

PATIENT REGISTRATION

PATIENT INFORMATION: PLEASE PRINT

Last Name: _____ First Name: _____ MI: _____

Date Of Birth: _____ Age: _____ SSN: _____ Gender: Male Female

Primary Care Physician: _____ Referring Physician: _____

Home Address: _____

City, State & Zip Code: _____

Preferred Contact Phone: (____) _____ (Check One) Home Work Mobile

Alternate Contact Phone: (____) _____ (Check One) Home Work Mobile

Email Address: _____

Emergency Contact Name: _____ Relationship To Patient: _____

Emergency Contact Phone: (____) _____

Ethnicity Of Patient: Hispanic Origin Non-Hispanic Origin Unknown Declined To Answer

Race Of Patient: American Indian/Alaskan Native Asian Black/African American
 Native Hawaiian/Other Pacific Islander White Unknown Declined To Answer

Preferred Language Of Patient: English Spanish Other _____

Employment/Student Status: Full Time Employed Part Time Employed Unemployed Retired
 Part Time Student Full Time Student Not A Student

Employer Name: _____ Employer Phone: _____

Occupation: _____

Marital Status: Registered Domestic Partner Married Divorced Single Separated Widowed

Spouse's Name: _____ Spouse's Date Of Birth: _____

FINANCIALLY RESPONSIBLE PERSON (IF DIFFERENT FROM PATIENT):

Full Name: _____ Address: _____

City, State & Zip Code: _____

Date Of Birth: _____ Social Security Number: _____

Home Phone: (____) _____ Work Phone: (____) _____ Mobile Phone :(____) _____

Employer Name: _____

Relationship To The Patient: (Check One) Self Spouse Child Parent Other: _____

PATIENT REGISTRATION

ACCOUNT TYPE: Cash/Self-Pay Insurance Lien Workman's Comp

INSURANCE COMPANY INFORMATION:

Primary Insurance Company Name: _____

Claims Address: _____

Policy Holder Name: _____ Date Of Birth: _____

Policy Holder Employer: _____ Policy Holder SSN: _____

Policy Number/ID: _____ Group Number: _____

Relationship To The Patient: (Check One) Self Spouse Child Parent Other: _____

Secondary Insurance Company Name: _____

Claims Address: _____

Policy Holder Name: _____ Date Of Birth: _____

Policy Holder Employer: _____ Policy Holder SSN: _____

Policy Number/ID: _____ Group Number: _____

Relationship To The Patient: (Check One) Self Spouse Child Parent Other: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I certify that the information that i have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Serge C. Kaska MD. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature: _____ Date: _____

Medicare Patients Only:

Do You Currently Reside In A Skilled Nursing Facility? Yes No

In Medicare cases, Serge C. Kaska, MD, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature: _____ Date: _____

In compliance with the American Recovery and Reinvestment Act of 2009 (AARA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

PATIENT FINANCIAL AGREEMENT

Your Responsibilities and Acknowledgments

The patient or the patient's Legal Representative* is responsible for the following:

- ❖ Determine if Serge Kaska, MD is a participant in your medical insurance plan.
- ❖ Know what services are covered by your medical insurance. The cost of any service NOT covered by insurance is the responsibility of the patient, and will be billed in full to the patient.
- ❖ Ensure we have your correct medical insurance and address information. Our office will bill your insurance for services rendered.
- ❖ Pay your deductible and/or co-payment at the time of the visit, before services are rendered. If co-payment is not paid at that time, our office may charge an additional administrative fee of \$20.
- ❖ Our office will bill the patient for balances due from co-insurance, deductibles, or for non-covered services.
- ❖ All outstanding charges shall be paid within the initial billing cycle - 30 days.
- ❖ We request at least 24 hour notice if you must cancel or reschedule an appointment.
- ❖ A Self-Pay/Cash Patient is one who does not have medical insurance that covers Serge Kaska, MD. Self-Pay/Cash Patients are expected to pay in-full at the time services are rendered, unless other arrangements have been made. Please contact our office to make prior arrangements for payment.
- ❖ Payments may be made via VISA, MasterCard, Cashier's Check or Cash. Personal checks are **not** accepted.
- ❖ Overdue accounts shall be sent to a collections agency or may be subject to legal action. Relevant personal and account information will be released in this course of action. The costs of such action shall be added to the patient's outstanding balance.

*Legal Representative is defined as the parent of a minor child or person named in a legal document such as a Power of Attorney or Guardianship. Please provide us a copy of the pertinent legal document.

I agree to these terms and acknowledge that this is a binding agreement.

Print Name of Patient or Patient's Legal Representative

Signature of Patient or Patient's Legal Representative

If Legal Representative, State Relationship to Patient

Date



HIPAA - RELEASE OF PROTECTED HEALTH INFORMATION

TO BE COMPLETED BY PATIENT

Please list the family members, significant others, or other persons, if any, whom we may inform about your general medical condition and your diagnosis. This may also include treatment plan, prognosis, payment information and health care options:

Name: _____ Relationship: _____ Phone: (____) _____

Name: _____ Relationship: _____ Phone: (____) _____

Name: _____ Relationship: _____ Phone: (____) _____

Please list family members, significant others, or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name: _____ Relationship: _____ Phone: (____) _____

Name: _____ Relationship: _____ Phone: (____) _____

Please print the telephone number where you want to receive calls about your appointments, labs, and x-ray results or other health care information. This may include surgery scheduling information, and post-operative instructions:

Home: (____) _____ Mobile: (____) _____

(I am fully aware that a mobile phone is not a secure and private line)

Do you wish to communicate with our office via email? Yes No
(Consider e-mail like a postcard that can be viewed by unintended persons.)

