FARMINGTON VALLEY ORTHOPEDIC ASSOCIATES, P.C.

Patient Name_____

Address _____ Apt# _____ Contact Number (c) (h) (w) _____

Town _____ State ____Zip _____ Secondary (c) (h) (w) _____

Sex (M) (F) Age _____ Date of Birth _____

Parent's Name (if minor)_____ Social Security Number _____

Email _____ Parent's SSN (if minor)_____

Emergency Contact:

Name: _____ Relationship _____

Contact Number (c) (h) (w) _____

Primary Physician _____

Address _____ Phone _____

Is this injury related to: Workers comp _____ Car Accident _____ Liability ____ Other _____

Carrier Name _____ State injury occurred ___ Date of Injury_____

Address _____ Claim/Policy # _____

Town _____ State ____ Zip _____ Employer /Contact #_____

Adjuster _____ Phone _____

Attorney Name _____ Phone _____

PRIMARY INSURANCE _____

Membership ID # _____ Group Number _____

Subscriber Name _____ Relationship to Patient _____

Subscriber DOB _____

SECONDARY INSURANCE _____

Membership ID # _____ Group Number _____

Subscriber Name _____ Relationship to Patient _____

Subscriber DOB _____

GUARANTOR INFORMATION *(Financial Responsibility)*

Name _____ Date of Birth _____ SSN _____

Contact Number (c) (h) (w) _____ Secondary (c) (h) (w) _____

Address_____ Apt # _____

City _____ State _____ Zip _____

INSURANCE AUTHORIZATION/ASSIGNMENT AND PATIENT RESPONSIBILITY

I request that payment of authorized Medicare/Other insurance company benefits be made on my or my dependents behalf to Farmington Valley Orthopedic Associates, P.C. for services rendered to me by a FVOA provider. I authorize any holder of medical information about me or my dependents to release to CMS or my insurance company any information needed to determine the benefits payable for services provided. I understand that I am financially responsible for any costs not paid by my medical insurance plan.

Patient Signature: _____ Date: _____

(Please complete 2nd page)

Patients Name:		Age:	Birth Date: / /
Primary Care Physician:	Height:	Weight:	Pregnant? ☐ Yes ☐ No
Referred by:	Smoker: ☐ Yes ☐ No	Number of Packs/Day:	
	Alcohol: ☐ Yes ☐ No	How much?	
	Drug Use: ☐ Yes ☐ No	Explain:	

Reason for visit: ☐ Right ☐ Left		
Date of onset injury:	**Job Related?** ☐ Yes ☐ No	**Auto Accident?** ☐ Yes ☐ No
Was there an injury: ☐ Yes ☐ No	Explain:	
What Makes the Pain/Problem Better/Worse?		

Have you had any X-Rays, MRI or CT Scans related to this injury? ☐ Yes ☐ No

If yes, when and where?

On a scale of 0-10 (10 is the worst), how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the **quality** of the pain? ☐ Sharp ☐ Dull Stabbing ☐ Throbbing ☐ Aching ☐ Burning

Prior Treatment: (Surgery, Braces, Physical Therapy, Injections, Medications)

Medical History (Check all that apply - provide explanation in space provided below)

☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems ☐ Bleeding Problems ☐ Cancer ☐ Ulcers

List ALL Current Medical Conditions:

Family History: Have any direct relatives had any of the following

☐ Diabetes ☐ High Blood Pressure ☐ Rheumatoid Arthritis ☐ None

Review of Systems / Problems (Check all that apply - provide explanation in space provided below)

☐ Hepatitis / HIV	☐ Shortness of Breath	☐ Eye / Vision	☐ Skin / Rash
☐ Steroids Use?	☐ Chest Pain	☐ Stomach / Intestine	☐ Varicose Veins
☐ Headaches / Dizziness	☐ Ears / Nose / Throat	☐ Swollen Glands	☐ Weight Loss / Gain
☐ Fever / Chills	☐ Wheezing / Coughing	☐ Urinary Problems	☐ Psychiatric

Explain Conditions / Symptoms from above

List ALL Prior Surgeries/Hospitalizations:

List ALL Current Medications – include dietary Supplements, vitamins and / or diet pills

Local Pharmacy **Pharmacy Address** **Phone Number**

Do you have allergies to medication? ☐ Yes ☐ No If Yes please explain.

Do you have a Latex Sensitivity? ☐ Yes ☐ No

Reviewed By M.D: _____ M.D. Date: _____/_____/_____

Summary Of Notice Of Privacy Practices
As Required By Federal Law

Farmington Valley Orthopedic Associates, P.C.
Susan Baldwin, Practice Administrator
(860)677-0079

The following is a brief summary of your rights and our responsibilities as detailed in the Notice of Privacy Practices posted in our waiting room. This summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the notice.

1. **Information we may collect.**
   Identification and insurance information
   Medical information and reports from other healthcare providers
2. **How we use your information.**
   Your information is used for treatment, payment and healthcare operations within our practice
   To refer you to other healthcare providers for additional treatment
3. **Disclosures of Your Health Information.** We may disclose your information to our business associates such as, medical transcriptionists, collection agencies and others who assist in the operations of our practice. We may call you regarding appointments, insurance information and test results and may also leave a message on your answering machine if applicable. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.
4. **Other Uses and Disclosures.** Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization. (refusal to release information to your insurance company for payment will result in your personal and immediate responsibility for your bill.)
5. **Your Health Information Rights.** You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
   - **a.** You may request restrictions on certain uses and disclosures of your information
   - **b.** You may request that your receive your information from us in a certain way
   - **c.** You may inspect and copy your medical records with reasonable advance notice
   - **d.** You may request an amendment to any record you believe is inaccurate
   - **e.** You may request an accounting of disclosures made of your records
   - **f.** You have the right to receive a copy of the Notice of Privacy Practices
   - **g.** You have the right to be notified of a Breach of PHI
6. **Changes to the Notice.** We reserve the right to change the Notice. If we do so, we will post it in our office, and provide a copy upon request.
7. **Complaints.** You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing a complaint.

Farmington Valley Orthopedic Associates, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient:_____Date:_____

I hereby acknowledge that I have been offered or received a copy of Farmington Valley Orthopedic Assoc., P.C.'s Notice of Privacy Practices.

Signature of Patient/Guardian:_____

With whom do you allow us to share your personal medical information?

Name	Relationship	Phone Number

Signature of Patient/Guardian:_____Date:_____

Consent for Medical Treatment

I hereby voluntarily consent to outpatient care from Farmington Valley Orthopedic Associates health care providers, encompassing routine diagnostic procedures, examinations, and medical treatment including (but not limited to) routine laboratory work, x-rays and administration of medication as prescribed by the providers.

I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. If I have concerns regarding any test or treatment recommended by my health care provider, I am encouraged to ask questions.

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

Signature of Patient/Guardian:_____Date_____

For Office Use Only:

□ Signed form received by:_____

□ Acknowledgement refused:

Efforts to obtain:_____
Reason for refusal:_____