

# Orlin & Cohen Medical Specialists Group

Patient Label

Sports Medicine, Joint Replacement, Arthroscopy & Reconstructive Surgery, Foot & Ankle Surgery, Knee & Shoulder Reconstruction, Spinal Surgery & Pain Management, Hand & Elbow Surgery, Trauma

## NEW PATIENT INFORMATION FORM

LAST	M.I.	FIRST		
STREET # & NAME OR P.O. BOX		CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE		
SS #	DOB	SEX	E-MAIL	
NAME OF SPOUSE/PARTNER/GUARDIAN (EMERGENCY CONTACT)			PHONE	
REFERRING PHYSICIAN NAME	ADDRESS	PHONE		
PRIMARY CARE PHYSICIAN NAME	ADDRESS	PHONE		
INSURANCE: PRIMARY	SECONDARY			
INSURED	EMPLOYER	ADDRESS	INSURED DOB	

Work/Sports Status: Full Time / Part Time / Injured / Disabled / Student / Retired / Playing Sports / Light Duty / Not working due to the Injury

Does this visit involve a workman's Compensation issue? YES / NO Hand Dominance:  LEFT  RIGHT

Was your injury reported to your employer  Yes  No

Chief Complaint / History of Present Illness: Height \_\_\_\_\_ Weight \_\_\_\_\_

Body Part Injured: LEFT / RIGHT \_\_\_\_\_ Cause: Sports/Work/Auto/Other

Date of Injury/Accident/Onset: \_\_\_\_\_ Time & Place \_\_\_\_\_

How did the Injury Occur? \_\_\_\_\_

Was Injury  Gradual  Sudden  Repetitive Motion

How does it affect / bother you? \_\_\_\_\_

Pain at Rest: (No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Worst Pain Imaginable)

Pain at Activity: (No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Worst Pain Imaginable)

Does anything make your pain better or worse? (Please list) \_\_\_\_\_

Have you been treated for this problem before? YES / NO Date(s): \_\_\_\_\_

By whom? \_\_\_\_\_

Prior surgery for this problem? YES / NO Date(s): \_\_\_\_\_

Physical therapy for this problem? YES / NO Date(s): \_\_\_\_\_

If you were/are unable to work/play, list dates of disability: \_\_\_\_\_ to \_\_\_\_\_

Have you had any prior tests or imaging studies for this problem? YES / NO

If yes, list facility, type & date: \_\_\_\_\_

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**Past Medical History: (PHX)** Please list none if the question does not apply.

Medical Problems: \_\_\_\_\_  
 \_\_\_\_\_

Previous Hospitalizations & Surgical Procedures: (Provide Dates) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all allergies (drug, food, environmental): \_\_\_\_\_  
 \_\_\_\_\_

Current Medications: (Include Doses and Frequency) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Family Medical History: (Include Medical Illness Affecting Patient's Immediate Family) \_\_\_\_\_  
 \_\_\_\_\_

**Social History: (Check Boxes and Fill Blanks)**

- Married     Single     Divorced     Widowed     Other: \_\_\_\_\_  
 Alcohol Use:     Occasional     Daily     Heavy     None  
 Tobacco Use:     Yes     No    (Type: \_\_\_\_\_ Packs Per Day \_\_\_\_\_ Years Used: \_\_\_\_\_)  
 Recreational Drug Use:     Yes     No    (Types: \_\_\_\_\_)

**REVIEW OF SYSTEMS: (Check All That Apply)**

GENERAL

- Weight Change
- Fever or Chills
- AIDS/HIV
- Night Sweats
- Bleeding
- Lumps or Masses
- Dizziness or Fainting
- Diabetes Mellitus
- Thyroid Problem
- Cancer

GASTROINTESTINAL

- Difficulty Swallowing
- Jaundice
- Hepatitis
- Reflux
- Ulcer

GENITOURINARY

- Urinary Infections
- Incontinence
- Urinary Frequency
- Venereal Disease
- Menopause

CARDIOVASCULAR

- Chest Pain
- Heart Disease
- High Blood Pressure
- Mitral Valve Prolapse
- Thrombophlebitis/DVT/PE

