

Keith A. Robertson, M.D.

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

PRIMARY INSURANCE

Insurance Co _____

ID # _____

Group # _____ DOB _____

Subscriber _____

Subscribers Relationship to Patient _____

Address _____

Phone _____ Co-Pay \$ _____

SECONDARY INSURANCE

Insurance Co _____

ID # _____

Group # _____ DOB _____

Subscriber _____

Subscribers Relationship to Patient _____

Address _____

Phone _____ Co-Pay \$ _____

THIS IS AN AUTHORIZATION FOR MEDICAL TREATMENT, RELEASE OF MEICAL INFORMATION AND FINANCIAL AGREEMENT. I/WE DIRECTLYLY ASSIGN ALL MEDICAL/SURGICAL BENEFITS TO THE ORTHOPAEDIC SURGEON AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE ORTHOPAEDIC SURGEON TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

Patient Signature or Legal Guardian

Print Name

Date

INDUSTRIAL QUESTIONNAIRE

Please complete all the questions as completely as possible by filling in the blanks or circling. If a question does not apply to you, please mark N/A after that question. Please write legible. Thank you.

PERSONAL INFORMATION:

Today's Date: _____

Name: _____
Last First M.I.

Sex: Male Female Height: _____ Weight: _____ Dominant Hand: Right Left

Language: English Spanish Other: _____ Interpreter Name: _____

Do you have an attorney? Yes No Name: _____

HISTORY OF WORK INJURY: Answer all questions as the relate to this injury.

Date of injury: _____ Occupation: _____

Job Duties: _____

Employer at the time of injury: _____

In your words, describe how the injury/illness occurred. Be Specific: _____

Did you receive medical treatment for this injury?: Yes No Date: _____

Where: _____ With: _____

What treatment have you received for this injury? List medication, physical therapy, ect: _____

What testing have you had done?

	Yes	No	Body Part	Location/Date
X-rays	Yes	No	_____	_____
MRI	Yes	No	_____	_____
CT Scan	Yes	No	_____	_____
EMG/NCS	Yes	No	_____	_____
Other	Yes	No	_____	_____

What were you told was wrong? _____

Present Complaints: _____

Describe your symptoms: _____

Circle all that apply.

Do you have pain? Yes No

Describe your pain: Sharp Dull Burning Slight Moderate Severe Occasional

Do you notice any of the following: Swelling Catching Locking Tingling Grinding Weakness

Numbness Deformity Other _____

Does the pain radiate? Yes No If yes, Where? _____

Circle the number which best describes your pain on scale of 1 – 10.

1 2 3 4 5 6 7 8 9 10 (1 = Hardly 10 = Severe)

Past Medical History

Have you been injured at work before? Yes No If yes, When? _____

Have you ever injured the same body part before? Yes No
If yes, When? _____ Describe the Injury: _____

Circle all **ILLNESSES** that you have: None High Blood Pressure
Diabetes
Other _____ Heart Disease Paralysis- Temp or permanent Ulcers
Caner Asthma

List all **SURGERIES** you have had:

Type of operation	Date	Type of operation	Date

List all **MEDICATIONS** you are presently taking, include medications such as aspirin & vitamins

Medication & dosage	Frequency	Medication & dosage	Frequency

List all **ALLERGIES** to medications: _____

Are you claustrophobic (uncomfortable in enclosed areas)? Yes No

Do you have any retained metal (metal joints, pins, pacemaker) Yes No

If yes, Where _____

Do you smoke? Yes No

If yes, How long? _____ How many pack per day? _____

Do you use the alcohol in any form? Yes No

If yes, how long? _____ How, much? _____

List any FAMILY HEALTH PROBLEMS, such as cancer, heart, lung, or kidney disease, stroke, hypertension, or allergies? _____

PERSONAL HEALTH HISTORY Circle all that apply

General Constitutional	Recent weight gain, Recent weight loss, Fever, Chills, Sweats
Eyes	Blurry Vision, Double vision
Ear, Nose, Mouth, Throat	Hearing loss, Dizziness, Tooth or Gum disease
Cardiovascular	Chest pain, Heart attack, Skipping heartbeat, High blood pressure Shortness of breath, Heart murmur, Heart disease
Respiratory	Pneumonia, Chronic cough, Tuberculosis, Coughing up blood, Wheezing, Asthma
Gastrointestinal	Heartburn, Diarrhea, Black stools, Bloody stools, Ulcers, Yellow skin, Constipation
Genitourinary	Frequent urination, Difficulty urinating, Bloody urine, Woman: Excessive bleeding during periods, bleeding between periods, Pregnancies, How many _____. Men: Difficulty starting urinary stream, Difficulty maintaining erections
Musculoskeletal	Muscle pain, Joint pain, Joint swelling, Arthritis
Skin	Rashes, Ulcers, Infection
Neurologic	Numbness, Tingling, Weakness, Seizures, Loss of coordination
Psychiatric	Emotional problems, Anxiety, Depression, Mood swings
Endocrine	Diabetes, Thyroid or other glandular problems
Hematological	Anemia, Easy bruising, Easy bleeding

OCCUPATIONAL HISTORY

Did you continue to work after the injury? Yes No

If you were off work, from what date: ____/____/____ to what date: ____/____/____

Did you work with restrictions? No Yes: _____

What were your work duties at the time of injury? **Circle all that apply.**

Standing	Sitting	Walking	Climbing	Reaching	Twisting	
Bending						
Squatting	Crawling	Pushing	Pulling	Kneeling	Typing	Driving
Lifting 1-10 lbs		Lifting 11-24lbs		Lifting 25-50 lbs.	Lifting over 75lbs	

Signature of injured worker

Date

Signature of interpreter

Date

Keith A. Robertson, M.D.

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

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:

Keith A. Robertson, M.D.

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

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 _____

Print Name of Patient

Date
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 Healthcare, 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 <u>at the time of office visit.</u>	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 <u>services you receive are covered by the plan:</u> All applicable copays and deductibles are requested <u>at the time of the office visit.</u>	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you.

If You Have...	You Are Responsible For...	Our Staff Will...
	If the <u>services you receive are not covered by the plan</u> : Payment in full is requested at the time of the visit.	File an insurance claim on your behalf.
HMO with which we are <u>not contracted</u>.	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— <u>at the time of the visit.</u>	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 <u>\$140 deductible, we ask that it be paid at the time of service.</u> Any services not covered by Medicare are requested at the time of the visit. <u>If you have Regular Medicare as primary, and also have secondary insurance or Medigap:</u> No payment is necessary at the time of the visit. <u>If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% copay is requested at the time of the visit.</u>	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	<u>If we have verified the claim with your carrier</u> No payment is necessary at the time of the visit. <u>If we are not able to verify your claim</u> 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

Date

Witness/Staff

Keith A. Robertson M.D.
Physician Name