

East Coast Orthopaedics and Sports Medicine

Date: _____ **Signature:** _____

Reason for today's visit: _____

When did symptoms appear?/Date of Injury? _____

Describe symptoms/injury: _____

Date: _____ **Signature:** _____

Reason for today's visit: _____

When did symptoms appear?/Date of Injury? _____

Describe symptoms/injury: _____

Date: _____ **Signature:** _____

Reason for today's visit: _____

When did symptoms appear?/Date of Injury? _____

Describe symptoms/injury: _____

Date: _____ **Signature:** _____

Reason for today's visit: _____

When did symptoms appear?/Date of Injury? _____

Describe symptoms/injury: _____

Date: _____ **Signature:** _____

Reason for today's visit: _____

When did symptoms appear?/Date of Injury? _____

Describe symptoms/injury: _____



Patient Information

Please complete form in its entirety
If something does not apply, please fill in with N/A

76 West Jimmie Leeds Road Suite 103 Galloway, NJ 08205
712 East Bay Ave, Manahawkin, NJ 08050
P 609-748-2922 F 609-748-2911

PATIENT:						
Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Home Phone	
					Cell Phone	
Mailing Address	City	State	Zipcode	Marital Status		
Employer	City	State	Zipcode	Work Phone		

RESPONSIBLE PARTY: (To be filled out only if patient is under 18 years old with information of person signing form)						
Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Home Phone	
					Cell Phone	
Mailing Address	City	State	Zipcode	Marital Status		
Employer	City	State	Zipcode	Work Phone		

PRIMARY DOCTOR:	REFERRING DOCTOR:	ADDRESS:	PHONE:	FAX:

INSURANCE INFORMATION:					
Primary Insurance Company	Subscriber's Name	Birthdate & SSN	Relationship	Policy Number/Group Number	Copay
Secondary Insurance Company	Subscriber's Name	Birthdate & SSN	Relationship	Policy Number/Group Number	Copay
Third Insurance Company	Subscriber's Name	Birthdate & SSN	Relationship	Policy Number/Group Number	Copay

EMERGENCY CONTACT INFORMATION:			
Contact Name	Relationship	Primary Phone Number () -	Secondary Phone Number () -

Patient Release:

I certify that the information I have provided is correct. I authorize the release of medical information as necessary to process insurance claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED, on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature: _____
(Signature of patient or patient's legal representative)

Date: ____ / ____ / ____

Name: _____ Height: _____ Weight: _____ R/L Handed: _____

MEDICAL HISTORY

Description	Onset Date

SURGICAL HISTORY

Procedure	Date of Procedure

SOCIAL & FAMILY HISTORY (Check all that apply)

<input type="checkbox"/> Tobacco Use/Abuse	<input type="checkbox"/> Alcohol Use/Abuse
<input type="checkbox"/> Illegal Substance Use	<input type="checkbox"/> Cocaine
<input type="checkbox"/> LSD	<input type="checkbox"/> PCP
<input type="checkbox"/> Marijuana	<input type="checkbox"/> Methamphetamines
<input type="checkbox"/> Prescription Drugs	<input type="checkbox"/> Other

Smoking Status: CURRENT FORMER NEVER

Family History: (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> PAU |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Bleeding Diathesis | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Stroke | |

MEDICATIONS

Name	Dose	Instructions	Start Date	End Date

***Please add additional medications on back

ALLERGIES

Type	Reaction	Onset Date

Patient Signature: _____ Date: _____
 Physician Signature: _____ Date: _____

Name: _____ Height: _____ Weight: _____ R/L Handed: _____

REVIEW OF SYSTEMS (Circle All That Apply)

Constitutional: Fever, Night Sweats, Weight Change, Well Developed

HEENT/Neck: Vision changes, Double vision, Nasal/Sinus problems, Thyroid, Ear Pain, Salivary Gland, Difficulty swallowing, Throat Pain, Swelling

Respiratory: Cough, Shortness of breath, Blood in sputum, chest pain, wheezing

Cardiovascular: Chest Pain, Palpitations, Arrhythmias, Syncope/Fainting, Murmurs, Orthostatic Hypotension, Shortness of Breath with Exertion, Intermittent Claudication/Pain in legs with exertion, Cyanosis, Peripheral Edema/Swelling of extremities, Shortness of Breath, Diaphoresis

Gastrointestinal: Nausea, Vomiting, Diarrhea, Abdominal Pain, Hematemesis/Vomiting Blood, Hematochezia/Blood in Stool, Rectal Pain, Stomatitis, Hemorrhoidal Pain, Constipation, Organomegaly/Enlarged organs

Genitourinary: Pelvic Pain, Dysuria/Pain with urination, Hesitancy, Frequency, Dyspareunia/Pain with Intercourse, Testicular Swelling, Epididymis

Hematologic: Weakness, Fatigue, Cold Intolerance, Dizziness, Epistaxis, Purpura, Petechiae, Gum Bleeding, Easy Bruising, Neutropenia, Lymphadenopathy

