ORTHOPEDIC ASSOCIATES *of* MEADVILLE, P.C.

640 Alden Street • Meadville, Pennsylvania 16335
Telephone (814) 724-1252 • Facsimile (814) 333-8871

Your Appointment is: _____

Welcome to Our Practice

Please take a few moments now and complete the enclosed health questionnaire and registration form. Be sure to bring the information to our visit.

If you have had tests completed such as an X-ray, MRI, CT Scan, EMG, or other tests, you must bring them along with their written test results to your office visit. We recommend you contact the physician or the hospital where the tests were completed at least one week in advance of your visit to ensure you are able to retrieve them. Be sure to ask and obtain the written report from your test, as well as the test itself.

You should plan to arrive 20 minutes prior to your first appointment to finish the registration process with our office. Plan to arrive 10 minutes before your follow-up appointments. Your appointment may be rescheduled if you arrive late as a courtesy to other patients. You must bring with you:

1. Health Questionnaire Form - First Visit - Fully Completed - Fill in All Blanks
2. Test Results with Written Report
3. Registration Form - First Visit - Fully Completed
4. Drivers License - First Visit
5. **Health Insurance Card - Every Visit**

We participate with the following insurance plans: Cigna, Health America/Health Assurance/Coventry, Highmark/ Keystone/Security Blue/Freedom Blue, InterGroup Network, Medicare, Railroad Medicare, Pennsylvania Medical Assistance, United Healthcare, UPMC, Tricare, Vantage Network, Great-West and the following Medicare Advantage: Advantra, Advantra Freedom, Humana Gold, Today's Options Medicare, Smart Value, Aetna Medicare, Sterling Option One, Cigna Medicare Access Plus, Wellcare, Medical Mutual Medicare, Preferred Care and Independent Health.

We will file your insurance for most other health plans, except other Medicare Advantage Plans, as a courtesy to you if we do not participate with your insurance carrier. However, you are responsible for payment of services if your carrier does not reimburse our practice. We do not participate with other Medicare Advantage Plans. Therefore, these patients will be responsible for payment of services at the time services are rendered. All self-pay patients must pay for their services at the time of the office visit.

All co-payments are due at the time of your appointment visit - which may be rescheduled if you do not pay your co-payment during your visit. We accept cash, personal checks, debit cards, Visa, and MasterCard.

Minors must be accompanied by a parent, legal guardian or custodian.

We thank you for choosing Orthopedic Associates of Meadville, P.C.

An Orthopedic Center of Excellence For Over Thirty Years

Hand/Wrist Surgery, Spine Surgery, Total Joint Replacements
Sports Medicine, Shoulder Surgery, Foot & Ankle Surgery, Wound Recovery

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Dear Patient:

Enclosed you will find a packet of materials that we find very useful in assessing your particular spinal condition. You are requested to fill these out and answer the papers honestly, to give us the most accurate picture possible of your condition.

You should be forewarned that my practice deals exclusively with spinal conditions. Due to the nature of this practice and the length of time required with each patient, appointment delays are the rule rather than the exception. I would ask your understanding and patience for these delays. They are not meant as an oversight or a slight of you and your time. They are a result of trying to give each person and each problem the time required.

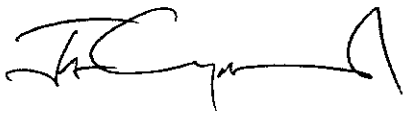
Spinal problems are quite complex and, in trying to reach an accurate diagnosis and successful treatment, I have found that time and attention to detail is critical.

Although scheduling delays are common, sometimes running 1-2 hours, each person receives the individual time and consideration that is due them as a patient. If you find this particular arrangement uncomfortable or intolerable, then please ask the reception staff to reschedule your appointment with another physician.

I ask that you please do not "blame" the appointment staff. They are merely trying to accommodate the numerous patients and my particular practice the best they can. Scheduling overruns are due directly to the length of time I spend with my patients; not to scheduling errors.

If you have any questions regarding this particular issue, please feel free to contact my office via telephone prior to your appointment.

