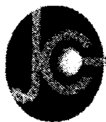


Initial Visit History Form

Name:______________________________ Date:____________________________ Social Sec. #:_______________

Phone (home):__________________ Phone (cell) ____________________ Age:_____ DOB: __________ Sex: M / F

Home Address: ____________________________________City/State__________________________Zip________

Name of your Primary Care Doctor: ____ Phone:______________________

Were you referred by a Physician? Y / N Name: ____________________________ Phone:_____________________

Emergency Contact: ___________________________________ Phone:_______________________________________

Insurance Information: (Primary): ________________________________ ID#________________________________

(Secondary): ______________________________ ID#________________________________

What Pharmacy do you use? Name: ____________________________ Address: ______________________________

Phone:____________________________________

Reason for today's visit: (briefly state history of problem and when symptoms began) _________________________

____

____

____

Problem due to: (check) ___car accident __work related __school injury __other

If work or motor vehicle accident, do you have a lawyer assigned to your case? Y / N

Lawyer Name: ___________________________________ Phone: ____

Past Medical History: Have you ever had any of the following medical problems?

Yes	No		Yes	No		Yes	No		
___	___	Stroke	___	___	Cancer	___	___	Thyroid Disease	____ **None** (check
___	___	Ulcers	___	___	Hepatitis	___	___	Rheumatoid Arthritis	her if nothing to
___	___	Coltis	___	___	Diabetes	___	___	High Blood Pressure	report)
___	___	Asthma	___	___	Tuberculosis	___	___	Nervous Disorder	
___	___	Lyme disease	___	___	Heart Disease	___	___	Bleeding Disorders	
___	___	Arthritis	___	___	Kidney Stones	___	___	Endocrine Problems	

Explain any positive responses above (and other medical problems not listed):______________________________

____

____

____

Past Surgical History: (list all surgeries)____

____

____ None:________ (check here if nothing to report)

Medications (list): ____

____

____ None:________ (check here if nothing to report)

Allergies (medicines): ____

____ None:________ (check here if nothing to report)

Review of Systems: Are you having problems with any of the following?

Yes	No		Yes	No		Yes	No	
___	___	Eyes	___	___	Psychiatric problems	___	___	Digestion/Bowel Movement
___	___	Ears, Nose, Throat	___	___	Joint pain	___	___	Stomach burning
___	___	Lungs/breathing	___	___	Immune system	___	___	Cardiovascular problems
___	___	Recent weight loss	___	___	Urinary problems	___	___	Hematologic/bleeding problems
___	___	Weakness/fatigue	___	___	Chest pain	___	___	Neurologic problems

Patient Name________________________________

Explain positive responses (review of systems):____

____

Family Medical History: List medical problems of your relatives (ex. Diabetes, Cancer, Scoliosis, Osteoporosis, Hypertension, etc.):

Grandparents: ____

Mother:______________________________ Father:______________________________

Siblings:____

Children:____

None:________ (check here if nothing to report)

Social History: Occupation: ______________________ Working Now? Yes / No / Retired

Preferred Language:__________________ Race: __________________ Ethnicity:__________________

Do you smoke: Yes / No / Quit Packs per day: _____ If quit, years smoked: ____years

Alcohol use (circle one): Never / Occasional / Daily / Heavy / History of Alcoholism

Any history of Drug use (list): ____

(Circle One) Married / Single / Divorced / Widowed

Do you live at home or in a facility?(circle) Home / Facility (name):______________________

Are you on a special diet?____

Are you right handed or left handed? (circle) Right Left

How often do you exercise? (circle) Several times a day / Once a day / few times a week /a few times a month / Never

Authorization to Release Information

I hereby authorize Dr. Jacob and all medical affiliates to release any health care information necessary to facilitate processing of claims, audit of payments and routine professional medical communication with my referring and/or primary care physicians and any necessary medical/surgical facilities. Jesu Jacob, D.O., P.C. maintains a record of health care services provided to you. You may request to see and obtain copies of that record at any time. Jesu Jacob, D.O., P.C. will otherwise not disclose your records or personal health information to others unless you direct us in writing or unless required by law.

Medical Consent

I give my consent for all routine, usual and customary tests, exams and procedures as prescribed by Dr. Jacob and/or any affiliates of Jesu Jacob, D.O., P.C. for myself or my minor child or as legal guardian.

Assignment of Insurance Benefits

I hereby authorize Jesu Jacob, D.O., P.C. to request on my behalf and to collect directly all public and private insurance coverage due for products and services supplied by Jesu Jacob, D.O., P.C. in the event that benefits are paid directly to me, I will endorse to Jesu Jacob, D.O., P.C. all checks for such payments and hand them over immediately.

Financial Responsibility

I acknowledge that I am financially responsible for all charges. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. If it becomes necessary to effect collections of any amount owed on this or any subsequent visits or procedures, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and interest and collection charges for overdue payments. I agree to a collection charge of 40% of my unpaid balance at time of collection determination. I hereby authorize Jesu Jacob, D.O., P.C. to release information necessary to secure payment of benefits or fees.

