Orthopaedic & Rehabilitation
Specialists of Central Illinois

Kenneth Tuan, M.D.
Susan Wu, M.D.

Patient

Patient's Name _____

SSN _____ Gender M/F

Birthdate _____ Age _____

Email Address _____

Home Address _____

City/State _____ Zip _____

Phone _____

Responsible Party (if different than Patient)

Name _____

Relationship _____

Address _____

City/State _____ Zip _____

Phone _____

INJURY

*Is patient being seen today for an injury related to work? ☐ Yes ☐ No

*Is patient being seen today for an accident related to automobile, or other injury that is being billed to any other insurance besides your health insurance? ☐ Yes ☐ No

If you answered **YES** to one of the above questions in this section, you will need to complete a short accident form. Please ask the front desk staff about this form.

All work, automobile, or liability injuries must be billed accordingly. Our office will **not** bill your health insurance if another person/company is responsible for your injury. Incorrect information will result in you being responsible for payment.

Patient Initials _____

*** PLEASE COMPLETE BOXES BELOW ***

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

Policy/ID#: _____

Group #: _____

Policy Holder or Self

Last Name: _____ M.I. ____

First Name: _____

DOB: _____

Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____

Policy/ID#: _____

Group #: _____

Policy Holder or Self

Last Name: _____ M.I. ____

First Name: _____

DOB: _____

Relationship to Patient: _____

PATIENT

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Student Status: ☐ Full Time ☐ Part Time ☐ Not Student

Work Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Self Employed ☐ Active Duty

PATIENT EMPLOYMENT

Name of Employer_____

Address_____ Phone (____)_____

EMERGENCY CONTACT

Name of Local Friend or Relative:

Last Name: _____ First Name: _____ Relationship: _____

Home Ph: _____Work Ph: _____ Cell Ph: _____

Consent for Treatment:

I am asking to receive care from the above listed health care providers. I understand this care may include (1) diagnostic procedures (which may include laboratory tests and x-ray examinations) and (2) medical and surgical treatment. I permit the health care providers and their employees to provide me with services which are considered necessary or advisable. No guarantees have been made to me about the outcome of this care. In the event I decide to refuse the recommended treatment considered necessary or advisable by the health care providers, I relieve the health care providers of all responsibility for any ill effects which might result from my action.

_____ _____

PATIENT OR GUARDIAN SIGNATURE **DATE (MM/DD/YYYY)**

Who can we thank for referring you to our office?_____

Section Below for Office Use Only

☐ Copy of primary ins card ☐ HIPAA Privacy Notice given: Date_____by_____

☐ Copy secondary ins card ☐ All data entered: Date_____by_____

ORTHOPAEDIC AND REHABILITATION SPECIALIST OFFICE POLICIES

Thank you for choosing Orthopaedic and Rehabilitation Specialist. We pride ourselves on providing all patients with excellent services. To keep you informed of our office policies, please read the following, initial each policy, and sign at the bottom.

MINORS:
A parent or legal guardian must accompany patients who are minors on each patient's visit. This accompanying adult is responsible for payment of the account. _____ **INITIAL**

COPAYS, DEDUCTIBLES AND NON-COVERED SERVICES:
All co-pays, are **due at the time of service.** These charges **cannot** be waived by our practice, as they are a requirement placed on you by your insurance carrier. **We accept cash, check, credit cards.** You are responsible for any non-covered services as determined by your insurance plan. Although we file claims to insurance plans on your behalf, you are ultimately responsible for payment of the bill. **Workers Compensation and Accident Insurance** does not always pay 100%. If your case is denied, you are responsible for payment. **Charges incurred as the result of a liability claim are the patient's responsibility.** When provided with complete billing information, we are willing to work with you in collecting from other insurance. Please realize that litigation is usually lengthy and the doctor needs to be paid **by six months from first date of service.** _____ **INITIAL**

FORMS: (FMLA, DISABILITY, INSURANCE COMPANY FORMS)
We cannot fill out forms "on demand". All forms will be processed and completed in a 7 day period of time. The fee for each form is $10.00. _____ **INITIAL**

MISSED APPOINTMENTS:
We request the courtesy of a 24hr notice when cancelling so that we can contact another patient who needs our care. A fee of $25 will be applied to your account after your 2nd no call no show appointment. _____ **INITIAL**

PAST DUE BALANCES:
You will be asked to pay any past due balances when making appointments or before seeing the doctor. If your balance is especially high, we can set up a monthly payment plan. _____ **INITIAL**

RETURNED CHECKS:
There will be a $35.00 charge added to your account for any check returned by your bank.
_____ **INITIAL**

COLLECTION POLICY:
All efforts will be made to work with our patients on outstanding balances. If an account must be sent to collections and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection of the account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of the balance. _____ **INITIAL**

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE (MM/DD/YYYY)

HIPPA

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THE FOLLOWING: PHYSICIANS, FAMILY, INSURANCE, SHORT TERM DISABILITY PROVIDERS, ETC.