Sincerely,



James R. Macielak, M.D., FACS

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PATIENT INFORMATION			DATE			
LAST NAME FIRST M.			PATIENT SOCIAL SECURITY NUMBER			
STREET ADDRESS			BIRTHDATE	AGE	SEX	MARITAL STATUS
CITY STATE ZIP CODE			HOME PHONE NUMBER		CELLPHONE NUMBER	
WORK PHONE NUMBER			DAYTIME PHONE NUMBER		DRIVERS LICENSE NUMBER	
EMPLOYER	STREET ADDRESS	CITY	STATE	ZIP CODE		
EMERGENCY CONTACT			RELATIONSHIP		PHONE NUMBER	
HAVE YOU BEEN A PATIENT OF OUR OFFICE IN THE PAST? YES NO IF SO, HAS YOUR NAME CHANGED? YES NO IF YES, WHAT WAS YOUR PREVIOUS NAME? _____						

RESPONSIBLE PARTY IF OTHER THAN PATIENT				
LAST NAME FIRST M.	SOCIAL SECURITY NUMBER	BIRTHDATE	RELATIONSHIP	
ADDRESS	HOME PHONE ( )	WORK PHONE ( )		
EMPLOYER	EMPLOYER ADDRESS			

PRIMARY CARE PHYSICIAN INFORMATION	
NAME	ADDRESS
REFERRING PHYSICIAN INFORMATION	
NAME	ADDRESS

PRIMARY INSURANCE INFORMATION		
NAME OF INSURANCE	IDENTIFICATION NUMBER	POLICY/GROUP NUMBER
POLICY HOLDER'S NAME	RELATIONSHIP	EMPLOYER
SECONDARY INSURANCE INFORMATION		
NAME OF INSURANCE	IDENTIFICATION NUMBER	POLICY/GROUP NUMBER
POLICY HOLDER'S NAME	RELATIONSHIP	EMPLOYER
IF WORKER'S COMPENSATION ❑ OR AUTO ACCIDENT ❑		
NAME OF INSURANCE	CLAIM NUMBER	DATE OF INJURY
STREET ADDRESS	CITY	STATE ZIP CODE
EMPLOYER AT TIME OF INJURY	ADDRESS	PHONE NUMBER ( )

MEDICARE I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits assigned to Orthopedic Associates of Meadville, P.C.

OTHER I authorize Orthopedic Associates of Meadville, P.C. to furnish information to any insurance carrier concerning my illness and treatment and I hereby assign in Orthopedic Associates of Meadville, P.C. all payments for medical services rendered to myself or my dependents. I also understand that I am responsible for any amount not covered by my insurance.

Signature _____

Name:

Chart:

Date:

Patient Name _____

Date of Birth _____

NOTICE ACKNOWLEDGMENT

I understand that, under HIPAA, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

NOTICE OF PRIVACY PRACTICES brochures are available at the registration department. I understand that Orthopedic Associates of Meadville, P.C. has the right to change it's privacy practices from time to time and I may contact Orthopedic Associates of Meadville, P.C. to obtain a current copy of the brochure.

I understand that I may request in writing that you restrict how my private information is used. I also understand that by law you may not be able to agree to the requested restrictions.

Name: _____ Signature: _____ Date: _____

MEDICAL RELEASE (including minors)

I hereby authorize Orthopedic Associates of Meadville, P.C. to furnish information and/or discuss information contained in my medical record, including appointment information, treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis with the following person or persons: (including nurse case managers, if applicable). Any request to restrict this information must be submitted in writing, I also understand that by law OAM may not be able to agree to the requested restrictions.

YOU MUST LIST THE NAMES OF ALL FAMILY MEMBERS AND/OR OTHER PERSONS WE CAN RELEASE INFORMATION TO, EITHER WRITTEN OR VERBALLY, REGARDING YOUR CARE!

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Further, I hereby authorize and give my consent to Orthopedic Associates of Meadville, P.C. to leave messages on my answering machine/voicemail system for the following:

_____ Appointment reminders (including return telephone calls)

_____ Prescription Refills

_____ Test Results

_____ **Do not leave message**

Signature _____ Date _____

Student Resident Consent

The physicians at Orthopedic Associates of Meadville are proud to play an integral role in the teaching of residents from Lake Erie College of Osteopathic Medicine (LECOM) and the training of student interns.

As part of their education residents, students, and interns may be present for or participate in your care. Our physicians are responsible to oversee, direct and monitor each student. While a resident, intern or student may perform care without the attending physician present, rest assured that our physicians make all final decisions regarding your care and treatment.

AT ANY TIME, YOU HAVE THE RIGHT TO REQUEST THAT A RESIDENT, INTERN, OR STUDENT IS NOT PRESENT FOR YOUR CARE AND DOES NOT PERFORM YOUR CARE.

Your signature acknowledges you have received and read this information regarding your rights.

