ORTHOMANHATTAN

Roosevelt Hand to Shoulder Center
485 Madison Avenue, 8th FL
New York, New York 10022
Ph: 212-658-1122 Fax: 212-826-4107

My Appointment today is with (Please Check):
☐ O. Alton Barron, MD
☐ Louis W. Catalano III, MD
☐ Steven Z. Glickel, MD

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____
SEX: ☐ MALE ☐ FEMALE GENDER IDENTITY: ☐ MALE ☐ FEMALE ☐ OTHER: _____
PREFERRED PRONOUNS: ☐ HE/HIS ☐ SHE/HER ☐ THEY/THEM
ADDRESS: _____ZIP: _____
EMAIL: _____ SOCIAL SECURITY #: _____
HOME PHONE: _____ MOBILE PHONE: _____
WORK PHONE: _____
OCCUPATION: _____ EMPLOYER'S NAME: _____
PHARMACY NAME: _____PHONE: _____
PHARMACY ADDRESS: _____
REFERRING PHYSICIAN: _____ PHONE: _____
PRIMARY CARE PHYSICIAN: _____ PHONE: _____
EMERGENCY CONTACT NAME: _____
CONTACT PHONE #:_____ RELATIONSHIP: _____
HOW DID YOU HEAR ABOUT US? ☐ DOCTOR ☐ FRIEND/FAMILY ☐ SOCIAL MEDIA
☐ INTERNET SEARCH ☐ INSURANCE ☐ OTHER_____

Authorization for Release of Medical Information to Others:

☐ Do not release information

☐ I authorize Dr. O. Alton Barron, Dr. Louis W. Catalano, III, Dr. Steven Z. Glickel to use the contact information listed below to discuss/disclose information regarding my appointments, billing information and medical care to include results.

NAME: _____ RELATIONSHIP: _____ PHONE: _____
NAME: _____ RELATIONSHIP: _____ PHONE: _____

Acknowledgement Of Receipt Of Notice Of Privacy Practice

I, the undersigned, have been informed that the U.S. Government requires I sign this Notice Of Privacy Practices. The privacy regulations were created by the HIPAA ACT of 1996 to protect patient privacy. I understand that the full text of the Act is available to me upon request.

SIGNATURE: _____ DATE: ____/____/_____

Cancellation Policy and Patient No show Agreement

We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of orthopedic care. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to an appointment. Cancellations of appointments are not accepted outside our office business hours. There will be a $50.00 fee applied to your account for a missing appointment without providing a notice of at least one business day. If an emergency arises and you have forgotten about the appointment. Please do still call the office, so we may document it.

SIGNATURE: _____ DATE: ____/____/_____

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NAME: _____
DATE OF BIRTH: ____/____/_____

INSURANCE

PRIMARY INSURANCE: _____ MEMBER ID: _____
POLICY HOLDER FIRST NAME: _____ LAST NAME: _____
POLICY HOLDER DOB: ____/____/_____ RELATIONSHIP TO PATIENT: _____
SECONDARY INSURANCE: _____ MEMBER ID: _____
POLICY HOLDER FIRST NAME: _____ LAST NAME: _____
POLICY HOLDER DOB: ____/____/_____ RELATIONSHIP TO PATIENT: _____

FINANCIAL ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have Insurance coverage and assign Dr. O. Alton Barron, Dr. Louis W. Catalano, III, Dr. Steven Z. Glickel, all insurance benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance. This may include any deductible, co-pay or co-insurance for which I am responsible, and any non-covered items. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all insurance submissions.

SIGNATURE: _____ DATE: ____/____/_____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to: Dr. O. Alton Barron, Dr. Louis W. Catalano, III, Dr. Steven Z. Glickel, for services furnished to me by them. I authorize any holder of medical information about me to release to the Center for Medical Services and its agents any information needed to determine these benefits payable for related services.

SIGNATURE: _____ DATE: ____/____/_____

SELFPAY PATIENTS ONLY

I understand that I will be responsible for all charges related to the services provided to me by my provider. I understand that the charges presented to me are due in full on the day of service, unless arrangements have been made with the physician. I also understand that these charges are solely in relation to professional services provided by the physician, and or other services that are performed in the office or for surgery.

