



Date: _____

PATIENT INFORMATION			
Patient Name (First, Last)	Sex M _____ F _____	Marital Status S _____ M _____ W _____ D _____ Sep _____	Date of Birth
Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	Social Security Number
Race/Ethnicity ___Caucasian ___Clack/African American ___Asian ___Native American ___Asian Pacific American ___Pacific Islander ___Native Hawaiian ___Subcontinent Asian American ___American Indian or Alaskan Native ___Latino/Hispanic ___Other Race ___More than One Race ___Unknown ___I Do Not Wish To Provide This Information			
Patient Email Address	Family Physician	Referring Physician	
Date of the Injury	Are you Currently Employed? YES _____ NO _____	If Employed, Patient Employer	
Is this a workers' compensation claim? YES _____ NO _____	Is this injury a result of an automobile accident? YES _____ NO _____	Advanced Directive Do you have one of the following? ___Power of Attorney ___No Advanced Directive ___Living Will ___Decline to Provide	
Emergency Contact	Phone Number	Relation to the Patient	
Pharmacy Name	Pharmacy Address	or	Pharmacy Phone Number
PRIMARY INSURANCE INFORMATION			
Primary Insurance Company	Policy ID & Group Number	Effective Date	
Policy Holder's Name <small>If Policy Holder is different then patient</small>	Policy Holder's Social Security Number	Policy Holder's Date of Birth	Policy Holder's Employer
Subscriber of the Insurance ___Patient ___Spouse ___Father ___Mother ___Other		Subscriber Address (If different than the patient)	
SECONDARY INSURANCE INFORMATION			
Secondary Insurance Company	Policy ID & Group Number	Effective Date	
Policy Holder's Name <small>If Policy Holder is different then patient</small>	Policy Holder's Social Security Number	Policy Holder's Date of Birth	Policy Holder's Employer
Guarantor Name (If patient is a minor)	Guarantor Address	Guarantor Phone Number	

* Per Office Policy, Guarantor is person presenting with the patient at time of services

R. JOHN ELLIS, JR., M.D.
MARK G. SMITH, M.D.
G. JEFFREY POPHAM, M.D.
AKBAR NAWAB, M.D.
MICHAEL L. SALAMON, M.D.
MATTHEW R. PRICE, M.D.
DANIEL E. RUEFF, M.D.
SEAN M. GRIFFIN, M.D.
BRENT J. SINICROPE, M.D.
EVAN B. RHEA, M.D.
HANNAH O. LEASURE, PA-C
MEGAN A. COURTNEY, PA-C
RACHEL D. FISHER APRN
LILLIE M BECHT, PA-C
MADELINE WHITFIELD, PA-C

ORTHOPAEDIC SURGERY
FRACTURES
JOINT REPLACEMENT
SPORTS MEDICINE



HIPAA Acknowledgment Form

I acknowledge the Practice has provided me the opportunity to have a copy of its Notice of Privacy Practices. The copy provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.

I am aware that the Practice participates in one or more Health Information Exchanges. A Health Information Exchange is an electronic network that allows your providers to securely retrieve and provide access to your health records for a better picture of your health needs to other healthcare providers.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date

EASTPOINT OFFICE
13151 MAGISTERIAL DRIVE, SUITE 200
LOUISVILLE, KENTUCKY 40223
Telephone 502-587-1236
Fax 502-587-0126

NEW ALBANY OFFICE
3605 NORTHGATE COURT
NEW ALBANY, INDIANA 47150
Telephone 812-321-6321
Fax 812-287-0806

SOUTHEND OFFICE
5120 DIXIE HIGHWAY, SUITE 103
LOUISVILLE, KENTUCKY 40216
Telephone 502-449-0449
Fax 502-449-3277

R. JOHN ELLIS, JR., M.D.
MARK G. SMITH, M.D.
G. JEFFREY POPHAM, M.D.
AKBAR NAWAB, M.D.
MICHAEL L. SALAMON, M.D.
MATTHEW R. PRICE, M.D.
DANIEL E. RUEFF, M.D.
SEAN M. GRIFFIN, M.D.
BRENT J. SINICROPE, M.D.
EVAN B. RHEA, M.D.
HANNAH O. LEASURE, PA-C
MEGAN A. COURTNEY, PA-C
RACHEL D. FISHER APRN
LILLIE M BECHT, PA-C
MADELINE WHITFIELD, PA-C



ORTHOPAEDIC SURGERY
FRACTURES
JOINT REPLACEMENT
SPORTS MEDICINE

**CONSENT TO TREATMENT/BENEFIT ASSIGNMENT/FINANCIAL
RESPONSIBILITY
(SIGNATURE REQUIRED)**

I hereby give my consent for treatment to ELLIS & BADENHAUSEN ORTHOPAEDICS, PSC. I assign the benefits allowed by my insurance company to be paid to their office instead of myself. I have been notified by Ellis & Badenhausen Orthopaedics, P.S.C. that I am responsible for payment, should any of my charges be denied due to lack of referral. In addition, I understand that I am responsible for any Durable Medical Equipment not covered by any insurance company. I agree to be personally and fully responsible for payment of any amounts unpaid by my insurance company.

