

**Phoenixville Orthopedic Associates
RPS Orthopedic Associates**

• John J. Pell, MD • H William Schaaf, MD • Frederic E. Liss, MD •

Injury / Accident / Fall Questionnaire

Your insurance company mandates this form. Please fill it out completely for all Injuries, Accidents, and Falls. This includes home, work, and auto related incidences.

Patient Name: _____ SS# _____

Date of Appointment: ____ / ____ / ____

Please answer the following questions in detail. Failure to provide complete information may delay in the processing of your claim. Completion of this claim does not guarantee payment.

Is this claim the result of an accident/injury/fall? ___ Yes ___ No

Is this claim related to a work accident/injury/fall? ___ Yes ___ No

Is this claim the result of an automobile accident? ___ Yes ___ No

Date of Accident: ____ / ____ / ____ Time of Accident: _____

Location of Accident/Injury/Fall: _____

Description of how Accident/Injury/Fall occurred: _____

Diagnosis or nature of Accident/Injury/Fall: _____

Signature of Patient: _____

Date: ____ / ____ / ____

Please have parent /guardian sign if patient is under the age of 18.

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Name: _____

Reason for your visit today: _____

Describe your symptoms: _____

When did your symptoms begin: _____

Have you been treated for this problem by another Physician or facility? _____ Yes _____ No

If yes what doctor, where, and when _____

Check all tests you have had related to this problem: X-ray MRI EMG CAT SCAN
 Other _____

Where and when were they done? _____

Have you ever been treated with steroids? Yes No Example: Cortisone, Prednisone

If yes when and, for how long. _____

Signature of Patient: _____ Date: ____/____/____

Please have parent /guardian sign if patient is under the age of 18.

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ALL PATIENTS PLEASE COMPLETE

Insurance Authorization and Assignment.

I hereby authorize Phoenixville Orthopedic Associates/RPS Orthopedic Associates to furnish information to insurance carriers concerning my illness and treatment. I hereby assign to the physician(s), all payments for medical services rendered to myself or my dependent. I understand I am responsible for any amount not covered by insurance. I request that payment of authorized Medicare benefits be made on my behalf to Phoenixville Orthopedic Associates/RPS Orthopedic Associates for any services provided to me by these physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: ____/____/____

MEDICARE PATIENTS PLEASE COMPLETE

I request that payment of Medicare/Medigap benefits be made to me \, or on my behalf to Phoenixville Orthopedic Associates/RPS Orthopedic Associates for any services provided to me by Drs. Pell, Liss, Schaaf,. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits and the benefits payable for related services.

Signature: _____ Date: ____/____/____
Medicare Beneficiary Signature

Medicare (HIC)#: _____ Medigap Plan Name: _____

In compliance with Medicare regulations, please answer the following questions:

- Do you or your spouse work for a company that provides you with health insurance? ___ Yes ___ No
- Are you entitled to Medicare because of disability or end stage renal disease? ___ Yes ___ No
- Is the illness or injury the result of an automobile accident or other injury? ___ Yes ___ No
- Has treatment for the accident or illness been authorized by the VA? ___ Yes ___ No
- Are you entitled to any benefits under the Federal Black Lung Program? ___ Yes ___ No

I certify this information is true and complete to the best of my knowledge.

Signature: _____ Date: ____/____/____

Yearly Check of Information

Information reviewed. No changes necessary. Initials _____ Date: ____/____/____

Information reviewed. Please change the following: _____

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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE AND
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION**

The acknowledgement of notice and consent authorizes Phoenixville Orthopedic Associates /RPS Orthopedic Associates to use and disclose health information about you for treatment, payment and health care operations purposes.

NOTICE OF PRIVACY PRACTICES

Phoenixville Orthopedic Associates/RPS Orthopedic Associates has a notice of privacy practices, which describes how we may use and disclose your protected health information. It also describes how to access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

AMENDMENTS

We reserve the right to change our notice of privacy act practices, and to make the change effective for all protected health information we maintain. This includes information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer at:

Phoenixville Orthopedic Associates
Attention Privacy Officer
400 Main Street
Phoenixville, PA 19460

Phone: 610-935-1120

Fax: 610-935-5507

ACKNOWLEDGEMENT & CONSENT

I have received the Notice of Privacy Practices for Phoenixville Orthopedic Associates/RPS Orthopedic Associates. Phoenixville Orthopedic Associates/RPS Orthopedic Associates are authorized to use and disclose health information about _____ (patient name) for treatment, payment, and healthcare operations and purposes consistent with its Notice of Privacy Practices.

Financial Policy

A copy of our financial policy is posted at the receptionist desk. Please read it carefully. If you have any questions, or if you would like a copy, please feel free to ask the receptionist.

Signature of patient or personal representative

_____/_____/_____
Date

Personal representative information (if applicable)

Name of personal representative

Relationship to patient

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Portal Activation Instructions

We now have a patient portal available from our website for our patients use. This allows you to have real-time access to your medications, labs, and upcoming appointments. You will also be able to request refills, and send a message your provider. We require all patient's with internet access to pre register via the patient portal.

To get started, please go to our website, www.bone-dox.com. First, select New Patient Forms. Print these forms, fill them out, and bring them to your appointment. This will save you time at your first visit. Next click the link for patient portal. Click on the link Activate patient portal account.

The sign up process also requires an activation code. You should have been given this code when you scheduled your appointment with the office.

Note: This code is case sensitive and will need to be entered exactly

You will be prompted to fill out some basic personal information, as well as create a login name and password. You will be able to make changes to your personal information once your portal account has been activated. Once in your patient account, please complete your medical history, current medications, and allergies.

Please be as thorough as possible when filling out your personal information and medical history. This will save us time on the day of your appointment, and will help us provide you the best medical care possible.

This web based patient portal is to be used for **NON-URGENT** issues only.

Thank you for your cooperation,

Phoenixville Orthopedic Associates
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