MESSIEH ORTHOPEDICS
MICHAEL S. MESSIEH, M.D.
DEMOGRAPHICS/INSURANCE INFORMATION

Date: _____

Patient name: _____ Date of birth: ____/ ____/_____

SS#: _____ Race: _____

Ethnicity: _____Language: _____

Home address: _____

City: _____ State: _____ Zip code: _____Email: _____

Home Phone#: _____ Cell #: _____Work#: _____

Family/Primary Doctor: _____ Phone #: _____

Who/How were you **REFERRED** to our office? Physician Or Person's Name_____

PRIMARY INSURANCE INFORMATION

Primary Insurance Carrier Name: _____

Are you covered by additional Insurance? _____Yes _____No

Additional Insurance Carrier Name: _____

PLEASE PROVIDE THE OFFICE STAFF WITH YOUR INSURANCE CARDS AND PHOTO ID SO THAT WE ARE ABLE TO COPY AND PLACE IN YOUR MEDICAL RECORD

EMERGENCY CONTACT INFORMATION

In case of an emergency who should be notified? Please list up to 4 names, phone numbers & relationship

Name of Emergency Contract Telephone Number **Relationship to Patient**

May we release your medical information to the above names? _____Yes _____No

ADDITIONAL INFORMATION

In the event that Messieh Orthopedics may need to contact me at my home or on any of the numbers I have provided above, I authorize the office to leave a message on my machine, voicemail or with anyone who answers: _____Yes _____No

The office staff may only leave a message and/or speak with anyone listed under my emergency contacts: _____Yes _____No

_____

_____

Signature of Patient, Parent, Guardian or Personal Representative
Date

_____

_____

Please print name of Patient, Guardian or Personal Representative
Relationship to Patient

MESSIEH ORTHOPEDICS
MICHAEL S MESSIEH, M.D.
Office Policy Information

OUR OFFICE POLICY

Patient Name: _____Date of Birth:_____

BASIC POLICY : Payment is due in full at the time of service.
PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also file to most secondary insurance carriers for you. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, occasional fees may be due and payable in full from you. HMO patient, it is your responsibility to obtain authorization from your PCP prior to being seen and to provide our office with the name and address of your PCP.
MEDICARE PATIENTS: We bill Medicare for you. All co-payments or deductibles are due at the time of service. We will also file to your secondary insurance carrier for you.
SURGERY FEES: All co-pays, deductibles and payments for non covered surgical procedures are due prior to your surgery. Prior authorization may be required from your carrier. Self pay surgeries require 50% deposit prior to scheduling surgery.
NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.
AUTO ACCIDENT CASES: If you are injured in an auto accident, we will need your adjuster's name, claim number and insurance carrier prior to services. PIP coverage will be verified prior to services. Deductible and co-pays are due at the time of service.
WORKER'S COMPENSATION: If your injury is work related, we will need a copy of notice of injury from your employer, the case number and carrier name prior to your visit in order to file work comp claim.
MEDICAL RECORDS FAX: I authorize Focus Orthopedics Inc, Dr. Michael S. Messieh, to transmit my medical records electronically. If they are received by another party in error, I absolve Focus Orthopedics Inc of any and all liability relating to such submission of said records. I give permission for Focus Orthopedics, Inc to send my records to my primary care physician.
APPOINTMENT/FORMS: 24 hour notice is required for all appointment cancellations. Multiple failures to notify the office of cancellation and/or no show of appointments my result in your termination of care.

_____

CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION
FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to Messieh Orthopedics, Inc, Dr. Michael S. Messieh, to provide whatever treatment he/they deem necessary to the patient. I certify that the information I furnish is true and correct. I am fully aware that it is a felony to falsify any information relating to my medical condition.

I hereby authorize Focus Orthopedics, Inc, Dr. Michael Messieh to submit a claim to my insurance carrier, or its intermediaries for all covered services rendered by the physician. I also authorize my insurance carrier, or its intermediaries to issue payment directly to the physician. A photocopy of this assignment is considered to be as valid as an original.

