

Welcome to McLean County Orthopedics!

On behalf of the office staff and physicians, we are pleased you have chosen us to provide you with quality healthcare.

There may be the need to order diagnostic testing or imaging to aid in the diagnosis and treatment of your condition. The results of these tests or imaging can take time. Results will be discussed in the office with the physician during the follow-up appointment unless otherwise noted by your physician's staff. During this time, you may be prescribed medications to aid in your treatment. This time will give us a chance to see how the medications are helping you.

After your initial consultation, you will be given a follow-up appointment if necessary. At this appointment, all of your testing or imaging results will be discussed and reviewed with you.

Please be assured that if a test or imaging result is of immediate concern to the physician, we will call you to discuss the result and ask that you come in sooner.

Depending on your type of follow-up appointment, you could be given a follow-up appointment with one of our certified physician assistants or nurse practitioners. Your physician will have already approved all treatment plans.

Our office will verify your insurance benefits prior to your appointment. Based on the information provided to us by your insurance carrier, you may be required to pay a co-pay, a part or all of your deductible, or a percentage of your total bill depending on your specific benefit at the time of your appointment. If you have a balance on your account, you will be required to pay that balance upon your next visit to our office.

Our goal is to have the physician on time for your appointment. We care for very complex patients, and so we may need to tend to emergencies, causing a delay in your appointment. Please be assured that when it is your turn, your physician will show you the same attention and respect.

McLean County Orthopedics Office Policies

We would like to thank you for choosing McLean County Orthopedics as your orthopedic, pain, and therapy provider. We have written this policy to keep you informed of our current office policies.

Office Hours: Our physician offices are open Monday – Friday 7:30 a.m. – 5 p.m. Our Walk-In Ortho Care Clinic (no appointment necessary) is open Monday – Friday 8 a.m. – 6 p.m. and our therapy department is open Monday – Thursday 6:30 a.m. – 7:00 p.m., Friday 6:00 a.m. – 4:30 p.m., and Saturday 7:00 a.m. – 11:00 a.m.

Appointments: We see patients by appointment only. Same day appointments are usually available dependent on the physician. The Walk-In Ortho Care Clinic does accept walk-ins.

After Hours and Emergencies: For a serious emergency call 911 immediately. If you are not sure and you call our office, please be sure to tell the person who answers the phone that it is an urgent situation. If you call the office after hours, you will reach our answering service.

Urgent Need or Sudden Change in Symptoms: Please call early in the day as same-day appointments can fill up quickly. If there are no available appointments with your physician, the receptionist will offer an appointment with their mid-level provider (physician assistant or nurse practitioner) or transfer you to their nurse or medical assistant who will discuss your needs with the physician and determine what you should do.

Cancellations: Please call within 24 hours of your scheduled appointment if you are unable to keep your scheduled appointment. This allows us to provide that time slot to another patient.

Running on Time: We know your schedule is busy and that your time is valuable. Please let us know if you have waited more than 30 minutes so we can double check to see if you have been properly checked in. Remember that we are running several different schedules.

Treatment of Minors: Patient under the age of 18 must be accompanied by a parent or legal guardian for treatment. They must attend by themselves or with someone else **IF** the legal guardian has filled out MCO's Authorization to Treat a Minor form.

Lab Work: Some procedures or the diagnostic process calls for lab work to be conducted. We will send your lab work to any lab of your preference. Be sure to let us know of your lab preference at every visit.

Nurse or Medical Assistant: We often refer to staff that assists our providers as “nurses”. They do help you and the physicians, and you probably think of them as nurses. However, some of them are not technically “nurses” because they are not licensed by the state as an LPN or RN. Some are “medical assistants”. This means they have technical school or on-the-job training providing medical assistance to the physicians. They ask about symptoms, schedule test, surgeries or imaging, and call in prescriptions. They work under the direct supervision of the doctor.

