PREFERRED PEDIATRIC ORTHOPEDIC SURGERY

PATIENT INFORMATION Date: _____

Patient Full Name: _____ Sex: _____ Date of Birth: _____

Age: _____ Email: _____

☐ Home # _____ ☐ Cell # _____ Check preferred contact #

Address: _____ City: _____ State: _____ Zip: _____

Child Social Security Number: _____ Ethnicity: _____

Parents Names: _____ Referred by: _____

Family members treated by Dr. Joffe / Dr. Pehlivan: _____

PEDIATRICIAN INFORMATION

Pediatrician's Full Name: _____ Pediatrician's Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Reason for today's visit: _____

Please Circle: Right Left Both Spine Other: _____

Date problem began: _____ How did this occur? _____

Please select one of the following if applicable: ☐ School Accident ☐ Chronic Condition

☐ Motor Vehicle ☐ Sport Injury ☐ Noticed at Birth

Was the patient seen in the Emergency Room / Urgent Care? _____

Date of Visit: _____ Which Emergency Room / Urgent Care? _____

PATIENT INFORMATION Height: _____ Weight: _____

Age of first Menstruation _____ Last Menstrual Period (date) _____

Please list any allergies: _____

Are you pregnant or is there any chance of pregnancy? Yes: ☐ No: ☐

Medical History (Please check all that apply):

☐ Asthma ☐ Autism ☐ Fractures

☐ Seasonal Allergies ☐ Developmental Delays ☐ Sprains

☐ Cerebral Palsy ☐ Epilepsy / Seizures ☐ Arthritis

☐ ADHD ☐ Bone / Joint Infections ☐ Dislocations

☐ Emotional or Psychiatric Disorder ☐ Scoliosis

☐ Other (Please List): _____

PATIENT INFORMATION CONTINUED

Please list all current medications (tablets, patches, inhalers, drops, liquids, ointments, injections, etc.) including prescription, over-the-counter, herbal, vitamin, and dietary supplements:

Medication	Dose / How often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

COVID Vaccine Y / N (date) _____ Past COVID Diagnosis? Y / N

Does the patient smoke? Yes: ☐ No: ☐ Do any family members smoke? Yes: ☐ No: ☐

Please document any unlisted Medical Problem: _____

Please document any surgeries: _____

Birth History: _____ Birth Weight: _____

Please select delivery presentation type: Head First: ☐ Breech: ☐ Twin/Multiples: ☐ C-Section: ☐

In ICU after delivery? _____ Please list any perinatal complications _____

YOUR INSURANCE COMPANY

In the past few years, the number of different health insurance plans has increased. Even within one company, there may be several plans with varying benefits and requirements.

It is your responsibility to ensure that proper authorization and referrals for the services provided from PPOS are covered.

- Some plans require REFERRALS from your Primary HealthCare Physician (The referral must be received before the appointment)
- Some plans require a specific facility to be used for your MRI, CT scans, Ultrasounds, Blood Work and Surgical procedures

OUT OF NETWORK COVERAGE

You should be aware that in the event an out of network insurance plan covers all or part of your treatment, payment for some may be mailed directly to you. **If an insurance company sends you payment, they are meant to be sent to PPOS.** It is your responsibility to send immediately with all the associated paperwork from the insurance company. As a courtesy to our patients, we file insurance; however, we will not become involved in disputes between you and your insurance companies regarding deductibles, co-payments, covered charges, secondary insurance, or other matters regarding payment.

APPEALS

I hereby authorize Preferred Pediatric Orthopedic Surgery to appeal any denial or fair compensation for coverage by my health care provider for services rendered by Preferred Pediatric Orthopedic Surgery to my child. I further understand and acknowledge that any payment issued by my insurance carrier for services rendered by Preferred Pediatric Orthopedic Surgery as a result of this appeal must be remitted to Preferred Pediatric Orthopedic Surgery. In the instance my appeal is denied, I remain responsible for all payments due and owing Preferred Pediatric Orthopedic Surgery for services rendered.

RECORDS

You, the patient, are entitled to any and all records that pertain to your medical condition. For medical/legal reason we never release the original records. Records are only released to the patient or someone that the patient specifically designates. Copies of the office assessments, outside test results, and x-rays are available. If you would like to view your records or obtain copies of your records the office will comply with your request within 30 days after a written release is received. Please note that there is a fee for copying records and x-rays.

NO SHOW POLICY

Effective May 1, 2021 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $25.00 fee. Any established patient who fails to show or cancels/reschedules an appointment with no 24 hours' notice a second time will be charged a $50.00 fee. If a third No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be dismissed from PPOS. Any new patient who fails to show for their initial visit will not be rescheduled. The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

PATIENT PRIVACY

In order to protect your privacy and in accordance with Federal Law, we do not leave confidential medical information on answering machines or with anyone other than the patient or patient's legal guardian without prior authorization. Please read and sign below acknowledging receipt of the policy.

Please indicate below your preference:

☐ We may leave detailed messages on this answering machine # _____

☐ Do not leave detailed messages on any answering machine

☐ Permission to fax medical instructions to my child's school

Signature: _____ Date: _____

Please print your name: _____

*__If over the age of 18__ please list who we can speak to other than yourself regarding medical information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Insurance Information

*If you have your insurance card with you today, fill out the **BOLD** sections only

Primary Insurance Information

Primary Insurance Company Name: _____

Subscriber ID Number: _____ Group Number: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Person Responsible for Account (Guarantor): _____ Phone Number: _____

Relationship to Patient: _____ **Guarantor's Birth Date:** _____Guarantor's SS #: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer: _____ **Work Phone #:** _____ **Occupation:** _____

Business Address: _____ **City:** _____ **State:** _____ **Zip**: _____

Secondary Insurance Information

Secondary Insurance Company Name: _____

Subscriber ID Number: _____ Group Number: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Person Responsible for Account (Guarantor): _____ Phone Number: _____

Relationship to Patient: _____ Guarantor's Birth Date: _____ Guarantor's SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone #: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Assignment and Release

I hereby authorize payment directly to PPOS, all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted doctor and/or provider or supplier of services in this office to release any information required to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ **Date:** _____