____
____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature _____ Date: _____

Patient Name (Printed): _____ DOB: _____

Updated: June 12, 2015, replacing November 21, 2013 version

Elite Orthopedics of North Hills
Patient Narcotic/Pain Management Contract

I understand that treatment by Dr. Thomas Carrell, M.D. may include an attempt to manage my pain, and that some of the medications needed may carry a risk of causing addiction or are prone to overuse and abuse. Because of this, special care must be taken in their use.

As a result, I agree to the following:

1) That narcotics prescribed will be taken exactly as directed with adjustment made only if and as instructed.
2) There are no early refills or replacement of lost prescriptions for any reason, as federal law prohibits the writing of more than a certain number of pills at a time, and doctors and pharmacists are held accountable. If I have a change in pain requiring accelerated use of narcotics, I must discuss this with Dr. Thomas Carrell before running out of medications. Stolen medications will only be replaced after I present a police report copy to Dr. Thomas Carrell.
3) Attempts at altering prescriptions, selling medications, or obtaining narcotics from sources other than Dr. Thomas Carrell.
4) If I take medication inappropriately, I risk immediate discharge from Dr. Thomas Carrell office.
5) One pharmacy will be used. Any transfer of prescriptions must be done with Dr. Thomas Carrell's approval within ten (10) business days of advanced warning: Dr. Thomas Carrell will discuss my care and use of these medications with the pharmacist as he deems necessary.
6) Refill request will be made during regular business hours and at least five (5) business days in advance.
7) Narcotic medications are to be used only by me. I will protect them from use by another person or from theft by safely locking them in a protected place.
8) If I run out of medicine, I may go through narcotic withdrawals symptoms such as diarrhea, abdominal pain, headaches, runny nose, agitation, and/or anxiety. In some extreme cause, seizures may occur which can lead to death.
9) I use no illicit drugs.
10) I will consent to random testing of urine for drug abuse profile testing at office visit to determine if I am using controlled or illicit drugs which are not prescribed by Dr. Thomas Carrell. If these tests are refused, the medication will not be prescribed.
11) Appointment will be made at least every three (3) months for re-assessment as narcotics are potentially dangerous and easily over used/abused drugs.
12) Medications are given as part of an overall treatment programs, I will do everything in my power to cooperate and participate in the range of non medicinal efforts to be undertaken. I will not take medication different than the prescriptions instructions.
13) When there are no alternative other than to manage my pain with long-term use of narcotics, I agree that regular attempts to reduce dosage and /or develop alternative approaches to functional comfort will be part of the plan, and I will cooperate with them.
14) I have a history of gambling addictions, substance abuse of any kind, drug abuse, alcoholism, bipolar syndrome/disease, or I have none of the diagnoses. ***(Circle all correct diagnoses/statements).***

I have read, understood, and agree to these statements.

_____ _____
Signature Date

_____ _____
Provider Signature Date

Please DO NOT use Patient Portal to communicate with your Practice for urgent or emergency medical issues. If you are experiencing an urgent medical need, please contact us by phone.

For emergencies call 911.

Patient Portal User Agreement and Consent

Effective: August 10, 2012

The Patient Portal (defined below) is owned and operated by the practice to which you are seeking to online access (the "Practice"). The Practice has adopted this user agreement ("User Agreement" or "Agreement") to make you aware of the terms and conditions of your use of the Patient Portal and any derivative websites of the Patient Portal (collectively, the "Patient Portal"). In the event that you purport to be the agent of, represent, or otherwise act on behalf of any other person, references to "you," "your" or "User" shall include such entity or person in addition to such representative, and your acceptance of this Agreement shall constitute acceptance on behalf of such person.

The Practice uses reasonable efforts to maintain the Patient Portal, but the Practice is not responsible for any defects or failures associated with the Patient Portal, any part thereof or any damages (such as lost profits or other consequential damages) that may result from any such defects or failures. The Patient Portal may be inaccessible or inoperable for any reason, including, without limitation: (a) equipment malfunctions, (b) periodic maintenance procedures or repairs which the Practice may undertake from time to time or (c) causes beyond the control of the Practice or which are not foreseeable by the Practice. In addition, the Practice makes no guarantees as to the web sites and information located worldwide throughout the Internet that you may access as a result of your use of the Patient Portal, including as to the accuracy, content, or quality of any such sites and information or the privacy practices of any such site. The Practice is not a backup service for storing data you submit to the Patient Portal, and the Practice shall have no liability regarding any loss of such data. You are solely responsible for creating backups of any data you submit using the Patient Portal.