Nurse Call: What is a “nurse call”? This is what we say when someone comes into the office without an appointment and asks for samples, want to leave a form to be filled out, has a question, etc. The receptionist will ask you to sign in and will notify the nurse that you are here. The nurse will come to talk with you as soon as he/she can. Remember that scheduled appointments take priority over walk-ins, so you may have a bit of a wait. We recommend that you call first.

Speaking with a “Nurse”: To speak with a nurse via phone, you can choose that option from the auto-attendant or be transferred by the receptionist. Often at the time you call, the nurse may be helping the physician, and your call is answered by voicemail. Please leave a detailed message including your full name with spelling and your date of birth. The nurse will call you back as soon as he/she can.

Test Results: If you have diagnostic testing, i.e., labs, x-ray, echo, ultrasound, MRI, CT, etc., please schedule a follow-up appointment within 7-10 days to go over the results with your physician. You will be subject to your copay/co-insurance. Results may sometimes be given over the phone.

Prescription and Refills: The best time to get a prescription refill is at your appointment. If you need to call for refills, don’t wait until you have run out. Most refills require the physician’s approval and/or a prior authorization through your insurer. If your physician is out for the afternoon, it may be the next business day before it will be authorized. Don’t go to the pharmacy to wait for your prescription to be called in. Call them first to see if it is ready. Refill requests call to us before 2:00 p.m. will be handled by the end of the day. After 2:00 p.m., it may be the next morning before your request can be addressed. Some medications have potential side effects that must be monitored. We require check-ups every 3 or 4 months for these medications. Be sure to keep those follow-up appointments. Some prescriptions cannot be called in. The prescription must be printed for you to pick up. Do not call after hours for prescription refills. There is no access to your chart, and we may not be able to help you.

Medication Samples: We sometimes offer you samples to help you try out a new medication before you purchase it. Remember that samples are not a long-term way to fill your prescription.

We do not always have samples of your medications. Please do not rely on samples for medications you take long-term.

Narcotics: Due to Illinois state law, you will need to come into the office to pick up your narcotic prescription to take to the pharmacy of your choice to be filled. You will need to bring a photo ID with you and sign a prescription pick-up form.

Referrals: Referrals are handled by our referral department. Sometimes this can be done on the same day as your appointment and sometimes it can take a few weeks depending on your insurance and/or the urgency of your situation. Someone will contact you as soon as the referral authorization is obtained.

As a patient, it is your responsibility to ensure that your specialist is covered by your insurance plan. It is also your responsibility to ensure your specialist receives your test results. You should pick up a copy of your test results from our office and hand deliver them to your specialist. We will send all records needed for referrals made by our physicians. Dependent on location, they may be mailed or faxed.

Dismissal: If you are “dismissed” from the practice, it means you can no longer schedule appointments, get medication refills, or consider us to be your physician. You have to find a physician in another practice.

Common Reasons for Dismissal

- Failure to keep appointments – frequent no-show
- Noncompliance – you don’t follow physician instructions about an important health issue
- Abusive to staff
- Failure to pay your bill

Dismissal Process

We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on the dismissal letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical records to your new physician after you let us know who it is and sign a release form.

A COPY OF YOUR MEDICAL RECORDS CAN BE REQUESTED AND MAILED OR GIVEN TO YOU UPON YOUR REQUEST. IF REQUESTING, FILL OUT THE ENCLOSED REQUEST FORM AND MAIL BACK IN THE ENVELOPE PROVIDED. PLEASE ALLOW UP TO 2 WEEKS TO RECEIVE THE RECORDS.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name (printed): _____ Date of Birth: _____

Daytime Phone: _____ Evening Phone: _____

I authorize McLean County Orthopedics, 1111 Trinity Lane Suite 111 Bloomington, IL 61704;
Dr. _____ to release my information from my medical records.