Signature _____ Date _____

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FAX 814/333-8871

GUIDELINES FOR PRESCRIPTION REFILLS

1. Our office requires a **7 day notice for prescription refills.**

2. Medications will be refilled between **9 AM and 4 PM Monday - Friday.** **No refills on the weekends or holidays. The "on-call" physicians will not refill medications.**

3. Safety of your prescriptions is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Lock up your prescription medicines and keep them away from children.

4. Our physicians may not refill prescriptions for pain medicine if you are receiving similar medicines from another physician.

5. Be aware of the effect of other medications you may be taking. Ask your doctor or your pharmacist whether you can take them along with pain medication.

6. Do not drink alcoholic beverages while taking pain medication. Obey warnings regarding sedation of certain medicines.

7. Follow the prescribed dose of medication. Do not give your medications to other people and do not take medication from others.

8. Preferred Pharmacy & Location: _____
(This pharmacy will be used for your refills unless otherwise specified.)

9. Orthopedic Associates of Meadville may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I agree and will comply with the above guidelines.

Print Patient Name: _____ DOB: _____

Signature: _____ Date: _____
(Patient, Parent or Guardian)

PAST MEDICAL HISTORY

Name _____ Date _____

Date of Birth _____ Date of injury _____

1. Do you have or have you ever had any of the following? If so, please check.

HEART AND VASCULAR	LUNGS	OTHER SYSTEMS	
__ Heart attack	__ Bronchitis	__ Diabetes - Insulin/Non	__ Arthritis/rheumatism
__ Angina or chest pain	__ Emphysema	__ Thyroid problems	__ Glaucoma
__ High blood pressure	__ Asthma	__ Kidney/bladder problems	__ Bleeding problems/anemia
__ Palpitation/heart skipping	__ Tuberculosis	__ Stomach or duodenal ulcer	__ Psychiatric problems
__ Heart murmur	__ Sinusitis	__ Heartburn or burping	__ Back problems
__ Stroke	__ Hay-fever	__ Convulsions - epilepsy	__ Alcoholism
__ Edema - ankle swelling	__ Respiratory infections	__ Dizzy or fainting spells	__ Drug Addiction
__ Varicose veins	__ Shortness of breath	__ Hepatitis/jaundice/liver	__ Cancer - type _____
__ Phlebitis or blood clots	__ Black lung	__ Pregnant Y / N	__ Bone disorders
__ Other heart-circulation problems	__ Other lung problems	__ HIV/AIDS	__ Fibromyalgia
_____	_____	__ Depression / Anxiety	__ Other _____

2. Please list prior surgeries and dates _____

_____

3. Are you taking any medications on a daily basis? Please list below or attach a separate listing.
   Drug Name Strength Dosage

_____

_____

_____

4. Do you have any allergies to medications? If so, please list medication and reaction

_____

5. List any unusual childhood illnesses (scarlet or rheumatic fever, etc.)

_____

6. Do any medical problems run in your family? _____ DVT/Blood Clots _____ Other
   _____ Hypertension _____ Diabetes _____ Heart Disease _____ Rheumatic arthritis. _____ Cancer

7. Do you smoke cigarettes, cigars or a pipe?
   If so, how many per day? _____, for how many years? _____

8. Do you drink alcohol? YES No If yes, how much per week _____

9. Do you live in a _____ one story home, _____ two story home or other? _____

10. Who lives at home with you? _____

11. Do you typically use a walker/cane/wheelchair? _____

12. What is your occupation? _____

13. Are you able to operate a vehicle? _____

14. Who is your primary care physician? _____

(for office use)
Height _____ Weight _____ B/P _____ Age _____ BMI _____

The above information is true and complete to the best of my knowledge.

