Warner orthopedics & wellness

CIEM
CENTER for INNOVATIONS in EVALUATIVE MEDICINE

Meredith Warner, MD MBA

www.WarnerOrthopedics.com

How did you hear about us?

Name:_____

Patient Demographics:

Patient: _____
First MI Last

Mailing Address: _____
Street Apt

_____
City State Zip

_____
Home Phone Cell/Alternate Phone

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

Race:_____ Social Security No.:_____ Email:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Spouse's Name:_____

I am: ☐ Left Hand Dominant ☐ Right Hand Dominant

Emergency Contact Name:_____
Name/Relationship to Patient Home Phone Cell/Alternate Phone

Primary Care Physician: _____

Occupation: _____

Are you on: Light Duty - Since Date:_____ Disabled – Since Date:_____

Do you work with metal, welding, or grinding? ☐ No ☐ Yes

Additional Questions:

Is there any chance that you are pregnant? ☐ No ☐ Yes If yes, then notify front desk

Medical Claim Information:

Is this a job related injury?	☐ No	☐ Yes	If yes, complete Sections I, III
Is your visit today part of a legal, disability or liability related issue?	☐ No	☐ Yes	If yes, complete Sections II, III
	If No, Skip I, II, III		

I. Workmen's Compensation Claims: (Please complete if your visit is the result of a work related injury.)

DATE OF INJURY/ACCIDENT:_____

DID YOU REPORT THIS TO YOUR EMPLOYER? ☐ No ☐ Yes

Employer	Work Compensation Contact Person		Contact's Phone
Employer's Address	City	State	Zip Code
Work Compensation Carrier	Phone	Claim Number	Adjuster

II. Legal/Disability/Liability Claims: (Please complete if your visit is the result of legal, disability or liability issue.

DATE OF INJURY/ACCIDENT:_____

Law Office / Disability / Liability Office Name	Lawyer/Agent's Name	Phone

Address	City	State	Zip Code

III. Past Settlement or Trust fund: (Please complete if you filled out Sections I or II)

Have you received a past settlement related to your problem?	☐ No	☐ Yes
Is there a trust / set aside fund associated to your problem?	☐ No	☐ Yes
Have you or will you be applying for disability?	☐ No	☐ Yes
Date Applied:_____		

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CHIEF COMPLAINT: Why are you here?_____

Date of Injury or Onset of Symptoms:_____ **Body Part to be Examined**_____ ☐ Left ☐ Right

Main Problem: ☐ Pain ☐ Numbness ☐ Weakness ☐ Stiffness ☐ Unstable ☐ Swelling ☐ Popping/Grinding
Other_____

How Complaint/Injury Occurred: ☐ Gradual Onset ☐ Sudden/Traumatic Other_____

PREVIOUS OR CURRENT TREATMENTS FOR THIS CONDITION:

Have you been seen by another MD? ☐ No ☐ Yes If yes, list MD:_____

(Check all that apply)

X-rays/Tests: ☐ X-ray ☐ MRI Scans ☐ CAT Scan ☐ Myelogram ☐ Nerve Study Other_____

Therapies: ☐ Physical Therapy ☐ Chiropractic Care ☐ Injections Other_____

CURRENT MEDICATION: ☐ None Pharmacy Preference:_____

Please list any prescriptions and/or non-prescription medications. include herbs, vitamins, and nutritional supplements.
(Leave blank if you brought a copy of your medications)

Name	Strength	Frequency

ALLERGIES:

Do you have any DRUG / FOOD / LATEX allergies? ☐ None If yes, list below:

Allergy	Reaction	Allergy	Reaction

SOCIAL HISTORY:

Tobacco/Nicotine Use: ☐ Non-smoker ☐ Current every day ☐ Current some days ☐ Former Smoker

Alcohol Use: ☐ Do not drink ☐ Occasional ☐ Frequent

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS: ☐ No Medical Problems OR *(Check all that apply)*

HEAD
- ☐ Trauma

EYES
- ☐ Wears glasses/contacts
- ☐ Glaucoma
- ☐ Blindness
- ☐ Cataracts

EARS
- ☐ Hearing Aids

NOSE / SINUSES
- ☐ Sinus Infections
- ☐ Allergic Rhinitis

MOUTH / TEETH
- ☐ Dentures

CARDIOVASCULAR
- ☐ HTN
- ☐ Myocardial infarction
- ☐ Other heart disease
- ☐ Aneurysm
- ☐ Murmur
- ☐ Dysrhythmia
- ☐ Angina
- ☐ DVT

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD/Bronchitis/Emphysema
- ☐ Pneumonia
- ☐ Pleuritis

GASTRINTESTINAL
- ☐ Ulcer
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Gallbladder Disease
- ☐ Hiatal Hernia
- ☐ Heartburn
- ☐ GERD