NAME OF ENTITY TO RECEIVE INFORMATION:

Name: _____ Phone #: _____

Address: _____ Fax #: _____

INFORMATION TO BE RELEASED: COMPLETE RECORDS **OR** AS INDICATED BELOW

PROGRESS NOTES IMAGING REPORTS HISTORY AND PHYSICAL OPERATION REPORT
 CONSULTATION PHYSICAL THERAPY NOTES OTHER: _____

Date(s) of service: _____

PURPOSE OF RELEASE:

CHANGING PHYSICIAN CONSULTATION/SECOND OPINION LEGAL MILITARY INSURANCE
 CONTINUATION OF CARE INDIVIDUAL REQUEST DISC OTHER: _____

I know and accept the information on my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency (HIV), behavioral or mental health services or treatment for alcohol and drug abuse.

I know and accept that the confidential information released because of this authorization may be re-released by the recipient and no longer protected under the Privacy Rule.

I know and accept that this authorization may be cancelled by completing the Authorization Revocation Form at any time unless McLean County Orthopedics has already released information. If not canceled, this consent will expire in six (6) months from the date signed.

I know that I have the right to look over the information that I have authorized to be released.

I know and accept that I may refuse to sign this authorization. I do not have to sign this form in order to receive treatment except in situations where research related treatment is provided solely for the purpose of creating protected health information for disclosure to a third party (e.g. drug screening, fitness for duty examinations, pre-employment, or life insurance physicals).

If I do not sign this authorization, no information will be released.

I know and accept there may be a charge for copies of records and X-rays.

NOTICE TO RECEIVING AGENCY/PERSON

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act and/or under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Records, and under the Illinois HIV/AIDS Confidentiality Act, no such records, nor information from such records may be further disclosed unless the person who consented to third disclosure specifically consents, in writing, to such re-disclosure. A general authorization for release of medical or other information.

Patient/Representative Signature **at request submission**

Relationship (if not patient)

Date Requested

Patient/Representative Signature **at document release**

Relationship (if not patient)

Date Released

Witness Signature / Date Released

Type of Photo I.D.

Amount / Date Paid

OFFICE FINANCIAL POLICY

Thank you for choosing MCO as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. In order to keep our fees to a minimum, we require you to pay at the time of service. If you are unable to pay the full amount, we have payment plans that may be available to you. In order to achieve the clinic goals of providing the finest medical care at the lowest cost, we need your assistance and understanding of our payment policy.

Self-Pay: FULL PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT THE TIME OF SERVICE. We accept cash, checks, and credit cards. If you are unable to pay the full amount, we will work with you to set up a payment plan.

Insurance: PAYMENT OF CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. Service may be denied if payment is not made at check-in time. As a courtesy to our patients, our office will file an insurance claim for services rendered, but ultimately you are responsible for the bill. By law, your insurance company must remit payment or deny your insurance claim within 45 days of initial notice. If your insurance company has not paid your account in full within 60 days, we may ask for your assistance in getting your insurance company to pay the balance or the balance may be billed to you. We will file the claim to your insurance company, but your insurance policy is a contract between you and your insurance company.

Insurance Coverage Changes: In the event that your insurance coverage changes to a plan where we are NOT PARTICIPATING PROVIDERS, you will be responsible for payment of all fees at the time service is rendered. We ask that you participate in any disputes with your insurance carrier regarding your policy guidelines and insurance payments.

Financial Responsibility of Minors: Unless prior arrangements have been made, charges for a minor child seen in the office are the responsibility of the adult accompanying the minor child.

Returned Checks: Returned checks are subject to a \$50.00 charge. Returned checks older than 30 days may be subject to legal action.

Disability, Insurance Forms, Attending Physician Statement, FMLA: There will be a charge of \$15.00 for the completion of medical forms, and you may be required to schedule an appointment. Payment is due at the time that you pick up these forms. Please allow 7-10 business days for the completion of these forms. If you would like the forms mailed to you or the insurance company, payment will be due prior to mailing.

