ROBERT C. PETRUCELLI. M.D. P.A.

Fellow-American Academy of Orthopedic Surgeons
Adult/Pediatric Orthopedics - Sports Medicine - Arthroscopic Surgery
Joint Replacement - Reconstructive Surgery - Foot and Hand Surgery

PATIENT INFORMATION

Patient Name _____ _____
(Last) (First) (M.I.) (Nickname)

Address _____
(Street) (Apt. #)

_____
(City) (State) (Zip Code)

Date of Birth _____ Home Phone # _____

Social Security #_____ Work Phone # _____

Email Address _____Cell Phone **#** _____

Please Circle: Male / Female Marital Status: Single / Married / Widowed / Divorced / Domestic Partner

What is your preferred language? _____

Race: African American / American Indian / Asian / Caucasian / Native Hawaiian / Other / Refuse to Answer

Please Circle One: Ethnicity: Hispanic/Latino or Not Hispanic/Latino or Refuse to Answer

Please Circle: Do you Smoke? YES NO - How Much? _____ Do you chew tobacco?: YES NO

Please Circle: Are you a former smoker? YES NO If yes, what date/year did you quit?_____

Please Circle: Do you drink alcohol? YES NO - How Often? _____/wk

- **Your Primary Doctor's Name: _____**

Group Name: _____

Address:_____

Phone: _____ Fax: _____

IS THIS VISIT THE RESULT OF AN AUTO OR WORKER'S COMPENSATION ACCIDENT? **Yes** **No** **Date of Accident** _____

Has this accident been reported?
Yes **No**

PRIMARY INSURANCE INFORMATION

Insurance Company _____

Patient's ID# _____Group #_____ Effective Date _____

Subscriber/Cardholder Name _____Subscriber DOB_____

Subscriber SS# _____Relationship to Patient _____

Address (if different from patient) _____

_____Phone # _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____

Patient's ID# _____ Group #_____ Effective Date _____

Subscriber/Cardholder Name _____Subscriber DOB_____

Subscriber SS# _____ Relationship to Patient _____

Address (if different from patient)_____

_____Phone # _____

EMPLOYMENT HISTORY

- Are you currently working? : YES /NO Date stopped:_____
- Name of employer: _____
- Address, City, State, zip: _____

It is the policy of this practice that any fees or co-payments are due and payable at the time of each visit. By signing below, you agree to be financially responsible for all bills incurred that are not covered or paid by insurance, as determined by your insurance company, while receiving care at this office. It is the patient's responsibility to provide current insurance card(s) for primary and secondary insurances, obtain and keep current referrals for each visit and to notify us of all changes in coverage. Failure to obtain referrals will be the sole responsibility of the patient. As a courtesy, insurance billing is provided for all plans in which the practice is a participating member. By signing below, you agree that all insurance payments be made directly to Dr. Robert Petrucelli, M.D.
It is also understood that all co-payments are due at time of service and that you are responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by your insurance as not covered or not medically necessary and/or fees incurred should my account require collection action. There will be an additional $50 collection fee for all outstanding balances sent to an outside collection agency. The entire balance is the responsibility of the guarantor and delinquent accounts will be assessed at an interest rate of 1.5% monthly. If your account is turned over to collections, all costs incurred for collection, attorney, court, etc. will be your responsibility.
All requests for copies of records, x-rays or any other documents will be processed and payment is due prior to or at time of receipt. If you change your mind and no longer want the copies, you are still responsible and agree to make payment for any copies that have been made at your request.
By signing below, you authorize the use of this signature on all insurance submissions (medical, auto or worker's compensation) and on all legal submissions/medical records to an attorney, law enforcement representative and doctors or facilities that may also be involved in your medical care.

Signature_____ Date _____

(If under 18 years of age, a parent or guardian must sign for patient)

PATIENT RESPONSIBILITY
FOR FOLLOW-UP CARE PLEDGE

I, _____ (please print patient's name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment and/or outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medication shall by my sole responsibility (or my guardian who has attending this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to: blood test, MRI, CT scan, this timely recommendation is important and essential to the ultimate success of my treatment and/or outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow the medical advice given by any medical person in this office. I also understand that any bad health outcome from my failure to follow the advice of my doctors should be expected.

