MOTIONORTHOPAEDICS

Seeing Doctor: _____

Please complete the following health questionnaire. We are concerned with your overall health, as well as your orthopedic problems. This information is confidential and will be reviewed with you by your doctor today. It is designed to help you recall your history and provide details that will help in your diagnosis and treatment plan. Thank you.

Name: _____ Nickname: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Sex: _____

Who referred you: _____ Relationship: _____

Language: _____

Race: _____

Ethnicity: _____

Are you: ☐ Right Hand dominant ☐ Left Hand dominant Are you pregnant? ☐ Yes ☐ No

Currently Working? ☐ Full ☐ Light ☐ Disabled ☐ Part-Time ☐ Retired

Acute Injury? ☐ Yes ☐ No Date of Injury: _____ Work Injury? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No

State of Accident: ☐ Missouri ☐ Illinois ☐ Other: _____

Are you represented by an attorney in this case? ☐ Yes ☐ No

Name/address of attorney: _____

Problem for which you are seeing the doctor today:(Please Circle) ☐ **Right** ☐ **Left** ☐ **Both** ☐ **Knee** ☐ **Shoulder** ☐ **Elbow** **Other:** _____

☐ New Injury ☐ Continued Problem ☐ Second Opinion ☐ Referral for Surgery

When did this problem start? _____ Over time, the condition is getting: ☐ Better ☐ Worse ☐ Same

How did the problem begin (specifically)? _____

Rate your pain from 1 to 10 with 10 being the most painful: Now: _____ At its worst: _____

Location of pain: ☐ Front ☐ Back ☐ Inside ☐ Outside ☐ Deep ☐ Superficial ☐ Radiating ☐ The Whole Area

Is the pain: ☐ Constant ☐ Dull ☐ Aching ☐ Intermittent ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Burning

Do you have: ☐ Weakness ☐ Stiffness ☐ Loss of Motion ☐ Locking ☐ Catching ☐ Popping ☐ Grinding ☐ Giving way

When do you experience it most: _____

Anything make it better? _____ Worse? _____

Who have you seen for this problem? _____

Have you seen an orthopedic Surgeon for this problem? ☐ Yes ☐ No Whom and when? _____

What was the surgeon's diagnosis of your problem? _____

What was the surgeon's recommendation for you? _____

What treatments have you tried? ☐ Rest ☐ Compression ☐ Elevation ☐ Bracing ☐ Physical Therapy ☐ Exercise ☐ Ice

☐ Chiropractic ☐ Massage ☐ Acupuncture ☐ Injection: ☐ Cortisone ☐ Trigger Point ☐ Synvisc/VISCO ☐ PRP Stem

Other: _____

Has anything Helped? ☐ Yes ☐ No If yes, which? _____

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Medications - Please list all medications that you are currently taking including any medications you are taking for this specific problem. List **ALL** prescriptions, blood thinners, aspirin, vitamins, over the counter medications, supplements, complementary and alternative medicines. Pharmacy & phone:

Name	Dose	Frequency	How Long?	Name	Dose	Frequency	How Long?

Allergies: (List Below) ☐ Yes ☐ No Are you allergic to latex or adhesives? ☐ Yes ☐ No Other:

Medication/Exposure	Reaction	Medication/Exposure	Reaction

Surgical History - Please list All previous surgeries and serious injuries, broken bones and illnesses:

Date	Surgery/Illness/Injury	Surgeon's Name	Date	Surgery/Illness/Injury	Surgeon's Name

Testing - List all medical tests including X-Ray, MRI, CT Scan, Nerve (EMG/NCV) and Bone Scan pertaining to this problem?

Date	Test Performed	Results/Name of facility where tests performed

Medical History - Please check **ALL** current or previous medical conditions:

Cardiovascular: ☐ Heart Disease, ☐ High Cholesterol, ☐ High Blood Pressure, ☐ Irregular Heart Beat

Other/Explain:

Hematology/Oncology: ☐ Blood Clots ☐ Bleeding Disorders ☐ Stroke ☐ Cancer, Other/Explain:

Pulmonary: ☐ Asthma, ☐ Emphysema ☐ Chronic Bronchitis ☐ Lung Disease Other:

Musculoskeletal: ☐ Lupus, ☐ Raynaud's ☐ Osteoarthritis, ☐ Rheumatoid Arthritis, ☐ Osteoporosis, ☐ Gout, ☐ Fibromyalgia

Other:

Gastrointestinal: ☐ Ulcers, ☐ Reflux, ☐ Indigestion, ☐ Hernias, ☐ Crohn's, ☐ IBS Other:

Genitourinary: ☐ Kidney Disease, ☐ Frequent Urinary Tract Infections, ☐ Kidney Stones Other:

Neurologic: ☐ Strokes ☐ Seizure Disorder, ☐ Diabetic Peripheral Neuropathy Other:

Psychiatric: ☐ Depression, ☐ Anxiety, ☐ Bipolar, ☐ ADHD, ☐ Narcolepsy Other:

Have you ever had a blood transfusion: ☐ Yes ☐ No If yes, when?

