MOTIONORTHOPAEDICS

Dear Friends and Patients,

Thank you for choosing Motion Orthopaedics.

Motion Orthopaedics constantly strives to provide the highest quality comprehensive care for you and your family.

We have organized this building to include providers that complement our services so that you can get the care you need in one convenient location. This includes:

- Fellowship Trained Orthopedic Surgeons with subspecialty training in specific areas
- Digital x-rays and electronic medical records in our state of the art facility
- High resolution digital MRI and MR Arthrograms at Emerson Road Imaging Center
- Medical Equipment (DME) is available on-site through our office

If surgery is required, Emerson Road Surgery Center and North Campus Surgery Center are located within the building. These facilities are staffed with experienced nurses and staff that work closely with our physicians to provide the highest quality specialized care in an efficient and personalized fashion.

Financial Disclosure
The physicians at Motion Orthopaedics, specifically, Dr. Michael Milne, Dr. Timothy Farley, Dr. David King, Dr. James Doll, Dr. Donald Bassman, and Dr. Tyler Krummenacher all of which are located at 633 Emerson Road, Creve Coeur, Missouri 63141, have 5% or more ownership interest in some of the surgery and imaging facilities listed above, as well as other related entities as permitted by state and federal laws.

You have complete freedom of choice as you select your providers and facilities.

Our physicians and staff are happy to provide you with the names of other service providers and will help coordinate your appointments with your provider of choice.

For more information, visit our website at www.motion-ortho.com

We appreciate the opportunity to serve you and your family.

PRINT Patient's Name _____ Date _____

Signature (Patient/Guardian) _____ PRINT Guardian's Name _____

Revised 04/2016

POS Reorder # 1522276

Seeing Doctor:

Please complete the following health questionnaire. We are concerned with your overall health, as well as your orthopedic problems. This information is confidential and will be reviewed with you by your doctor today. It is designed to help you recall your history and provide details that will help in your diagnosis and treatment plan. Thank you.

Name: _____ Nickname: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Sex: _____

Who referred you: _____ Relationship: _____

Are you: ☐ Right Hand dominant ☐ Left Hand dominant Are you pregnant? ☐ Yes ☐ No

Currently Working? ☐ Full ☐ Light ☐ Part-Time ☐ Disabled ☐ Retired ☐ Other _____

Acute Injury? ☐ Y ☐ N Date of Injury: _____ Work Injury? ☐ Y ☐ N Car Accident? ☐ Y ☐ N

State of Accident: ☐ Missouri ☐ Illinois ☐ Other: _____

Are you represented by an attorney for this issue? ☐ Yes ☐ No

Name/address of attorney: _____

Who Referred you to our clinic: _____ Self _____ Friend _____ Physician Name _____

Reason for visit/chief Complaint: Please describe injury/complaint & how long condition has been present:

_____

_____

Problem for which you are seeing the doctor today: Right Left Both _____

☐ New Injury ☐ Continued Problem ☐ Second Opinion ☐ Referral for Surgery

When did this problem start? _____ Over time, the condition is getting: Better Worse Same

How did the problem begin (specifically)? _____

Testing - List all medical tests including X-Ray, MRI, CT Scan, Nerve (EMG/NCV) and Bone Scan pertaining to this problem?

Date	**Test Performed**	**Results/Name of facility where tests performed**

Medical History - Please circle **ALL** current or previous medical conditions:

Cardiovascular: Heart Disease, Heart Attack, Angina, High Cholesterol, High Blood Pressure, Irregular Heart Beat

Other/Explain: _____

Endocrine : Thyroid disease, diabetes, other: _____

Hematology/Oncology: PE, Blood Clots, Bleeding Disorders, Stroke, Cancer, Other/Explain: _____

Have you ever had a blood transfusion: ☐ Yes ☐ No If yes, when? _____

Pulmonary: Asthma, Emphysema, Chronic Bronchitis, Lung Disease Other: _____

Do you have sleep apnea? ☐ Yes ☐ No

Musculoskeletal: Lupus, Raynaud's Osteoarthritis, Rheumatoid Arthritis, Osteoporosis, Gout, Fibromyalgia

Other: _____

Gastrointestinal: Ulcers, Reflux, Indigestion, Hernias, Crohn's, IBS Other: _____

Genitourinary: Kidney Disease, Frequent Urinary Tract Infections, Kidney Stones Other:

Neurologic: Strokes, Seizure Disorder, Peripheral Neuropathy, Other: _____

Psychiatric: Depression, Anxiety, Bipolar, ADHD, Narcolepsy, Schizophrenia, Other: _____

Infectious Disease: Hepatitis, TB, HIV/AIDS

Have you or anyone in your family had any problems with anesthesia? ☐ Yes ☐ No

Please list the physician treating you for any for the following conditions: Diabetes, peripheral neuropathy, artheriosclerosis of the arteries in your extremities, Buerger's disease or chronic thrombophlebitis.

Name _____ **Location**_____ **Date last seen**_____

Prior Hospitalization: _____

Prior surgeries: _____

_____

_____

Family History - Do any of the following run in your family?

