KOMAN

ORTHOPEDICS & SPORTS MEDICINE

Patient Registration Form

Personal Information	Today's Date:	
Last Name:		
First Name:	Middle Initial:	
Address:		DOB:
City:		Sex (M or F):
State:	Marital Status:	
Zip Code:	Email Address:	
Home Phone:	Social Security #:	
Work Phone:	Employer:	
Cell Phone:		
Primary Care Physician:	PCP Phone:	
Referring Physician:		
Other referral source:		
Responsible Party Name:	SS#:	DOB:
Insured:		
Relationship to Insured:		
Insurances: Primary:	Subscriber ID:	
Secondary:	Subscriber ID:	
Workers' Compensation Information (if applicable):	Claim Number: Adjuster Name: Adjuster Phone:	
Emergency Contact Name:		
Emergency Contact Number:	Relationship:	

INITIAL EVALUATION FORM
Koman Orthopedics and Sports Medicine

NAME: _____

Age: _____ **Today's Date:** _____

Date of Birth: _____

Height: _____ **Weight:** _____

Who referred you to us?
Please give name of person/physician:

_____

Your Occupation:

_____

Where is your problem? (please circle)

Shoulder	Elbow	Wrist/Hand
Knee	Hip	Ankle/foot
Back	Neck	Other

Which side(s)? Right / Left / Both

Dominant Arm? Right / Left

Problem(s) (please circle all that apply):
- Pain
- Weakness
- Instability /giving way /dislocation
- Stiffness
- Swelling
- Other _____

How did you injure yourself?
- No injury
- Sports (which sport?) _____
- Motor vehicle accident
- Work/ job -
  - Workers claim? Yes / No

Date of injury? _____

Sports level: none/recreational/college/ professional

How long have you had symptoms?
_____Days _____Mos. _____ Yrs.

Please briefly describe the injury:

_____

_____

Diagnosis (if you know or have been told)?

_____

_____

Previous treatments (other than surgery)?
(medications, physical therapy, injections, bracing)

_____

_____

Previous surgery for this problem (include dates)

_____

_____

How severe is the pain? (*0 = none, 10 = severe pain)*

At rest? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Do you have night pain? Yes / No

Does it waken you from sleep? Yes / No

Are you currently working? Yes / No / Retired
Normal job? Limited duty?

What makes your problem better?

_____

What makes your problem worse?

_____

Please describe your current limitations?

_____

Have you had any previous imaging studies?

X-rays	Yes / No	date: _____
MRI	Yes / No	date: _____
CT scan	Yes / No	date: _____
Other	Yes / No	date: _____

INITIAL EVALUATION FORM
Koman Orthopedics and Sports Medicine

PAST MEDICAL HISTORY:

High blood pressure _____
Heart problems _____
History of heart attack _____
Stroke _____
Kidney disease _____
History of Cancer _____
Osteoporosis _____
Blood clot/embolus _____
Blood clotting disorder _____
Diabetes _____
Skin infections _____
MRSA _____
Other _____

ALLERGIES:

NO KNOWN DRUG ALLERGIES
Penicillin
Sulfa
Other _____

SOCIAL HISTORY:

Marital status: _____
Alcohol use: Daily Socially Never
Tobacco use: Yes - Packs per day _____
No

MEDICATIONS: (please list all medications you are currently taking)

_____
_____
_____
_____
_____
_____
_____
_____

SURGICAL HISTORY:

_____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY:

	DIABETES	HYPERTENSION	HEART DISEASE	STROKE	MENTAL ILLNESS	CANCER	UNKNOWN	NO KNOWN FAMILY HISTORY
FATHER	☐	☐	☐	☐	☐	☐	☐	☐
MOTHER	☐	☐	☐	☐	☐	☐	☐	☐
SON(S)	☐	☐	☐	☐	☐	☐	☐	☐
DAUGHTER(S)	☐	☐	☐	☐	☐	☐	☐	☐
PATERNAL GM	☐	☐	☐	☐	☐	☐	☐	☐
PATERNAL GF	☐	☐	☐	☐	☐	☐	☐	☐
MATERNAL GM	☐	☐	☐	☐	☐	☐	☐	☐
MATERNAL GF	☐	☐	☐	☐	☐	☐	☐	☐