Infectious Disease: ☐ Hepatitis ☐ TB ☐ HIV/AIDS

Have you or anyone in your family had any problems with anesthesia? ☐ Yes ☐ No

Do you have sleep apnea? ☐ Yes ☐ No Explain:

Do you have Diabetes: ☐ Yes ☐ No

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Review of Systems - Check if you have **CURRENT** symptoms or current known medical problems in the following areas.

	Yes	No		Yes	No		Yes	No		Yes	No
Chest Pain	☐	☐	Nervousness	☐	☐	Voice Changes	☐	☐	Tingling	☐	☐
Palpitations	☐	☐	Unusual Thirst	☐	☐	Sinusitis	☐	☐	Memory Loss	☐	☐
Short of Breath	☐	☐	Nosebleeds	☐	☐	Hearing Loss	☐	☐	Insomnia	☐	☐
Heavy Sputum	☐	☐	Bruise Easily	☐	☐	Ringing in Ears	☐	☐	Freq. Urination	☐	☐
Nausea	☐	☐	Slow to Heal	☐	☐	Blurred Vision	☐	☐	Incontinence	☐	☐
Vomiting	☐	☐	Joint Pain	☐	☐	Double Vision	☐	☐	Pain Urinating	☐	☐
Diarrhea	☐	☐	Joint Swelling	☐	☐	Weight Gain	☐	☐	Lumps/Cysts	☐	☐
Headaches	☐	☐	Weakness	☐	☐	Weight Loss	☐	☐	Fatigue	☐	☐
Dizziness	☐	☐	Back/Neck Pain	☐	☐	Fevers	☐	☐			

Is your primary doctor aware of the above symptoms or known medical problems? ☐ Yes ☐ No

Social History:

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ How long? _____ Quit Date: _____

Do you drink alcohol? ☐ Yes ☐ No How much per day/week? _____ Have you ever used rec. drugs? ☐ Yes ☐ No

Family History - Do any of the following run in your family?

Yes	*No*		*Whom?*	*Yes*	*No*		*Whom?*
☐	☐	Bleeding Problems	_____	☐	☐	Diabetes	_____
☐	☐	Blood Clots	_____	☐	☐	Arthritis	_____
☐	☐	Cancer	_____	☐	☐	Genetic Problems	_____
☐	☐	Heart Problems	_____	☐	☐	Osteoporosis	_____
☐	☐	Lung Problems	_____	☐	☐	Collagen Disorders	_____

Has anyone in the family died at a young age or unexpected cause? If yes, who and what cause? _____

If you are a student, where? _____ What Grade? _____ Sports? _____

Coach/Trainer's Name: _____ Phone Number, if known: _____

Hobbies: Golf Tennis Soccer Baseball Football Wrestling Hockey Running Track/XC Lacrosse Exercise Basketball Hunting Skiing Bowling Hiking Softball Volleyball Field Hockey Weight Lifting Swimming

List here: _____

I certify that this information is true and correct to the best of my knowledge. Please type below.

_____ _____

Patient or Responsible Parent (if under 17 years old) Date

MOTIONORTHOPAEDICS

633 Emerson Road
Creve Coeur, MO 63141
P# (314) 991-2013 F# (314) 991-2006

Dear Friends and Patients,

Thank you for choosing Motion Orthopaedics.

Motion Orthopaedics constantly strives to provide the highest quality comprehensive care for you and your family.

We have organized this building to include providers that complement our services so that you can get the care you need in one convenient location. This includes:

- Fellowship Trained Orthopedic Surgeons with subspecialty training in specific areas
- Digital x-rays and electronic medical records in our state of the art facility
- High resolution digital MRI and MR Arthrograms at Emerson Road Imaging Center
- Medical Equipment (DME) is available on-site through our office

If surgery is required, Emerson Road Surgery Center and North Campus Surgery Center are located within the building. These facilities are staffed with experienced nurses and staff that work closely with our physicians to provide the highest quality specialized care in an efficient and personalized fashion.

Financial Disclosure

The physicians at Motion Orthopaedics, specifically, Dr. David King, Dr. Timothy Farley, Dr. James Doll, Dr. Tyler Krummenacher, Dr. Jason Browdy, Dr. Jason Young, & Dr. Scott Zehnder all located at 633 Emerson Road, Creve Coeur, Missouri 63141, have 5% or more ownership interest in some of the surgery and imaging facilities listed above, as well as other related entities as permitted by state and federal laws.

