



The Expertise You Expect, The Compassion You Deserve

Dear Patient,

Welcome to our practice! Thank you for choosing Reconstructive Orthopedics for your orthopedic ailment. With 80 years of combined experience, our physicians are proud to provide patients with quality service in a compassionate environment.

We would like to make your visit to our office as pleasant, friendly and convenient as possible. We understand that your time is valuable. Therefore, to minimize your wait time while in our office, we ask that you carefully read and fully complete the attached paperwork and bring it with you to your first appointment. This packet includes three forms: Patient Information & History; Privacy Practice Acknowledgement; and our Medication Agreement/Policy.

In order to provide you with the best care, we will need to know your full medical history, any symptoms you may have and any treatment that you have received for your orthopedic condition. All pertinent radiology films, laboratory or test results should be brought to our office at the time of your visit. Please bring a list of your medications to your appointment, as well.

You will be asked to present a valid photo identification (e.g.: Driver's License) and your insurance card at each visit. If your insurance plan requires a referral, please contact your primary care physician prior to the appointment. Our group NPI# is: **1659319002**. In most instances, your PCP can electronically issue the referral. Otherwise, you will be required to bring the paper referral with you.

Please come to the office prepared to pay your specialist co-pay at the time of service. For your convenience, we accept Visa, MasterCard, personal check or cash.

If you are limited for time and are not able to complete these forms ahead of time, please come to the office at least 20 minutes prior to your scheduled appointment time to complete the necessary paperwork in the office.

We value the trust that you have placed in our practice. Once again, thank you for choosing Reconstructive Orthopedics where you will receive the expertise you expect and the compassion you deserve.

If you need to contact the appointment scheduling department about your appointment, you may do so by dialing 1-800-896-RECON (7326).

Reconstructive Orthopedics
Management Team

Tower Medical Building - Ste 6, 737 Main Street, Lumberton, NJ 08048 609-267-9400
Elmwood Business Park - Bldg E100 773 Rt 70 East, Marlton, NJ 08053 856-673-3960
Voorhees – 200 Bowman Drive, 1st Floor, Voorhees, NJ 08043 856-673-3960
Harbor Pavilions - 570 Egg Harbor Road, Ste B2, Sewell, NJ 08080 856-256-0051
Cherry Hill - 1004 Haddonfield Road, Cherry Hill, NJ 08002 856-784-4444
Somerdale – 1 Somerdale Square, Somerdale, NJ 08083 856-784-4444

PATIENT INFORMATION & HISTORY FORM

Name _____ Birth date ____/____/____ AGE _____ M / F (circle)

Referring Physician _____ Height _____ Weight _____ R / L Handed?

Is your injury due to a motor vehicle accident? Y/N

Is your injury filed under Workers Compensation? Y/N

PAINFUL or PROBLEM AREA _____ Started WHEN / HOW? _____

What Makes it BETTER? _____ WORSE? _____

Any Treatments? (Physical Therapy, Injections, etc...) _____

PRIOR injuries to the SAME area? _____ How Severe? No Pain.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

If you brought Radiology Studies with you, please circle all that apply: MRI CAT Scan X-rays Bone Scan EMG

MEDICAL HISTORY Please circle & fill out any that apply to you ...

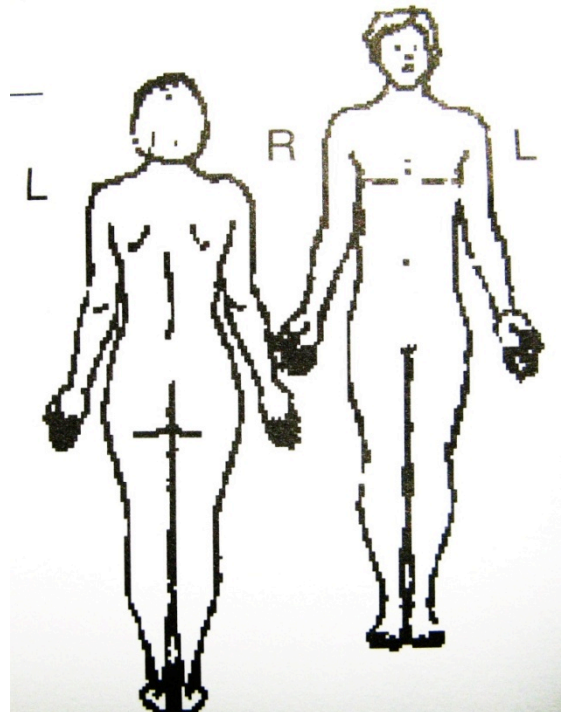
Mark the drawing below to show your pain or problem area

Diabetes; Foot-ankle problems; Cancer (type) _____; Heart disease;