______________________________ ______________________________ ______________

Signature of Patient/Guarantor **Printed Name of Patient/Guarantor** **Date**

PATIENT COPY

JACOB CENTER FOR ADVANCED ORTHOPAEDICS

Jesu Jacob, D.O. ,P.C.

Orthopaedic Surgery

217 East Main Street
☐ Bay Shore, NY 11706

66 Harned Road
☐ Commack, NY 11725

NOTICE OF PRIVACY PRACTICES

WHO WILL FOLLOW THIS NOTICE.

This notice describes our practice's privacy practices and that of:

- Any physician or health care professional authorized to enter information into your medical chart.
- All departments and units of the practice.
- All employees, staff and other office personnel.
- All these individuals, sites and locations follow the terms of this notice. In addition, these individuals, sites and locations may share medical information with each other or with third party specialists for treatment, payment or office operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our office.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to the practice's office personnel who are involved in taking care of you at the office or elsewhere. We also may disclose medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care provided you have consented to such disclosure. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about procedures you received at the office so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for medical office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to our physicians, staff and other office personnel for review and learning purposes.

Individuals Involved In Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and/or receive a copy of your medical information that may be used to make decisions about your care. To inspect and/or receive a copy of medical information that may be used to make decisions about you, you must submit your request in writing to Sports Medicine and Musculoskeletal Care. If you request a copy of the information, we may charge a fee for the costs of copying and mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with the Office Manager at the Jacob Center for Advanced Orthpaedics or with the Office of Civil Rights within the Department of Health and Human Services by visiting their Web site at www.hhs.gov/ ocr/hipaa. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of the Notice of Privacy Practices of the Jacob Center for Advanced Orthopaedics and Jesu Jacob, D.O. ,P.C.

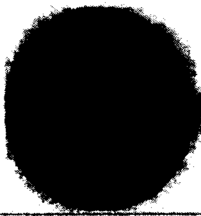
Signature of Patient/Guarantor____

DATE

Printed Name of Patient____

This person has my permission to receive my medical information: __________________________

Signature of Patient or Authorized Individual __________________________________



[illegible] Orthopaedics

NARCOTICS AGREEMENT

This office specializes in Orthopaedic Surgery, Orthopaedic Trauma, Sports Medicine, and Joint Reconstruction. We treat and diagnoses orthopaedic conditions. **WE ARE NOT A PAIN MANAGEMENT CENTER.** We will only be able to dispense narcotic medication to post-operative patients on average for a period of 3 months. These patients will be weaned off of pain medication at this time. Any narcotic pain medication needed after this time period will have to be handled by a pain management physician. If you need narcotic pain medication on a regular basis or prior to surgery to manage pain you will have to obtain those medications from a pain management specialist or your primary care physician. If another provider is dispensing pain medication to you for the same or a different condition we will not be able to dispense any narcotics to you.

Pain medications will not be called in after hours. You will have to be seen in the office for a physical exam and evaluation in order for Dr. Jacob to assess whether the narcotic medication is appropriate for you. At that time, if deemed necessary, the medication prescription will be sent to your pharmacy on file. A specified amount of the narcotic will be prescribed and that medication should last you until your next regularly scheduled appointment.

New York State regulations require the doctor to inquire on a special database what medications have been dispensed to each patient prior to prescribing a new medication prescription. The new process will not allow us to prescribe any new narcotics to a patient with a history of multiple narcotic medications from multiple providers. **IF ANOTHER PHYSICIAN IS PRESCRIBING A NARCOTIC MEDICATION TO YOU, YOU MUST GO BACK TO THAT PHYSICIAN IN ORDER TO REQUEST ANY ADDITIONAL NARCOTIC PRESCRIPTIONS.**

NO EXCEPTIONS!!!

This office reserves the right to prescribe medication based on appropriateness and medical necessity. We are not required to prescribe narcotic medications to every patient that has painful symptoms. If you need to manage your pain, you must seek care from a pain management specialist that is trained in managing Schedule 4 class drugs for your safety and wellbeing.

Please sign below acknowledging that you have read, understood, and will comply with our office policy.

Patient Signature_______________________________ Date ____________

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form

Use this form if you receive a surprise bill for health care services and want the services to be treated as in-network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at 1-800-342-3736.

A surprise bill is when:

1. You received services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a non-participating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a non-participating physician instead of from an available participating physician; OR

2. You were referred by a participating physician to a non-participating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:
I (or my dependent) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

X **Patient Name:** ______________________

X **Patient Address:** ______________________

X **Insurer Name:** ______________________

Patient Insurance ID No.: ______________________

Provider Name: Jesu Jacob **Provider Telephone Number:** 631-670-7800

Provider Address: 66 Harned Rd. Commack, NY 11725

Date of Service: ______________________

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

X______________________ (Signature of patient)

X______________________ (Date of signature)

NYS FORM OON-AOB (5/26/15)