You have complete freedom of choice as you select your providers and facilities.

Our physicians and staff are happy to provide you with the names of other service providers and will help coordinate your appointments with your provider of choice.

For more information, visit our website at www.motion-ortho.com.

We appreciate the opportunity to serve you and your family.

Signature: _____ DATE: _____

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Patient Information

Patient Name:

Social Security #:

Address:

City, State & Zip Code:

Date of Birth: **Gender:**

Employment / Student Status:

- ☐ Full time employed
- ☐ Part time employed
- ☐ Unemployed
- ☐ Retired
- ☐ Full time student
- ☐ Part time student

Employer Name & Address:

Occupation:

Please circle best phone number to reach you at:

- ☐ **Cell #:**
- ☐ **Home #:**
- ☐ **Work #:**

Email Address:

Referring Physician/Health Professional:

Referring Physician Phone/Address:

Primary Care Physician:

Primary Care Phone #:

Emergency Contact Name & Phone:

Relationship to Patient:

☐ **Married** ☐ **Single** ☐ **Other**

Spouses Name:

Financially Responsible Person (if different from above)

Full Name:

Address:

City, State, Zip Code:

Date of Birth:

Employer Name:

Social Security #:

Cell #

Home #:

Work #:

Relationship to the patient (check one):

☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Date Reviewed _____ Initials _____

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Insurance Company Information

Motion Orthopaedics

Primary Insurance Company Name:		Secondary Insurance Company Name:	
Address, City, State & Zip:		Address, City, State & Zip:	
Policy Holder:	Date of Birth:	Policy Holder:	Date of Birth:
Policy Holder Employer:	Policy Holder SSN:	Policy Holder Employer:	Policy Holder SSN:
Policy Number:	Group Number:	Policy Number:	Group Number:
Relationship to the Patient (check one): ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other		Relationship to the Patient (check one): ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	

Medicare Lifetime & Medigap Signature on File:

I request that payment of authorized Medicare, Medigap, and all other insurance company benefits be made on my behalf to Motion Orthopaedics for any services furnished to me by the provider. I authorize any holder of medical information about me to be released to my health insurance company or the Health Care Financing Administration and its agent's needed to determine these benefits or benefits payable for related services.

Advanced Beneficiary Notice of Medicare Non-Coverage and Terms of any other insurance:

I understand that when accepting any treatment or durable medical goods from my provider the charges will be billed to my insurance company or Medicare for an official decision on payment, which is sent to me in a Summary Notice. I understand that if my insurance or Medicare doesn't pay, I am responsible for payment, but I can appeal to my insurance company or Medicare by following the directions in the Summary Notice. If my insurance or Medicare does pay Motion Orthopaedics will refund any payments I made to you, less co-pays and deductibles. I understand it is my responsibility to know the terms of my insurance plan. If I do not present my current insurance card or any required referral numbers or forms from my primary care physician for specialty care at the time of every visit I am choosing to go outside my plan. Additionally, there may be charges that are not covered by my insurance company. I understand I am responsible for all charges incurred by me, and I further agree to prompt payment of any services billed in these situations.

I authorize payment of medical benefits provided by my medical insurance described on a standard health form to Motion Orthopaedics for services provided during my care and treatment as described on the standard health care form information necessary to process claims. I understand that I am financially responsible for the charges covered by this authorization, and I will be responsible for any collection fees or cost associated with collections. I understand I may request a copy of and/or review the Notice of Privacy Practices at any time. I give the physicians of Motion Orthopaedics permission to view my prescription history from external sources including pharmacies, other physicians, hospitals and my health insurance.

Signature: _____ **Date:** _____

Authorization & Consent For Release of Information:

This form allows Motion Orthopaedics to release records from our office to discuss medical treatment and any billing issues with the following people:

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

May we leave voice mail messages on your telephone? ☐ Yes ☐ No If Yes: Check all that apply as able to leave a message: ☐ Home # ☐ Cell # ☐ Work #

May we text your cell phone? ☐ Yes ☐ No Cell Phone # _____

May we call your cell phone regarding any billing issues? ☐ Yes ☐ No

Preferred Pharmacy Name/Address: _____ Pharmacy Phone No.: _____

Authorization to Release Information:

Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither Motion Orthopaedics nor any affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do it.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this Authorization.

Patient/Legal Representative Signature _____ **Date:** _____ **Relationship:** _____

633 Emerson Road
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P# (314) 991-2013 F# (314) 991-2006

Patient Consent to ePrescriptions

Motion Orthopaedics has implemented ePrescribing in our office. ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software also lets your doctor see important information, like drug interactions and your prescription history.