I hereby authorize Messieh Orthopedics, Inc, Dr. Michael S. Messieh to release any medical information in connection with these services to any person or corporation which is or may be liable for any or any portion of the charges, including insurance companies, health care plans, worker's compensation carriers, adjusters or attorneys, to the extent necessary to obtain. Also, to the patient's personal physician, referring physicians or primary care physician. I am aware that any/all information contained within my medical records/chart is property of Focus Orthopedics, Inc. I further agree that I am responsible for payment of any remaining balance after insurance payments have been made, including any collection costs or legal fees occurred to collect these balances.

BINDING ARBITRATION

I AGREE THAT any dispute will be resolved by binding arbitration. When the patient and the physician agree to arbitration, they agree to give up their constitutional rights to have a potential medical malpractice claim resolved in court. Binding arbitration means that physician and the patient agree to litigate outside the court system any claims that may arise from rendering or failing to render medical care and treatment before an arbitration panel. The arbitration panel is required to follow the state law and their decision is binding upon the parties. The patient has had an opportunity and ability to know and understand the terms of the agreement before signing and agree
that the terms are reasonable and fair. I understand that a video from FPIC explaining the purpose and fundamentals of the arbitration agreement is available for viewing.

Signature of Patient:_____ Date:
_____

Signature of Responsible Person(if other than
patient):_____Date:_____

MESSIEH ORTHOPEDICS
MICHAEL S. MESSIEH, M.D.
PATIENT QUESTIONNAIRE

Patient Name:_____ DOB:_____ Age:___ Height:_____ Wt:_____
Sex: ( )F ( )M

What are you seeing the doctor for? Please explain your reason for this visit. Please circle your answer.

Neck	Low Back	<u>if more than one, list below which one is worse</u>
Right Shoulder	Right Hip	
Left Shoulder	Left Hip	
Right Elbow	Right Knee	
Left Elbow	Left Knee	
Right wrist/hand	Right foot/ankle	
Left wrist/hand	Left foot/ankle	

Date problem began:_____

Describe your current problem below:
_____new injury or problem (less than 6 weeks duration)
_____sub acute problem (6 weeks-3 months duration)
_____chronic problem (problem has been treated over time period of more than 3 months)
_____re-injury (you injured this same area before, received treatment, had no problems until new injury occurred)

Is your problem a result of an injury? YES NO DATE:_____

<u>**If your problem is a result of an injury, where did it occur? Please circle below**</u>

HOME WORK MOTOR VEHICLE EXERCISE OTHER:_____

What cause your injury/problem?

_____fall	_____fighting
_____lifting	_____twisting
_____throwing	_____collision/contact
_____reaching	_____collision/contact
_____pulling	_____other/

specify_____
Explain in your own words how this injury or problem occurred:
_____
_____

_____
_____

**Have you talked to a lawyer concerning your injury ? YES NO

**Are you receiving or have you applied for worker's compensation concerning your injury? YES NO

**Have you received previous treatment for your current problem? YES (if yes, specify) NO

Medicine Physical therapy Surgery Injections Other_____

Did you go to the Emergency Room? ( )YES ( )NO Date of E.R. visit:_____

ON A SCALE OF 0-10 (WITH 10 BEING THE WORST PAIN IMAGINABLE), HOW WOULD YOU SCORE YOUR PAIN TODAY?

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

MESSIEH ORTHOPEDICS/MICHAEL S. MESSIEH, M.D.
MEDICAL HISTORY INFORMATION

Patient:_____ DOB:_____

MEDICAL HISTORY: Do you have or have you ever had any of the following? (Check all that apply)

___Stroke
___Heart trouble
___Hypertension
___Diabetes
___Arthritis
___Gout
___Seizures
____Mental Illness
___Kidney disease
___Cancer
___Bleeding disorders
___Alcoholism
___Lung Disease
___TB
___Phlebitis
___Anemia
___Stomach Ulcer
___Liver Disease
___Thyroid Disease
___Other/Specify_____