The Patient Portal is a secure website that allows you to use a computer to interact with medical information via the internet. The Patient Portal also allows you to communicate with the Practice via secure messaging. Please note that all communication via the Patient Portal will be included in your permanent patient record.

Responsibilities, Risks and Benefits:

The Patient Portal is provided as a convenience to you at no cost and is only available in English at this time. We do not sell or give away any private information, including email addresses. We reserve the right to suspend or terminate the Patient Portal access at any time and for any reason.

All messages sent to you will be electronically secure. Messages and emails from you to any staff member must be sent through the Patient Portal for security and confidentiality reasons.

The Patient Portal messages will be handled by our staff in a manner similar to how phone communication is handled.

Although we strive to reply to Patient Portal messages within one business day, we cannot guarantee that we will be able to address your messages in that timeframe. We encourage you to use the Patient Portal at any time but understand that we can only reply to messages during our office hours, excluding holidays recognized by the Practice. If you do not receive a response within two business days, please feel free to call our office.

You are responsible to provide us with your correct email address and inform us immediately of any change. You are also responsible for the protection of your login information and password.

Please understand that all electronic communications carry some degree of risk, even in a secured environment. Even with all due precautions, online communications may be intercepted, forwarded or changed without a patient's or the healthcare provider's knowledge. By using or accessing the Patient Portal, you expressly accept these risks.

Note that it is easier for a patient's identity to be stolen or for someone to try to impersonate a patient via online communication.

Online communications are admissible as evidence in court just as medical records are in the event the physician-patient privilege is waived or if a court orders disclosure.

Online communications may disrupt or damage a computer if a computer virus is transmitted via an attached file, hyperlink or other method. You assume liability for such disruptions or damages caused by such transmissions.

Responses to online communications are limited by the information provided and your question may necessitate a follow-up phone call or a request to meet with you in person to gain further information.

Electronic communications will be viewed by not only the physician, but the staff members assigned to handle such communications and any other provider covering for the patient's physician if the patient's physician is unavailable to respond.
Applicable law may allow a health care professional to determine that a minor patient is "mature" to keep a portion of the minor's medical information confidential. If the minor patient is determined "mature" by his or her physician, all Patient Portal communication will be with the minor directly and a new consent form with the minor's email address will be required.
Applicable law may also permit confidential communication with a minor patient in regards to treatment and reporting of sexually transmitted diseases to the minor and communications with pregnant minors in regards to questions about the health of her fetus. In these situations, all Patient Portal communications will be directly with the minor and a new consent form with the minor's email address will be required.
The Practice will keep a copy of all medically important online communications in your medical record secure pursuant to applicable federal and state laws and regulations. Print or store in a secure place (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you.
The Practice will not forward online communications with you to third parties except as authorized or required by law.
Please note that online communications should never be used for emergency communications or urgent requests. These should occur via telephone or using existing emergency communications tools as noted above.
Follow-up is solely your responsibility. You are responsible for scheduling any necessary appointments and for determining if an online communication did not receive a response.
You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. The Practice is not responsible for breaches of confidentiality caused by you or an independent third-party.

Guidelines for Safe Online Communications

Take steps to keep your online communications to and from the Practice confidential, including:

Do not store messages on your employer-provided devices (e.g. computer, cell phone, tablet, etc.); otherwise personal information could be accessible or owned by your employer.
Use a screen saver or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private.
Do not allow other individuals or third parties access to the devices(s) upon which you store medical communications.
Keep your login and password information secure and confidential.
Do not use email for medical communications. Standard email lacks the necessary security and privacy features and may expose medical communications to employers or other unintended third-parties.

Access to Online Communications

The following pertains to access to and use of online communications:

Online communications do not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement.
The Practice may stop providing online communications with you or change the services provided online at any time without prior notification to you.

