



# Northwest Ohio Orthopedics & Sports Medicine, Inc.

## Patient Information (Please print in pen)

Legal Last Name:	Legal First Name:	Middle Name:	SSN:
Mailing Address:	City:	State:	Zip:
Home Telephone:	Cell Phone:	Other Phone:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth (mm-dd-yyyy):	Date of Injury/Onset:	Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
If Medicare, are you currently residing in a Skilled Nursing Facility: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Facility _____			
If you are Medicare, have you received Physical, Occupational, or Speech Therapy services since the beginning of the year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, do you know if you have exceeded the Medicare cap? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Medicare, are you currently receiving Home Health Services: <input type="checkbox"/> Yes <input type="checkbox"/> No Type of service: _____			
If yes, Name of Agency: _____ Date of Last Service: _____			

### Physician Information

Primary Care Physician (PCP):	City/State of PCP:	Physician who referred you here:
May we send medical information to your PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No		City/State of Referring Physician:

### Employer Information

Employer:	Employer Phone:	Employment Status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> None
Address:	City:	State: Zip:

### Responsible Party (For Minors and/or Dependents for Insurance Purposes)

If Minor, Does child live with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____		
Mother's Legal Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:
Father's Legal Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:

### Emergency Contact

Contact Name:	Phone:	Relationship:
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### Health Care Primary Insurance

Name of Insurance:	ID #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____		

### Secondary Insurance

Name of Insurance:	ID #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____		

**Authorization:** I, with my signature, authorize Northwest Ohio Orthopedics and Sports Medicine, Inc. (NWO) to provide medical care for me, or to this patient for which I am the legal guardian.

I also authorize NWO, to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payment for these services to NWO, realizing I am personally responsible for the charges incurred, including items determined to be non-covered.

I also acknowledge that I have been given or have been offered a copy of the "Practice's" privacy policy as required by law. I request the following restrictions be placed on the "Practice's" use and/or disclosure of my health information (leave blank if NO).

Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



MEDICAL QUESTIONNAIRE (PG. 1)

Patient Legal Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

Age: \_\_\_\_\_  F  M Dominant Hand:  R  L Height/Weight \_\_\_\_\_/\_\_\_\_\_

Family Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Who requested you visit this office? \_\_\_\_\_

What is the main reason for this visit?  Pain  Numbness  Weakness  Swelling  Stiffness  Other  
What body part is involved? Please mark below.

Grid of checkboxes for body parts: Neck, Arm, Knee, Shoulder, Wrist, Foot, Elbow, Pelvis, Ankle, Finger, Hand, Hip, Toe. Includes RT/LT and T/B for fingers and toes.

How long ago did it start? \_\_\_\_ Days \_\_\_\_ Weeks \_\_\_\_ Months \_\_\_\_ Years. Have you had a problem like this before?  Y  N

In this section, check ONE Box which best describes how your problem started. Please answer the questions below the boxes you check.

Sections for injury types: No Injury, Injury, Injury at Work, Work Related, Auto Accident. Includes 'Answer/Comment' column with lines for notes.

\*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 your pain?  Sharp  Dull  Stabbing  Throbbing  Aching  Burning

\*Is your pain:  Constant  Intermittent (Comes & Goes)

Does your pain awake you from sleep?  Y  N

Do you have:  Numbness  Weakness  Swelling  Stiffness  Bruising  Loss of control of bowel or bladder?

Since your problem started, is it:  Getting Better  Getting Worse  Unchanged

What makes your symptoms worse?  Standing  Walking  Lifting  Exercise  Twisting  Bending  Lying in Bed  Squatting  Kneeling  Stairs  Sitting  Coughing  Sneezing

What makes your symptoms better?  Rest  Elevation  Ice  Heat  Other

What medications are you taking now or have you taken previously for this problem? \_\_\_\_\_

Have you had any of these treatments?  Injection  Brace  PT/OT  Cane/Crutch  Chiropractic  Acupuncture  None

Were you seen in the Emergency Room for this?  Y  N If yes, Where? \_\_\_\_\_

What tests/scans have you had for this problem?  X-Rays  MRI  CAT scan  Bone Scan  Nerve Test (EMG/NCV)

Have you previously had surgery in this same general area?  Y  N (If Yes, List Below)

Date: \_\_\_\_\_ Procedure: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Date: \_\_\_\_\_ Procedure: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Current work status?  Regular  Retired  Light duty (How long? \_\_\_\_\_)

Not working due to this problem (Since when? \_\_\_\_\_)  Disabled

Are you currently receiving or plan to apply for:  Disability  Workman's Comp  Unemployment  None



REVIEW OF SYSTEMS (PG 2)

Patient Legal Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

1. M/S Have you had a prior problem with this same Orthopedic condition in the past?  Y  N

\*Please explain: \_\_\_\_\_

Do you have:  Joint pain or swelling  Back Pain  Gout  Rheumatoid Arthritis  Osteoporosis
 Prior Fracture (which bone) \_\_\_\_\_  None of the above

Have you had a Bone Density Scan for Osteoporosis within the last 2 years?  Y  N

Have you had any of these symptoms? If not, mark NONE.

