Keith A. Robertson, M.D.

Diplomate American Board of Orthopedic Surgery
Fellow American Academy of Orthopedic Surgeons

PATIENT INFORMATION FOR MEDICAL RECORDS – PLEASE PRINT

Last Name ________________________________ **First Name** ______________________________ **MI** _____

Address __________________________________ **City** ____________________ **State** ______ **Zip** _________

Cell Phone ( ) ________________________ **Work Phone** ( ) _________________________

Sex M F **Marital Status** S M **Date of Birth** _______ / _______ / _______ **Age** __________

Social Security Number _______ / _______ / _______ **Employer/Occupation** ______________________________

Employer Phone ______________________ **Address** ____

Referring Physician _________________________ **or Referred By** ____________________________________

In case of Emergency Contact_____________________________ **Relationship** _________________________

Phone ( ) ___________________________ **Address** ____

IF PATIENT IS A MINOR, PLEASE COMPLETE USING PARENT INFORMATION:

Mother's Name _____________________________ **Father's Name** _____________________________

Mother's Phone _____________________________ **Father's Phone** _____________________________

Mother's SS # _______________________________ **Father's SS #** _______________________________

INSURANCE INFORMATION
IS THIS A WORK RELATED INJURY? YES NO (If Yes please ask for work comp packet)

PRIMARY INSURANCE	**SECONDARY INSURANCE**
IF HMO WHICH IPA? REGAL, SEAVIEW, VALLEYCARE	
Insurance Co _________________________________	**Insurance Co** _______________________________
ID # ____	**ID #** _______________________________________
Group # ____________________ **DOB** ___________	**Group #** _____________________ **DOB** _________
Subscriber ___________________________________	**Subscriber** _________________________________
Subscribers Relationship to Patient_________________	**Subscribers Relationship to Patient** ______________
Address ______________________________________	**Address** ___________________________________
Phone _____________________ **Co-Pay $** _________	**Phone** ___________________ **Co-Pay $** __________

______________________________ ______________________________ __________________

Patient Signature or Legal Guardian **Print Name** **Date**

New Patient Questionnaire
Fill in all blanks (attach another sheet if more space is needed)

Name:		*do not write in this column*
Age:	Date of birth:	
Dominant Hand: Right Left Ambidextrous		
Reason for visit: (What happened? How?)		
Location of problem: (which body part)		
Describe symptoms: (sharp pain, throbbing, numbness, tingling, etc)		
Describe the severity: (mild, moderate, severe, disabling, etc) Pain scale 1 2 3 4 5 6 7 8 9 10 (circle) (1=hardly any pain, 10=terrible pain)		
Duration of symptoms: (intermittent, constant, number of minutes, etc)		
Timing of symptoms: (after exercise, at night, when typing, etc)		
What makes the problem better: (rest, heat, cold, etc) What makes it worse:		
Other associated symptoms: (bruising, tingling, etc)		
Prior injury to same body part: (when, what happened)		
Course of the problem: (getting better, worse, no change, etc)		
When did the problem start: (give dates)		
Describe other medical treatment: (name of doctors, tests ordered, etc)		

List or circle other illnesses: (high blood pressure, heart disease, asthma, diabetes, kidney disease, liver disease, thyroid disease, rheumatoid arthritis, stroke, bleeding disorder, etc)		*do not write in this column*
List previous surgeries: (include dates)		
List all medications: (specify dose, frequency, attach sheet if necessary)		
Drug allergies:		
Diseases that run in the family:		
Occupation:	Weight: Height:	
Smoking: (Packs per day) (Number of years)	Alcohol: (number of drinks per week)	

Do you have: (check all that apply)

Constitutional
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue

Eyes
- ☐ Glasses
- ☐ Blurred vision
- ☐ Cataracts
- ☐ Glaucoma

Ears, nose, throat
- ☐ Ringing in the ears
- ☐ Ear infections
- ☐ Sinus problems
- ☐ Loss of sense of smell
- ☐ Oral ulcers

Cardiovascular
- ☐ Chest pain
- ☐ Heart murmurs
- ☐ Leg swelling

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ History of pneumonia
- ☐ History of tuberculosis

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation

Genitourinary
- ☐ Painful urination
- ☐ Incontinence
- ☐ Impotence

Musculoskeletal
- ☐ Joint swelling
- ☐ Limited range of motion
- ☐ Back pain
- ☐ Fracture

Skin
- ☐ Rash
- ☐ Bruising
- ☐ Skin cancer

Neurologic
- ☐ Weakness
- ☐ Coordination problems
- ☐ Numbness or tingling

Psychiatric
- ☐ Emotional disturbance
- ☐ Drug and alcohol problem

Hematologic
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Easy bruising

Immunologic
- ☐ Rheumatoid arthritis
- ☐ Autoimmune disorder
- ☐ Seasonal allergies

Signature:	Date:

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

By signing this document, I acknowledge that I have read the "Notice of Privacy Practices" for **Keith A.Robertson, M.D.** I also understand that if I wish to be given a copy of "these" practices I will be given such.