The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescription filled

Patient Consent

I agree that Motion Orthopaedics may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature: _____ DATE: _____

MOTIONORTHOPAEDICS

633 Emerson Road
Creve Coeur, MO 63141
P# (314) 991-2013 F# (314) 991-2006

NOTICE OF PRIVACY PRACTICES

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a health care provider were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the health care provider in diagnosis and treatment of your condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because other health-care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena,

discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Session Notes: I do keep "Session notes" and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

   a. For my use in treating you.

   b. For my use in training or supervising associates to help them improve their clinical skills.

   c. For my use in defending myself in legal proceedings instituted by you.

   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

   e. Required by law and the use or disclosure is limited to the requirements of such law.

   f. Required by law for certain health oversight activities pertaining to the originator of the session notes.

   g. Required by a coroner who is performing duties authorized by law.

   h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a health care provider, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a health care provider, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the patients who received one form of care versus those who received another form of care for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "session notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on the date of signature

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

☐ I agree and sign this document

Signature: _____ DATE: _____

MOTIONORTHOPAEDICS

633 Emerson Road
Creve Coeur, MO 63141
P# (314) 991-2013 F# (314) 991-2006

Thank you for choosing Motion Orthopaedics. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** Our providers participate in many insurance plans, including Medicare. If you are not insured by a plan your provider is contracted with, payment in full is expected at each visit. If you are insured by a plan your provider is contracted with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** If your insurance plan requires you to have a referral, it is your responsibility to receive this referral from your primary care provider BEFORE your appointment. Please contact your insurance company with any questions you may have regarding your coverage. Their phone number can usually be found on the back of your insurance card.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This is required by your insurance plan as part of your contract with your insurance company.

3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. (For Medicare patients, you must sign an Advance Beneficiary Notice of Noncoverage (ABN). For contracted plans, the claim will be processed with the insurance company before patient is billed - per our contracts).

4. **Proof of insurance.** All patients must complete our patient information form before seeing a provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We must have copies and information for both your Primary and Secondary insurance plans.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance may automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter asking you to contact our Billing Service within 10 days of the date on the letter to make payment in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care.

8. **Missed appointments.** Our policy is to charge for missed appointments. Any appointment that is cancelled within 24 hours of the time of your appointment will be charged $50.00 for that missed appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. **Payments.** We accept cash, check, certified check, MasterCard, Visa, American Express and Discover cards as a form of payment. There will be a $25.00 fee for all returned checks.

10. **Telephone Consumer Protection Act (TCPA).** I agree that the facility, Motion Orthopaedics or any other collection or servicing agency or agencies retained but the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voicemail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

Our practice is committed to providing the best care possible to our patients. Our charges are based on data regarding the usual and customary charges for our area.

Thank you for reviewing our financial payment policy. Please let us know if you have any questions or concerns.

Please note: The physicians of Motion Orthopaedics do not consent to audio or video recordings of any kind during evaluation and treatment. We kindly ask that you silence your phone and refrain from usage during your exam.

I have read and understand the financial payment policy and agree to abide by its guidelines:

☐ I agree and sign this document

Signature: _____ DATE: _____

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I _____ agree to participate in a telemedicine evaluation. Telehealth is the use of electronic information and telecommunications to support and promote long distance clinical healthcare.

I understand that during this evaluation, my provider will evaluate and treat my medical condition as they would in the office. During the telemedicine evaluation my doctor may:

- Discuss details of my medical history, tests, radiology results and examinations
- Conduct a physical examination through the use of interactive video, audio, and telecommunication technology.
- Have a medical assistant or technologist present for all or part of the visit
- Take video, audio and or photos during the visit if appropriate

I understand that all existing laws regarding access to medical information and copies of my medical records apply to this telemedicine consultation. Please note: not all telecommunications are recorded.

I understand that reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation and all existing confidentiality protections apply to information disclosed during this telemedicine consultation.

I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical care.

I understand that I can withdraw my permission to receive telehealth at any time and do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. If I do not choose to participate in a telemedicine session, I understand that no action will be taken against me that will cause a delay in my care and that I may pursue face to face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee therefore this telemedicine session will eliminate the need for me to see a provider in person.

I understand that my provider will submit a bill to my medical insurance carrier for this telehealth visit. I understand that I am financially responsible to the practice for any amounts due that are not covered by my insurance policy. I agree to pay all charges for services rendered by the practice during my telehealth visit.

☐ I have read this form and understand the risks and benefits of the telehealth visit. I agree to a telehealth visit under the terms explained above. I consent to receive healthcare services via telemedicine.

Signature: _____

DATE: _____