SIGNATURE: _____ DATE: ____/____/_____

WORKER'S COMPENSATION OR NO FAULT: DATE OF ACCIDENT: ____/____/_____
INSURANCE NAME: _____ POLICY #/CASE #: _____
PHONE: _____ ADJUSTER: _____
CLAIM ADDRESS: _____ ZIP: _____

WORKER'S COMPENSATION AGREEMENT

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered. I acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

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DATE OF BIRTH: ____/____/_____

New York "Surprise Law" April 2015 (For patients with out of network health insurance)

I have reviewed the information provided and understand that (1) if I choose to use a non-participating health care professional, such services may not cover under my plan, if my health insurance plan does not have out-of -network benefits, and (2) if my insurance health plan has out-of-network benefits, I understand that by using my out-of-network benefits. I may incur greater costs for which I will be financially responsible from an in-network provider. I wish to obtain services from Dr. O. Alton Barron, Dr. Louis W. Catalano, III, Dr. Steven Z. Glickel. I understand they are NOT a "Health Plan" participating health care professional. I also acknowledge that I am utilizing my out of network benefits, if I have out-of- network benefits. I acknowledge the information was given to me prior to my appointment and I agree.

SIGNATURE: _____ DATE: ____/____/_____

FEE DISCLOSURE FOR OUT-OF-NETWORK PATIENTS

Your provider does not participate in the network of your healthcare plan.

It is important for you to understand what your health care plan covers if you obtain services from an out-of-network physician.

- Your plan may choose not to cover out-of-network services.
- If your plan covers out-of-network services, your plan may require higher copays, deductibles and coinsurance for out-of-network care.

The patient acknowledges that this provider is an out-of-network provider but has elected to obtain the services. PROVIDER: DR. _____

SIGNATURE: _____ DATE: ____/____/_____

INSURANCE CHECKS SENT TO THE PATIENT

I have been informed that the checks from my insurance company may be sent directly to me. I understand that these checks from my insurance company are for services provided to me by my provider or staff.

I AGREE TO GIVE THESE INSURANCE CHECKS TO MY PROVIDER. I AGREE AND ACKNOWLEDGE NOT TO CASH OR DEPOSIT THESE CHECKS. IN THE EVENT I FALSELY WITHHOLD SUCH CHECKS I AGREE AND ACKNOWLEDGE THAT I AM ULTIMATELY RESPONSIBLE FOR THE AMOUNT OF THESE CHECKS DUE TO MY PROVIDER, DR. _____.

SIGNATURE: _____ DATE: ____/____/_____

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NAME: _____
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MEDICAL HISTORY QUESTIONNAIRE

HOW DID THE INJURY OCCUR?

☐ WORK/EMPLOYMENT ☐ AUTO ACCIDENT ☐ SPORTS ☐ OTHER: _____

DATE OF INJURY (IF APPLICABLE): ____/____/_____
PLEASE SPECIFY BODY PART/INJURY/PROBLEM: _____
_____
_____
_____

TAKING MEDICATION FOR IT? ☐ NO ☐ YES
PLEASE SPECIFY MEDICATION: _____ DOSAGE: _____
WHAT MAKES IT BETTER?: _____
MAKES IT WORSE?: _____

PRIOR TREATMENT FOR IT? ☐ NO ☐ YES
PLEASE SPECIFY TREATMENTS, DOCTORS, PHYSICAL/OCCUPATIONAL THERAPISTS:
_____
_____

PRIOR IMAGING/REPORTS ON IT? ☐ NO ☐ YES
PLEASE SPECIFY WHICH IMAGING FACILITY AND WHEN IT WAS TAKEN/DONE:
_____
_____

DOMINANT HAND? ☐ LEFT ☐ RIGHT ☐ BOTH
WHAT IS YOUR HEIGHT? _____ft. _____ in. WHAT IS YOUR WEIGHT? _____pounds
RATE YOUR PAIN ON A SCALE FROM 1 (LEAST) TO 10 (MOST)

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

PLEASE LIST ANY CURRENT MEDICATIONS/DOSAGE (if you have a list, please provide to the staff):
_____
_____
_____

PLEASE LIST ANY KNOWN ALLERGIES:
_____
_____

PLEASE INDICATE ANY PREVIOUS SIGNIFICANT FRACTURES/INJURIES (WHERE AND WHEN?):
_____
_____

SURGICAL HISTORY AND PREVIOUS HOSPITALIZATIONS (PLEASE INCLUDE WHEN):
_____
_____

ANY HISTORY OF ANESTHESIA COMPLICATIONS? ☐ NO ☐ YES
PLEASE DESCRIBE:
_____

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SOCIAL HISTORY

TOBACCO USE: ☐ Never a smoker ☐ Occasional Smoker ☐ Past Smoker ☐ Current Smoker
Tobacco Use Details: _____

ALCOHOL USE: ☐ Never ☐ Monthly or less ☐ 2-4x month ☐ 2-3x a week ☐ 4+ a week

How many drinks containing alcohol do you have a typical day when you are drinking?
☐ One or two ☐ Three or four ☐ Five or six ☐ Seven, eight or nine ☐ Ten or more