Medical Records: We will provide you a copy of your medical records upon request and for a fee. You will need to sign a letter of release prior to having them copied. Please allow up to 72 hours for this request to be processed.

Imaging: We will provide you a copy of your X-rays upon request and for a fee. You will need to sign a letter of release at the time of pick up. Please allow 72 hours from the time of your request.

Billing: If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first, if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.

Collections: Account that are not paid within 30 days begin our in-house collection process. If your balance becomes 65 days old, your doctor will be notified and you may be subject to dismissal from the practice.

As stated above, the primary goal of our practice is to provide the finest medical care and services to the people in our community. Since our practice also has financial obligations that must be met, we ask all patients pay for their co-pays and deductibles at the time of service.

I have read, understand, and agree to abide by the financial policy set forth.

Signature of Patient, Parent, Guardian, or Personal Representative

Date

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used, so that you may decide whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature, even after a specific diagnosis has been made, and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other healthcare providers or the designees as deemed necessary, medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Signature of Patient, Parent, Guardian, or Personal Representative

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Privacy Notice describes how we may use and disclose your protected health information to carry out our treatment, payment, or healthcare options and for other purposes permitted or required by law. We must follow the privacy practices described in the Notice while it is in effect. We reserve the right to change the terms of this Notice and make the new Notice effective for all future protected health information we maintain. We will post the most current Notice and make the new Notices available to anyone. You may request a copy of the current Notice at any time. This Privacy Notice also describes your rights to access and control your "protected health information," which is health information that is created or received by your health care provider.

USES OR DISCLOSURES OF PROTECTED HEALTH INFORMATION

We will use and disclose health information to provide treatment, obtain payment, and conduct health care operations.

1. **Treatment:** To provide and coordinate your health care. For example, we may disclose protected health information to other health care professionals who may be treating you or consulting with us. Examples include your physicians, anesthesia provider, or pharmacist.
2. **Payment:** To obtain payment for services. This may include contact with your insurance company to get the bill paid and to determine the benefits of your health plan. We may also disclose information to another provider involved in your care so the provider can get paid.
3. **Operations:** To perform our own healthcare activities such as qualified assessment and improvement, licensing or credentialing, and general business administration.
4. **Other Uses and Disclosures:** To remind you of appointment or to a family member, friend, or another person to the extent necessary to help you with your healthcare or payment for your healthcare or to notify family or others involved in your care concerning your location and condition. You may object to these disclosures. If you do not or cannot object, we will use our professional judgment to make reasonable assumptions about to whom we can make disclosures. Your consent is required prior to the use and disclosure of your personal health information for marketing purposes.
5. **Other Uses and Disclosures Permitted:** to comply with laws and regulations.
 - a. **When legally required** by any federal, state, or local law.
 - b. **When there are risks** to public health such as:

- i. To prevent, control, or report disease, injury, or disability as required or permitted by law.
 - ii. To report vital events such as birth or death required by law.
 - iii. To conduct public health surveillance, investigations, and interventions required by law.
 - iv. To collect or report adverse events and product defect, track Food and Drug Administration (FDA) regulated products; enable product recalls, repairs or replacement, and review.
 - v. To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
 - vi. To report to an employer information about an individual who is a member of the workforce as legally permitted and required.
- c. **To report suspected abuse, neglect, or domestic violence** as required by law.
- d. **To conduct health oversight activities** such as audits, civil, administrative, or criminal investigations, proceedings, or actions, inspections, licensing or disciplinary actions, or other activities necessary for appropriate oversight as required or authorized by law.
- e. **In connection with judicial and administrative proceedings** such as in the course of any judicial or administrative proceeding.
- f. **For law enforcement purposes.** Examples are:
- i. As required by law for reporting certain types of wounds or other physical injuries.
 - ii. Upon court order, court-ordered warrant, subpoena, summons, or similar process.
 - iii. For the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.
 - iv. Under certain limited circumstances, when you are the victim of a crime.
 - v. If there is concern that your health condition was the result of criminal misconduct.
 - vi. In an emergency to report a crime.
- g. **For research purposes** when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.
- h. **In the event of a serious threat to health or safety** and consistent with applicable law and ethical standards of conduct, if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety, or the health and safety of the public.
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- i. **For specified government functions** relating to military and veterans activities, national security, protective services, medical suitability determinations, correctional institutions, and law enforcement situations.
- j. **For worker's compensation** to comply with worker's compensation laws or similar programs.