Table with 4 columns: Symptom Category (e.g., GI, ENDO, CON), Symptoms (checkboxes), NONE, Year, Explanation/Comments. Rows include GI, ENDO, CON, EYE, ENT, CV, RS, GU, SK, NEU, PSY, HEM.

Are you ALLERGIC to any medications, metals, soaps, dyes, food, environment etc.?  Y  N If yes, please list and describe reaction.

Medical History

Have you had cortisone within the past year?  Y  N

Are you a diabetic?  Y  N 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: What operations have you had and when?  NONE \_\_\_\_\_

Have you ever had a reaction to anesthesia?  Y  N

Previous hospitalizations, other than for surgery?  NONE \_\_\_\_\_

Past/Current health problems or diagnosis \_\_\_\_\_

Have you ever had:  Heart Attack (year) \_\_\_\_\_  High Blood Pressure  Blood Clots (year) \_\_\_\_\_  Stroke
 Heart Failure  Ankle Swelling  Kidney Failure  Asthma  Sulfa Allergy
 Aspirin Sensitivity  Stomach Ulcers  Bleeding Ulcers  Stomach-ache/taking Anti-Inflammatory

(including Advil/Aleve) Name of the Anti-Inflammatory have you had a problem with: \_\_\_\_\_

Cancer (Type) \_\_\_\_\_  MS  Polio  NONE of the above

Family History

Have any direct relatives had any of the following disorders? If so, which relative?

Diabetes \_\_\_\_\_  High Blood Pressure \_\_\_\_\_  Heart Disease \_\_\_\_\_
 Rheumatoid Arthritis \_\_\_\_\_  NONE of the above

Social History

Do you use Tobacco?  Y  N Packs/ day \_\_\_\_\_ Alcohol?  Y  N How often?  Daily  \_\_\_\_\_/week

Do you use Drugs?  Y  N Marital History: M S D W How many people live with you? \_\_\_\_\_  Student

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Do you like your job?  Y  N

Do you plan to be working 6 months from now?  Y  N

\*\*Please Sign: The information contained on these forms is accurate to the best of my knowledge. Patient Signature: \_\_\_\_\_

# SYMPTOM CHECKLIST

Patient Legal Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Please indicate which of the following symptoms you experience:

**Office Use Only**

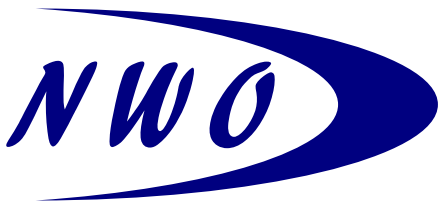
Symptom	Side of the Body				Clinical Assessment
	Right	Left	Both	None	
<b>Back and Leg Pain</b>					Confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Pain in your buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exam Notes:
Pain or burning in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness or tingling in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weakness in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of strength in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Foot Pain</b>					Confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Pain or burning in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exam Notes:
Numbness or tingling in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feels like pins and needles in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Increased sensitivity to touch on your feet (for example, it hurts when bed covers touch them)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble feeling your feet when you walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discomfort or pain at right in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Hand, Finger or Wrist Pain</b>					Confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Pain or burning in your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exam Notes:
Numbness or tingling in your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty gripping things with your hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty forming things with your hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discomfort in hands wakes you up at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Diabetes Mellitus</b>					Eye Exam Documentation: <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have diabetes? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> No					Exam Notes:
If yes, are you receiving care from an Ophthalmologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, date of your last Dilated Eye Exam? _____ <input type="checkbox"/> Don't Know					

## Physician Use Only

Physician Review: \_\_\_\_\_

Schedule NCS Date: \_\_\_\_\_

Schedule RIS Date: \_\_\_\_\_



# Northwest Ohio Orthopedics & Sports Medicine, Inc.

## EXPLANATION OF CONDITION

Patient Legal Name: \_\_\_\_\_  
First MI Last

### CONDITION/ACCIDENT/INJURY DETAILS

Symptoms first begin on: \_\_\_\_/\_\_\_\_/\_\_\_\_ or have been experiencing for \_\_\_\_ days \_\_\_\_ weeks \_\_\_\_ months \_\_\_\_ years.