I have requested to correspond using email. I understand that there is no guarantee of confidentiality using email. Initial: _____

May confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail?
 Yes No

Signature of Patient or Legal Guardian

Date

NOTE: Uses and disclosures of health information may be permitted without prior consent in an emergency.
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PRIVACY PRACTICES ACKNOWLEDGEMENT

NOTE: A copy of our office Privacy Policy is available upon request.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Please Print Patient Name

Date of Birth

Signature of Patient or Legal Guardian

Date

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Representative: _____



MEDICAL HISTORY FORM

PATIENT INFORMATION (PLEASE PRINT)

Patient Name: _____ Preferred Name (If Different): _____

Age: _____ Sex: F M Height: _____ Weight: _____ Dominant Hand: R L

Primary Care Physician?: _____ Who Referred You To Us?: _____

Work Status: Employed Unemployed Disabled Retired Occupation: _____

REASON FOR VISIT:

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
L R	L R	L R	L R	L R	L R	L R	L R		

Numbness Pain Weakness Swelling Stiffness Other: _____

How Long Ago Did It Start?: _____ Days _____ Weeks _____ Months _____ Years

Have You Had A Problem Like This Before?: Y N

DESCRIPTION OF PROBLEM:

In this section, check the **ONE BOX** which best describes how your problem started. Then provide the information requested next to the right of the box you checked.

No Injury: Gradual Onset Sudden Onset **Injury:** Accident Sports Date Of Injury: _____

Injury At Work: Date Of Injury: _____ **Auto Accident:** Date Of Accident: _____

Please Describe Problem Briefly: _____

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 None

The Pain Is: Constant Comes and goes (intermittent) Absent

Do You Have: Swelling Bruises Numbness Tingling Weakness Locking/Catching Giving Way

Since My Problem Started, It Is: Getting Better Getting Worse Unchanged

What Makes Your Symptoms Worse?: Standing Walking Lifting Exercise Twisting Lying In Bed

Bending Squatting Kneeling Stairs Sitting Coughing Sneezing Other: _____

Which Make Your Symptoms Better?: Rest Elevation Ice Heat Other: _____

TREATMENTS FOR PROBLEM:

Have You Had Any Of These Treatments?: Medication Injection Brace Physical Therapy Crutches

Were You Seen In The E.R. For This Problem?: Y N Where? _____ Date: _____

What Tests Have You Had For This Problem?: X-Rays MRI CT Scan Bone Scan Nerve Test None

Have You Ever Had Surgery For A Problem In This Same Area?: Y N

Procedure: _____ Surgeon: _____ Date: _____

MEDICAL HISTORY FORM

PAST MEDICAL HISTORY:

List Current Medical Problems: _____

List Current Medications And Dosage: None See Patient Provided Medication List See List Below:

MEDICATION NAME	DOSAGE	FREQUENCY

Preferred Pharmacy: Name: _____
Street/City: _____ Phone: (____) _____

Allergies (Medication Or Latex): None _____

Are You Diabetic? Y N If Yes, Treatment: Insulin Oral Meds Diet None

Are You Taking, Or Have You Ever Taken, Blood Thinners?: Y N If Yes, Which One: _____

PAST SURGICAL HISTORY OR HOSPITALIZATIONS:

Have You Ever Had Surgery: Y N If Yes, Please List: _____

Have You Or A Family Member Ever Had A Reaction To Anesthesia?: Y N If Yes, Please Explain: _____

Have You Ever Had (Check All That Apply, Or None, If None Apply):

- Heart Attack (Yr ____) Stroke (Yr ____) Blood Clots (Yr ____) Heart Failure
- High Blood Pressure Ankle Swelling Kidney Failure
- Stomach Ache While Taking Anti-Inflammatory Medication (Caused By Advil Aleve Other: _____)
- Cancer (Location) _____ None Apply



MEDICAL HISTORY FORM

FAMILY AND SOCIAL HISTORY:

Have Any Direct Relatives Had Any Of The Following Disorders? If So, Which Relative?:

Diabetes: _____ High Blood Pressure: _____

Rheumatoid Arthritis: _____

Marital History: Married Unmarried Divorced Widowed

Do You Have Children?: Y N **If Yes, How Many?:** _____

Alcohol Use?: Y N **If Yes, How Often?:** Rarely Socially _____ Drinks Daily _____ Drinks Per Week

Recovered Alcoholic

Recreational Drugs?: Y N **If Yes, How Often?:** _____ **Type:** _____

Do You Currently Use Tobacco?: Y N **If Yes, Packs Per Day:** _____

Are You A Former Smoker?: Y N **How Long Did You Smoke For?:** _____ **When Did You Quit?:** _____

Exercise/Sports Activities: _____