Psychiatric: Depression, Anxiety, Psychosis, Insomnia, Agitation, Mood Swings, Confusion, Disorientation, Visual/Auditory Hallucination, Delirium

Musculoskeletal: Joint Pain, Back Pain, Sciatica, Muscle Pain, Stiffness, Decrease ROM, Strength, Weakness, Swelling, Spasms

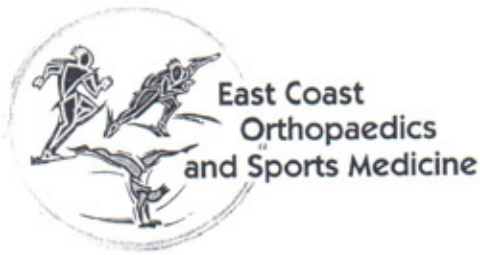
Neurological: Memory Loss, Paresthesias, Tremors, Seizure, Headache, Dizziness, Paralysis

Endocrine: Abnormal Weight Gain/Loss, Heat/Cold Intolerance, Thyromegaly, Hot Flashes, Menopause, Dysmenorrhea, Galactorrhea, Diplopia/Double Vision, Polyuria/Increased Frequency of Urination, Polydipsia/Excessive Thirst, Polyphagia/Excessive Hunger

Allergy/Immunology: Rhinorrhea, Sneezing, Rash, Urticaria, Recurrent Infection, Angioedema

Dermatologic: Ulcerations, Urticaria, Candidiasis, Papules, Macules, Malar rash, Signs of Keratosis, Vesicular Eruption, Abrasion, Onychomycosis, Ecchymosis/Bruising, Lacerations, Contusions

Patient Signature: _____ Date: _____
Physician Signature: _____ Date: _____



AGREEMENT AS TO RESOLUTION OF CONCERNS

“I”, “Patient/Guardian” shall be understood to mean _____.
(Patient Name)

“Physician” shall be understood to mean Raymond Weiand, DO; of East Coast Orthopaedics & Sports Medicine, LLC.

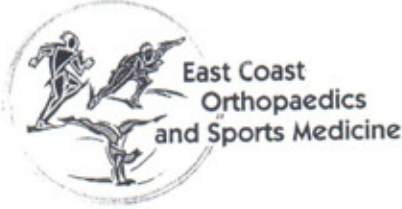
Further, I understand that I am entering into a contractual relationship with East Coast Orthopaedics and Sports Medicine, LLC, offices of Dr. Raymond Weiand, for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by East Coast Orthopaedics and Sports Medicine, LLC, I, (the patient/guardian and/or my representative), agree not to advance, directly or indirectly, any false, meritless and/or frivolous claim(s) of medical malpractice against Dr. Raymond Weiand or East Coast Orthopaedics and Sports Medicine, LLC.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient/guardian and or my representative) agree to use American Board of Medical Specialties (“ABMS”) board-certified expert medical witness(es) in the same specialty as the Physician. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Osteopathic Academy of Orthopaedics and American Board of Orthopaedic Surgery. In further consideration for this, Dr. Raymond Weiand agrees to the same stipulations.

Patient/Guardian Signature: _____

Signature of Dr. Raymond Weiand: _____

Date: ____/____/____



FINANCIAL POLICY

I understand that the Practice's billing staff will file all claims for services rendered to my insurance carrier.

I, however, acknowledge that I am responsible for any balances that may be due to the Practice because of any/all of the following:

- ✓ Co-insurance or co-pay amounts
- ✓ Yearly deductible amounts
- ✓ Non-covered services
- ✓ Out-of-network charges
- ✓ Surgical Assistants not covered by your insurance company
- ✓ Terminated coverage
- ✓ No insurance coverage
- ✓ Exhausted auto benefits
- ✓ Denied worker's compensation claim
- ✓ No referral obtained from primary care physician
- ✓ Failure to respond to insurance carrier correspondence

I understand that I will receive a statement for any balance due after my carrier has processed the claim. I understand and am agreeable that the balance of my statement will be paid in full to the Practice within thirty (30) days.

If I am unable to pay the entire amount, I am responsible to *immediately*, upon receipt of the statement, call the billing office at 609-748-2922 x 110 or 111 to arrange a monthly payment plan. I understand that in order to set up a payment plan, I will be required to show proof of financial hardship in the form of pay-stubs and/or federal tax returns.

I understand that if I should present a check to the Practice that is returned by the bank for non-sufficient funds, I will be charged the amount of the check plus a \$25 processing fee. I also understand that I will no longer be able to pay by check for any monies owed to the Practice.

I understand that this Practice charges \$10 for any forms that need to be filled out/signed or any letters that need to be dictated on my behalf. This charge is payable in advance to the service being provided.

I understand that failure to provide the Practice with a valid social security number as well as a valid driver's license/Green card/Passport for the patient or patient's legal representative will result in my having to pay for services in full up front. I understand that in such a case, payment will be expected by cash or credit card only. I understand that I will be issued a receipt that I may submit on my own to my insurance company for reimbursement.

I understand that this Practice does not do third party billing and does not accept letters of protection from attorneys. All balances are due at the time of service.

