Plancher Orthopaedics & Sports Medicine, PLLC
New Patient Packet

PATIENT INFORMATION **DATE:** _____

First Name: _____ M: ____
Last Name: _____
Address: _____
City, State, Zip: _____
Phone 1: _____ □ Home □ Work □ Mobile
Phone 2: _____ □ Home □ Work □ Mobile
Phone 3: _____ □ Home □ Work □ Mobile

SSN#: _____ Gender: □ M □ F
DOB: _____/_____/_____ Age: _____
Marital Status: □ Married □ Single □ Divorced □ Widowed
Race/Ethnicity: _____
Primary Language: _____
Email Address: _____
Height: _____ Weight: _____ Dominant Hand: _____

Patient Employment Information
□ Employed □ Retired □ Student
Occupation: _____
Employer: _____
Phone: _____
Address: _____
City, State, Zip: _____

Primary Care Physician
Name: _____
Phone: _____
Address: _____
City, State, Zip: _____
Were you referred to us by this doctor? □ Yes □ No

Pharmacy Information
Primary Pharmacy: _____
Phone: _____
Address: _____
City, State, Zip: _____

Emergency Contact
Name: _____
Phone: _____
Address: _____
Relationship: _____

INSURANCE INFORMATION

Primary Insurance
Insurance Carrier: _____
Insured ID: _____
Policy Group #: _____
Policy Holder: _____
□ Self □ Spouse □ Parent □ Partner
DOB: _____/_____/_____ SSN#: _____

Secondary Insurance
Insurance Carrier: _____
Insured ID: _____
Policy Group #: _____
Policy Holder: _____
□ Self □ Spouse □ Parent □ Partner
DOB: _____/_____/_____ SSN#: _____

Did you sustain this injury at work? □ Yes □ No
(If no, you may skip this section. If yes, the information below is mandatory prior to seeing your doctor)

Worker's Compensation Information
Insurance Carrier: _____
Billing Address: _____
City, State, Zip: _____
Claim Number: _____
Employer (at time of injury): _____
Attorney (if applicable): _____

Date of Injury: _____
Body Part(s): _____
Claims Adjuster: _____
Adjuster Phone: _____
Adjuster Fax: _____
Location of Injury: City: _____ State: _____

Are your injuries car accident related? □ Yes □ No
(If no, please continue with the rest of the packet. If yes, please inform the front desk)

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How did you hear about us (please specify)?

□ Our Website/Twitter/Facebook □ Web Search □ Insurance Website

□ Hospital _____ □ Doctor Referral _____ □ Advertisement _____

□ Patient Referral _____ □ Staff Member _____ □ Other _____

Symptoms made worse by: _____

_____

_____

Symptoms made better by: _____

_____

_____

Treatment (prior to visit): _____

_____

_____

_____

Has another physician treated you for this injury? □ Yes □ No

(If yes, please provide physician's name & phone):

Name: _____

Phone: _____

Personal Medical History: _____

_____

_____

_____

_____

Prior Surgeries (please list year, surgery, doctor): _____

_____

_____

_____

_____

**Women only*: are you or do you have any reason to believe you may be pregnant? □ Yes □ No

Medications (include over the counter): _____

_____

_____

Allergies: _____

_____

_____

**Women only*: are you taking oral contraceptive medication? □ Yes □ No

Major Family Medical Conditions: _____

_____

_____

_____

Smoking History: □ Never □ Currently Smoke □ Quit Smoking

packs per day _____; if quit, when you last smoked? _____

Alcohol Use: □ Never □ Rare □ Social □ Frequent

REVIEW OF SYSTEMS

Make check mark for all that apply

	Do you have this problem?	Do you receive treatment for it?	Does it limit your activities?
Heart Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
High Blood Pressure	□ No □ Yes	□ No □ Yes	□ No □ Yes
Lung Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
Diabetes	□ No □ Yes	□ No □ Yes	□ No □ Yes
Ulcer or Stomach Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
Kidney Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
Liver Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
Anemia or other Blood Disease	□ No □ Yes	□ No □ Yes	□ No □ Yes
Cancer	□ No □ Yes	□ No □ Yes	□ No □ Yes
Depression	□ No □ Yes	□ No □ Yes	□ No □ Yes
Osteoarthritis, Degenerative Arthritis	□ No □ Yes	□ No □ Yes	□ No □ Yes
Rheumatoid Arthritis	□ No □ Yes	□ No □ Yes	□ No □ Yes
Back Pain	□ No □ Yes	□ No □ Yes	□ No □ Yes
Thyroid Disorder	□ No □ Yes	□ No □ Yes	□ No □ Yes
Other:	□ No □ Yes	□ No □ Yes	□ No □ Yes