PATIENT NAME

DATE

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

EASTPOINT OFFICE
13151 MAGISTERIAL DRIVE, SUITE 200
LOUISVILLE, KENTUCKY 40223
Telephone 502-587-1236
Fax 502-587-0126

NEW ALBANY OFFICE
3605 NORTHGATE COURT
NEW ALBANY, INDIANA 47150
Telephone 812-321-6321
Fax 812-287-0806

SOUTHEND OFFICE
5120 DIXIE HIGHWAY, SUITE 103
LOUISVILLE, KENTUCKY 40216
Telephone 502-449-0449
Fax 502-449-3277

R. JOHN ELLIS, JR., M.D.
MARK G. SMITH, M.D.
G. JEFFREY POPHAM, M.D.
AKBAR NAWAB, M.D.
MICHAEL L. SALAMON, M.D.
MATTHEW R. PRICE, M.D.
DANIEL E. RUEFF, M.D.
SEAN M. GRIFFIN, M.D.
BRENT J. SINICROPE, M.D.
EVAN B. RHEA, M.D.

**ELLIS & BADENHAUSEN
ORTHOPAEDICS, P.S.C.**

HANNAH O. LEASURE, PA-C
MEGAN A. COURTNEY, PA-C
RACHEL D. FISHER APRN
LILLIE M. BECHT, PA-C
MADELINE A. WHITFIELD, PA-C

INSURANCE

We will bill your insurance company as a courtesy to you. If they do not respond to our claim within sixty (60) days, you are responsible for the entire amount of the bill. You are responsible for any amounts not paid by your insurance company, including amounts applied to deductible, non-covered charges, copays, and co-insurance. You will receive a monthly statement once the insurance company has paid or denied your claim OR if the insurance company has not responded within sixty (60) days of the filing of the claim.

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY; WE ARE NOT A PARTY TO THAT CONTRACT.

PAYMENT PLANS

Payment plans are available by contacting the bookkeeping Office at (502) 587-7269. We accept Visa, American Express, Mastercard, and Discover and can take your payments over the phone.

MEDICARE

We accept assignment on Medicare payments. However, Medicare will only pay for services that it determines to be "reasonable and necessary," Section 862 (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, it will deny payment for that service.

WORKER'S COMPENSATION

We will make every effort to verify coverage on your worker compensation claim before your visit. If, for some reason, payment is denied or claims are unpaid by the worker's compensation carrier, you are responsible for the bill. If your worker's compensation is denied and you have health insurance, we will be glad to file that for you under the conditions stated above.

REFERRALS

You are responsible for seeing that you have a referral for each visit, service, and supply. We will be glad to help you in the process but, should payment be denied for a lack of referral, you are responsible for your balance.

EXPRESS PRIOR CONSENT TO WIRELESS TELEPHONE CONTACT

By signing below, you consent and agree to receive calls and text messages at the wireless telephone number set forth below, including, but not restricted to, communications regarding billing and payment for goods and services, which could result in charges to you. **Such calls and text messages include, but are not restricted to, calls using an automatic telephone dialing system, or an artificial or prerecorded voice, or by any other form of electronic communication now known or later discovered,** from us, our affiliates, contractors, services, clinical providers, attorneys, or their agents, including collection agencies. **You are not required to sign this Consent or to agree to enter into this Consent as a condition of purchasing property, goods, or services from the practice.**

PATIENT SIGNATURE

PRINT NAME

PATIENT HOME ADDRESS

CELL PHONE NUMBER

DATE

EASTPOINT OFFICE
13151 MAGISTERIAL DRIVE
SUITE 200
LOUISVILLE, KENTUCKY 40223
Telephone 502-587-1236
Fax 502-587-0126

NEW ALBANY OFFICE
3605 NORTHGATE COURT
NEW ALBANY, INDIANA 47150
Telephone 812-321-6321
Fax 812-287-0806

SOUTHEND OFFICE
5120 DIXIE HIGHWAY
SUITE 103
LOUISVILLE, KENTUCKY 40216
Telephone 502-449-0449
Fax 502-449-3277

ST MATTHEWS OFFICE
4123 DUTCHMANS LN, PLAZA 3 SUITE
101
LOUISVILLE, KENTUCKY 40207
Telephone 502-587-1236
Fax 502-587-0126

R. JOHN ELLIS, JR., M.D.
 MARK G. SMITH, M.D.
 G. JEFFREY POPHAM, M.D.
 AKBAR NAWAB, M.D.
 MICHAEL L. SALAMON, M.D.
 MATTHEW R. PRICE, M.D.
 DANIEL E. RUEFF, M.D.
 SEAN M. GRIFFIN, M.D.
 BRENT J. SINICROPE, M.D.
 EVAN B. RHEA, M.D.
 HANNAH O. LEASURE, PA-C
 MEGAN A. COURTNEY, PA-C
 RACHEL D. FISHER APRN
 LILLIE M BECHT, PA-C



ELLIS & BADENHAUSEN
ORTHOPAEDICS

INFORMATION RELEASE FORM

HIPAA Privacy Rules provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. Ellis and Badenhausen Orthopaedics require direct designation by the patient to release personal protected information.

