THE KNEE CENTER OF WNY CONFIDENTIAL

MEDICAL HISTORY FORM

Name________________________Birthdate______________Date______________

Age____________Height_______________Weight______________

Chief Complaint____________________________________Left or Right side

Work Related? Yes or No Are you working? Yes or No Onset date________

Litigation? Yes or No

Primary Care Physician Name:____

Referred by:____

List any allergies you have to drugs, food or other items:

________________ ________________ ________________ __________________

List the medications you are now taking:

_____________________ ____________________ ____________________

_____________________ ____________________ ____________________

Are you currently under medical care for any reasons? If yes, please explain:

List All Operations:

Operation Performed	Year	Hospital	Doctor
________________________	_____	______________	______________
________________________	_____	______________	______________

REVIEW OF SYSTEMS (CHECK ALL THAT APPLY) AND DESCRIBE

_Constitutional-Weight Loss/Gain, Loss of Hair _____________
_Ear/Nose/Throat Problems _____________
_Gastro-Intestinal System Problems _____________
_Genito-Urinary System Problems _____________
_Skin Problems _____________
_Integumentary Problems (Cancer, Lesions) _____________
_Endo Problems (Diabetic, Thyroid Problems) _____________
_Hemi/Lymph System Problems _____________
_Eye Problems _____________
_Musculoskeletal System Problems _____________
_Neurologic System Problems _____________
_Immunology Problems _____________
_Respiratory System Problems _____________
_Psychiatric Problems _____________
_Anemia or Blood Disorders _____________

(DOCTOR USE ONLY)

HPI

__ LOCATION
__ SEVERITY
__ TIMNG
__ MODIFYING FACTORS
__ QUALITY
__ DURATION
__ CONTEXT
__ ASSOCIATED SIGNS AND SYMPTOMS
__ 3 CHRONIC OR INACTIVE CONDITIONS

Occupation______________________________ Married Yes or No # of Children__________

Do you: Smoke?_________Packs per day_________# Years smoked_______________

Drink Alcohol?_______________Drinks per Day_______________

KNEE CENTER OF WNY DATE________________

PATIENT NAME________________________________MALE/FEMAL

ADDRESS____

DATE OF BIRTH__/__/__ HOME #____________________

CELL#__________________ SS#:________________________

PHARMACY____________________________PHARMACY#________________

PRIMARY PHYSICIAN____

PRIMARY INSURANCE_______________________ID#___________________

NAME OF INSURED__________________________DOB___/___/___

SECONDARY INSURANCE_____________________ID#___________________

IF YOUR VISIT IS GOING TO BE COVERD UNDER WORKERS COMPENSATION OR NO FAULT YOU MUST FILL IN AREA BELOW

WORK RELATED YES OR NO MOTOR VEHICLE ACC. YES OR NO

INSURANCE CARRIER____

ADDRESS____

WCB#_____________________________OR CLAIM#______________________

CARRIER CASE#_____________________OR POLICY#____________________

DATE OF INJURY OR ACCIDENT_________________________

ADJUSTER____

NAME, ADDRESS, AND PHONE# OF EMPLOYER AT THE TIME OF THE ACCIDENT

____

ATTORNEY NAME AND
PHONE#____

NO FAULTS – A LIEN LETTER IS NEEDED FROM THE ATTORNEY!

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I HAVE REVIEWED & UNDERSTAND THE ABOVE FINANICAL POLICY & AGREE WITH THE STATED TERMS. I ALSO AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO THE KNEE CENTER OF WNY, PC & RELEASE OF MEDICAL INFORMATION NECESSARY FOR TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS

____DATE____________
SIGNATURE

KNEE CENTER OF WESTERN NEW YORK

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/ 14/ 03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $ 0.75 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: KNEE CENTER OF WESTERN NEW YORK

Telephone: 839-5858

E-mail:

Address: 100 CORPORATE PARKWAY, SUITE 112, AMHERST, NY 14226

DOCTOR POLICY-PATIENT COPY

*YOU WILL NOT BE SEEN WITHOUT AN UPDATED REFERRAL, IF ONE IS REQUIRED BY YOUR INS.COMPANY. IF WE DO NOT HAVE A REFERRAL YOUR APPOINTMENT MAY BE RESCHEDULED. IT IS YOUR RESPONSIBILITY TO CALL YOUR MEDICAL DOCTOR TO OBTAIN A REFERRAL.