_____ _____

Patient or Guardian Signature Today's Date

WORKER'S COMPENSATION AND AUTO PATIENTS ONLY ASSIGNMENT OF BENEFITS FORM

I hereby irrevocably assign to Robert C. Petrucelli, MD any and all of my rights and benefits to institute in my name an arbitration case with the American Arbitration Association for the payment of any and all outstanding medical bills for treatment rendered for any condition resulting from an accidental injury sustained on _____ which the insurance carrier was obligated to pay in accordance with their contractual agreement. I also hereby irrevocably assign to Robert C. Petrucelli, MD all of my rights and benefits under any insurance contracts for payment of services rendered by Robert C. Petrucelli, MD. I irrevocably direct that all such payments go directly to Robert C. Petrucelli, MD. I further hereby irrevocably authorize Robert C. Petrucelli, MD to institute any further proceedings necessary to **enforce and/or protect my interests as set forth herein. I agree to cooperate fully, as required, with all such proceedings.**
This Assignment of Benefits has been explained to my full satisfaction and I understand its nature and effect.

Patient's Signature_____
(If under 18 years of age, a parent or guardian must sign for patient)

Witness Signature _____

Date_____

MEDICARE PATIENTS ONLY

"I request that payment of all authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services."

Patient (or authorized) Name_____

Patient (or authorized) Signature_____

Health Insurance Claim Number (Medicare ID)_____

Date_____

Orthopedic Initial History Survey

Patient Name (Please Print) _____ Date: _____

Age_____ Female_____ Male_____Height _____/_____ Weight_____ Did you bring x-rays? _____

REASON FOR VISIT? (Location – Please circle Right or Left)							
Neck___	Arm R / L	Shoulder R / L	Hand R / L	Finger R / L	Leg R / L	Knee R / L	Foot R / L
Back ___Mid ___ Lower		Elbow R / L	Wrist R / L	Pelvis R / L	Hip R / L	Ankle R / L	Toe R / L

Check which best fits how your problem started.

HOW LONG HAS THIS PROBLEM BEEN PRESENT? Days___ Week___ Months____ Years___

___NO INJURY (Onset was: ___ Gradual ___ Sudden)
Why do you think it started?
___INJURY (Accident or Sport NOT Auto or Work Related)
Date_____ Where and how did it happen?
What sport_____ School_____
___INJURY AT WORK
Date_____Where and how did it happen?
___AUTO ACCIDENT
Date_____ How was your car hit?

ANSWER: Please describe how you injured yourself.
_____
_____
_____
_____
_____
_____
_____
_____

What makes your pain/discomfort feel better? _____

What makes your pain/discomfort feel worse? _____

REVIEW OF SYSTEMS

1. **ARE YOU ALLERGIC TO ANY MEDICATIONS**? ___Yes ___No
   If yes, please list_____

2. **ARE YOU A DIABETIC**? ___Yes ___No **TREATMENT**: ___Insulin ___Oral Meds ___Diet ___None

3. **GI** **Do you have:** __Stomach Ulcers __Blood in Stool __Stomach pain with Anti-inflammatory

Please check all that apply or mark NONE	None	Year	Explain Details/Comments
CON __Weight loss __Fever __Cancer	____	____	_____
EYE __Glasses __Contacts __Cataract	_____	____	_____
ENT __Hearing loss	_____	____	_____
CV __High blood pressure __Heart attack	_____	_____	_____
__Blood clots	_____	_____	_____
RS __Asthma __Pneumonia __Short of Breath	____	____	_____
GU __Kidney disease	_____	____	_____
SK __Skin Ulcers __Rash __Lumps	_____	____	_____
NEU __Seizures __Stroke __Headaches	_____	____	_____
PSY __Depression __Sleep disorder	_____	____	_____
HEM __Easy bleeding __Easy bruising __Anemia	____	____	_____

MEDICAL HISTORY

ARE YOU CURRENTLY BEING TREATED BY A PAIN MANAGEMENT PHYSICIAN? _____Yes _____No

ARE YOU TAKING, OR HAVE YOU EVER TAKEN BLOOD THINNERS? ___Yes ___No if yes, type: _____

PAST HOSPITALIZATION / SURGICAL HISTORY ___None

_____

_____

HAVE YOU EVER HAD A REACTION TO ANESTHESIA? ___Yes ___No

_____

FAMILY HISTORY: MOTHER – ALIVE (AGE)_____ DECEASED (AGE)_____ CAUSE OF DEATH:_____

FATHER - ALIVE (AGE)_____ DECEASED (AGE)_____ CAUSE OF DEATH:_____

Robert C. Petrucelli, M.D., P.A.
ACKNOWLEDGEMENT of PRIVACY PROCEDURES

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY #

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND ANSWER ALL OF THE QUESTIONS.

This Notice of privacy Procedures describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment and/or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, and any other use required by law.

TREATMENT:
We will use your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you, and/or to review your health information with a case manager who is coordinating your care.

