Dear Patient:

Thank you for choosing Gotham City Orthopedics, LLC. To provide outstanding patient care, we ask that all patients take the time to complete the attached forms which include information that will allow us to accurately process your demographic, insurance information and patient history. Any incorrect or illegible information provided may cause delay and/or errors in your insurance billing. If you need assistance or have any questions regarding the attached paperwork, our Patient Registration Specialists will be more than happy to assist you.

We thank you for choosing Gotham City Orthopedics, where every patient is treated like an MVP.

Sincerely,

The Management and Staff of
Gotham City Orthopedics, LLC

Visit our website at www.gothamcityorthopedics or follow us on Facebook for up-to-date information.

Today's Date	Referring Doctor	Primary Care Doctor

Last Name First Name Middle	Marital Status (Circle One) Single Married Widowed Domestic Partnership Divorced Separated

Street Address	City	State	Zip Code

Date of Birth	Age	Sex	Social Security #	Home Phone	Cell Phone
		M or F	- -		

Occupation/Student	Employer/School	Employer/School Phone	Email Address

How did you hear about our office? (Circle One) Doctor's Office (name) _____

Family Member Friend Internet Insurance Plan Other _____

Emergency Contact Name:	Phone:

Insurance Information

Primary Insurance	Secondary Insurance or School Insurance
Subscriber's Name:	Subscriber's Name:
Subscriber's D.O.B.:	Subscriber's D.O.B.:
Subscriber's SSN:	Subscriber's SSN:
ID#:	ID#:
Copay:	Copay:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Gotham City Orthopedics or insurance company to release any information required to process my claim.

Patient Signature: _____ **Date:** _____

GOTHAM CITY ORTHOPEDICS, LLC

INITIAL PATIENT QUESTIONNAIRE TO BE COMPLETED BY ALL NEW PATIENTS

COMMERCIAL

The information provided is confidential and will not be released without your consent. It is requested in order to provide you with a comprehensive level of care.

Date of Exam: _____ Date of Accident/Injury: _____

Patient Name: _____ ◯ Male ◯ Female

Date of Birth: _____ Age: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

What body part(s) are you being seen for? _____

_____

The patient was referred for Orthopedic consultation by: _____

HISTORY OF PRESENT INJURY

Please describe in detail how the accident or injury occurred including from date of injury and progression of symptoms: _____

_____

_____

Have you had previous injury(ies) to this/these body part(s)?: [◯] No [◯] Yes

If yes, were you previously treated?: [◯] No [◯] Yes

If yes, by whom?: _____

What treatment(s) were you given? ☐ None ☐ Physical Therapy

☐ Medication ☐ Injection ☐ Bracing ☐ Chiropractor

☐ Surgery ☐ Other _____

Did you fully recover from the prior injury(ies)? ◯ No ◯ Yes

History of: ☐ Locking ☐ Clicking ☐ Giving way ☐ Acute swelling

☐ Popping ☐ Crepitation ☐ Chronic Swelling

☐ Pain while ascending or descending stairs

Ability to perform job duties and activities of daily living? ◯ No ◯ Yes

If no, please explain why: _____

_____

What activities make your pain worse? ☐ None ☐ Standing ☐ Bending

☐ Twisting ☐ Sitting ☐ Kneeling ☐ Pivoting ☐ Walking

☐ Reaching ☐ Squatting ☐ Carrying ☐ Lifting ☐ Stairs

☐ Overhead Activities ☐ Other _____

What has helped decrease your symptoms? [ ] None [ ] Exercise [ ] Sitting

☐ Rest ☐ Massage ☐ Heat/Cold Packs ☐ Physical Therapy

☐ Medication _____

☐ Other _____

IMMEDIATE CARE POST INJURY

Did you go to an emergency room (ER)? ◯ No ◯ Yes

If yes, name of the ER _____ Date: _____

Did you?: ◯ Arrive by ambulance

◯ Arrive in a private car

◯ Drive yourself

What was/were your complaint(s)? _____

What body part(s) was/were hurt? _____

What treatment(s) did you receive? _____

In ER, were x-rays taken? ◯ No ◯ Yes

If yes, what was x-rayed? _____

Results: _____

What other treatment(s) did you receive in ER? ☐ None ☐ Medication

☐ Cane ☐ Crutches ☐ Arm sling ☐ Ace Bandage

☐ Splint ☐ Cast ☐ Neck collar ☐ Brace

☐ Other _____

Were you admitted overnight to a hospital? ◯ No ◯ Yes

If yes, name of hospital: _____

How many days? _____

What treatment was given (surgery, traction, etc.)? _____

_____

To be reviewed by MA/PA

YOUR CURRENT COMPLAINTS

History of present illness:

A) On a scale from 1-10 (10 being the worst), your current pain is? _____

B) Where does the pain occur? _____

C) When does the pain occur? [ ]Rest [ ]Light Activity [ ]Moderate (shopping, heavy yard work, etc.) [ ] Heavy (sports, laboring, etc.)