PATIENT RIGHTS

YOU HAVE THE RIGHT TO:

1. **See and copy your medical records** and other records used to make treatment and payment decisions about you. There are some limitations, based upon the federal law. You must submit a written request. We may charge you a fee for copying, mailing, or incurring other costs in complying with your request. We may deny your request to see or copy your protected health information if, in our professional judgment, we determine the access requested is likely to endanger the life or safety of you or another person. You have the right to request a review of this decision. You have the right to request an electronic copy of your medical records if available.
 2. **Request a restriction on uses and disclosures of your protected health information.** The practice is not required to agree to a restriction, and we will notify you if we deny your request. If the practice does not agree to the requested restriction, we will abide by this agreement unless use or disclosure of information becomes essential to provide emergency treatment.
 3. **The right to request to receive confidential communications** by alternative means or at an alternative location. You have the right to request that we communicate with you in a certain way. We will not require you to explain your request. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or another method of contact.
 4. **The right to request we amend your protected health information.** A request for amendment must be in writing, and it must explain why the information should be amended. Under certain circumstances, we may deny your request.
 5. **The right to receive an accounting of disclosures.** You have the right to request an accounting of how we, or our business associates, disclosed your protected health information for purposes other than treatment, payment, or healthcare operations. We are not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting can be made in writing. We are not required to provide an accounting for disclosures that occurred prior to April 14, 2003, or for a period of time in excess of six years. The first accounting you request during a 12-month period will be without charge. Additional accounting requests may be subject to a reasonable fee.
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6. **The right to obtain a paper copy of this notice at any time.**
7. **The right to participate actively in decisions regarding your medical care including the right to refuse treatment by your physician and select an alternative physician.**
8. **The right to be notified in the event of a breach of your individual personal health information.**
9. **The right to opt out of communications for fundraising programs.**
10. **You may request that your health plan not be informed of your treatment if you have paid your bill in full the day of treatment.**

COMPLAINTS

You have the right to express complaints to the practice if you believe that your privacy rights have been violated. We encourage you to express any concerns you have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint. You may complain to the practice Privacy Officer in person, by phone, or in writing. You also have the right to express complaints to the Secretary of the United States Department of Health and Human Services.

**CONTACT PERSON
MCLEAN COUNTY ORTHOPEDICS
PRIVACY OFFICER - JAMES SCHAEFER
1111 TRINITY LANE, SUITE 111
BLOOMINGTON, IL 61704
PHONE 309-662-5967**

AUTHORIZATION FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that the Practice cannot share your Protected Health Information (PHI) without your permission, except in certain situations. For example, your PHI can be shared without your permission if it is used to facilitate your healthcare treatment, payment, or for healthcare operations. By signing this form, you are permitting us to share your PHI as you indicate below.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that treatment, payment, or enrollment or eligibility for benefits will not depend in any way on whether or not I sign this authorization. I further understand that I may inspect and copy any information disclosed pursuant to this authorization and that I will receive a copy of this form upon signing it if the Practice is soliciting my signature.

I understand that if the organization authorized to receive the information is not a health plan, healthcare provider, or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed below and no longer protected.