NEUROLOGIC

- Seizures
- Numbness
- Weakness

EAR-EYES-NOSE-THROAT

- Visual Change
- Hearing Change
- Tinnitus
- Bleeding Gums

RESPIRATORY

- Cough/Sputum
- Tuberculosis
- Shortness of Breath
- Asthma
- Emphysema

PSYCHOLOGICAL

- Depression
- Bipolar
- ADD/ADHD
- Other

MUSCULOSKELETAL

- Back Pain
- Joint Pain
- Joint Swelling
- Neck Pain

SKIN

- Itching or Rash
- Wound Discharge

All Systems Reviewed & Negative

**Providers Notes Section:**

**Pharmacy Information Sheet**

We can send your prescriptions directly to your pharmacy so that there is less waiting time for you. If you know your pharmacy, please complete the below form. Please be aware that the easiest way for us to find your pharmacy is to know the zip code.

Your Name:		Date of Birth:	
Pharmacy Name:			
Address:			
City:	State:	Zip:	
Pharmacy Phone #:	Pharmacy Fax:		

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

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## CONSENT TO LEAVE MESSAGES /SHARE INFORMATION WITH FAMILY & FRIENDS

I understand that my healthcare information is protected. I understand that, in order for Orlin & Cohen to leave detailed messages containing specific health information on my voice mail or answering machine, I need to give permission for Orlin & Cohen to do so.

### Consent for Leaving Messages

I give my permission for messages regarding the following to be left on my phone number(s) below:

Enter "Y" or "N".

Appointment Reminders/Changes     Account Payments/Balances     Cost Estimates     Needed Treatment/Completed Treatment     Test Results  
Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

### Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law, we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form. The name(s) listed below are family members or friends to whom I grant permission for Orlin & Cohen to verbally discuss my care using their best judgment and grant them permission to disclose information regarding the following (Enter Y or N):

Appointment Reminders/Changes     Account Payments/Balances     Cost Estimates     Needed Treatment/Completed Treatment  
 Test Results

	NAME	RELATIONSHIP	PHONE NUMBER
1.	_____	_____	_____
2.	_____	_____	_____

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

\_\_\_\_\_  
Printed Name (Patient/Parent)

\_\_\_\_\_  
Signature (Patient/Parent)

\_\_\_\_\_  
Date

## CONSENT TO E-MAIL AND TEXT COMMUNICATIONS

I consent to communicate with Orlin & Cohen through e-mail and/or text messaging. If I am signing this document for another person, I agree that I am consenting for this patient and I will provide the relationship (parent, relative, health care agent, guardian, surrogate) where indicated below. I agree that:

Text messaging will be used only for the purpose of providing me with appointment-related information. Text messaging may not be used to communicate with my healthcare provider. I understand that text messages will be sent unencrypted which means that they will not be protected and others may be able to access the information as it is sent.

I understand that e-mail communication should not be used for emergencies or for communicating time-sensitive information. E-mail communication will be processed during routine business hours.

In the event of a medical emergency, I should call 911 or go to the nearest Emergency Department. E-mail should be used only for non-urgent issues. It should not contain sensitive information such as information regarding sexually transmitted diseases, HIV/AIDS, mental health, developmental disabilities or substance abuse. I understand that any e-mail communication between my provider and me regarding my care may become part of my medical records.

By providing my e-mail address, I am agreeing to receive e-mails. Emails that are sent from Orlin & Cohen will be encrypted to keep them secure, unless I request to receive unencrypted e-mails. I understand that most personal e-mail services do not encrypt or otherwise protect e-mails. Therefore, there is a risk that e-mails I send from my e-mail account to my provider may be accessed by others not affiliated with my provider. As a result, I understand that if I communicate with my provider using my personal e-mail account, it may not be secure and there is a risk that my health information may be obtained by others not affiliated with my provider. Despite this risk, I authorize my provider to send my personal health information via e-mail.

I further acknowledge that e-mails and text messages may be subject to technical malfunctions. Therefore, I understand that e-mail and text message delivery is not guaranteed and potentially subject to unauthorized disclosure to third parties.

I accept that my healthcare provider or I can terminate e-mail communication and/or text messaging at any time.