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Written Acknowledgement of Receipt of the Notice of Privacy Practices

Last Name	First Name	Date of Birth

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have any further questions or complaints, I may contact:

Plancher Orthopaedics & Sports Medicine
Greenwich, CT – (203) 863-2003
New York, NY – (212) 876-5200

I also understand that I am entitled to receive updates upon my request if the Plancher Orthopaedics & Sports Medicine Notice of Privacy Practices is amended or changed in a material way.

Signature	Relationship to Patient	Date

TO BE COMPLETED BY COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT:

On _____, I attempted to obtain a Written Acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

☐ Patient declined to sign this Written Acknowledgement

☐ Patient did not understand the request to sign the Written Acknowledgement

☐ Other (please specify): _____

_____

_____

Name of Employee	Title of Employee	Date

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HOW MAY WE CONTACT YOU REGARDING PERSONAL HEALTH INFORMATION?

Patient Name:_____ Date of Birth_____

Do you have any visual/hearing impairment? _____ If yes, please explain _____

Lab of Choice _____ Pharmacy of Choice / Location _____

Primary Care Physician_____ Primary Language Spoken (if other than English) _____

Emergency Contact (name/relationship/Telephone number)_____

Next of Kin (name/relationship/Telephone number)_____

Email Address: _____
We only use our patient e-mail addresses to send you a satisfaction survey, to have you included in our database for our patient portal and for patient education

Phone:
Please indicate the best telephone number to reach you and the best time of day to reach you.

(_____) _____ Time of Day _____

☐ Please check the box if you do not want us to leave a voice mail/answering machine message disclosing personal health information.

In the event I do not answer the number above, I authorize POSM to disclose my personal health information such as test results, medications, and appointment information on the following voice mail and/or answering machine:

Contact Number: (_____) _____

POSM may speak to the following individuals to inform them of a future appointment, or to leave a message for you to return a call to our office. (Unless box is checked below, NO detailed information will be given to these individuals other than appointment information.)

Name:_____Phone:_____Relationship_____

☐ In addition to myself, I give the office permission to speak with the individual listed above and share limited health information

Name:_____Phone:_____Relationship_____

☐ In addition to myself, I give the office permission to speak with the individual listed above and share limited health information

Signature:_____ Today's Date: _____
(Valid unless revoked in writing)

If not signed by the patient, please indicate your legal relationship to the patient : _____

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Assignment of Benefits

Your signature is required for us to protect any insurance claims and to ensure payment of services is rendered.

I authorize the release of all medical information necessary to process my insurance claims or that is pertinent to medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. This assignment will remain in effect until revoked by me in writing.

A photocopy of the assignment is to be considered as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.
I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

_____ _____
Signature Date

_____ _____
Signature of Parent or Guardian (if patient is a minor) Date

Billing Waiver for Insurance Patients

I understand that my insurance carrier may deny payment for certain screenings, labs, tests, DMEs, supplies, or injections in the doctor's office. It is my right to refuse these, and my responsibility to pay for them if I accept to receive them.

I also understand that any DME and/or supplies that are purchased are non-refundable.

Insurance Release and Authorization:

I, _____, clearly understand the above information and accept responsibility for my bill.

_____ _____
Patient Signature Date

We may use your email address to send you periodic updates on the Orthopaedic Foundation for Active Lifestyles and/or Plancher Orthopaedics & Sports Medicine Practice.

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Office Policies

Kevin D. Plancher, MD

TO OUR PATIENTS:

Please review the following Office Policies:

Your current insurance card and valid picture ID is required at each visit.

Co-payments are required by your insurance plan and must be paid at each visit. If not paid at the time of visit, a $10 fee will be added. If a referral is needed with your health plan, it is YOUR full responsibility to make sure it has been received. If your referral is not received prior to your appointment, your appointment may be cancelled or you may be fully financially responsible for the visit cost(s).

Payment in full for all services not covered by your insurance plan must be paid each visit.

