HEARTLAND
Orthopedic Specialists

The One To Trust.

Jefferson C. Brand, M.D.
Fellowship-Trained
in Sports Medicine

Paul A. Dale, M.D.

Patrick E. Hurley, D.O.

Dennis P. Weigel, M.D.

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Shoulder & Elbow

Hand & Wrist

Hip

Knee

Foot & Ankle

Joint Replacement

Sports Medicine

If you have had x-rays, MRI, EMG, CT, ultrasound done, please <u>hand carry</u> all films to your appointment. The doctor will be reviewing all records relative to the problem for which you are being seen. If you do not have these available for the doctor, your appointment will be rescheduled.

Appointment Date: _____

Check in Time: _____ a.m. p.m.

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LOCATION OF APPOINTMENT

_____ Appleton Medical Clinic, Appleton, MN

_____ Glacial Ridge Hospital, Glenwood, MN

_____ Prairie Ridge Hospital & Health Services Morris, MN

_____**Please fill out all forms and hand carry them to your appointment.**

_____**Please fill out all forms and return in the enclosed envelope.**
Please keep the top form and credit policy.

Dear Patient:

You have been scheduled for an orthopaedic evaluation.

Enclosed please find registration forms for you to fill out prior to coming for your appointment. **It is very important that the forms are filled out completely and accurately. Please mail these forms back to us prior your appointment in the enclosed envelope. Please allow enough time for the forms to reach us in time for your appointment.** If these forms do not reach us in time, you will need to complete them again when you arrive. This could cause a delay in your being seen. Please provide all medications (including dosage) you are currently taking. Please bring your insurance card(s) as a copy will be made for your chart. **<u>Co-Payments are always due at the time of visit</u>**.

We look forward to serving you in the best way possible. Please feel free to call our office if you have any questions at (320) 762-1144 *or* (800) 762-1177.

Heartland Orthopedic Specialists Staff

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Today's Date: ____/____/____ **Date of Appointment**: ____/____/____

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. ***PLEASE FILL OUT EVERY ITEM.*** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Patient Name: _____**Age**_____ ☐ Male ☐ Female Occupation_____

Retired ☐ **No** ☐ **Yes**

Name of Primary Care (Family) Physician_____

Pharmacy Preference (include location) _____

Are you taking ANY kind of medication now? ☐ **No** ☐ **Yes** If yes please list below.

Medication	Dosage	Medication	Dosage

HEIGHT_____ **WEIGHT**_____

Are you allergic to any medications? ☐ **No** ☐ **Yes** If yes please list below.

Medication Name	Type of Reaction

Non-Medication Allergies

Are you allergic to any food? Specify_____ Type of reaction_____

Are you allergic to any non-medical things such as latex, tape, metal? ☐ No ☐Yes

If yes, specify_____ Type of reaction_____

Are you allergic to contrast dye? ☐No ☐ Yes Iodine/Betadine? ☐No ☐ Yes

Past Medical History- Problems you have been ***diagnosed with***:

Cancer	☐ No	☐ Yes Type_____	Osteoporosis	☐ No	☐ Yes
Migraine Headache	☐ No	☐ Yes	Scoliosis	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes	Spinal Stenosis	☐ No	☐ Yes
Angina	☐ No	☐ Yes	Shingles	☐ No	☐ Yes
Atrial Fibrillation	☐ No	☐ Yes	Neuritis	☐ No	☐ Yes
Cong. Heart Failure	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes
Heart Attack	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes	Anxiety	☐ No	☐ Yes
Hypertension	☐ No	☐ Yes	Depression	☐ No	☐ Yes
Asthma	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes Type_____
COPD	☐ No	☐ Yes	Thyroid Deficiency	☐ No	☐ Yes
Gastrointestinal Reflux	☐ No	☐ Yes	Thyroid Excess	☐ No	☐ Yes
Hepatitis	☐ No	☐ Yes Type_____	Anemia	☐ No	☐ Yes
Kidney Disease	☐ No	☐ Yes	Hemophilia	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes Type_____	HIV/AIDS	☐ No	☐ Yes
Disk Disorder neck	☐ No	☐ Yes	MRSA	☐ No	☐ Yes
Disk Disorder back	☐ No	☐ Yes	Other_____		

SURGERIES AND HOSPITALIZATIONS

Have had problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes
If yes please list what type of problems_____
Have you ever had surgery before? ☐ No ☐ Yes

If yes please list all surgeries and dates they occurred:

PROCEDURE	DATE	PROCEDURE	DATE

FAMILY HISTORY

Heart Disease	☐ Father	☐ Mother	☐ Brother	☐ Sister
Hypertension	☐ Father	☐ Mother	☐ Brother	☐ Sister
Arthritis	☐ Father	☐ Mother	☐ Brother	☐ Sister
Osteoporosis	☐ Father	☐ Mother	☐ Brother	☐ Sister
Dementia	☐ Father	☐ Mother	☐ Brother	☐ Sister
Epilepsy	☐ Father	☐ Mother	☐ Brother	☐ Sister
Stroke	☐ Father	☐ Mother	☐ Brother	☐ Sister
Alcoholism	☐ Father	☐ Mother	☐ Brother	☐ Sister
Depression	☐ Father	☐ Mother	☐ Brother	☐ Sister
Diabetes	☐ Father	☐ Mother	☐ Brother	☐ Sister
Bleeding problems	☐ Father	☐ Mother	☐ Brother	☐ Sister
Anemia	☐ Father	☐ Mother	☐ Brother	☐ Sister
HIV/AIDS	☐ Father	☐ Mother	☐ Brother	☐ Sister
MRSA	☐ Father	☐ Mother	☐ Brother	☐ Sister

