

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: CURRENT SCHOOL INCLUDES GRADE LEVEL Full Time / Part Time / Injured / Disabled / Student / Retired / SPORTS/OCCUPATION INCLUDE POSITIONS 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

Patient Billing Acknowledgement

I, «Client Full Name» assign and transfer any monies or benefits to which I may be entitled from government agencies, insurance carriers, health plans or others financially responsible for my healthcare ("Health Plan") and authorize payment of benefits direct to Orlin & Cohen Rehabilitation Services for services provided to me. If my Health Plan refuses to pay my claim, I authorize Orlin & Cohen Rehabilitation Services to pursue payment and appeal on my behalf. I understand that my policy may have limitations. I accept full responsibility for any claims denied by my insurance.

MY BENEFITS: The following information was provided to us by your carrier. If it differs from your actual coverage, you are responsible for any balance due.

Primary Insurance Carrier: Self Pay
Initial Exam: \$150.00
Follow-up sessions: \$100.00
Please note as a self-pay patient your insurance will not be used or billed. Due to that, we are unable and do not provide detailed invoices for reimbursement of payments.
_____ (Initial)

I hereby authorize Orlin & Cohen Rehabilitation Services and its providers to release any information acquired in the course of my examination and treatment to my physicians including protected health information for purpose of payment, my continued care and treatment and health operations.

_____ (Initial)

I agree to pay at the time of service.

_____ (Initial)

I agree that a photocopy of this acknowledgment form to be as valid as the original.

_____ (Initial)

I hereby authorize Orlin & Cohen Rehabilitation Services clinical staff to speak to the following individual(s) _____ regarding my condition. Relationship to patient _____.

_____ (Initial)

I HAVE READ AND UNDERSTAND MY BENEFIT COVERAGE AND FINANCIAL RESPONSIBILITIES DETAILED ABOVE. I HAVE ANSWERED ALL STATEMENTS ABOVE TO THE BEST OF MY KNOWLEDGE AND ACKNOWLEDGE THAT ANY MISREPRESENTATIONS MAY LEAD TO ADDITIONAL FINANCIAL RESPONSIBILITY.

Signed: _____ Date: _____

Thank you for choosing Orlin & Cohen Rehabilitation Services!

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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: _____