What symptoms are you experiencing? \_\_\_\_\_

What body parts are affected? \_\_\_\_\_

Have any of these body parts been injured before? YES NO If yes, please describe: \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

Give a brief description of the accident. Please include location of the accident (home, work, school, auto, etc.) and a brief description (fall, bump against, collision, cut, struck by, etc.). \_\_\_\_\_

Will you seek payment from another party? YES NO If yes, who? BWC MVA Other

If an attorney is involved, please provide name, address, and phone number: \_\_\_\_\_

Was this injury sustained in an automobile accident? YES NO If yes, please complete the following:

### MOTOR VEHICLE ACCIDENT INFORMATION

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ State Accident Occurred: \_\_\_\_\_ Time: \_\_\_\_\_

Auto Insurance Name: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

Adjuster's Phone Number: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_ MVA Work Related? Y N

**We will bill your motor vehicle insurance; however, you are ultimately responsible for your account balance.** We do require your health insurance information since most auto coverage is limited. We will bill your health insurance for any remaining balance after your Auto Insurance has paid. \*\*Please note that should your motor vehicle accident require litigation proceedings, you will be required to speak with our financial counselor to arrange monthly payments in order to keep your account current during your hearings.\*\* Once your claim has been settled, any overpayments you have made on the account will be refunded to you at that time.

### AUTHORIZATION

I, with my signature, authorize **Northwest Ohio Orthopedics And Sports Medicine, Inc.**, and any employee working under the direction of the care provider, to provide medical care for me, or to this patient for which I am the legal guardian. I also authorize **Northwest Ohio Orthopedics And Sports Medicine, Inc.**, to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I understand that I am responsible for all co-payments, deductible, and other amounts that may be deemed my responsibility by the insurance plan, as required by my contract with my insurance plan and state regulation.

Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_



# Northwest Ohio Orthopedics & Sports Medicine, Inc.

## FINANCIAL POLICY

### **Regarding Your Insurance:**

Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. We make every effort to get claims paid; however, please remember that your insurance policy is a contract between you, your employer, and your insurance company. Any balance remaining after the insurance has paid, is the **patient/guarantor's responsibility** (i.e. co-pay, co-insurance, non-covered benefits, exclusions, etc.). If NWO is not in your insurance plan, the patient/guarantor is responsible for all charges. If you do not have insurance, a payment plan must be arranged, prior to treatment, with our Financial Counselor. Partial payment for self-pay patients is required at the time of the initial visit.

In an effort to minimize insurance errors and maximize insurance payment, please bring your most recent insurance card(s) with you to every visit. **Co-payments are to be paid at the time of your visit.** In the event we receive payment from your insurance company for services you have paid for, a refund will be made to you in a timely manner.

### **Payment Information:**

We accept cash, check, and credit/debit card payments. Credit cards and/or checks can be "kept on file" for your convenience. This information is securely stored by an authorized vendor. Notification will be given before a payment transaction is performed. If you are unable to pay your balance in full, a payment plan arrangement can be made or you can sign up for CareCredit with the option of no interest financing. Contact our Financial Counselor at 419-427-3116 for more information. These options will lessen the possibility of your account being sent to a collection agency because of non-payment. A fee of \$30.00 will be applied and collected from your account if payment is returned non-paid.

### **Past Due Accounts:**

If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. A 10-day notice prior to sending your account to a collection agency will be mailed to you.

### **Orthopedic No-Show Fee:**

Missed or non-cancelled appointments will result in a service fee.

### **Imaging No-Show Fee:**

Cancellation within 24 hours prior to a scheduled MRI or a scheduled CT will be subject to a \$50.00 no-show fee.

### **Durable Medical Equipment:**

If you need to return a product, and you are the original purchaser, you need to do so within 10 days of receiving. All products must be returned in its original packaging with all instructions and parts. The product must be in new condition. We reserve the right to refuse any product not in new condition for health safety reasons. There is a 30% restocking fee on all returns. Upon notification that the product has been returned in new condition, a credit will be issued to your account less the restocking fee. For product exchanges, upon receipt of the returned product we will credit your account minus the 30% restocking fee if a product needs to be exchanged. This charge will be waived if NWO made the mistake in providing you with the wrong product.

### **FMLA, Disability, and Drug Company Assistance Forms:**

Any patient needing forms filled out by our office will incur a one time \$15.00 fee per form. Payment for this service is due at the time of drop-off or pick-up.