I understand that this authorization is voluntary and may be revoked at any time by signing the revocation section of my copy of this form and returning it to the Practice. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

I hereby authorize the use and/or disclosure of my PHI as described below:

Patient Name: _____

Person/Organization to receive information:

Name: _____ Relationship: _____
Medical or Billing or Both

Name: _____ Relationship: _____
Medical or Billing or Both

Name: _____ Relationship: _____
Medical or Billing or Both

Name: _____ Relationship: _____
Medical or Billing or Both

Name: _____ Relationship: _____
Medical or Billing or Both

Signature of Patient, Parent, Guardian, or Personal Representative

Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

Print Name

Signature of Patient, Parent, Guardian, or Personal Representative

Date

FOR PRACTICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify): _____

**If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for six (6) years.*

PATIENT PORTAL POLICY

To better serve our patients, McLean County Orthopedics has established a patient portal through which our patients can communicate with our staff, put in requests (medical records, prescription refills, etc.), and access your patient care summary. Please allow at least 1 to 2 business days for a response.

If you do not wish to sign up for the patient portal, please write DECLINE.

OUR PATIENT PORTAL IS NOT FOR EMERGENCY USE. IF YOU HAVE AN EMERGENCY CALL 911 OR GO TO YOUR LOCAL EMERGENCY ROOM.

To access your patient portal:

1. Our office will activate your patient portal and you will receive an email with your username and password.
2. Go to our website, www.mcleancountyorthopedics.com.
3. Click the "Access Patient Portal" button.
4. Login with your username and password given to you.

Please sign below if you would like us to activate you patient portal.

By signing below, you are agreeing that we may send medical related information to you via email and that we may respond via email.

Signature of Patient, Parent, Guardian, or Personal Representative

Date

PATIENT INFORMATION RECORD

Please print or write legibly and use blue or black ink.

PATIENT'S NAME				TODAY'S DATE	HOME PHONE NUMBER
MARITAL STATUS S M W D SEP	DATE OF BIRTH	SEX	AGE	EMAIL	MOBILE PHONE NUMBER
STREET ADDRESS (PERMANENT)				CITY/STATE	ZIP CODE
PATIENT'S EMPLOYER					
ADDRESS		CITY/STATE		ZIP CODE	WORK PHONE NUMBER
EMERGENCY CONTACT NAME				EMERGENCY CONTACT PHONE NUMBER	
ARE YOU COLLECTING SOCIAL SECURITY DISABILITY? YES NO				SOCIAL SECURITY START DATE	
CURRENT WORK STATUS: WORKING DISABLED UNEMPLOYED RETIRED SICK LEAVE					WORK RESTRICTIONS YES NO
WHAT TYPE OF WORK DO YOU DO?				DOES IT CONTRIBUTE TO YOUR PAIN? YES NO	

Physician: _____

RESPONSIBLE PARTY INFORMATION (if other than patient)

SPOUSE'S NAME	STREET ADDRESS, CITY, STATE, & ZIP CODE	PHONE NUMBER
SPOUSE'S SOCIAL SECURITY NUMBER		SPOUSE'S DATE OF BIRTH
SPOUSE'S EMPLOYER	OCCUPATION	EMPLOYER PHONE NUMBER
MOTHER'S NAME	STREET ADDRESS, CITY, STATE, & ZIP CODE	PHONE NUMBER
MOTHER'S SOCIAL SECURITY NUMBER		MOTHER'S DATE OF BIRTH
MOTHER'S EMPLOYER	OCCUPATION	EMPLOYER PHONE NUMBER

FATHER'S NAME	STREET ADDRESS, CITY, STATE, & ZIP CODE	PHONE NUMBER
FATHER'S SOCIAL SECURITY NUMBER		FATHER'S DATE OF BIRTH
FATHER'S EMPLOYER	OCCUPATION	EMPLOYER PHONE NUMBER

REFERRAL INFORMATION

NAME OF HOSPITAL AND/OR PHYSICIAN WHO REFERRED YOU TO OUR PRACTICE	
PRIMARY CARE PHYSICIAN (FIRST & LAST NAME)	STREET ADDRESS, CITY, STATE, & ZIP CODE
WHICH MCO PHYSICIAN ARE YOU SEEING?	
HAVE YOU EVER BEEN SEEN AT MCLEAN COUNTY ORTHOPEDICS, LTD? YES NO	IF YES, WHO AND WHAT YEAR?