Yes	*No*		*Whom?*	*Yes*	*No*		*Whom?*
☐	☐	Bleeding Problems	_____	☐	☐	Diabetes	_____
☐	☐	Blood Clots	_____	☐	☐	Arthritis	_____
☐	☐	Cancer	_____	☐	☐	Genetic Problems	_____
☐	☐	Heart Problems	_____	☐	☐	Osteoporosis	_____
☐	☐	Lung Problems	_____	☐	☐	Collagen Disorders	_____

Has anyone in the family died at a young age or unexpected cause? If yes, who and what cause? _____

Social History:

General education: ☐ High School ☐ College ☐ Post graduate or other _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ How long? _____ Quit Date: _____

Do you drink alcohol? ☐ Yes ☐ No How much per day? _____ Have you ever used rec. drugs? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No Describe: _____

What Sports or activities do you participate in? _____

Work demands: ☐ Sedentary ☐ Moderately active ☐ Heavy Labor

Current Medicines & dosage: _____

_____

_____

Allergies: Known **DRUG** allergies & reactions _____

Known **FOOD** allergies & reaction _____

Known **METAL** allergy ☐ yes ☐ no Known **Latex** Allergy ☐ Yes ☐ No

Review of Systems - Check if you have **CURRENT** symptoms or current known medical problems in the following areas.

	Yes	No		Yes	No		Yes	No		Yes	No
Chest Pain	☐	☐	Nervousness	☐	☐	Voice Changes	☐	☐	Tingling	☐	☐
Palpitations	☐	☐	Unusual Thirst	☐	☐	Sinusitis	☐	☐	Memory Loss	☐	☐
Short of Breath	☐	☐	Nosebleeds	☐	☐	Hearing Loss	☐	☐	Insomnia	☐	☐
Headaches	☐	☐	Weakness	☐	☐	Weight Loss	☐	☐	Fatigue	☐	☐
Dizziness	☐	☐	Back/Neck Pain	☐	☐	Fevers	☐	☐			

Is your primary doctor aware of the above symptoms or known medical problems? ☐ Yes ☐ No

Name of Primary Care Physician: _____

I certify that this information is true and correct to the best of my knowledge. Please sign below.

_____ _____

Patient or Responsible Parent (if under 17 years old) Date

MOTIONORTHOPAEDICS

Patient Information

Patient Name:	**Please mark best phone number to reach you at:** ❑ **Cell #:**
Social Security #:	❑ **Home #:**
Address:	❑ **Work #:**
City, State & Zip Code:	**Email Address:**
Date of Birth: / **Gender:**	**Referring Physician/Health Professional:**
	Referring Physician Phone/Address:
Employment / Student Status: ❑ Full time employed ❑ Full time student ❑ Part time employed ❑ Part time student ❑ Unemployed ❑ Retired	**Primary Care Physician:**
	Primary Care Phone #:
Employer Name & Address: _____ _____	**Emergency Contact Name & Phone:**
	Relationship to Patient:
Occupation: _____ _____	**Married** ❑ **Single** ❑ **Other** ❑ **Spouses Name:**

Financially Responsible Person (if different from above)

Full Name:	**Social Security #:**
Address:	**Cell #:**
City, State & Zip Code:	**Home #:**
Date of Birth:	**Work #:**
Employer Name/Address:	**Relationship to the Patient (check one):** ❑ Self ❑ Spouse ❑ Child ❑ Parent ❑ Other

Date Reviewed _____ Initials _____

Insurance Company Information

Motion Orthopaedics

Primary Insurance Company Name:		Secondary Insurance Company Name:	
Address, City, State & Zip:		Address, City, State & Zip:	
Policy Holder:	Date of Birth:	Policy Holder:	Date of Birth:
Policy Holder Employer:	Policy Holder SSN:	Policy Holder Employer:	Policy Holder SSN:
Policy Number:	Group Number:	Policy Number:	Group Number:
Relationship to the Patient (check one): ❑ Self ❑ Spouse ❑ Child ❑ Parent ❑ Other		Relationship to the Patient (check one): ❑ Self ❑ Spouse ❑ Child ❑ Parent ❑ Other	

Authorization & Consent For Release of Information:

This form allows Motion Orthopaedics to release records from our office and to discuss medical treatment and any billing issues with the following people:

Name:_____ Relationship:_____ Telephone:_____

Name:_____ Relationship:_____ Telephone:_____

May we leave voice mail messages on your telephone? ❑ Yes ❑ No If Yes: Check All that apply as able to leave a message:
May we text your cell phone? ❑ Yes ❑ No Cell Phone #_____ ❑ Home # ❑ Cell # ❑ Work #
May we call your cell phone regarding any billing issues? ❑ Yes ❑ No

Preferred Pharmacy Name/Address:_____ Pharmacy Phone No.:_____

Authorization to Release Information:

Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither Motion Orthopaedics nor any affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do it.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this Authorization.