Patient's Name: ______________________________
Please Print Name

Signature: ___________________________________ **Date: ____________**
Signature of Patient or Personal Representative

If signed by legal representative, please describe relationship to patient:

____

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Permission to correspond via Email

Dr. Keith A. Robertson and Staff may decide to use email to facilitate communication and billing.

Risk of using email

I want to use email to communicate to the physicians and staff about my/the patient's personal health care and billing. I understand that both the Providers and staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that there are known and unknown risks that may affect the privacy of my personal health care information when using email to communicate. I acknowledge that those risks include, but are not limited, to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- Email may be sent to the wrong address by any sender or receiver and is not guaranteed.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread computer viruses.

Conditions for the use of email

I agree that I must not use email for medical emergencies or to send time sensitive information to my/the patient's Providers. I understand and agree that it is my responsibility to follow up with the Providers or staff, if I have not received a response to my email within a reasonable time period. I agree that the content of my email messages should state my question or concern briefly and clearly and include the subject of the message in the subject line, and clear patient identification including patient name and contact information in the body of the message. I agree it is my responsibility to inform the Providers and/or staff of any changes to my email address. I agree that, if I want to withdraw my consent to use email communications about my/the patient's healthcare, it is my responsibility to inform my/the patient's Providers or the staff member only by email or written communication.

Understanding the use of email

I give permission to the Dr. Keith A. Robertson and staff to send me email messages that include my/the patient's personal health care information and understand that my email messages may be included in my/the patient's medical record. I have read and understand the risks of using email as stated above and agree that email messages may include protected health information about me/the patient, whenever necessary.

In addition Dr. Keith A. Robertson and Staff, may utilize text messages to confirm appointment times, and inform you of missed appointments. If you would like to receive appointment reminders via text please provide us with a personal cell phone number. Information via text message will only include appointment times and missed appointments. Text messages will not include personal healthcare information or billing information.

Cell Phone# ___________________________Initial___________

_______________________________________ ___________________________Date__________

Print Name of Patient **Signature of Patient or Representative**

____

Witness signature

Email Address____

Keith A. Robertson, M.D.

General Orthopedic Surgery and Sports Medicine
American Board of Orthopedic Surgery
Fellow American Academy of Orthopedic Surgeons

Patient Payment Policy

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

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?

We accept payment by cash, check, VISA, Mastercard, HRA, HSA, debit, and Discover.

Do I Need A Referral?

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, your appointment may be re-scheduled. It is your obligation to insure authorization for your visit.

Which Plans Do You Contract With?

All major carriers such as Blue Cross, Blue Shield, Aetna, Cigna, Healthnet, United Healtcare, Medicare, Regal, Seaview, ValleyCare. Many smaller plans fall under the large carriers. Please call your carrier or our office to confirm.

What Is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained below.

Patient deductibles and co-pays will not be adjusted/written off. It is a violation of the provider's contract with the insurance company. The outcome for the provider could be the loss of his/her contract and 100% non-payment of services to which he/she could not recoup from the patient. Thank you for your understanding of this policy.

Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visits, x-ray, injection, and other charges **at the time of office visit.**	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable copays and deductibles are requested **at the time of the office visit**. If the services you receive are not covered by	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you.

	the plan: Payment in full is requested at the time of the visit.	File an insurance claim on your behalf.
HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit. You are considered to be non-insured and/or a cash pay patient.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, copay, non-covered services—**at the time of the visit.**	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services. File an insurance claim on your behalf.
Medicare	If you have Regular Medicare, and have not met your **$140 deductible, we ask that it be paid at the time of service**. Any services not covered by Medicare are requested at the time of the visit. If you have Regular Medicare as primary, and also have secondary insurance or Medigap: No payment is necessary at the time of the visit. **If you have Regular Medicare as primary, but no secondary insurance:** **Payment of your 20% copay is requested at the time of the visit.**	File the claim on your behalf, as well as any claims to your secondary insurance.
Medicare HMO	All applicable copays and deductibles at the time of the office visit. Prior authorization required. See above.	File the claim on your behalf, as well as any claims to your secondary insurance.
Worker's Compensation	If we have verified the claim with your carrier No payment is necessary at the time of the visit. If we are not able to verify your claim Payment in full is requested at the time of the visit.	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures.
Worker's Compensation (Out of State)	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
Occupational Injury	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

Surgery

If your physician recommends surgery, you will be escorted to his Surgery Coordinator who will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Surgery Coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Surgery Coordinator.

What if My Child Needs to See the Physician?

A parent or legal guardian, 18 years of age or older, must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to ***Keith A Robertson,MD****.*

I authorize ***Keith A Robertson,MD*** *to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

__________	______________________________	_______________________
Date	**Signature**	**Printed Name**
____________	______________________________	**Keith A. Robertson M.D.**
Date	**Witness/Staff**	**Physician Name**