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All of my questions have been answered and I understand and concur with the information

Print Patient Name: _____ Date of Birth _____

Email address: _____

_____ _____ _____

Signature Relationship Date

☐ I am over the age of 18 and have sole responsibility of my medical care

□ Yes

□ No (We do not offer the Patient Portal to minors or those patients which do not make their own medical decisions at this time. We apologize for the inconvenience).

☐ I choose not to participate in Patient Portal at this time because:

□ I do not have an E-mail address
□ I do not wish to share my E-mail address
□ English is not my preferred language
□ Other

Elite Orthopaedics of North Hills

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

Elite Orthopedics of North Hills

Date:_____

MEDICAL QUESTIONNAIRE

Please complete all paperwork

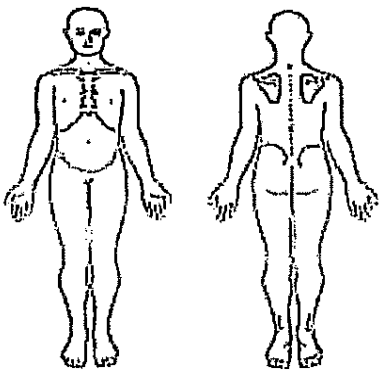
Patient Name: _____Date of Birth: _____

Gender: ☐ Male ☐ Female Age: _____ Dominant Hand: ☐ Right ☐ Left Did you bring X-rays? ☐Yes ☐No

What is the main reason for your visit with us today?

☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other: _____

What body part is involved? Please mark on the diagram below.



How long ago did it start? _____ Days _____Weeks _____Months _____Years

Have you had a problem like this before? ☐ Yes ☐ No

On a scale of 0-10 (10 is the worst), how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Fleeting Does your pain wake you from sleep? ☐ Yes ☐No

Do you have? ☐ Swelling ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of control of bowels or bladder

Since my problem started, it is: ☐ Getting better ☐ Getting Worse ☐ Unchanged

What makes your symptoms ***worse?***

☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in Bed ☐ Bending

☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing ☐ Sneezing ☐ Overhead reaching

☐ Pushing ☐ Pulling ☐ Lifting above shoulder joint line

What makes your symptoms ***better?*** ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other: _____

Have you had any of these treatments? ☐ Injections ☐ Brace ☐ Physical Therapy ☐ Cane/Crunches

What tests/scans have you had for this problem? ☐ X-rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Nerve Test (EMG)

Do you have any drug allergies? ☐ Yes ☐ No If yes, type and reaction _____

Do you have any metal allergies? ☐ Yes ☐ No If yes, type and reactions _____

Current work status? ☐ Regular ☐ Light Duty (How long? _____) ☐ Not working due to this problem

☐ Disabled ☐ Retired ☐ Student ☐ Unemployed

When is the last day you worked your regular job? _____

MEDICAL HISTORY:

Do you have or have you ever had any of the following conditions:

Please check here if the answer to all conditions listed below is "NO" _____

Y	N	Conditions	Y	N	Conditions
		ALCOHOL/DRUG PROBLEM			HEPATITIS
		ALZHEIMER'S DISEASE			HERNIA
		ARTHRITIS			HIGH CHOLESTEROL
		ASTHMA			HIV/AIDS
		BACK INJURY			HYPERTENSION
		BACK PAIN			JOINT PAIN
		BLEEDING TENDENCIES			JOINT SPRAIN
		BOWEL PROBLEMS			KNEE INJURY
		BRONCHITIS			LIVER
		BURSITIS			LUNG CANCER
		CARPAL TUNNEL SYNDROME			MAJOR ACCIDENTS
		COPD/EMPHYSEMA			MIGRAINES/NECK PAIN
		DEQUERVAIN'S			NEUROPATHY
		DEPRESSION			OCD
		DIABETES			PACEMAKER
		DIVERTICULITIS			RHEUMATOID ARTHRITIS
		EASY BLEEDING			SCIATICA
		EMPHYSEMA			SHOULDER DISLOCATION
		EPILEPSY			SICKLE CELL ANEMIA
		FIBROMYALGIA			SLEEP APNEA
		FRACTURE HISTORY			SPINAL CORD INJURY
		GI BLEED			STROKE
		GOUT			ULCERS
		HEART ATTACK ;IF YES, WHEN?			OTHER(SPECIFY_____)