Patient/Legal Representative Signature:_____ Date:_____ Relationship:_____

Medicare Lifetime & Medigap Signature on File:

I request that payment of authorized Medicare, Medigap and all other insurance company benefits be made on my behalf to Motion Orthopaedics, for any services furnished to me by the provider. I authorize any holder of medical information about me to be released to my health insurance company or the Health Care Financing Administration and its agent's needed to determine these benefits or benefits payable for related services.

Advanced Beneficiary Notice of Medicare Non-Coverage and Terms of any other insurances:

I understand that when accepting any treatment or durable medical goods from my provider the charges will be billed to my insurance company or Medicare for an official decision on payment, which is sent to me on a Summary Notice. I understand that if my insurance or Medicare doesn't pay, I am responsible for payment, but I can appeal to my insurance company or Medicare by following the directions on the Summary Notice. If my insurance or Medicare does pay Motion Orthopaedics will refund any payments I made to you, less co-pays or deductibles. I understand it is my responsibility to know the terms of my insurance plan. If I do not present my current insurance card or any required referral numbers or forms from my primary care physician for specialty care at the time of every visit I am choosing to go outside my plan. Additionally, there may be charges that are not covered by my insurance company. I understand I am responsible for all charges incurred by me, and I further agree to prompt payment of any services billed in these situations.

I authorize payment of medical benefits provided by my medical insurance described on a standard health form to Motion Orthopaedics for services provided during my care and treatment as described on the standard health care form information necessary to process claims. I understand that I am financially responsible for the charges covered by this authorization, and I will be responsible for any collection fees or cost associated with collections. I understand I may request a copy of and/or review the Notice of Privacy Practices at any time. I give the physicians of Motion Orthopaedics permission to view my prescription history from external sources including pharmacies, other physicians, hospitals and my health insurance.

Signature:_____ Date:_____

MOTIONORTHOPAEDICS

Patient Consent to ePrescriptions

Motion Orthopaedics has implemented ePrescribing in our office.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information, like drug interactions and your prescription history.

The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescriptions filled

Patient Consent

I agree that Motion Orthopaedics may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

PRINT Patient's Name _____ Date _____

Signature (Patient/Guardian) _____ PRINT Guardian's Name _____

633 Emerson Road
Creve Coeur, MO 63141
Phone 314-991-2013
www.Motion-Ortho.com

MOTIONORTHOPAEDICS

Michael J. Milne, MD
David J. King, MD
Timothy D. Farley, MD
James T. Doll, DO
Donald R. Bassman, MD
Tyler R. Krummenacher, MD

FINANCIAL PAYMENT POLICY

Thank you for choosing Motion Orthopaedics. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** Our providers participate in many insurance plans, including Medicare. If you are not insured by a plan your provider is contracted with, payment in full is expected at each visit. If you are insured by a plan your provider is contracted with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. If your insurance plan requires you to have a referral, it is your responsibility to receive this referral from your primary care provider BEFORE your appointment. Please contact your insurance company with any questions you may have regarding your coverage. Their phone number can usually be found on the back of your insurance card.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This is required by your insurance plan as part of your contract with your insurance company.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. (For Medicare patients, you must sign an Advance Beneficiary Notice of Noncoverage (ABN). For contracted plans, the claim will be processed with the insurance company before patient is billed – per our contracts).

4. **Proof of insurance.** All patients must complete our patient information form before seeing a provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We must have copies and information for both your Primary and Secondary insurance plans.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance may automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter asking you to contact our Billing Service within 10 days of the date on the letter to make payment in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care.

8. **Missed appointments.** Our policy is to charge for missed appointments. Any appointment that is canceled within 24 hours of the time of your appointment will be charged $50.00 for that missed appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. **Payments.** We accept cash, check, certified check, MasterCard, Visa, American Express and Discover cards as a form of payment. There will be a $25.00 fee for all returned checks.

10. **Telephone Consumer Protection Act (TCPA).** I agree that the facility, Motion Orthopaedics or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-email address I provide to the facility or otherwise associated with my account.

Our practice is committed to providing the best care possible to our patients. Our charges are based on data regarding the usual and customary charges for our area.

Thank you for reviewing our financial payment policy. Please let us know if you have any questions or concerns.

I have read and understand the financial payment policy and agree to abide by its guidelines:

Signature of patient or responsible party Date

Michael J. Milne, MD
David J. King, MD
Timothy D. Farley, MD
James T. Doll, DO
Donald R. Bassman, MD
Tyler R. Krummenacher, MD

MOTIONORTHOPAEDICS

PATIENT NAME: _____

APPT DATE/TIME: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of Motion Orthopaedic's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information. Should our Notice of Privacy Practices change, we will provide you with a revised copy as provided in the Notice of Privacy Practices.

_____ _____

PRINT Patient's Name Date

_____ _____

Signature (Patient/Guardian) PRINT Guardian's Name

FOR MOTION ORTHOPAEDICS USE ONLY

Inability To Obtain Acknowledgement

If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____

_____

_____

_____

Signature of Motion Orthopaedics representative: _____

Name of Motion Orthopaedics representative: _____

Date: _____