FEES FOR MISSED VISITS OR LATE CANCELLATIONS WILL BE CHARGED AS FOLLOWS:

OFFICE VISITS
Without 24 hour notice: $50 charge

SURGERIES
There will be a $250 cancellation fee for any surgeries that are cancelled without a medical reason.

If you request any medical records, forms, or X-Ray/CD's there is a fee that must be paid before we can release any information.

We are open Monday through Friday, 8:30am – 5:30pm. Doctors are available 24/7 for EMERGENCIES AFTER 5:30PM, weekends and holidays.

Thank you for your understanding and cooperation. We look forward to serving you,

Plancher Orthopaedics & Sports Medicine Physicians & Staff

I reviewed the above policy:

_____ _____

Patient Signature Date

Plancher Orthopaedics & Sports Medicine

New York Office
1160 Park Avenue
New York, NY 10128
Tel. (212) 876-5200

Connecticut Office
31 River Road – Suite 102
Cos Cob, CT 06807
Tel. (203) 863-2003

Dear Patients,

The enactment of the Affordable Health Care Act has and is changing the practice of medicine in this country. These changes are affecting the ability of medical clinics to provide the level of care and personalized medicine that has been the hallmark of this medial practice in the past. We have been providing these services for free but can no longer continue to do so. Unfortunately, we are forced to join the large number of physicians in this area that are doing this already. In order to continue to provide the service you expect, certain changes in our billing practice have been in place effective April 2, 2012.

1. The following options are available for services provided. **You must choose one**:
   A credit card for choices (a), (b), and (c) must be kept on file (no debit cards):

   a) **A $250 fee for unlimited** telephone management of medical problems (prescriptions, clarifications, rehab/physical therapy renewals) with the ancillary staff and for after hour telephone contacts.
   b) **A $125 fee for up to five (5) phone calls** after hours and telephone management of medical problems (prescriptions, clarifications, rehab/physical therapy renewals) with the ancillary staff.
   c) **A $25 fee for each individual call** after hours and telephone management of medical problems (prescriptions, clarifications, rehab/physical therapy renewals) with the ancillary staff.
   d) **None of the above** – All management of medical problems will require a brief office visit appointment. For all emergencies you are advised to call 911 or go to your nearest emergency room for immediate treatment.

2. You are responsible to **provide complete and correct insurance billing information**, including presentation of your current insurance card to Plancher Orthopaedics & Sports Medicine, PLLC.
   Failure to present the correct billing information at the time of service may result in a denial of benefits from your insurance carrier. In this event, I understand that I will be billed for services rendered by Plancher Orthopaedics & Sports Medicine, PLLC. This includes correct effective and/or termination dates. I am responsible to pay for co-pays, deductible, and co-insurance percentages required by my insurance plan.

3. I understand that I will be billed a **$50 cancellation fee** for missed appointments or no shows (less than 24 hour notice, for any reason). When cancelling an appointment on a weekend or after hours, please leave your name and time of appointment with the answering service (212-876-5200). This service is available to take calls 24 hours a day, 7 days a week.

If you have any questions regarding this information, please feel free to discuss them with the billing or front desk staff. I am in receipt of this letter.

_____ _____

Patient Signature Patient Name (Print)

_____

Date

This notice is renewed annually unless otherwise altered 7/11/2013 (rev3)

Plancher Orthopaedics & Sports Medicine
1160 Park Avenue New York, NY 10128
212 876-5200

Patient Credit or Debit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with Plancher Orthopaedics & Sports Medicine. In providing us with your credit card information, you are giving Plancher Orthopaedics & Sports Medicine permission to automatically charge your credit card on file for your co-pay [or any other patient(s) you have listed on this form] at time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays: Co-pays are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, Plancher Orthopaedics & Sports Medicine will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

I authorize Plancher Orthopaedics & Sports Medicine *to charge co-pays and outstanding balances on my account to the following credit card:*

Visa	**MasterCard**	**American Express**	**Discover**
☐	☐	☐	☐

Credit Card Holder's Name: _____

Credit Card Number: _____ Sec. Code _____

Expiration Date: _____ Billing Zip Code: _____

Patient Signature: _____

Date: _____

If you wish to opt out of the Patient Credit or Debit Card on File Agreement, please check box below and sign and date.

☐ **DECLINE**

Patient Signature: _____ Date: _____