SURGERY/ HOSPITALIZATION/ ACCIDENT/ INJURY HISTORY

ALL OPERATION/CONDITION REQUIRING HOSPITALIZATION/ ACCIDENT/INJURY	YEAR

PERSONAL HABITS

DO YOU REGULARLY DRINK ALCOHOL	YES	NO	IF YES, WHAT AMOUNT? _____
DO YOU DRINK >4 CUPS OF CAFFEINATED BEVERAGES PER DAY?	YES	NO	IF YES, WHAT AMOUNT? _____/Type_____
DO YOU SMOKE?	YES	NO	IF YES, HOW MANY PACKS PER DAY?____/What age?____
ARE YOU A FORMER SMOKER?	YES	NO	IF YES, WHEN DID YOU QUIT? _____
HAVE YOU EVER USED STREET DRUGS	YES	NO	IF YES, WHAT TYPE? _____
ARE YOU CURRENTLY USING STREET DRUGS?	YES	NO	IF YES, WHAT TYPE? _____

RELATIVE	YEAR OF BIRTH	IF DECEASED, AGE AT DEATH	MEDICAL PROBLEMS/ CAUSE OF DEATH
MOTHER			
FATHER			
BROTHERS			
SISTERS			
Have you ever been screened or treated for depression?	When?		
Vaccinations:			
Have you had a flu shot?	When?		
Have you had a pneumonia shot?	When?		

MEDICATION LIST

Name of Medication	Dosage	How often?

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked.
Use as much space to the right as needed

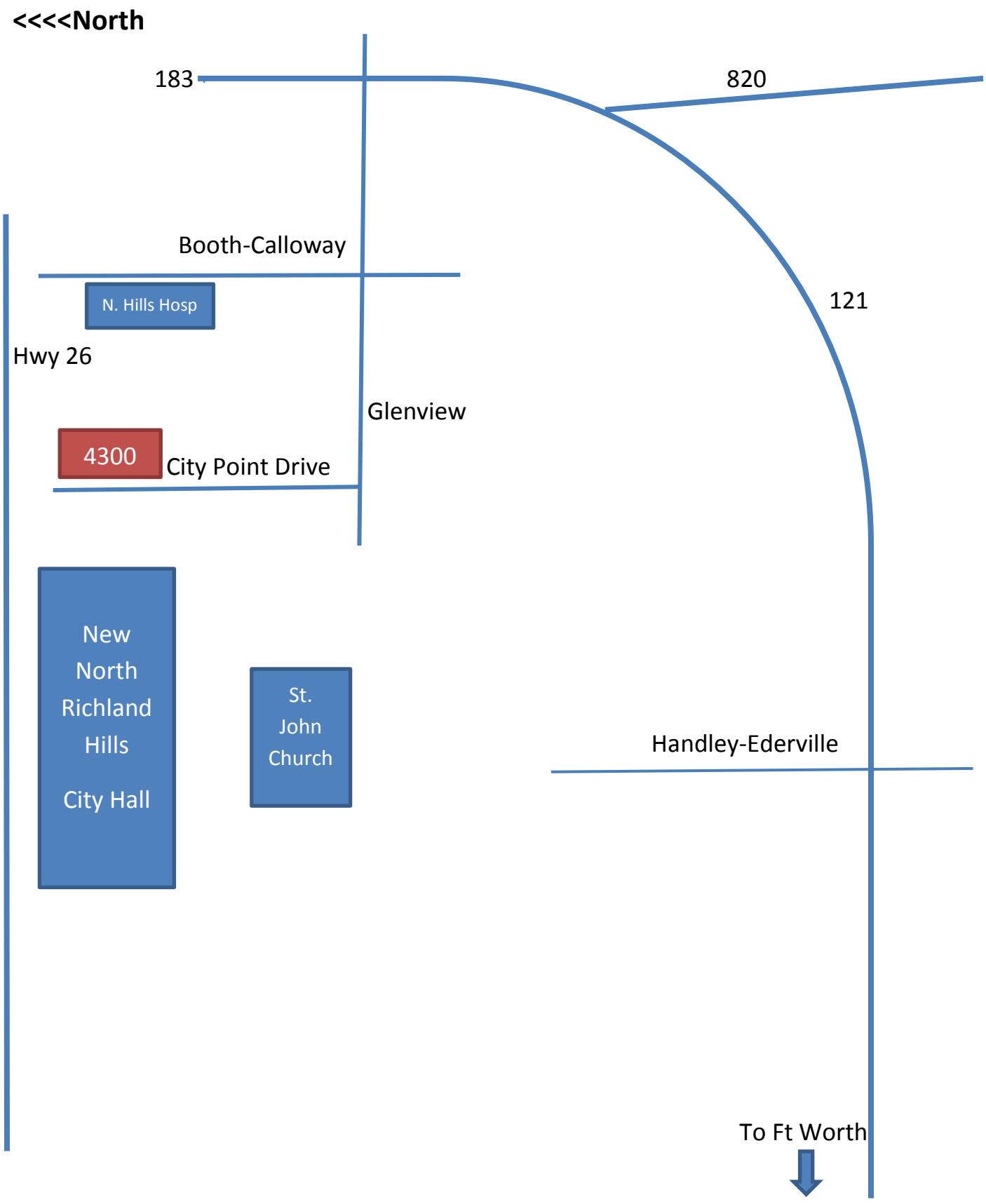
Answer/ Comments:

☐ **NO INJURY** (onset was: ☐ Gradual or ☐ Sudden)
Why do you think it started?

☐ **INJURY** (☐ Sport ☐ Accident- NOT auto or Work)
Date: ___/___/___ where and how did it happen?
From a ☐ Lift ☐ Twist ☐ Fall ☐ Bend ☐ Pull ☐ Reach?

☐ **WORK- RELATED – (BUT NO INJURY)**
Date: ___/___/___ How did your job cause this problem?

☐ **AUTO ACCIDENT**
Date: ___/___/___


<<<<North
183
820
Booth-Calloway
N. Hills Hosp
121
Hwy 26
Glenview
4300
City Point Drive
New North Richland Hills City Hall
St. John Church
Handley-Ederville
To Ft Worth

Medicare Secondary Payor Development Form

Facility Name	COID	Patient's Retirement Date	Spouse's Retirement Date	Spouse's Deceased Date
Elite Orthopadics of North Hills	**24199**	✓	✓	✓

Patient's Name	Account No.	Medicare No.
		✓

You must ask the patient each question in sequence and comply with any instructions which follow an answer. Failure to obtain information regarding Medicare as a secondary payor is a violation of your Provider agreement with Medicare.

Does the patient have an HMO policy? ☐ No ☐ Yes

If Yes, name, address and phone of HMO:

✓

Does the HMO replace Medicare? ☐ No ☐ Yes

If Yes, the HMO will be primary. If No, it will be secondary.

Is this patient an inpatient? ☐ No ☐ Yes

Was the patient given Important Message? ☐ No ☐ Yes

If No, why not?

Has patient been an Inpatient in a health care facility within the last 60 days? ☐ No ☐ Yes

If Yes, name, address and phone of facility:

Has the patient had any outpatient medical services in the last 72 hours? ☐ No ☐ Yes

If Yes, name, address and phone of facility:

1. Are you receiving Black Lung (BL) Benefits?

✓ ☐ No

☐ Yes; Date benefits began:

If Yes, BL is Primary only for claims related to BL.

2. Are the services to be paid by a government program such as a research grant?

☐ No

✓ ☐ Yes; *Government program will pay primary benefits for these services.*

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

✓ ☐ No

☐ Yes; *DVA is primary for these services.*

4. Was the illness/injury due to work related accident or condition?

✓ ☐ No; **Go to Question 5.**

☐ Yes; Date of injury/illness:

Name, address and phone of Workers Compensation Plan:

Policy or ID Number:

Name, address and phone number of your employer:

If Yes, Workers Compensation is Primary Payor only for claims related to work related injury or illness. **Go to Question 8.**

5. Was the illness/injury due to a non-work related accident?

✓ ☐ No; **Go to Question 8.**

☐ Yes; Date of accident:

6. What type of accident caused the illness/injury?

✓ ☐ Automobile ☐ Non-Automobile

Name, address and phone of no-fault or liability insurer:

Insurance Claim Number:

No-Fault insurer is Primary payor only for those claims related to the accident. **Go to Question 8.**

☐ Other (explain)

