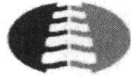


HUDSON
ORTHOPEDIC PAIN & SPINE

Today's Date: ____________________ Who referred you to our practice: ______________________

Name First: _______________Last: _______________ SSN: ________________________ DOB: __________

Sex: ____________ Height___________ Weight____________ Age: _____________

Home Address: ________________________ City: ____________________ State: ______ Zip: ______

Home Phone: __________________ Cell Phone: _________________ Work Phone: _____________

Email:___________________________________

Insurance:

Primary Medical Insurance: ___________________________ Member ID#: ____________________

Secondary Medical Insurance: _________________________ Member ID#: ____________________

Are you the policy holder: Y/N If No, who is the policy holder: _____________________ DOB: ______

Is your condition the result of a ***Car Accident, Slip and Fall or Workers Compensation***: Y/N If Yes, please specify below:

____

Date of Injury/ Accident: ______________________ Are you represented by and attorney Y/N, if yes please list contact below:

Law Firm: ______________________ Phone Number: _____________________________________

If Auto, Car Insurance Policy #: ______________________ Claim #: ____________________________

If Workers Comp, Employer Name: ______________ Employer Contact: _______________________

Adjuster Name: ______________________________ Claim #: _______________________________

Primary Doctor: ___________________________________ Phone #: _________________________

City/State: _ __________________________________

Pharmacy________________________ City: ____________________________ State: ____________

Phone #: ________________________

55 Meadowlands Parkway Suite 310
Secaucus, NJ 07094
P: 844-300-4677 F: 201-392-3571

Dr. Christine Corradino
Dr. Danielle Groves

Authorization to Release Information:

This will authorize you to prepare medical reports and/or permit the bearers to review, inspect, copy and/or photocopy any or all of the following in your possession or control.

X-Ray, films and reports

All Medical Records

Specific Request below: ____

____

Photostat copies of this authorization will be considered as valid as original.

Patient Name: ______________________________

DOB: ______________________________________

Signature: ___________________________________

Date needed by: ___________________ **Date:** _________________

Patient Name: ______________________________ **DOB**:____________________

Dominant Hand: Right Left

Chief Complaint:

Description of Symptoms: (select only one primary symptom and one affected area)

Pain Numbness/Tingling Fracture Stiffness Other:____

Shoulder	Right/Left	Neck	Right/Left
Upper Arm	Right/Left	Upper Back	Right/Left
Elbow	Right/Left	Mid Back	Right/Left
Forearm	Right/Left	Low Back	Right/Left
Wrist	Right/Left	Buttocks	Right/Left
Hand	Right/Left	Tail Bone	Right/Left
Thumb	Right/Left		
Index	Right/Left		
Middle	Right/Left		
Third	Right/Left		
Little	Right/Left		
Pelvis	Right/Left		
Hip	Right/Left		
Thigh	Right/Left		
Knee	Right/Left		
Lower Leg	Right/Left		
Ankle	Right/Left		
Foot	Right/Left		
Great Toe	Right/Left		
2nd Digit	Right/Left		
3rd Digit	Right/Left		
4th Digit	Right/Left		
5th Digit	Right/Left		

Pain Radiates: ____
____
____

Is your problem the result of **an injury/accident: Y/N** If **yes,** please circle:
Injury at work Auto Accident Sport Injury Prior Surgery

Have you had a problem like this before: Y/N If Yes, please explain:
____
____
____

Have you been to the ER for this condition: **Y/N** If Yes, when: _____________
Have you had prior Imaging (XRAY, MRI. CT SCAN) If Yes, when: _____________

Do you have any allergies: **Y/N** If yes please list: ____
Do you have any medical conditions? **Y/N** **If yes please circle:**

Hypertension	**Heart Condition**	**Thyroid Disease**	**Scoliosis**
Diabetes	**Cancer**	**Osteoporosis**	**Anxiety**
Depression	**Kidney Disease**	**Anemia**	**Stroke**

PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to ask us. We need to collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities, and your insurance company. This personal information includes items such as your name, address, phone number, date of birth, social security number, employer, health history, insurance policy and coverage, and any information you provide via our website. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress, and any test results or films.

How your information is used: The personal and health information gathered may be used and disclose with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked at any time with a written request. We do not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state, or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Safeguarding your personal and health information We are required by law to (1) make sure that medical information that identifies you is kept private, (2) provide you with our privacy policy, and (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your person and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic, and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your person or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Authorization for Access by others to your personal Health Information:

I hereby authorize____________________________________, to have the following access to my PHI:

Confirmation of Appointments **Diagnostic Testing** **Details of Surgery and Outcome**

Permission to leave detailed message on voicemail

By Submitting this form, I hereby permit Hudson Orthopedic Pain and Spine to disclose my PHI to the individuals listed above.

Initial:______________________Sign:_____________________________________ Date:_____________

Pledge of Care

I, ________________ (print first name), ________________ (print last name), hereby acknowledge and understand that even with the best training, skill experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and health outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

Initial:____________________ Sign:__________________________________ Date:____________

Financial Policy

Please be aware that some and perhaps all services which we provide may be considered uncovered services, and therefore considered not medically necessary under the Medicare program and other insurance carriers. You hereby authorize insurance payment directly to Hudson Orthopedic Spine & Pain Should payment be sent to you, it is your responsibility to return check to HOPS, within seven (7) collection proceedings wherein you agree to pay our reasonable attorney fees and costs for collection as well as potential criminal liability for theft and conversion of funds.

You assign your rights to benefits under your contract of insurance or third-party payment to HOPS, and its employees, agents and/or contractors, all benefits payable to you under your insurance policies and health benefits plan. If your insurance plan requires a referral prior to the commencement of treatment, it is your responsibility to have one prior to the commencement of examination or treatment.