PATIENT NAME **(**LAST**,** FIRST): _____ DATE OF BIRTH: _____/_____/_____

NAME OF PARENT OR GUARDIAN IF PATIENT IS A MINOR: _____

IN THE EVENT THAT ORSCI MAY NEED TO GIVE YOUR TEST RESULTS OR MEDICAL INFORMATION, MAY WE:

_____ LEAVE DETAILED MESSAGE ON AN ANSWERING MACHINE

_____ LEAVE A MESSAGE WITH MY SPOUSE OR FAMILY MEMBER

_____ CALL YOU ON YOUR CELLULAR PHONE; THE PHONE NUMBER IS: (_____) _____

_____ CALL YOU AT WORK; THE PHONE NUMBER IS: (_____) _____

I GIVE ORTHOPAEDIC AND REHABILITATION SPECIALIST, DR. TUAN, DR. WU, AND STAFF THE AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FAMILY, FRIENDS, CAREGIVER, PHYSICIAN, INSURANCE AND/OR SHORT TERM DISABILITY PROVIDER:

NAME: _____ RELATIONSHIP TO PATIENT _____

NAME: _____ RELATIONSHIP TO PATIENT _____

NAME: _____ RELATIONSHIP TO PATIENT _____

NAME: _____ RELATIONSHIP TO PATIENT _____

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE MEDICAL RECORDS DEPARTMENT OF ORTHOPEDICS AND REHABILITATION SPECIALIST, DR. TUAN, DR. WU.

I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION SHARED IN THE PROCESS OF TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

UNLESS OTHERWISE REVOKED THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: IF I FAIL TO SPECIFY A DATE, THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE SIGNATURE ON THIS FORM.

_____ _____

PATIENT OR GUARDIAN SIGNATURE *DATE (MM/DD!YYYY)*

Orthopaedic and Rehabilitation Specialists of Central Illinois, S.C.

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Letter

I, _____, hereby authorize the *physicians at*
(Name of Patient or Authorized Agent)

Orthopaedic and Rehabilitation Specialists of Central Illinois, S.C. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____ .
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

- Patient's file

Orthopaedic and Rehabilitation Specialists of Central Illinois, S.C.

Medical History Form

Patient Name: _____ Date: _____
Appointment with Dr. Tuan, Dr. Wu Age: _____

MEDICAL HISTORY: Please check any medical problems that you have been diagnosed with in the past or are currently being treated for.

❑ Hypertension (High Blood Pressure) ❑ Heart Disease (Heart Attack)
❑ Diabetes (On insulin *I* No insulin) ❑ High Cholesterol
❑ Thyroid (Overactive *I* Underactive) ❑ Stroke
❑ Cancer: _____
Other: _____
_____
_____
_____
_____
_____

MEDICATIONS currently taking (please list dosages if known):

_____
_____
_____
_____
_____

Please list any ALLERGIES to medications:
(Latex allergy ❑ Yes ❑ No) (Metal allergy ❑ Yes ❑ No)
_____
_____

Please list any SURGERIES that you have had (include date if possible):

_____
_____
_____
_____

SOCIAL History:
Do you use tobacco? ❑ Yes ❑ No If yes, packs per day _____
Do you drink alcohol? ❑ Yes ❑ No If yes, how often? _____

Marital status ❑ Married ❑ Single ❑ Divorced ❑ Widowed
How many people live with you? _____

Occupation:_____ ❑ Student ❑ Unemployed
Employer: _____

Orthopaedic and Rehabilitation Specialists of Central Illinois, S.C.

Family History: Any relatives with the following disorders? ❑ None

	Relative
❑ Diabetes	_____
❑ High Blood Pressure	_____
❑ Rheumatoid Arthritis	_____
❑ Cancer (specify type if known)	_____
❑ Other relevant disorders or illnesses	_____

REVIEW OF SYSTEMS: Have you had any of the following symptoms? None

Constitutional	❑ Weight loss *I* gain	❑ Loss of appetite	❑
Allergies	❑ Seasonal		❑
Eyes	❑ Blurred *I* double vision	❑ Loss of vision	❑
Ear, Nose, Throat	❑ Hearing loss	❑ Difficulty swallowing	❑
Endocrine	❑ Thyroid disease	❑ Heat or cold intolerance	❑
Cardiac	❑ Chest pain	❑ Palpitations	❑
Pulmonary	❑ Shortness of breath	❑ Cough	❑
Gastric	❑ Heartburn, ulcers	❑ Nausea *I* vomiting	❑
	❑ Blood in stool ❑ Hepatitis ❑ Liver disease		❑
Genitourinary	❑ Painful urination	❑ Kidney problems	❑
Skin	❑ Rashes	❑ Skin ulcers	❑
Neurological	❑ Seizures ❑ Dizziness	❑ Headaches	❑
Musculoskeletal	❑ Joint pains	❑ Muscle aches	❑
Psychological	❑ Depression	❑ Drug or alcohol addiction	❑
Hematologic	❑ Easy Bruising ❑ Easy bleeding ❑ Anemia		❑

Currently Pregnant ❑ Yes ❑ No ❑ Not applicable

Patient/Parent Signature:_____ Date: _____
(Unless patient is a Minor)
Reviewing Physician: _____