GENITOURINARY
- ☐ Hernia
- ☐ STD's
- ☐ Incontinence
- ☐ UTI(s)
- ☐ Nephrolithiasis
- ☐ Other kidney disease

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Gout
- ☐ Injury

SKIN
- ☐ Psoriasis
- ☐ Dermatitis
- ☐ Other skin condition(s)
- ☐ Mole(s)

NEUROLOGICAL
- ☐ Severe Headaches, migraines
- ☐ Stroke
- ☐ TIA
- ☐ Seizures
- ☐ Epilepsy

PSYCHIATRIC
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Hallucinations, delusions
- ☐ Suicidal ideation
- ☐ Suicide attempts

ENDOCRINE
- ☐ Type I Diabetic
- ☐ Type II Diabetic
- ☐ Hyperlipidemia
- ☐ Thyroiditis
- ☐ Hypothyroidism
- ☐ Thyroid disease
- ☐ Goiter

HEMATOLOGIC / ONC
- ☐ Anemia
- ☐ Cancer

INFECTIOUS
- ☐ Tuberculosis (dz)
- ☐ Tuberculosis (exposure)
- ☐ HIV
- ☐ STD's

FAMILY MEDICAL HISTORY (If yes, list family member)

Cancer	☐ No	☐ Yes _____
High Blood Pressure	☐ No	☐ Yes_____
Heart Problems	☐ No	☐ Yes_____
Hepatitis	☐ No	☐ Yes_____
Bleeding Problems	☐ No	☐ Yes_____
Diabetes	☐ No	☐ Yes_____
Seizures/Epilepsy	☐ No	☐ Yes_____
Asthma	☐ No	☐ Yes_____

PREVIOUS SURGERIES: Please list any surgeries performed: ☐ None

	Type	Year		Type	Da
1.			4.		
2.			5.		
3.			6.		

Have you had any issues with Anesthesia? ☐ No ☐ Yes If yes, please explain: _____

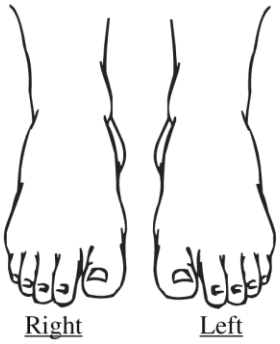
PAIN DIAGRAM: On a scale of 1 to 10, how would you describe your **average** pain level?

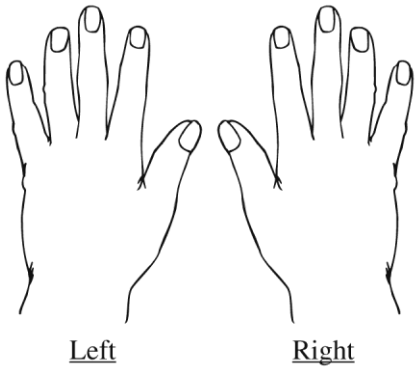
No Pain	0	1	2	3	4	5	6	7	8	9	10	Extreme Pain

Place an "X" on the area of pain; Use the appropriate symbol of other symptoms you may feel

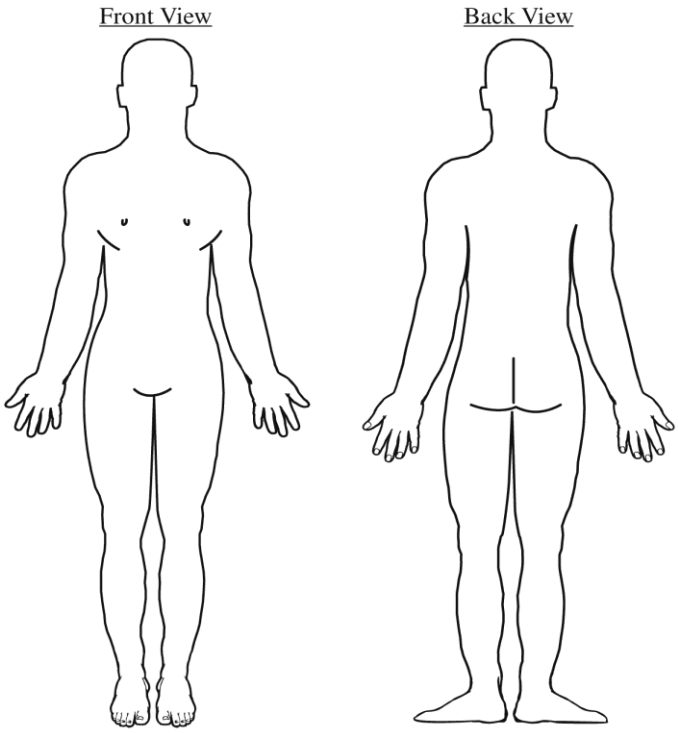
Pain	Aching	Numbness	Pins & Needles	Burning	Stabbing
X	¢	+	•	✓	/