7. Was another party responsible for this accident?

☐ No; **Go to Question 8.**

☐ Yes; Provide name, address and phone of any liability insurer:

Insurance claim number:

If yes, liability insurer is Primary only for those claims related to the accident. **Go to Question 8.**

8. Are you entitled to Medicare based on:

☐ Age; **Go to Questions 9 – 12.**

☐ Disability; **Go to Questions 13 – 16.**

☐ ESRD; **Go to Questions 17 – 23.**

9. Are you currently employed?

✓ ☐ Yes; Provide name, address and phone of your employer:

10. Is your spouse currently employed?

✓ ☐ No; Date of retirement:

☐ Yes; Provide name, address and phone of spouse's employer:

If the patient answered No to both questions 9 and 10, Medicare is primary. If the patient answered "Yes" to questions 1 – 4 or 5 – 7 then Medicare is NOT primary payer.

Do not proceed any further.

If yes to questions 9 or 10, go to questions 11 and 12.

11. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

☐ No; **Stop.** *Medicare is primary payer unless the patient answered Yes to questions 1 – 4 or 5 – 7.*

☐ Yes

Medicare requires this form to be completed for every Medicare patient. The information is used to determine if other payors are primary to Medicare. Medicare requires the patient to sign

Medicare Secondary Payor Development Form

the MSP form.

Medicare Secondary Payor Development Form

Patient's Name	Account No.	Medicare No.

12. Does the employer that sponsors your GHP employ 20 or more employees?
- ☐ No; **Stop.** *Medicare is Primary payer unless the patient answered "Yes" to questions 1-4 or 5 – 7.*
- ☐ Yes; **Stop.** *Group Health Plan is Primary. Obtain the following information.*

Name, address and phone of GHP:

Policy ID Number:

Group ID Number:

Name of Policy Holder Relationship to Patient

13. Are you currently employed?
- ☐ No; Date of Retirement
- ☐ Yes; Provide name, address and phone of your employer:

14. Is a family member currently employed?
- ☐ No
- ☐ Yes; Provide name, address and phone of employer:

If patient answers "No" to both questions 13 and 14, Medicare is Primary unless the patient answered "Yes" to questions 1–4 or 5–7. **Do not proceed any further.**
If Yes to questions 13 or 14, go to question 15 and 16.

15. Do you have your group health plan (GHP) coverage based on your own, or a family member's current employment?
- ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
- ☐ Yes

16. Does the employer that sponsors your GHP, employ 100 or more employees?
- ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
- ☐ Yes; **Stop.** *Group Health Plan is Primary. Obtain the following information:*

Name, address and phone of GHP:

Policy ID Number:

Group ID Number:

Name of Policy Holder Relationship to Patient

17. Do you have group health plan (GHP) coverage?
- ☐ No: Stop. *Medicare is Primary.*
- ☐ Yes; Provide name, address and phone of GHP:

Policy ID Number

Group ID Number:

Name of Policy Holder Relationship to Patient

Name, address and phone of employer, if any from which you received GHP coverage:

18. Have you received a kidney transplant?
- ☐ No
- ☐ Yes; Date of Transplant:

19. Have you received maintenance dialysis treatments?
- ☐ No
- ☐ Yes; Date dialysis began:

If you participated in self dialysis training program, provide date training started:

20. Are you within the 30 month coordination period?
- ☐ No; **Stop.** *Medicare is Primary.*
- ☐ Yes

21. Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and disability?
- ☐ No; **Stop.** *GHP is Primary during the 30 month coordination period.*
- ☐ Yes

22. Was your initial entitlement to Medicare (including simultaneous Entitlement) based on ESRD?
- ☐ No; *Initial entitlement based on age or disability.*
- ☐ Yes; **Stop.** *GHP continues to pay Primary during the 30th month coordination period.*

23. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?
- ☐ No; *Medicare continues to pay Primary.*
- ☐ Yes; *GHP continues to pay Primary during the 30 month coordination period.*

I understand that I am responsible for charges not covered by the Medicare program, and that such services include, but are not limited to the following: Cosmetic surgery, dental care, take-home drugs, private duty nurses, custodial care, television, telephone, private room (unless medically necessary), personal convenience items, non-FDA approved medical devices.

X X