D) Associated Symptoms: ☐ Paresthesias ☐ Radiating pain ☐ Chills

☐ Swelling ☐ Bruising ☐ Instability ☐ Fever

E) Do the symptoms wake you from sleep?: ◯ No ◯ Yes

Current treatment: ☐ None ☐ Physical therapy ☐ Medications

☐ Chiropractor ☐ Pain management ☐ Other _____

CURRENT ACTIVITY

Were you employed at the time of the accident/injury? ◯ No ◯ Yes

What is your job description? _____

What does your job entail? _____

What is your current level of activity? (check all that apply)

☐ Sedentary ☐ Mostly sitting ☐ Light labor ☐ Light sports

☐ Vigorous sports/heavy work ☐ Full duty at work

Have you missed any time from work? ◯ No ◯ Yes

If yes, how long have you missed work? _____

Have you been able to work? ◯ No ◯ Yes

Are you currently working? ◯ No ◯ Yes

PAST MEDICAL HISTORY

Do you have any of the following? ☐ None

☐ Arthritis ☐ Diabetes ☐ High blood pressure ☐ High cholesterol

☐ SLE (lupus) ☐ Gout ☐ Rheumatoid arthritis ☐ Hypothyroidism

☐ Emphysema ☐ Anemia/bleeding disorders ☐ Blood clots

☐ Kidney disease ☐ Asthma ☐ Seizures

☐ Collagen/skin disorder ☐ Mental Illness ☐ COPD

☐ Reflux/stomach ulcers ☐ Prostrate disease ☐ Bowel trouble

☐ Gall bladder disease ☐ Cancer _____

☐ Heart Disease ☐ Other _____

Have you ever been hospitalized for medical reasons? ◯ No ◯ Yes

If yes, what was the reason? ◯ Surgery ◯ Medical Illness

Details: _____

REVIEW OF SYSTEMS (To be entered by MA/PA)

HEIGHT:_____ WEIGHT: _____ HR: _____

Ethnicity: _____ Race: _____ Preferred language: _____

SOCIAL HISTORY

Smoking history: ◯ No ◯ Yes

If yes, how much? _____# packs/cigarettes per day

How many years? _____ Quit? _____ When? _____

Drinking history: [◯] No [◯] Yes

What other occupational and/or recreational activities do you engage in? _____

_____

PRIOR TESTING

MRI of the _____ Date: _____

Facility: _____

CT Scan: _____ Date: _____

Facility: _____

X-rays: _____ Date: _____

Facility: _____

EMG/NCV: _____ Date: _____

Facility: _____

Bone Scan: _____ Date: _____

Facility: _____

PAST SURGICAL HISTORY

☐ None ☐ Appendectomy ☐ Tubal ligation ☐ Gall bladder surgery

☐ Hysterectomy ☐ Cesarean section

☐ Stomach surgery ☐ Ulcer surgery ☐ Tonsillectomy

☐ Cyst/tumor surgery ☐ Fracture correction

☐ Other _____

Please provide date(s) of each surgery: _____

_____

Any complications?: _____

MEDICAL QUESTIONS

Mark all that currently apply: ☐ Metal in body ☐ Claustrophobic

☐ Pregnant ☐ Sleep Apnea ☐ Use a CPAP ☐ Snores

CURRENT MEDICATION(S) HISTORY

What medications are you taking? [ ] None

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Are you allergic to any medication(s) and/or food? ◯ No ◯ Yes

If yes, to what medication(s) and/or food are you allergic? _____

_____

Type of reaction? _____

_____

Are you allergic to latex?: ◯ No ◯ Yes

FAMILY MEDICAL HISTORY

Have any direct relatives had any of the following disorders? ◯ None for all

Father:
☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension
☐ Bleeding Problems ☐ Epilepsy ☐ Cancer
☐ Connective Tissue ☐ Muscular Dystrophy
☐ Stroke ☐ Osteoporosis ☐ Rheumatoid Arthritis
Comments: _____