PAYMENT:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS (TPO):
We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting/arranging for other business activities. For example, we may disclose your protected health information to:

- Medical school students that see patients at our office.
- We may use a sign-in sheet at the registration desk where you are asked to sign your name and indicate your physician.
- We may call you by name in the waiting room when your physician is ready to see you.
- We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
- With your specific approval, leave information at your home on an answering machine or to a duly authorized person acting on your behalf.

We may use or disclose your protected health information in the following situations without your authorization. These

situations include:

- As required by law;
- Public health issues as required by law – communicable diseases, health oversight, abuse or neglect;
- Food and Drug Administration requirements;
- Legal proceedings;
- Law enforcement, criminal activity, inmates;
- Coroners, Funeral Directors and Organ Donation;

- Research;
- Military Activity, National Security
- Workers' Compensation

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician of the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS:

The following is a statement of your rights with respect to your protected health information:

- You have the right to inspect and receive a copy of your protected health information. Under federal law, however, you **may not** inspect or copy Psychotherapy notes;
- Information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding;
- Protected health information that is subject to law that prohibits access to protected health information;
- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Procedures. Your request must state the specific restriction(s) requested and to whom you want the restriction(s) to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
- You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a copy of this notice, upon request.
- You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You have the right to object

or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying any supervisor, a member of our administration, or our designated Privacy Officer.

This notice was published and becomes effective April 14th, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy procedures with respect to your protected health information. If you have any objections to this form, please notify our Administration at (973) 252-0333.

Please answer the questions below and affix your signature acknowledging that you have received this Notice of our Privacy Policy and Procedures and have provided specific direction and authorization in protecting your health information.

****

Who may we provide with your personal health information?
Check all that apply

☐ **Spouse** ☐ **Children** ☐ **Parent** ☐ **other, specify**_____

Give name & phone number

_____

_____

May we leave personal health information on your answering machine at home?

☐ **YES** **NO** ☐

_____

Patient's Signature (A parent or guardian must sign for patient if under 18 years of age) Print Patient's Name Today's Date

PAYMENT AGREEMENT

Thank you for choosing our practice! First and foremost, we are committed to the success of your medical treatment and plan of care. Please understand that payment of your bill is part of this treatment and care.

OFFICE VISITS & OFFICE SERVICES
Patient's health insurance plans state that payment for copays is to be collected for office visits at time of service. If you do not have your copay for your visit, we can reschedule your appointment.

DO YOU NEED A REFERRAL?
Current referrals are necessary for ongoing care. If you have a plan that requires referrals, it is your responsibility to contact your Primary Care Physician and have referral sent to our office. If a referral is needed for your appointment, you may contact your PCP to request the referral be faxed to our office or you can bring the hardcopy provided by your primary doctor. We will not be able to keep your appointment if the required referral is not received and will need to reschedule your appointment.

PATIENT CANCELLATION AGREEMENT
This office requires twenty-four (24) hours notice for all patients cancelling office visits, new patient appointments and consults. If our office does not receive a minimum of twenty-four (24) hours notice, you will be charged $25 for the missed appointment or consult. This charge is not eligible to be submitted to your insurance. It will be billed directly to your account.

SURGERY
Our office will complete any pre-certification or authorization that may be required by your insurance company. We will review any deductibles and out of pocket expenses you will be responsible for as outlined by your insurance plan. We cannot assume that your deductible has been met. We will submit all charges to insurance for payment. However, please keep in mind that any calculated amount is an estimated cost. Unfortunately, there is always the possibility that after your insurance pays its portion, you may have a balance due towards copay, coinsurance or deductible. If your insurance denies payment on a surgical procedure, a flat rate fee will be applied and will be your responsibility.

DURABLE MEDICAL EQUIPMENT
At the time of your visit, the doctor may suggest a brace or support. If you purchase durable medical equipment from our office, all sales are final. There can be no returns or exchanges.

HOW MAY I PAY?

We accept payment by Cash, Check, Visa, MasterCard or Discover.

ACKNOWLEDGEMENT

I have read, understand and agree to the above Payment Agreement. I understand that my co-payment is due and payable at the time of service. I understand that charges not covered by my insurance company as well as applicable copayments, coinsurances and deductibles are my responsibility.

- In the event that outside collection and/or legal costs are incurred by this office to obtain payment due, responsible party agrees that they will be liable for any costs incurred.
- I authorize my insurance benefits to be paid directly to ROBERT C. PETRUCELLI, M.D., P.A

_____	_____	_____
Printed Name of Patient	Signature of Patient or Guardian	Date

MEDICATION LOG

Patient_____ Birthdate_____

Home Phone_____ Work Phone _____Occupation_____

Pharmacy_____ Pharmacy Phone_____

MEDICATION	DOSAGE	QTY.	FREQ.

Notes:_____

_____

_____

_____

_____