Name:
Chart:
Date:

Welcome to Our Practice

Your Appointment is: ____________________

Provider: ____________________

In order to efficiently and effectively provide you with quality care, please complete the enclosed forms and be sure to bring this information to your appointment.

Additionally, we ask that you:

- Arrive 30 minutes before your appointment time.
- Bring any x-rays, MRIs, CT scans, EMGS or other related tests, along with the written reports. If your studies were done at Meadville Medical Center, you do not need to bring them.
- Bring your insurance card(s) and photo ID, such as a driver's license.
- Bring the co-pay amount required by your insurance plan; this will be due at the time of service.
- Self pay patients must pay for their services at the time of the office visit. ***We accept cash, personal checks, debit cards, Visa, MasterCard, American Express and Discover.***
- Contact your PCP to obtain a referral if you have Gateway, AmeriHealth Caritas, Coventry Cares or UPMC for You.
- Please check with your health insurance plan to be sure that Orthopedic Associates of Meadville, PC is in network. Or call our office with any questions.

If you cannot keep your appointment for any reason, please call our office at (814) 724-1252 to cancel. There is a $25 No-Show Fee for failure to cancel your appointment at least one business day in advance or $50 for an EMG appointment with Dr. Wheeling.

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

Thank you for choosing Orthopedic Associates of Meadville, P.C.

Name:
Chart:
Date:

CONSENT for ELECTRO DIAGNOSTIC TESTING

****This consent form covers all areas that can be tested. Not all information may pertain to your particular test.**

I understand that I am being referred for Electro Diagnostic testing, (commonly termed EMG and nerve conduction studies) to try to clarify the cause of my symptoms.

<u>What happens to me if I have this test?</u>
Small wires will be taped to your skin and you will experience sensations as your nerves and muscles are stimulated. The discomfort of the electrical impulses is mild. There are no after side effects from this electrical stimulation. The other portion of the testing includes the placement of a small pin (similar to an acupuncture needle) in a number of my muscles. This part of the examination involves no electrical stimulation, but it allows us to record the electrical activity which is normally present in the muscles. A number of muscles will be examined in this way and the precise amount of testing depends upon what is found as the examination progresses. The entire procedure generally takes between 30 and 45 minutes.

<u>What are the risks?</u>
CARDIAC PACEMAKER: There are very minimal risks from the electrical stimulation if you have a cardiac pacemaker or defibrillator. You should inform the doctor and any staff about the presence of your pacemaker. Certain measures may be taken to reduce the risks.

<u>Bleeding:</u> If you are taking blood thinning medicine, then you have a slightly increased chance of bleeding as a result of the needle placement within your muscles. Even if you are not taking any of these medications, there is a risk of bleeding within the muscle or beneath the skin. (this is minimal and usually heals by itself within a few days) There is also a small risk of infection or localized pain or bruising. You do not need to stop your medications!!

<u>Chest Muscles:</u> If the testing requires placing a needle in any of muscles around your chest wall or diaphragm, there is a risk that air could enter the area around your lung and cause pain or difficult breathing. This problem usually heals by itself, but occasionally a small tube must be placed to evacuate the air, since in rare instances the pressure of air can be life threatening.

<u>What are the benefits of this test for me?</u>
The benefit to you from this testing is the possibility that more information will result which will help to clarify your diagnosis. It would then be possible that specific treatment might become available but there are no guarantees. The procedure itself is diagnostic and not therapeutic.

<u>What are my alternatives?</u>
There are no other tests which will provide the information derived in the examination. However, I may decline to have this test and your physician may choose to order different kinds of tests or go no further in my evaluation. If you give consent to proceed, you may withdraw that consent at any time during the examination.

If I choose to give informed consent, then I do so under no sense of duress or coercion. If I decide to withdraw my consent, this will not adversely affect my future medical care.

Patient Signature:____________________________________ Date:____________________
(PLEASE SIGN AND BRING WITH YOU TO YOUR APPOINTMENT)

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 ____________________ Phone ____________________
Name ____________________ Relationship ____________________ Phone ____________________
Name ____________________ Relationship ____________________ Phone ____________________

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**
_______ Permission to fax work status reports to employer
_______ Permission to fax gym/school excuses to school

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.

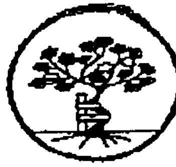
As part of their education, residents, students, and interns may be present for or participate in your care. Our physicians are responsible to oversee, direct and monitor each student. While a resident, intern or student may perform care without the attending physician present, rest assured that our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

Name:
Chart:
Date:



ORTHOPEDIC ASSOCIATES OF MEADVILLE, P.C.

11277 VERNON PLACE, SUITE 200 • MEADVILLE, PENNSYLVANIA 16335 • 814/724-1252
FAX 814/337-6043

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)

Name:
Chart:
Date:

PLEASE COMPLETE ALL SECTIONS

Patient Information

NAME: LAST FIRST MIDDLE SOCIAL SECURITY #

BIRTHDATE AGE SEX LANGUAGE: ☐ English ☐ Spanish / ____
ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

STREET ADDRESS RACE: ☐ White ☐ Asian ☐ Black ☐ American Indian ☐ Native American ☐ Unknown

CITY STATE ZIP CODE

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

EMPLOYER EMPLOYER ADDRESS

*If you have been a patient in the past under a different name, please enter that name: ____

Emergency Contact

NAME RELATIONSHIP

ADDRESS

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

Financially Responsible Party if other than Patient

NAME RELATIONSHIP

ADDRESS

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

Primary Care Physician

NAME PHONE#

ADDRESS

Insurance

Primary Insurance Information
NAME OF INSURANCE ID#

Secondary Insurance Information
NAME OF INSURANCE ID#

Workers Compensation ☐ YES ☐ NO -OR- Auto Accident ☐ YES ☐ NO
NAME OF INSURANCE

CLAIM # ____ DATE OF INJURY / ACCIDENT ____

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 of 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 OAM.

OTHER I authorize OAM to furnish information to any insurance carrier concerning my illness and treatment and I hereby assign in OAM 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. Initials: ____

Signature ____