Use diagrams below for Feet / Hands / Wrists





Use body diagrams below for all other problems



Assignment of Benefits and Designation of an Authorized Representative For Health Insurance Claims to Center for Innovations in Evaluative Medicine, LLC, d/b/a Warner Orthopedics and Wellness

This is a direct assignment of my rights and benefits under this or any other applicable policy to Center for Innovations in Evaluative Medicine, LLC, d/b/a Warner Orthopedics and Wellness ("Warner Orthopedics"), and direct payment of these benefits and other amounts to Warner Orthopedics, as required by La. R.S. Section 40:2010. I also hereby appoint the above designated provider to act as my authorized representative for any health benefit or other claim filed on my behalf for services rendered or requested by this authorized representative. I hereby assign to Warner Orthopedics, all of my rights to benefits from the Primary Insurance Company and all other insurance companies, employee benefit trusts, self-insurance plans, or other entities that are obligated to reimburse me or to pay benefits or other amounts for me or on my behalf for services rendered by Warner Orthopedics, as well as all of my rights to proceed against and file suits and claims against the Insurance Company with respect to these reimbursements, benefits, or other amounts, including, without limitation, my right to contest the amount of any payments made by the Insurance Company or to compel the payment of any amount. The undersigned does hereby sell, transfer, convey, grant and irrevocably and forever assign to Warner Orthopedics all known and unknown, past, present, and future rights, title and interest in and to all claims, demands, and/or causes of action, including without limitation all claims, demands, and causes of action pursuant to common law, statute, or in equity, and whether based upon tort, breach of contract, breach of fiduciary duty, insurance benefits, health care benefits and all other legal rights or recovery from or against any and all health plans or plan administrators, pursuant to which the undersigned is entitled to receive health benefits or monies to pay for medical care, hospital or other facility care, medical devices, or other medical treatment. I further instruct and direct the Insurance Company to pay directly to Warner Orthopedics all such reimbursement, professional or medical expense benefits, and other amounts allowable and otherwise payable under my current insurance policy by reason of services rendered by Warner Orthopedics, as payment toward Warner Orthopedics total charges. A photocopy of this Assignment shall be considered as effective and valid as the original.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Under Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights to privacy, which are outlined in the HIPAA/Notice of Privacy Practices provided. Your private health information (PHI) will be used to plan, conduct, and direct your treatment and follow-up among multiple health care providers involved in your treatment. Obtain payment from third party payers. Conduct normal healthcare operations such as quality assessment and physician certification. By signing this form, you consent to Dr. Meredith Warner and staff for use and/or disclosure of your private health information (PHI) to carry out treatment, payment, and health care operations. You have a right to review a NOTICE OF PRIVACY PRACTICES prior to signing this consent. This Notice provides information about how Dr. Meredith Warner and her staff may use and/or disclose protected health information about you for your treatment, payment, health care operations, and as otherwise allowed by law. The terms of this Notice apply to all records containing your PHI that are created or retained by this practice.
We reserve the right to revise or amend our Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time. You may revoke this consent in writing and it must be presented to the current office manager for our records, but such a revocation will not be effective as to the disclosure of records whose release you have previously authorized.

The signature below indicates that all information contained on these forms are accurate to the best of your knowledge. This includes your demographics, medical history, assignment of benefits, consent to use and disclose protected health information, and receipt of missed appointment policy. The signature of the Parent or Legal Guardian for the minor also acts as an authorization for Warner Orthopedics and Wellness and any physician or allied health provider associated with the practice the ability to perform outpatient services on the minor if the parent or legal guardian is not able to be present.

_____
NAME of PATIENT, Parent or Legal Guardian

_____ _____
SIGNATURE of PATIENT, Parent or Legal Guardian Date

_____ _____
WITNESS by Clinic Staff (Acknowledge review) Date

Document ID	Title	Effective Date
WOW001	**Patient Missed Appointment Policy**	**06/01/2019**

Purpose: **To outline the proper procedures for missed appointments**

Scope: **This procedure applies to all front office personnel.**

Procedure:

1 **We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to our patient's wellness and healing is something everyone in our clinic takes quite seriously.**

2 **Because we care so much about our patients, we realize that it would be a disservice to them if we did not emphasize the importance of their commitment to the care they receive and the actions we ask them to do.**

3 **Except for serious emergencies, it is expected that patients attend all their appointments. Our practice management system assists patients with this by emailing, calling and/or texting appointment reminders.**

4 **If a patient needs to re-schedule an appointment, we require a 24-hour notice. In such a case, patients will need to call our scheduling department during regular business hours. The make-up appointment should be within the same week. However, due to the popularity of our staff we cannot guarantee that we will be able reschedule the same week and this could delay the patient's compliance with their plan of care. (Reference #2 and #3)**

5 **In an instance of CANCELLATION, without 24-hour notice, we reserve the right to charge the patient a $25.00 cancellation fee.**

6 **In an instance of NO SHOW, the patient will be charged a $50.00 no show fee.**