Our office plans an extensive portion of time to spend with you on each visit. Cancelling or "no showing" causes a loss of this time, which could have been used to see other patients. We ask that you make every effort to keep your scheduled appointment. We reserve the right to charge you for the missed visit. This will not be covered by any insurance company. We ask that you please be considerate and help us to serve you better by keeping scheduled appointments.

First Time:

$Free of Charge   **Second Time: $50.00**   **Third Time: $75.00**

If you are greater than 30 minutes late for your appointment, you will need to be rescheduled and considered a no show.

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND HEALTH CARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT UNDER THE AGREEMENT.

Initial:____________________Sign:__________________________________ Date:__________

Patient Name: ______________________________

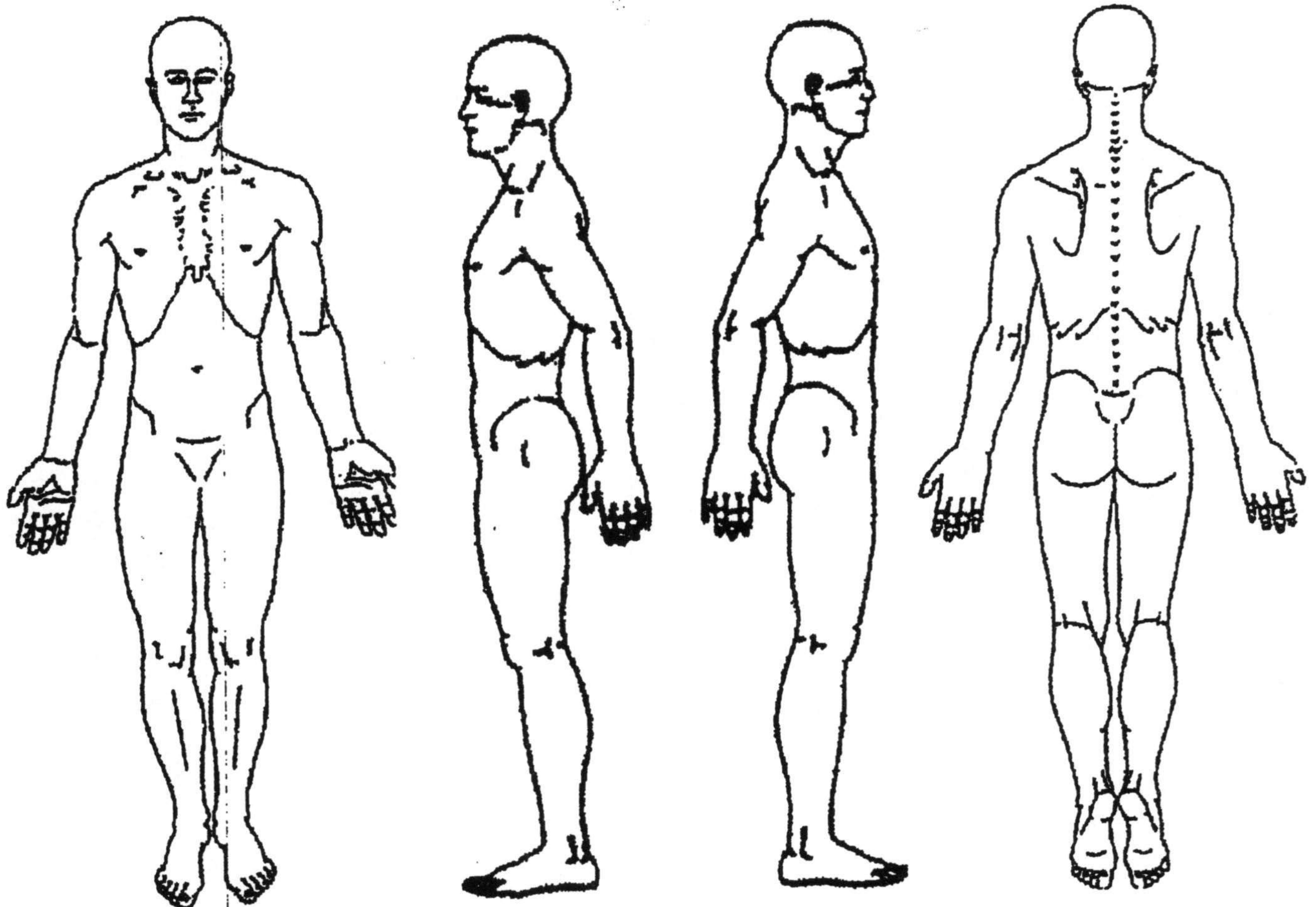
PAIN DRAWING

Instructions:

Only for the pain in the body region that you are seen for today, choose the symbol(s) shown below that best describes the pain you are having (e.g. XXX means it's a burning pain).

Stabbing /// Burning **XXX** Pins & Needles **000** Numbness === Aching +++

Draw onto the diagram below, using the symbols you chose above, to show where your pain is located.



Pain in arm(s) compared with neck:	Worse	Same	Less
Pain in leg(s) compared with back:	Worse	Same	Less

Pain Level in the last 7 days on average

Neck Pain:	1	2	3	4	5	6	7	8	9	10	Worse	Same	Improving
Low Back Pain:	1	2	3	4	5	6	7	8	9	10	Worse	Same	Improving
Thoracic Pain:	1	2	3	4	5	6	7	8	9	10	Worse	Same	Improving
Other ( ):	1	2	3	4	5	6	7	8	9	10	Worse	Same	Improving

PATIENT SIGNATURE ______________________ **PHYSICIAN SIGNATURE** ______________________

DATE: ______________________ **DATE:** ______________________