Mother:
☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension
☐ Bleeding Problems ☐ Epilepsy ☐ Cancer
☐ Connective Tissue ☐ Muscular Dystrophy
☐ Stroke ☐ Osteoporosis ☐ Rheumatoid Arthritis
Comments: _____

Sibling(s):
☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension
☐ Bleeding Problems ☐ Epilepsy ☐ Cancer
☐ Connective Tissue ☐ Muscular Dystrophy
☐ Stroke ☐ Osteoporosis ☐ Rheumatoid Arthritis
Comments: _____

Legal Assignment of Benefits &Designation of Authorized Representative

I, the undersigned, represent that I have valid and in-force insurance and/or employee healthcare benefits coverage, and hereby assign and convey directly to **Gotham City Orthopedics, LLC and all medical professionals, including physician assistants of this practice, including, but not limited to [Sean Lager, MD, F.A.A.O.S, Timothy Henderson, MD, Victor Ortiz MD, Joseph Weber- Lopez, MD, Kelly Carter PA-C, Dayana Cannan PA-C and Sarah Weinmann, PA-C** (the "provider(s)") as my Statutory Derivative Beneficiary (SDB), commonly known as an Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the Designated Authorized Representative(s) any and all plan documents, including Governing Plan Documents, including, but not limited to a written explanation of how level of benefit payments are determined for out-of-network providers, Summary Plan Description, 5500 Form (Plan Annual Return), Certificate for PPACA Grandfathered Health Plan, where applicable, insurance policy and/or settlement information upon written request from the Designated Authorized Representative(s) in order to claim certain medical benefits in connection for healthcare services provided to the undersigned. This, includes, but is not limited to, receiving disbursement benefit checks for claims submitted, member's rights to appeal claim denials, as well as to claim any applicable statutory penalties on behalf of the plan participant and beneficiary. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the Designated Authorized Representative(s) to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, cause of action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor, including, but not limited to, issuance of reimbursement checks, Explanation of Benefits and any/all correspondence related to claims reimbursement; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the Designated Authorized Representative(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the Designated Authorized Representative(s) against any such liable party or employee group health plan in my name with derivative standing but at such Designated Authorized Representative(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement.

_____	_____	_____
Signature of Insured / Guardian	Print Name of Insured/Guardian	Date

Limited Power of Attorney

I do not believe my employee health benefits plan would prohibit this assignment, but should same be the case or should my assignment be challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney-in-fact to collect payment for your medical services directly against the carrier in the case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining. **Initials**_____

Medical Records Authorization

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other healthcare provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports and any other report or information regarding my physical condition. Initials_____

_____	_____
Patient Signature or Authorized Signature for Minor	Date

AUTHORIZATION TO RELEASE INFORMATION

Date: _____

Patient's Name: _____

I hereby authorize Gotham City Orthopedics, LLC and its associates to provide treatment and or examination and release any information pertinent to my case in the course of my examination or treatment to my physician, insurance company, adjuster or attorney if applicable in this case.

I hereby authorize Gotham City Orthopedics, LLC to obtain any medical information from my referring physician including, but not limited to, clinical history and office notes.

By signing I authorize Dr._____ to release any medical request by Gotham City Orthopedics.

_____ _____

Patient Signature or Authorized Signature for Minor **Date**

Thank you for your cooperation.

Gotham City Orthopedics, LLC

Financial Policy

The surgeons, physicians and staff at our offices are dedicated to providing you with the best possible treatment, care and service, and regard your understanding of, and agreement with, our financial policies as an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made by yourself or your health coverage carrier, full payment of what, if anything, is due, will be payable at the time of service. For your convenience, **we accept cash, checks, Visa, MasterCard, Discover and American Express**. To ensure that you are qualified to be able to make payment arrangements of balances owed to *Gotham City Orthopedics, LLC.* you hereby authorize the practice to check your credit and employment history and to answer any questions about *Gotham City Orthopedics, LLC's* credit history with you. **YOU ALSO AGREE THAT *GOTHAM CITY ORTHOPEDICS, LLC* WILL RETAIN YOUR CREDIT CARD INFORMATION UNTIL THE FULL BALANCE OWED IS PAID. This will stay in effect until written notice from patient of withdraw**

Your Insurance Plan

If *Gotham City Orthopedics, LLC* participates with your insurance, the fees for our services will be billed to your insurance plan provided the procedure or treatment you are receiving is considered medically necessary. However, you are responsible for the payment of your in-network deductible, co-payments and/or co-insurance no later than at the time of treatment. These fees are mandated by your insurance carrier and cannot be waived. Please be prepared to pay these fees no later than at the time of your treatment. **We accept cash, checks, Visa, MasterCard, Discover and American Express**.