INSURANCE INFORMATION

PRIMARY INSURANCE		ADDRESS
POLICY/I.D. NUMBER		GROUP NUMBER
SECONDARY INSURANCE		ADDRESS
POLICY/I.D. NUMBER		GROUP NUMBER
IS THIS A WORK-RELATED INJURY? YES NO	CLAIM #	WORKMAN'S COMPENSATION INSURANCE CO.
ADJUSTOR NAME & PHONE NUMBER		WORK COMP INSURANCE ADDRESS
IS THIS A LIABILITY CLAIM? YES NO	CLAIM #	LIABILITY INSURANCE
LIABILITY INSURANCE ADDRESS		NAME
POLICY HOLDER NAME & ADDRESS		
INSURANCE CONTACT PERSON		PHONE NUMBER

DID AN INJURY CAUSE OR AGGRAVATE YOUR PROBLEM?

CAUSED AGGRAVATED NO INJURY

When was the first or most serious injury? _____

Please describe the injury, your main symptom, and indicate left or right: _____

List any surgeries you have had in relation to this problem (include date & type): _____

Do you have an attorney who will be representing you regarding this injury? YES NO

If yes, please indicate attorney's name, address, and phone number: _____

AUTHORIZATION

The undersigned authorizes McLean County Orthopedics, LTD. to release and/or obtain information in the course of treatment regarding medical condition of (patient's name) _____ to the previous named insurance company(s) and physician(s). This consent shall expire 1 year from the date that I sign this form. It is my intent that this consent shall cover any and all services from this provider at this time.

The undersigned also authorizes that their medical benefit payment be made directly to McLean County Orthopedics, LTD. In order to control our cost of billing, we request that co-pays be made at time of service. All patient balances are expected to be paid upon receipt of bill unless other payment arrangements are made. If the undersigned fails to pay any remaining balance for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection cost incurred. A collection fee will be assessed on the account balance at the time the account is placed for regular collection with the collection agency. In the event legal action is taken, the patient is responsible for payment of all court costs.

Signature

Date

MEDICAL HISTORY

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Colon Problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Enlarged Prostate |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer – Type _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Visual Changes |
| <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Degenerative Arthritis | <input type="checkbox"/> Frequent Pneumonia | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Duodenal Problems | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> ALS | <input type="checkbox"/> HIV | <input type="checkbox"/> Tremor | |

CURRENT MEDICATIONS (or bring in a current list to your appointment)

MEDICATION	REASON TAKEN	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

Flu shot vaccination: Yes No Date _____

ALLERGIES

MEDICATION/ALLERGEN	REACTION

SURGICAL HISTORY (not done at McLean County Orthopedics)

SURGERY	DATE

FAMILY HISTORY

	ALIVE/ DECEASED	DIABETES	HIGH BLOOD PRESSURE	ASTHMA/ LUNG DISEASE	CANCER (TYPE)	HEART ATTACK/ CAD	STROKE	OSTEOPOROSIS	HIGH CHOLESTEROL	ARTHRITIS
MOTHER										
FATHER										
SISTER										
BROTHER										
SON										
DAUGHTER										

SOCIAL HISTORY

ALCOHOL	<input type="checkbox"/> NONE <input type="checkbox"/> OCCASIONALLY: _____ DRINKS PER <input type="checkbox"/> DAY <input type="checkbox"/> WEEK <input type="checkbox"/> MONTH
TABACCO USE	<input type="checkbox"/> NEVER <input type="checkbox"/> CURRENT DAILY <input type="checkbox"/> CURRENT SOME <input type="checkbox"/> SMOKELESS TOBACCO FORMER <input type="checkbox"/> SMOKELESS TOBACCO CURRENT
CAFFEINE	<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, FREQUENCY: _____ CUPS PER DAY