***CO-PAYMENTS ARE DUE AT THE TIME OF APPOINTMENT. WE DO ACCEPT CASH, CHECK OR CHARGE (MASTER CARD AND VISA ONLY).**

*IF YOU ARRIVE MORE THAN 15 MINUTES LATE, YOUR APPOINTMENT WILL BE RESCHEDULED TO THE NEXT AVAILABLE APPOINTMENT. NO EXCEPTIOINS!

***IF YOU NEED TO CANCEL YOUR APPOINTMENT, WE REQUIRE A 24 HOUR NOTICE OR YOU WILL BE CHARGED A $40.00 NO SHOW FEE. THERE IS A $250.00 NO SHOW FEE FOR SURGERY.**

*IF YOU FAIL TO SHOW UP FOR 2 SCHEDULED OFFICE APPOINTMENTS WITHOUT CANCELLING, WE WILL BE UNABLE TO CONTINUE YOUR CARE.

*ALL MEDICATION REFILLS CALLED IN AFTER 4PM ON THURSDAYS WILL BE FILLED THE FOLLOWING MONDAY. IT IS YOUR RESPONSIBILITY TO PLAN ACCORDINGLY.

*IF YOU ARE WAITING FOR A RETURN CALL FROM A PHYSICIAN, THIS WILL BE HANDLED AS QUICKLY AS POSSIBLE. NON-EMERGENT CALLS WILL BE RETURNED AFTER OFFICE HOURS IN MOST CASES. ROUTINE CALLS SHOULD BE MADE DURING BUSINESS HOURS.

*OUR OFFICE IS OPEN MONDAY THUR FRIDAY, 8AM TO 4 PM. **CALLS MADE AFTER HOURS OR ON WEEKENDS ARE FOR EMERGENCIES ONLY.** IF YOU HAVE A CALL BLOCK ON YOUR PHONE, PLEASE TURN IT OFF SO OUR PHYSICIANS MAY RETURN YOUR CALL.

*WE APOLOGIZE FOR OUR PROLONGED WAIT TIMES, BUT WE OFTEN SEE A LARGE NUMBER OF UNSCHEDULED PATIENTS DUE TO EMERGENCIES. ALTHOUGH UNUSUAL, WAIT TIMES CAN BE UP TO 2 HOURS. PLEASE PLAN YOUR DAY ACCORDINLY.

DISABILITY PATIENTS

THERE IS A $10.00 FEE FOR DISABILITY FORMS TO BE FILLED OUT. THE PAPERWORK WILL NOT BE COMPLETED UNTIL THE FEE IS RECEIVED. **PLEASE DO NOT ASK THE PHYSICIAN TO FILL FORMS OUT DURING OFFICE VISITS.** FORMS ARE DONE ON A FIRST COME FIRST SERVED BASIS. WE MAY REQUIRE UP TO 10 DAYS TO PROCESSS PAPERWORK.

FINANCIAL POLICY

WE ARE COMMITED TO PROVIDING YOU WITH THE BEST CARE AND IN RETURN EXPECT FULL AND PROMPT PAYMENT FOR OUR SERVICES. YOUR CLEAR UNDERSTANDING OF THE FOLLOWING POLICIES IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP.

OFFICE VISITS AND SURGICAL PROCEDURES

1. CO PAYMENTS ARE DUE AT TIME OF SERVICE
2. WE PARTICIPATE IN MOST INS. PLANS. HOWEVER, INS IS A CONTRACT BETWEEN YOU AND YOUR CARRIER. ANY BALANCE DUE IS PER YOUR INS.