_____If none apply please initial

PAST SURGICAL HISTORY:
_____ _____
_____

_____ _____
_____

MEDICATIONS: Please list below your current medications, both prescription and over the counter; or (please supply list if you have one)
***I give permission to Messieh Orthopedics to access my prescription history** ( ) Yes ( ) No

Name: _____Dosage: _____Name: _____ Dosage:
_____

Name: _____Dosage: _____Name:
_____Dosage:_____

Name:
_____Dosage:_____Name:_____Dosage:_____

Name: _____Dosage: _____Name: _____Dosage:
_____

ALLERGIC TO ANY MEDICIATIONS? ( )YES ( )NO List
allergies:_____

FAMILY HISTORY:

	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer	Unknown
Father	( )	( )	( )	( )	( )	( )
Mother	( )	( )	( )	( )	( )	( )
Paternal Grandfather	( )	( )	( )	( )	( )	( )
Paternal Grandmother	( )	( )	( )		( )	( ) ( )
Maternal Grandfather	( )	( )	( )		( )	( ) ( )
Maternal Grandmother	( )	( )	( )		( )	( ) ( )
Siblings	( )	( )	( )		( )	( ) ( )

Employer:_____Job Title:_____
Current Work Status: ( ) Regular ( ) Light Duty ( ) Not Working now ( ) Disabled ( )Retired

SOCIAL HISTORY:
Marital Status: ( ) M ( ) S ( ) D ( ) W Are you currently living alone: ( ) Yes ( ) No
Do you use tobacco? ( )Yes ( )No If yes, # of packs per day:_____ ( )past history of smoking
Do you have children? ( )Yes ( )No If yes, # of children:_____. # of pregnancies_____
Alcohol use? ( )Yes ( )No If yes, how often: ( )moderate ( )occasionally: #_____drinks/week
Drug Overuse? ( ) Yes, current ( ) past problem ( ) Never used

REVIEW OF SYSTEMS (do you have or have you ever had) please **check all that apply**:

____Chills ____Fever ____Headache ____Cough ____Reading glasses ____Difficulty swallowing ____Breathing problems

____Wheezing ____Chest pain ____Change in bowel habits ____Stomach problems ____Anemia ____Arthritis ____Swollen joints

____Weakness ____Cold extremities ____Rash ____Dizziness

MESSIEH ORTHOPEDICS, INC
Michael S. Messieh, M.D.
Acknowledgement of Receipt of Notice of Privacy

Notice
Messieh Orthopedics, Inc reserves the right to modify the privacy practices outlined in the notice.

Signature
I have read and understand the Notice of Privacy Practices for (Messieh Orthopedics, Inc)

_____
Name of Patient (print)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative

I have chosen to receive a copy of the Privacy Act: Yes_____ No_____

MESSIEH ORTHOPEDICS
MICHAEL S. MESSIEH, M.D.

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name:_____
DOB:_____SS#:_____

Address:_____
_____

City:_____State:_____Zip:_____
_____

I hereby consent to the release and disclosure of my personal health information to:

(Individual or
Organization):_____

Address:_____
_____

City:_____State:_____Zip:_____
_____

For the following purpose (s):

____Continuing Medical Care ____Personal Use
____Information for Insurance Co. ____Information for Attorney
____Other (please specify)_____

My authorization for release includes my personal health information consisting of:
____Initial Evaluation ____Operative Reports ____Medical Status
____Progress/Office Notes ____Discharge Summary ____Work Status
____Xray Only ____X-ray Report Only ____Both Xray films and Report
____Non-Focus Orthopedics Inc films
____Other (please specify)_____

____Mail to above ____Call when records are ready/
Phone#:_____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within five (5) business days of Messieh Orthopedics having received this release authorization. I understand that I am free to revoke this release authorization at anytime by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164)

This authorization will expire one year from the date of this request. This authorization is not valid if not filled out completely.

Patient
Signature:_____Date:_____

FOR OFFICE USE ONLY:
Document flow: _____ Patient's Medical Record/scanned
This authorization was revoked on _____(date).