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Tobacco Use: ☐ None ☐ Current packs per day_____ ☐ other type of tobacco
Have you smoked in the past? ☐ no ☐ yes _____packs per day Date Stopped_____
Alcohol Use: ☐ None ☐ Socially ☐ Rarely ☐ Moderately ☐ Heavily
Drug Use: ☐ None ☐ Type/Frequency_____
Describe your home setting (living alone, with children, with parents, nursing home, other_____)

MR# _____

PATIENT INFORMATION

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Please Print Date: ____/____/____

Last Name_____**First Name**_____**MI**_____

Address _____

City _____**State** _____ **Zip** _____

Date of Birth _____/_____/_____ **Social Security #** _____-_____- _____

Phone ( )_____ **Cell Phone** ( )_____

E-mail address _____

Marital Status S___M___W___ **Male___ Female___**

Occupation_____ **Work Phone ( )** _____

Employer _____

Employer Address _____

Family Physician _____ **Referred By** _____

SPOUSE / PARENT / GUARDIAN INFORMATION / EMERGENCY CONTACT

Name _____ **Relationship**_____

Phone ( )_____ **Work Phone** ( )_____

Did you have an Injury ___yes ___no Date of Injury ___/___/___

Did injury occur on own property?___ yes ___no , if not where? _____

_____

Description of Injury? _____

INSURANCE
(PLEASE COMPLETE IN ENTIRETY)

Medicare # _____ **MA #** _____

➡ **1) Primary Insurance**_____ID # _____Group#_____

Insured's Name **REQUIRED** _____ Insured's DOB:_____

➡ **2) Secondary Insurance**_____ID # _____Group#_____

Insured's Name **REQUIRED** _____ Insured's DOB:_____

WORKER'S COMPENSATION *(if applicable)*

Worker's Compensation Company Name and Address _____

_____

Claim # _____ _____ Date of Injury _____/_____/_____

Name _____ **Date of Birth** ____/____/____

Did you have an Injury ___yes ___no **Date of Injury** ___/___/___

Did injury occur on own property? ___ yes ___no , **if not where?**

_____

Description of Injury? _____

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Name:_____ **Record #:**_____

DOB: _____/_____/_____

I authorize Heartland Orthopedic Specialists to release any medical information necessary to process my claims to Medicare, Worker's Compensation, other Treating Providers, or any insurance carrier who is handling my claims. I understand that if this is a worker's compensation claim my employer may be sent copies of my medical records pertaining to my worker's compensation claim.

No limitations will be placed on dates, history of illness, diagnosis, and therapeutic information, including anything related to mental health, alcohol, and/or drug abuse.

I understand that Heartland Orthopedic Specialists and its employees, who participate in my care, cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization, and I hereby release them from any liability arising from such disclosures.

I authorize payment of medical benefits to my physician or supplier for services described on attached claims. I have read the Credit Policy and hereby assume full responsibility for paying any medical services or supplies and finance charges.

Signature of
Patient/Legal Guardian: _____

Date: _____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights my health information.

Signed:_____ **Date:**_____/_____/_____

Relationship (if not signed by patient):_____

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only
If patient/patient's representative refused to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

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CREDIT POLICY

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INSURANCE & PATIENT RESPONSIBILITY

As a service to you, Heartland Orthopedic Specialists will submit your charges to all insurance companies for which you have provided us proof of coverage. In order to provide this service, we may copy or scan your insurance card at each visit. Your insurance policy is a contract between you and your insurance company. However, your account statement will always be sent to you, indicating the balance that you owe after insurance payments. Those amounts are due and payable 30 days after you get your statement. **If you are unable to pay the balance when due, we ask that you contact our business office at (320) 762-0857 to discuss making monthly payments. Co-Payments are always due at the time of visit to the clinic.**

Uninsured patients require a $100.00 payment, *due upon arrival*, to be applied to initial appointment or past charges. A $75.00 payment will be required at <u>each</u> visit thereafter.

FINANCE CHARGE

A **FINANCE CHARGE** of 0.5 percent per month will be added to the portion of your bill over 45 days old. This is equal to an **ANNUAL PERCENTAGE RATE** of 6 percent. The **FINANCE CHARGE** is applied to the **OVER 45 DAY BALANCE** after deducting payment and credits.

RETURNED CHECKS

We reserve the right to place a service charge of $25 on returned checks.

CREDIT CARD PAYMENTS

We accept VISA, MasterCard, Discover and American Express credit cards.

SENDING ACCOUNTS TO COLLECTIONS

The cost of maintaining and following up on old accounts is very high. Therefore, if you fail to pay your charges or to make monthly payments on your account, an administrative fee of $30 may be charged to your account and it will be turned over to a collection agency. You will be required to see a patient financial worker prior to another appointment being made. Once your account has been placed with a collection agency you will not be given another appointment until the account is paid in full. **Exception:** If you are being treated for a particular condition, we will not terminate service during that course of treatment (i.e. a fracture or surgery follow-up).

QUESTIONS ABOUT YOUR ACCOUNT

If you have questions regarding this credit policy, as it applies to your account, call our Business Office at 320-762-0857 or 866-762-0857.