How often do you have six or more drinks on occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

How often during the last year have you found you were unable to stop drinking once you had started?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

How often during the last year have you found that you failed to do what was normally expected from you because of drinking?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

HISTORY OF SUBSTANCE ABUSE? ☐ NO ☐ YES, PLEASE DESCRIBE: _____
DO YOU TAKE RECREATIONAL DRUGS? ☐ NO ☐ YES, PLEASE DESCRIBE: _____

REVIEW OF SYSTEMS (CHECK OFF ANY THAT APPLY):

CARDIOLOGY		**GASTROENTEROLOGY**		**NEUROLOGY**	
Chest pain	☐	Acid Reflux	☐	Burning pain: Feet?	☐
History of Heart Attack	☐	Black Stools	☐	Burning pain: Hands?	☐
Irregular Heart beat	☐	Blood in Stool	☐	Insomnia	☐
Known CAD	☐	Constipation	☐	Loss of feeling	☐
Murmur	☐	Diarrhea	☐	Migraines	☐
		Heartburn	☐	Pain	☐
CONSTITUTIONAL		Nausea	☐	Paralysis	☐
Chills	☐	Vomiting	☐	Periph. Neuropathy	☐
Fatigue	☐			Seizures	☐
Loss of Appetite	☐	**HEMATOLOGY**		Strokes	☐
Swollen Glands	☐	Blood Transfusion	☐	Tremor	☐
Night Sweats	☐	Anemia	☐	Vertigo	☐
Weight Gain	☐	Easy Bleeding	☐		
Weight Loss	☐	Easy Bruising	☐	**PSYCHOLOGY**	
		Enlarged Lymph	☐	Anxiety	☐
DERMATOLOGY				Depression	☐
Nail Changes	☐	**MUSCULOSKELETAL**		High Stress Level	☐
Psoriasis	☐	Arthritis	☐		
Skin Cancer	☐	Back Pain	☐	**RESPIRATORY**	
Tick bite	☐	Joint Pain	☐	Chest Pain	☐
		Joint Stiffness	☐	Cough	☐
ENDOCRINOLOGY		Joint Swelling	☐	Sinusitis	☐
Cold Intolerance	☐	Morning Stiffness	☐	Asthma/COPD	☐
Diabetes	☐	Neck Pain	☐		
Raynaud's Symptoms	☐	Raynaud's	☐	**UROLOGY**	
Thyroid Disorder	☐			UTI's	☐
		HIV/AIDS	☐	Incontinence	☐

DO YOU HAVE ANY MEDICAL PROBLEMS NOT LISTED ABOVE?
PLEASE SPECIFY: _____

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CURRENT AND PAST MEDICAL HISTORY

Please indicate if you have ever been treated for any of the following:

ILLNESS		ILLNESS		ILLNESS	
Stroke	☐	Colitis	☐	Coronary Artery Disease	☐
Seizures	☐	Kidney Disease	☐	Bleeding Diseases	☐
Emphysema	☐	Arthritis	☐	Hepatitis	☐
Asthma	☐	Diabetes	☐	HIV/AIDS	☐
High Blood Pressure	☐	Diabetic Devices	☐	Ulcers	☐
Heart Disease/Attack	☐	Thyroid Disease	☐	Parkinson's Disease	☐
High Cholesterol	☐	Cancer	☐	Stents/Implants	☐
Sleep Apnea	☐	Chemotherapy	☐	Defibrillator/Pacemaker	☐
Rheumatoid Arthritis	☐	Neuropathy	☐	GERD	☐

DO YOU HAVE ANY PROBLEMS NOT LISTED ABOVE? _____

PLEASE DESCRIBE ALL CONDITIONS IN DETAIL:

_____

_____

_____

_____

FAMILY HEALTH HISTORY

Please indicate if any member of your immediate family (mother, father, sister, brother, grandparent or child) has ever been treated for any of the following:

ILLNESS	RELATIONSHIP TO YOU	ILLNESS	RELATIONSHIP TO YOU
Stroke		Colitis	
Seizures		Kidney Disease	
Emphysema		Arthritis	
Asthma		Diabetes	
High Blood Pressure		Thyroid Disease	
Heart Attack		Breast Cancer	
High Cholesterol		Colon Cancer	
Ulcers		Prostate Cancer	

DOES ANYONE IN YOUR FAMILY HAVE ANY MEDICAL PROBLEMS NOT LISTED ABOVE?

PLEASE SPECIFY: _____

I, as the patient or legal guardian of the patient, state that all the above medical information is correct and accurate to the best of my knowledge.

PATIENT FIRST NAME:_____LAST NAME:_____

SIGNATURE:_____ DATE:___/_____/_____