Thank you for scheduling with our office.

If you are a **NEW patient or have not been seen in the office in 2+ years**:

- Please complete the forms attached.
- Please arrive to your appointment between 10-15 minutes early with these forms completed, your insurance cards and photo id.
- Also be sure to bring your co-pay at this time.
- If you have had any diagnostic studies performed such as x-rays, MRI's, EMG's, etc **you MUST bring in the copies of these tests at the time of your appointment as well as a CD of the images.**
    - Failure to do so may result in your appointment being rescheduled or these tests may need to be repeated.

If you need to reschedule your appointment, please call our office at **419-427-1984**, press **224**.

If you have any questions please feel free to call. Thanks and have great day.

Please be sure to check out our new patient portal by clicking on the blue patient portal button at the top right of the website.

- On the portal you can request appointments and pay your bills online. Check it out today!

Thank you
Northwest Ohio Orthopedics and Sports Medicine

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:	Email Address:
Home Telephone:	Cell Phone:	Other Phone:	Gender: □ M □ F	Status: □Married □Single □Widowed □Divorced
Date of Birth (mm-dd-yyyy):	Date of Injury/Onset:	Work Related: □ Yes □No	Auto Related: □ Yes □ No	

If Medicare, are you currently residing in a Skilled Nursing Facility: □ Yes □ No Name of Facility_____

If you are Medicare, have you received Physical, Occupational, or Speech Therapy services since the beginning of the year? □ Yes □No
If so, do you know if you have exceeded the Medicare cap? □ Yes □ No

If Medicare, are you currently receiving Home Health Services: □ Yes □ No Type of service:
If yes, Name of Agency:_____ Date of Last Service:

Physician & Pharmacy Information

Primary Care Physician (PCP):	City/State of PCP:	Physician who referred you here: City/State of Referring Physician:
May we send medical information to your PCP? □ Yes □ No		Preferred Pharmacy & City/State :

Employer Information

Employer:	Employer Phone:	Employment Status: □ FT □PT □Self □ Retired □Student □None	
Address:	City:	State:	Zip:

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

If Minor, Does child live with: □ Both Parents □ Mother □ Father □ 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:

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: □ Self □ Spouse □ Dependent □ Other		

Secondary Insurance

Name of Insurance:	ID #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to Patient: □ Self □ Spouse □ Dependent □ 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.

☐ **Foot** ☐ RT ☐ LT	☐ **Ankle** ☐ RT ☐ LT	☐ **Toe** ☐ RT B 2 3 4 5 ☐ LT

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.

❑ **No Injury** (Onset was: ❑ Gradual ❑ Sudden) **Answer/Comment**
Why do you think it started? _____

❑ **Injury** (❑ Accident-NOT auto or work ❑ Sport) _____
Date: _____ When/How did it happen?
What sport and school? _____ _____

❑ **Injury at Work** Date: _____ _____
From a ❑ Lift ❑ Twist ❑ Fall ❑ Bend
❑ Pull ❑ Reach _____

❑ **Work Related, but NO Injury** _____
Date: _____ How did your job cause this? _____

❑ **Auto Accident** Date: _____ _____
How was your car hit? _____

*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 **foot/ankle** condition in the past? ❑Y ❑N

*Please explain: _____

Do you have: ❑Joint pain or swelling ❑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.		**NONE**	**Year**	**Explanation/Comments**
2. **GI**	❑Heartburn/Ulcers ❑Nausea/Vomiting ❑Blood in Stool	☐		
	❑Hepatitis ❑Liver Disease			
3. **ENDO**	❑Thyroid Disease ❑Heat/Cold Intolerance	☐		
4. **CON**	❑Weight Loss ❑Frequent Fever ❑Loss of Appetite	❑		
5. **EYE**	❑ Blurred Vision ❑Double Vision ❑Loss of Vision	❑		
6. **ENT**	❑Hearing Loss ❑Hoarseness ❑Trouble Swallowing	❑		
7. **CV**	❑Chest Pain ❑Palpitations	❑		
8. **RS**	❑Chronic Cough ❑Shortness of Breath	❑		
9. **GU**	❑Painful Urination ❑Blood in Urine ❑Kidney Problems	❑		
10. **SK**	❑Frequent Rashes ❑Skin Ulcers ❑Lumps ❑Psoriasis	❑		
11. **NEU**	❑Headaches ❑Dizziness ❑Seizures	❑		
12. **PSY**	❑Depression ❑Drug/Alcohol addiction ❑Sleep disorder	❑		
13. **HEM**	❑Easy Bleeding ❑Easy Bruising ❑Anemia	❑		

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:** _____

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 (i.e. co-pay, co-insurance, non-covered benefits, exclusions, etc.) **is the responsibility of the undersigned responsible party**. If NWO is not in your insurance plan, **the undersigned responsible party 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, Family Medicine, Chiropractic, Podiatry and Pain Management No-Show Fee:
Missed or non-cancelled appointments will result in a $25.00 no-show fee. Chiropractic appointments must be cancelled within 24 hours of scheduled appointment.

Imaging No-Show Fee:
Cancellation within 24 hours prior to a scheduled MRI or 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.

Patient Name: _____

_____ _____
Signature of Responsible Party **Date**

Printed Name of Responsible Party: _____

Relationship to Patient (e.g., self, parent/guardian): _____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Consent for Minor to Receive Treatment

I, the parent/guardian of _____, give consent for my child to receive the following types of medical services at the Northwest Ohio Orthopedics & Sports Medicine, Inc. ("NWO"):. _____ _____ _____ that could include:

- ❑ Imaging services: CT, MRI, Ultrasound
- ❑ Chiropractic Care
- ❑ Physical/Occupational Therapy/ DME
- ❑ Pain Management

❑ **A parent will be present for all visits**

I understand that this consent form will be good until _____.

Except to the extent that the law requires my child's signed consent prior to disclosure, I understand that I will be entitled access to medical information concerning services provided to my child pursuant to this consent. I understand that nothing in this consent affects the ability of the NWO to provide medical services to my child without my consent to the extent expressly permitted under Ohio law.

I understand that I will be responsible for payment for any charges relating to services provided to my child pursuant to this consent, to the extent that such services are not covered in full by insurance or other third-party payor covering my child. NWO may release information regarding treatment to third party payers for billing purposes.

_____ _____

Signature of Parent / Legal Guardian Date

NOTARY PUBLIC SIGNATURE / STAMP / SEAL REQUIRED

State of Ohio
County of _____

Subscribed and sworn to me this _____ day of _____ 20 _____

Signature: _____
My commission expires: _____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Patient Medication List

Patient Name: _____ Date of Birth: _____

What medications do you currently take? (Including over the counter, vitamins/supplements)

☐ None

Name of Medication	Dosage	Doctor That Prescribed

Patient/Guardian Signature: _____ Date: _____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

THE NWO DOCTOR AND THE PATIENT

A WINNING PARTNERSHIP FOR YOUR TREATMENT, SURGERY AND RECOVERY

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.
Kimberly A. Smith, D.P.M.

And the Entire Staff of NWO