I understand that failure to pay my balance and/or arrange payments and follow that payment agreement will result in collection agency action and/or discharge from the Practice's care.

**** Medicaid and Managed Medicaid patients**** - I am fully aware that this Practice does not participate with any Medicaid or Managed Medicaid programs. I was given the opportunity to seek medical care at the orthopedic clinic, however, I have chosen to be seen at East Coast Orthopaedics. By signing below I am waiving my rights under Medicaid law and agree to be a self-pay patient with this Practice.

Print Patient Name

Date

Signature of Patient or Patient Legal Representative



PRIVACY CONSENT FORM/REQUIRED BY FEDERAL HIPAA LAW #101-191
For Use or Disclosure of Private Health Information

- Trust is the foundation of a doctor/patient relationship.
- The information that you provide us is kept in the strictest of confidence.
- While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health care information.
 1. It may be necessary to use or disclose your private health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health information.
 2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services.
 3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes.

Please note:

We have a more detailed "Notice of Privacy for Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our privacy practices you will be notified by a posting of the change in the office or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.

Patient Right Under HIPAA Law #101-191

1. You have the right to request that we do not disclose your private health information to specific individuals, companies or organizations under the following circumstances:
 - a. All requests must be in writing.
 - b. By law we are not required to agree with your restrictions, HOWEVER
 - c. If we agree with your restrictions, the restrictions are binding on us.
2. You have the right to REVOKE your Authorization under the certain conditions:
 - a. It must be in writing.
 - b. The request will not be honored if we have already released your private health information before we received your request to revoke the authorization.
 - c. If you were required to give you authorization as a condition of obtaining insurance, the insurance company may have the right to your private health information should they decide to contest any of your claims.

Medical Information Release (please answer yes or no for the following):

Family Doctor: Yes No
Spouse: Yes No
Parents (if patient is over 18) Yes No
Other: _____

May we leave a message on the phone numbers listed? Yes No

I have read your consent policy and agree to its terms. I also acknowledge that once I sign this consent form, I will receive a copy of this completed form for my own records.

Printed Patient Name

Printed Authorized Provider Name

Signature

Signature

Month/Day/Year

Month/Day/Year



**East Coast
Orthopaedics
and Sports Medicine**

Raymond Weiland, D.O.
Board Certified • Fellowship Trained in Trauma
Joint Reconstruction and Arthroscopic Surgery
Workers Compensation

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Weiland and East Coast Orthopaedics & Sports Medicine (“Physician”) agree to maintain the privacy of _____ (“Patient”) as outlined in the HIPAA form. The Physician takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information (PHI) to companies to market their products or services directly to the patients without their authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician agrees not to be paid for selling patient lists or PHI to any party for the purpose of marketing directly to his patients. Regardless of legal privacy loopholes, Physician will never attempt to leverage his relationship with Patient by seeking Patient’s consent for marketing products for others.

In consideration for treatment and the above noted patient protections, Patient agrees to refrain from directly or indirectly publishing or airing commentary regarding Physician and his practice, expertise and/or treatment. Physician has invested significant financial and/or marketing resources in developing his practice. Published comments on web pages, blogs, and/or mass correspondence could severely damage Physician’s practice. Physician has the right to equitable relief to prevent the initiation or continuation of publishing or airing of commentary regarding his practice, expertise and/or treatment.

Physician feels strongly about his patient’s privacy as well as his practice’s right to control its public image and privacy. Both Physician and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via web pages, bolgs, or other electronic, print, or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable for a period of five (5) years from Physician’s last date of service to Patient.

Patient has been given the opportunity to ask questions and receive adequate explanations to his/her satisfaction.

So agreed this _____ day of _____, 20____.

Patient Printed Name

Patient/Guardian Signature (required)

PATIENT SATISFACTION SURVEY

1. YOUR RESIDENT STATUS:

full time resident part-time resident visitor

2. YOUR MEDICAL PROVIDER:

	POOR	FAIR	OK	GOOD	GREAT
Was knowledgeable about your case?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gave you their full attention?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spent adequate time with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Answered your questions to your satisfaction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided appropriate advice, treatment and referral?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

comments _____

3. PRIMARY CARE MEDICAL ASSISTANTS & NURSES:

	POOR	FAIR	OK	GOOD	GREAT
Were the Medical Assistants and or Nurses, helpful and pleasant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

comments _____

4. APPOINTMENTS AND REGISTRATION:

	POOR	FAIR	OK	GOOD	GREAT
Did you find your interaction with the Front Desk staff to be friendly and helpful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did they answer questions to your satisfaction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My appointment was scheduled to my satisfaction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you see your provider promptly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

comments _____

5. FACILITY:

	POOR	FAIR	OK	GOOD	GREAT
Was the building neat and clean?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was your privacy maintained?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How would you say the facility compares with other facilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What is your overall satisfaction with the facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I was seen in: Galloway Cape May Court House Manahawkin

6. OVERALL EXPERIENCE:

	POOR	FAIR	OK	GOOD	GREAT
How do you rate your overall visit experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your feedback can help us provide you with the care and services you desire?

Comments _____