In the event your health plan determines a service /treatment to be "not covered"; you will be responsible for the complete charge. In that event, you will receive a statement and payment in full will be expected within **15 days**.

There are other instances where some insurance plans will send a payment directly to you. If you receive payments for the services you received, you are responsible for forwarding that payment directly to *Gotham City Orthopedics, LLC*. It is your responsibility to ensure the practice is paid the amount that has been sent to you plus any remaining balance. Be advised that not remitting such payment to *Gotham City Orthopedics, LLC* constitutes a breach of contract and an illegal, criminal conversion of funds not belonging to you and *Gotham City Orthopedics, LLC* will pursue all legal and criminal remedies available to it to obtain such payment.

Minor Patients

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

Missed Appointment & Return Check Fee

In order to provide the best possible service and availability to all our patients, it is our policy to charge a $30.00 fee for any appointments not cancelled at least one day prior or not cancelled at all. Please call us as soon as possible if you know you will need to reschedule your appointment to avoid this cancellation fee. If you make payment to the practice by check and it is returned by the bank for any reason, you will incur a fee of $30.00.

Collection Accounts

For all past due patient accounts with balances, including patients that are unlawfully retaining insurance company payments that are submitted to our collection agency/legal firm for collection, those collection fees, legal fees, court costs as well as interest accruing from the date of service will be your responsibility.

Disability & FMLA Forms

Payment of $25 per form is required for processing due at time of request
If you are an employee of the State of New Jersey and require a state disability form to be completed, there is no charge per state mandate.
Forms will be processed in 5-7 business days

I have read and understand the financial policy of Gotham City Orthopedics, LLC and I agree to be bound by its terms.

_____ _____

Patient Signature or Authorized Signature for Minor Date

Personal Release of Medical Information

Date: _____

Patient Name: _____

D.O.B.: _____ SS #: _____-_____-_____

I would like to give Gotham City Orthopedics, LLC authorization to release my health/ billing information to all of the following parties listed below: (Please exclude Physicians. This is strictly for any of your family members or friends whom you entrust with your healthcare information.)

	Name	D.O.B	Relationship
1.	_____	_____	_____
2.	_____	_____	_____

If you Do Not wish to list or release any of your private healthcare information, please check NA box below:

Not Applicable: ☐

Patient Signature: _____

Witness: _____

CREDIT CARD AUTHORIZATION FORM

Dated: _____

The undersigned hereby acknowledges that he/she incurred an injury on (Date:) _____ , and that the undersigned was treated by Doctor for that injury on (Date:) _____ although Doctor may be required to render more treatment to completely address the subject injury, the undersigned acknowledges that he/she is responsible for paying Doctor for the initial treatment received on the Date of Service, and undertakes to exert all effort possible, and to fully cooperate with Gotham City Orthopedics, LLC and Doctor, in seeking, compensation from the undersigned's insurance carrier for the services rendered by Doctor to the undersigned on Date of Service. Toward that end, in the event Gotham City Orthopedics, LLC has not received full payment for Doctor's services from the undersigned's insurance carrier within (30) days after Date of Service, then the undersigned hereby acknowledges and authorizes Gotham City Orthopedics, LLC to charge the undersigned's credit card or debit card for the remaining balance due. Your credit card will be stored in our secure electronic healthcare record database. The relevant information needed in order to submit such credit card or debit card charge is as follows:

◯ MasterCard ◯ Visa ◯ Amex ◯ Discover ◯ Debit

Card Number: _____ Expiration Date: _____

Security Code on Card: _____

Name **(Print Full Name As It Appears On Card):** _____

Signature: _____ Date: _____

Patients Name: _____

Address: _____

City/ Sate/ Zip: _____

Telephone: ( ) _____-_____ Cell: ( ) _____-_____

Email: _____

Insurance Carrier: _____

Identification Number: _____

Your signature will authorize the card to be used **only** when your balance becomes past due. (Your credit card information is stored electronically in an encrypted form a**nd cannot be viewed by our office staff.**)

◯ DECLINED _____(initials)