### **Medical Records Copying Fees:**

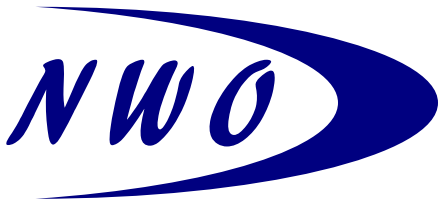
Charges for copying medical records vary depending on whether the individual/organization requesting the information is the patient/personal representative or a non-personal representative. In compliance with the Ohio Revised Code Section 3701.742, if the person requesting records is the patient/personal representative, fees are: \$2.88/page for pages 1-10, \$.60/page for pages 11-50, and \$.24/page for pages 51+. Fees for a non-personal representative are: \$17.70 retrieval fee, \$1.17/page for pages 1-10, \$.60/page for pages 11-50, and \$.24/page for pages 51+. Film prices for patient/representative and non-representative are: \$1.97/sheet or \$2.00/disc. Postage paid to send records will also be paid by the requestor.

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**Patient/Guarantor Signature**

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**Date**



# Northwest Ohio Orthopedics & Sports Medicine, Inc.

## THE NWO DOCTOR AND THE PATIENT

### **A WINNING PARTNERSHIP FOR YOUR TREATMENT, SURGERY AND RECOVERY**

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Since you have chosen care at NWO Orthopedics & Sport Medicine for your condition, we would like to emphasize the importance of developing a “therapeutic alliance.” The partnership between the patient and physician is very important as you move from having a problem, to being diagnosed and treated, including surgery, the recovery phase and beyond. At NWO Orthopedics & Sports Medicine, we will consider all available conservative treatment options for your condition before surgical intervention is entertained. The decision to proceed with surgical intervention will be made together by you and your NWO doctor, and only when both parties determine surgery to be your best option.

Although you can be assured that we at NWO will provide the best patient care possible and we believe our surgeons are second to none both in terms of technical ability and dedication to their patients, surgery is an art as much as a science and is dependent not only on the medical and surgical intervention by the doctors but also on your participation and the ability of your body to heal. Unfortunately as we age, our bodies oftentimes do not heal as they should, and with severe traumatic injuries, particularly involving the joint surface, there can be permanent and long term damage that occurs at the time of the injury which is irreversible despite current medical standards of treatment. Although there are unexpected outcomes with any medical/surgical intervention from the treatment phase to the recovery phase and beyond, we will work together as a team through these problems/complications and will be there with you every step of the way! We are aware that as a patient you can feel nervous and intimidated by the medical field and be apprehensive about your medical or surgical treatment. These emotions can lead to feelings of helplessness which is not desirable, and we would rather have you and your family involved as willing and active partners in the medical decision treatment process. We encourage you to share how you feel about the process and communicate this with our staff and ourselves, the physicians and care givers at NWO. Also, please note that we appreciate constructive criticism that will make our practice better to serve you and our community. Please feel free to ask any and all questions you should have regarding your diagnosis, your treatment or expected outcomes, and do not hesitate to voice any concerns or other comments that you have about your condition, the results of surgery, or any other aspects of the care that you receive at NWO.

Since it is our GOAL to engage you in being an active participant in **YOUR CARE**, you must understand your condition, the surgical intervention, and most importantly the expected outcome. To accomplish our therapeutic alliance and strengthen our relationship, we ask you to consider the following:

- The educational process will involve consent documents, educational pamphlets on your condition, as well as models in the exam rooms and posters. There will also be discussion about your treatment, any surgery that would be needed, your potential outcome and possible adverse events.
- Informed consent documents are not just legal documents, but are an important educational instrument. The purpose of the informed consent is to inform and teach you about your condition, the expected outcome as well as the risks that could affect your decision, both to undergo a given treatment procedure and the expected outcome. More importantly we feel it is **YOUR OPPORTUNITY TO ASK ANY ADDITIONAL QUESTIONS YOU MAY HAVE REGARDING THE TREATMENT OR PROCEDURE THAT WERE NOT DISCUSSED OR YOU MAY HAVE QUESTIONS ABOUT.**

Please understand that you will be seen, heard and understood at every step by both the physicians and the staff in the office as well throughout our facility. We emphasize education so that we can deliver information to you that makes sense and enhances your ability to become a partner in **YOUR CARE**. We request that you notify us of any concerns or constructive criticism so that you can make your care and the care for our community better. By enlisting your help we expect you to be an active participant in the decision making with the understanding that in the end **YOU** control much of what can and will happen in your healthcare treatment plan. Your involvement in this process can play a major role not only in improving your outcome and overall function, but the safety and outcome of other patients as well. Thank you and we look forward to our partnership.

Sincerely,

**Bruce E. Heck**, M.D.

**Brian P. Hecht**, M.D.

**Michael R. Tremains**, M.D.

Entire Staff of NWO