I understand that I am responsible for notifying the healthcare provider if I choose to discontinue e-mail communications or text appointment reminders or if my contact information has changed. The contact information is used for the purposes of this form will be the most current information on file with Orlin & Cohen.

### Request for Email Communication via Unencrypted Email Only

Orlin & Cohen strongly discourages communication sent without encryption. In addition to the risks identified above, sending e-mail unencrypted means others may be able to access the information and read it once it is transmitted over the Internet. By signing below and authorizing unencrypted email, I acknowledge the risks to which my information may be exposed.

\_\_\_\_\_  
Patient (Signature)

\_\_\_\_\_  
Date/time

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Agent/Relative/Guardian (Signature)

\_\_\_\_\_  
Date/time

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Relationship if other than patient

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

**PHYSICAL/ OCCUPATIONAL THERAPY CONSENT INFORMATION**

**CONSENT TO TREAT**

This information I have given this office is complete and true to the best of my knowledge. I authorize the therapists or provider and staff of Orlin & Cohen Rehabilitation Services to administer such procedures and treatment as they deem necessary. The therapists or provider have implied no guarantee of cure.

Patients Initials \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT TO TREAT A MINOR CHILD**

The information I have given this office pertaining to \_\_\_\_\_ is true and complete to the best of my knowledge. I authorize the therapists or provider and staff of Orlin & Cohen Rehabilitation Services to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. The therapists or provider have implied no guarantee of cure.

Parent/Guardian Initials \_\_\_\_\_ Date \_\_\_\_\_

**PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of information pertinent to my case to my insurance company, claims adjuster or attorney involved in this case.

Patients Initials \_\_\_\_\_ Date \_\_\_\_\_

I hereby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment directly to:

**Orlin & Cohen Rehabilitation Services  
LB#7805, PO Box 95000  
Philadelphia, PA 19195-0001**

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT**

I, \_\_\_\_\_, acknowledge that I have been provided with a copy of Orlin & Cohen Rehabilitation Services' HIPAA Privacy Notice. I would like to authorize the following parties to have access to my protected health information

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**HIPAA AUTHORIZATION TO RELEASE** I authorize/give permission to the following people to receive my protected health information. List school, office etc...

\_\_\_\_\_  
Signature \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**No-Fault Form A**

Was an automobile involved?:	Date of Injury: «Injury Date»
Are you still working?:	If "no", last date worked:
No Fault Carrier: «Payer Name»	Phone Number: Please see Verification note for Adjuster name and contact number
Address: «Payer Address»	City: «Payer City»
State: «Payer State»	Zip Code: «Payer Zip»
Policyholder's Name: «Client Full Name»	Claim Number: «Primary Claim ID»
Policy Number: «Primary Policy ID»	

**\*\* You must submit NF application to your carrier within 30 days of date of accident(DOA) in order for the carrier to cover services \*\*\***

**I hereby authorize payment of No-Fault benefits directly to Orlin & Cohen Rehabilitation Services. I understand that I am financially responsible for the charges applied to my No Fault deductible and for any claims denied for payment by the No-Fault carrier**

*I HEREBY AUTHORIZE TO Orlin & Cohen Rehabilitation Services RELEASE INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY NO-FAULT CARRIER AND/OR MY ATTORNEY.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NEW YORK MOTOR VEHICLE NO-  
FAULT INSURANCE LAW ASSIGNMENT  
OF BENEFITS FORM  
(FOR ACCIDENTS OCCURRING ON AND  
AFTER 3/1/02)**

I, «Client Full Name», ("Assignor") hereby assign to Orlin & Cohen Rehabilitation Services, ("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on «Injury Date», notwithstanding any other agreement to the contrary.

This assignment may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

\_\_\_\_\_  
(Print name of Patient)

X

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_

\_\_\_\_\_  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

Orlin & Cohen Rehabilitation Services

\_\_\_\_\_  
(Print name of Provider)

X

\_\_\_\_\_  
(Signature of Provider)

P.O. Box 95000 Lockbox 7805

\_\_\_\_\_  
Philadelphia, PA 19195

\_\_\_\_\_  
(Address of Provider)

\_\_\_\_\_  
(Date of signature)