Patient Signature _____ Date _____

Physician/PA Signature _____ Date _____

BACK HISTORY

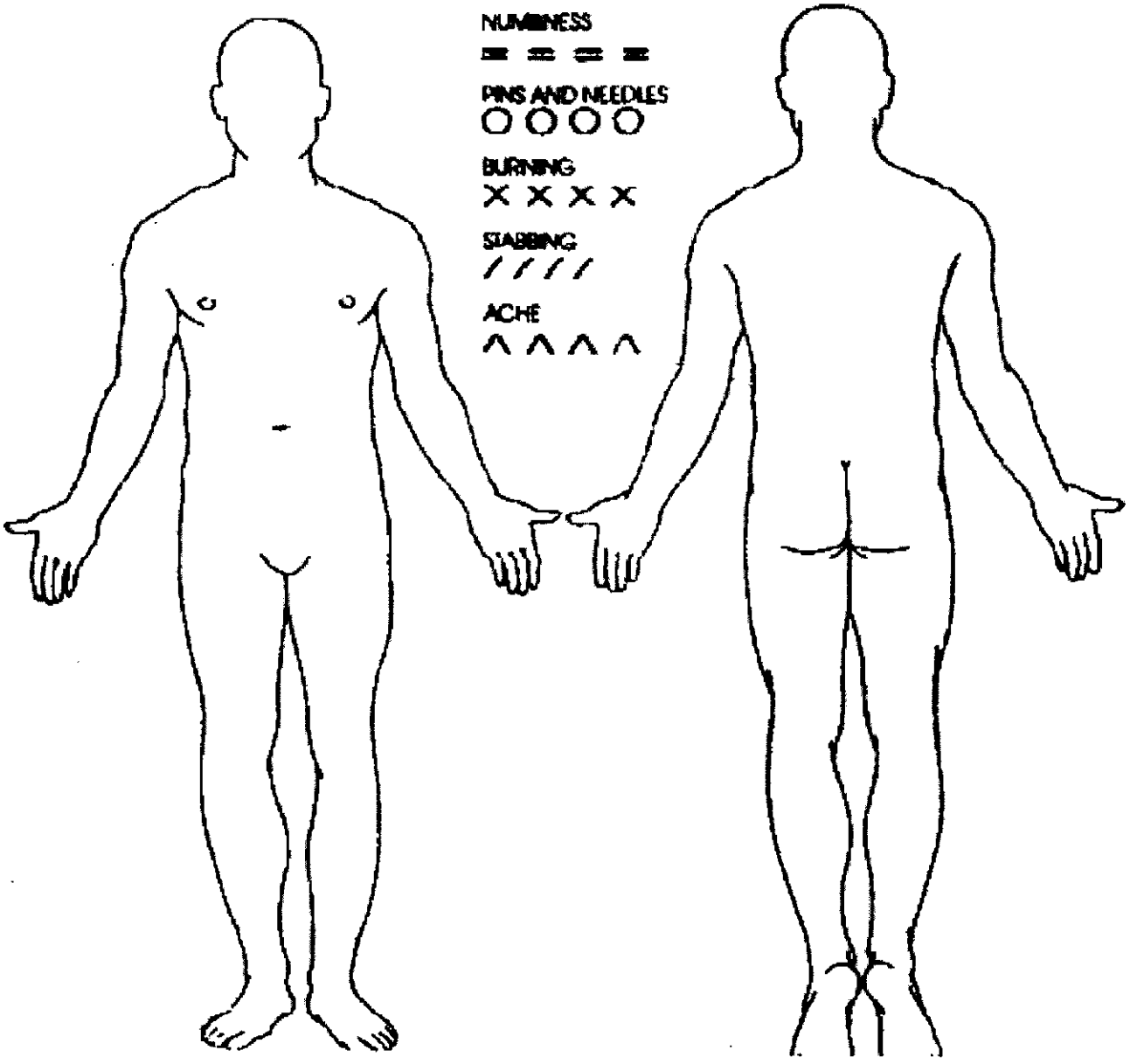
Name _____ Date of Birth _____

Please answer each question as carefully as possible. This information will help your doctor to understand what is wrong with your back.

1. History of previous spine problems _____
2. How and when did your present problem start? _____
   If accident, describe _____
3. Is pain better or worse than before? _____
4. Is pain daily? Yes No _____
5. Describe intensity of pain, is pain aching/sharp? _____
6. Does activity affect pain? _____
7. What aggravates it? _____
8. What makes it better? _____
9. Does the pain radiate or travel into your legs, especially below the knee? _____
10. Do you have any numbness or weakness? _____
11. Do you have loss of control - bladder or bowel function? _____
12. Does your back/neck hurt more than extremity? _____
13. What previous treatments have you had - medications, chiropractor, physical therapy, braces or injection. Please describe _____
14. Please describe your work history - date last worked, how long at this job, any previous job injuries, education level, work comp or social security? _____
15. Please list your past health problems _____
16. If you have had previous back surgery, please give date, type of surgery and result _____
17. Does pain wake you up at night? _____
18. What would you do if you didn't have the pain? _____
19. What would you like the Doctor to do for you? _____

Show me where it hurts

Mark these drawings according to where you hurt. (If the back of your neck hurts, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.



Form #223