INITIAL EVALUATION FORM
Koman Orthopedics and Sports Medicine

REVIEW OF SYSTEMS:

-GENERAL None Recent weight change Fever Weakness/fatigue
Other _____

-EYES None Vision change Glasses/Contacts Glaucoma Cataracts
Other _____

-EARS, NOSE, THROAT None Loss of hearing Ear ache/infection Ringing in ear Hoarseness
Other _____

-CARDIOVASCULAR None Chest pain Swelling in legs Shortness in breath Palpitations
Other _____

-RESPIRATORY None Shortness of breath Wheezing/Asthma Frequent Cough
Other _____

-GASTROINTESTINAL None Heartburn Acid Reflux Nausea or Vomiting Abdominal pain
Other _____

-MUSCULOSKELETAL None Arthritis/joint stiffness Muscle Aches Swelling of Joints
Other _____

-SKIN None Rash Ulcers Abdominal Scars Sores
Other _____

-NEUROLOGICAL None Headaches Fainting/Blackouts Numbness, tingling, loss of sensation Dizziness
Other _____

-PSYCHIATRIC None Depression Nervousness Anxiety Mood Swing
Other _____

-ENDOCRINE None Excessive thirst or hunger Hot/cold intolerance Hot Flashes
Other _____

-HEMATOLOGICAL None Easy bruising Easy bleeding Anemia
Other _____

Signature: _____ **Date: _____**

KOMAN

ORTHOPEDICS & SPORTS MEDICINE

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Koman Orthopedics and Sports Medicine Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Type or Print)

Patient's Date of Birth

Signature of Patient or Parent/Legal Guardian

Date

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

Koman Orthopedics and Sports Medicine
116 Westminster Pike, Suite 100
Reisterstown, MD 21136
410 833-9300

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Dr. Jon Koman	410-833-9300	jkoman@komanorthopedics.com
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

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ORTHOPEDICS & SPORTS MEDICINE

Authorization and Assignment of Insurance Benefits

The undersigned patient or authorized individual acting on behalf of the patient understands and agrees to the following:

1. I authorize payment of medical benefits to the provider rendering services.

2. I agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, services rendered or service to be rendered without obtaining my signature on each and every claim submitted for myself and or dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

3. I will pay to Koman Orthopedics and Sports Medicine any balance due for services rendered. I understand that if full payment is not made on my behalf by my (insurer, legal representation, or workers compensation insurance) I will be responsible for any outstanding balance.

4. Accounts are considered past due after 30 days. A service charge of $25 plus the rebilling fee will be added to your account if your check is returned from your bank for any reason. Bills turned over to our collection agency will be subject to a collection fee of 30% of the account balance. Other fees will apply if the account is forwarded to an attorney for a collection lawsuit. **Any additional medical services will be suspended until your account is paid in full.**

I agree to the statements set forth above in the authorization and assignment of insurance benefits.

_____ _____

Patient Signature (or agent/representative) Date

_____

Print Name

KOMAN
ORTHOPEDICS & SPORTS MEDICINE

116 Westminster Pike, Suite 100
Reisterstown, MD 21136

410-833-9300
fax 855-485-4166

Authorization to Disclose Health Information

I, _____ grant permission for the following person(s) to obtain information regarding medical care, speak with the provider and/or staff and pick up any information or prescriptions regarding the patient listed above.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient Date

KOMAN
ORTHOPEDICS & SPORTS MEDICINE
116 Westminster Pike Suite 100 Reisterstown, MD 21136
410-833-9300 fax: 855-485-4166

Surgery Facilities and Physician Ownership Disclosure

*Westminster Surgery Center
826 Washington Road
Suite 131
Westminster, Maryland 21157

*Timonium Surgery Center
1954 Greenspring Drive
Lower Level 18
Timonium, Maryland 21093

Northwest Hospital
5401 Old Court Road
Randallstown, MD 21133

Sinai Hospital
2401 West Belvedere Ave.
Baltimore, MD 21215

*Ownership Interest by Dr. Koman

All patients will receive the same treatment and care at any of the above facilities.

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I have reviewed the above listing of surgical facilities including those with an ownership interest by Dr. Koman and acknowledge I have the right to choose any of the above facilities.

_____
Name of Patient or Legal Representative

_____
Signature of Patient or Legal Representative Date