REVIEW OF SYSTEMS

GENERAL RECENT WEIGHT LOSS OF MORE THAN 10 LBS. <input type="checkbox"/> YES <input type="checkbox"/> NO RECENT WEIGHT GAIN OF MORE THAN 10 LBS. <input type="checkbox"/> YES <input type="checkbox"/> NO FEVER <input type="checkbox"/> YES <input type="checkbox"/> NO CHILLS <input type="checkbox"/> YES <input type="checkbox"/> NO NIGHT SWEATS <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE YOU SEEN YOUR PRIMARY CARE PHYSICIAN IN THE PAST YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO		CARDIAC CHEST PAIN <input type="checkbox"/> YES <input type="checkbox"/> NO SHORTNESS OF BREATH <input type="checkbox"/> YES <input type="checkbox"/> NO PULMONARY WHEEZING <input type="checkbox"/> YES <input type="checkbox"/> NO PNEUMONIA <input type="checkbox"/> YES <input type="checkbox"/> NO CHRONIC COUGH <input type="checkbox"/> YES <input type="checkbox"/> NO
GASTROINTESTINAL ABDOMINAL PAIN <input type="checkbox"/> YES <input type="checkbox"/> NO NAUSEA <input type="checkbox"/> YES <input type="checkbox"/> NO VOMITING <input type="checkbox"/> YES <input type="checkbox"/> NO DIARRHEA <input type="checkbox"/> YES <input type="checkbox"/> NO LIVER PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO	DERMATOLOGICAL OPEN SORES <input type="checkbox"/> YES <input type="checkbox"/> NO NEW MOLES <input type="checkbox"/> YES <input type="checkbox"/> NO POOR HEALING <input type="checkbox"/> YES <input type="checkbox"/> NO SKIN INFECTION <input type="checkbox"/> YES <input type="checkbox"/> NO EASY BRUISING <input type="checkbox"/> YES <input type="checkbox"/> NO	ENDOCRINE DIABETES <input type="checkbox"/> YES <input type="checkbox"/> NO DENTAL SIGNIFICANT PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO
MUSCULOSKELETAL SHOULDER PAIN <input type="checkbox"/> YES <input type="checkbox"/> NO WRIST/HAND PAIN <input type="checkbox"/> YES <input type="checkbox"/> NO HIP PAIN <input type="checkbox"/> YES <input type="checkbox"/> NO KNEE PAIN <input type="checkbox"/> YES <input type="checkbox"/> NO LOWER BACK PAIN <input type="checkbox"/> YES <input type="checkbox"/> NO LUPUS <input type="checkbox"/> YES <input type="checkbox"/> NO MUSCLE WEAKNESS <input type="checkbox"/> YES <input type="checkbox"/> NO FIBROMYALGIA <input type="checkbox"/> YES <input type="checkbox"/> NO	NEUROLOGICAL HEADACHES <input type="checkbox"/> YES <input type="checkbox"/> NO TREMORS <input type="checkbox"/> YES <input type="checkbox"/> NO SEIZURES <input type="checkbox"/> YES <input type="checkbox"/> NO CHANGES IN VISION <input type="checkbox"/> YES <input type="checkbox"/> NO	GENITOURINARY POOR KIDNEY FUNCTION <input type="checkbox"/> YES <input type="checkbox"/> NO PAIN WITH URINATION <input type="checkbox"/> YES <input type="checkbox"/> NO FREQUENT UTI <input type="checkbox"/> YES <input type="checkbox"/> NO HEMATOLOGICAL TRANSFUSION <input type="checkbox"/> YES <input type="checkbox"/> NO TRANSPLANT <input type="checkbox"/> YES <input type="checkbox"/> NO BLOOD THINNER <input type="checkbox"/> YES <input type="checkbox"/> NO

Patient Signature

Date