I, _____, HEREBY GIVE ELLIS AND BADENHAUSEN ORTHOPAEDICS PERMISSION TO RELEASE OR DISCUSS ONE OR MORE OF THE FOLLOWING ISSUES WITH:

Name	OFFICE	LABS	X-RAYS	CONSULTS	HOSPITAL	INS./BILLING	ALL

EXCEPTIONS: (DO NOT RELEASE THIS INFORMATION)

 PRINT PATIENT NAME

 PATIENT DATE OF BIRTH

 PATIENT SIGNATURE

 DATE

EASTPOINT OFFICE
 13151 MAGISTERIAL DRIVE, SUITE 200
 LOUISVILLE, KENTUCKY 40223
 Telephone 502-587-1236
 Fax 502-587-0126

NEW ALBANY OFFICE
 3605 NORTHGATE COURT
 NEW ALBANY, INDIANA 47150
 Telephone 812-321-6321
 Fax 812-287-0806

SOUTHEND OFFICE
 5120 DIXIE HIGHWAY, SUITE 103
 LOUISVILLE, KENTUCKY 40216
 Telephone 502-449-0449
 Fax 502-449-3277



Today's Date _____

Patient Data Sheet

Patient Name _____ Date of Birth _____

Occupation _____ Marital Status: Single / Married / Divorced / Widowed/ Separated

Family Doctor _____ Height _____ Weight _____

Who referred you to us? _____

Local Pharmacy/Phone #/Address _____

Reason for today's visit _____ Date of Injury _____

On a scale of 0 to 10, where 0 is no pain, and 10 is the worst pain you have ever experienced, how would you rate your pain today? (circle) 0---1---2---3---4---5---6---7---8---9---10

Are you pregnant or could you be pregnant? Y / N

Dominant Hand: Left / Right

Drug Allergies

Reaction

Drug Allergies

Reaction

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any **metals**? Y / N

Which metals? _____

Reaction: _____

Do you have any allergies to **foods**? Y / N

Which foods? _____

Reaction: _____

Do you have a **latex** allergy? Y / N

Reaction: _____

Current Medications

Dosage

Times per Day

Reason

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all Previous Surgeries

Date of Surgery

_____	_____
_____	_____
_____	_____
_____	_____

Do you smoke? Y / N If yes, how many packs per day? _____ Are you a former smoker? Y / N Quit Date: _____

Alcohol Use? Y / N How much/how often do you use alcohol? _____

Drug Use? Y / N Type/Frequency? _____

Do you have a Family History of any of the following? - Please select all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other (Please explain) _____ |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bone Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | |

Patient's Medical History - Please select all that apply to you.

- | | | |
|--|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Syncope (Fainting) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thromboembolic Disease |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Hepatitis (Type A / B / C) | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV Infection | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Transient Ischemic Attack |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cholesterol Problems | <input type="checkbox"/> Menopause | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Compartment Syndrome | <input type="checkbox"/> Migraines | <input type="checkbox"/> Staph Infection |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Wear Eyeglasses/Contacts |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Deep Vein Thrombosis/Blood Clot | <input type="checkbox"/> Fracture (Body Part) _____ |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Pulmonary Embolism | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Prostate Disorder | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prior Heart Attack | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Esophageal Reflux | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Renal Disorders | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Epilepsy/Recurrent Seizures | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other (Please List) _____ |
| <input type="checkbox"/> Rheumatoid Arthritis | | _____ |

Are you currently experiencing any of the following symptoms?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Weight Change | <input type="checkbox"/> Headache | <input type="checkbox"/> Coughing up Blood | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Eye symptoms | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Fast Heart Rate | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Unusual Fatigue | <input type="checkbox"/> Lump/swelling in Neck | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Skin Lesions |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Difficult/Painful Urination | <input type="checkbox"/> Enlarged Lymph Nodes | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Pruritus |
| <input type="checkbox"/> Blood in Urine | | <input type="checkbox"/> Easy Bruising | (Severe itching) |
| <input type="checkbox"/> Increased Urinary Frequency | | | |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Anxiety | | |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Depression | | |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Hallucinations | | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Other Psychological Problems (Please list) _____ | | |
| <input type="checkbox"/> Weakness | | | |

Physician Reviewed _____ Date _____