Heart attack or MI; High blood pressure; Circulation problems; Blood Clots;

DVT or Pulmonary embolism; Prior stroke or TIA; Breathing problems or COPD

Any other medical problems? _____



SURGICAL HISTORY: List all prior operations _____

ALLERGIES (include medications, shellfish, latex, antiseptics) _____

MEDICATIONS Please list ALL that you are taking (include blood thinners, steroids, inhalers)

- 1 _____ 2 _____ 3 _____
4 _____ 5 _____ 6 _____
7 _____ 8 _____ 9 _____
10 _____ 11 _____ 12 _____

FAMILY HISTORY Do you have a FAMILY history of

- () Heart disease () Cancer () Reaction to Anesthesia
() Bleeding or clotting disorders () Malignant Hyperthermia () Blood Clot or PE

SOCIAL HISTORY Occupation? _____

Out of Work Since? _____

Are you Disabled? Y / N

Smoke? Y / N # of Packs per Day? _____

Drink? Y / N

How Much per Week? _____

Do you Live Alone? Y / N

REVIEW OF SYSTEMS (Please CIRCLE all that apply; If left blank, will assume no issues apply)

- Pain at Night, Difficulty Sleeping, Insomnia Headaches, Migraines, Vertigo, Dizziness
Chest Pain, Palpitations, Reflux Shortness of Breath, Trouble Breathing, Asthma
Depression, Anxiety, Bipolar, other _____ Prior Musculoskeletal Injury _____
Urinary Infection, Prostate Problem, Gynecological Problem Numbness, Tingling, Weakness

Today's Date ____/____/____ PATIENT Signature _____ DOCTOR'S Signature _____



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NOTICE OF PRIVACY PRACTICES/HIE PARTICIPATION ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand information can and will be used to:

- ❖ Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment either directly or indirectly.
❖ Obtain payment from third-party payers.
❖ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand your participation in the Virtua HIE and acknowledge that I have received the Virtua HIE brochure that includes instructions and forms to opt-out of the Virtua HIE. I understand that failing to opt-out is my consent to participate in the Virtua HIE which will allow participating providers access to my Protected Health Information. I understand your Notice of Privacy Practice contains more complete description of the uses and disclosures of my health information.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

OFFICIAL USE ONLY

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices/HIE Participation Acknowledgement but was unable to do so as documented below:

Reason: _____

Date: _____ Initials: _____

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MEDICATION AGREEMENT/POLICY

I _____ understand that I am entering into an agreement between myself and Reconstructive Orthopedics and all physicians employed within. The conditions of this agreement cannot be changed or altered under any condition. They are as follows:

1. I will take **only** the amount of medication prescribed at the frequency prescribed. Increasing the amount of medication prescribed without consent may be harmful. It may also result in me completing my medication prior to my renewal date. In this case I will have to wait until my renewal date to refill my medication.
2. I will not interchange medication or give prescription drugs away.
3. It is the policy of Reconstructive Orthopedics that prescription refills will only be written between 9:00 a.m. on Monday and 3:00 p.m. on Thursday. **NO** prescriptions will be written between 3:00 p.m. on Thursday and 9:00 a.m. on Monday. Please be sure to evaluate your prescription requirements prior to Thursday.
4. I understand that treatment can be discontinued if I:
 - a. Give away, sell or misuse the drug(s)
 - b. OBTAIN narcotics from any other doctor or source
 - c. If the doctor feels that the narcotic has not been effectively managing your pain
5. I will use only one pharmacy to fill my medication. I agree to utilize: Name of Pharmacy: _____ Located: _____ Pharmacy phone number is: _____ If I change my pharmacy for any reason, I agree to notify Reconstructive Orthopedics at the time I receive a new prescription.
6. I also understand that my usage of narcotic medications will be communicated with my family/referring physician and pharmacy on a regular basis.
7. I agree to random drug testing via methods of saliva, urine, or blood testing to determine my compliance with the use of my pain medications and to determine if I am using any illegal controlled substances such as marijuana, cocaine, etc. I understand this information is crucial in my care and the Doctors ability to treat my pain. My misuse or abuse of any medication, prescribed or illegal will immediately terminate my doctor/patient relationship and will cause my care to be transferred back to my primary care physician at his or her discretion. Reconstructive Orthopedics at such time that it is found that I have misused any substance will be obligated only to provide me with the names and phone numbers of facilities that I may contact on my own to seek treatments if I feel necessary.

I have read and understand this document in its entirety. I consent to the terms and conditions stated. I also know that failure to abide to the terms of the agreement will result in the immediate termination of my Doctor/Patient relationship.

Signed: _____ Dated: _____

Provider Signature: _____

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