WELCOME TO OUR PRACTICE!

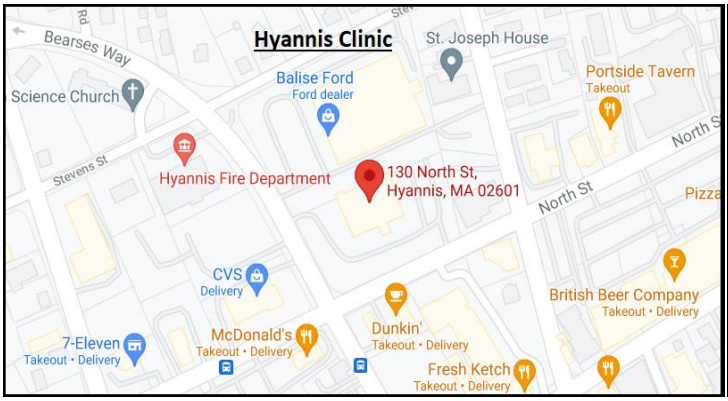
Cape Cod Orthopaedics and Sports Medicine - Cape Cod Orthopaedics Physical Therapy -

On behalf of our Physicians and Staff, thank you for choosing us for your orthopaedic and physical therapy services. As the premier provider on Cape Cod, we are working together to get you back to good health and the activities you love. We take pride in providing the highest quality care to our patients.

Enclosed you will find information to review and forms to be completed prior to your first visit. You can visit our websites: **www.capecodortho.com** and www.capecodortho.com/physical-therapy to meet our providers and learn more about the services we offer.

If this is your first visit, please arrive 15 minutes early to complete your registration process. If you encounter any delays or need assistance while waiting to see your provider, please inform our front desk staff.

If you would like to share your positive experience, or feel that your needs are not being met, please do not hesitate to contact us at reviews@capecodortho.com



Hyannis Clinic – 130 North Street Hyannis MA 02601

Sandwich Clinic – 18 6A Sandwich, MA 02563

Falmouth Clinic – 31 Edgerton Drive North Falmouth, MA 02556

Getting Ready for Your Visit

Please read over the following preparation tips to become familiar with our policies and procedures prior to your appointment. **If any documents listed below are unavailable at your appointment, it may cause delays or the need to reschedule your appointment.**

If you are unable to complete paperwork, are not mobile, or are in a rehabilitation facility: we require someone accompanies you for your visit, such as a family member or friend. *Please note: Wheelchair Transit Attendant's will not stay for your visit; they will only pick you up and drop you off.*

What to Bring

Please remember to bring the following documents to your appointment:

- Government issued photo ID
- Health insurance card and co-payment for your services. We accept payment by cash, check, VISA, MasterCard, Discover and American Express.
- If coming from outside Cape Cod Healthcare, please bring copies of relevant medical records (i.e. previous operative reports, recent radiology images and/or reports such as x-rays, MRI's, CT scans, bone scans and/or ultrasounds that relate to your problem area, recent treatment notes from another provider relevant to your problem area).
- A complete list of all medications and supplements you are currently taking, as well as dosages.
- A list of any known drug allergies and their side-effects.

When to Arrive - Please plan to arrive 15 minutes early for your appointment to allow for registration and check-in. If you are late, it may not be possible for you to be seen that day. Please contact our office staff promptly if you recognize you are going to be late for your appointment to avoid any no-show/cancellation fees.
X-Rays - Very often during treatment, your orthopaedic provider will require x-rays. Diagnostic x-rays are available at our facility. Please inform our staff if you have recently had an x-ray elsewhere related to your problem area.
What to Wear - Please dress so the body part you are having trouble with can be easily examined. Consider wearing layers that allow you to quickly and comfortably expose the body part of concern. Belts, jewelry and shoes must be removed to obtain x-rays. For physical therapy appointments, please dress in active wear and sneakers.

Billing & Insurance

Cape Cod Orthopaedics and Sports Medicine's fees are based upon the reasonable and customary charges prevailing in this area and consider the complexity of a particular problem. Additional time and more resources are required to diagnose and treat a new problem than to follow an existing one. For this reason, fees for a new patient or new problem visit are higher than fees for a routine follow up visit. If you have questions regarding our fees, please feel free to ask one of our Patient Account Representatives for clarification.

Depending on your specific insurance policy, you may need a referral authorization from your primary care physician prior to being seen in our office. If we have not received an authorization prior to your scheduled appointment, you may be rescheduled. *Note: if you were referred to our office from the Emergency Room, or local Urgent Care Center, you still need to contact your primary care physician to obtain an insurance referral, if one is required per your plan.*

You will be asked to confirm your demographic information at each visit. This is important for your insurance claim to be paid by your insurance company.

Insurance Plans
We encourage you to contact your insurance company with any questions you may have regarding your coverage prior to your appointment. Knowing your personal insurance benefits is your responsibility. Please notify us if your insurance changes throughout the course of your treatment.

Workers Compensation and Motor Vehicle Claims

- **Please notify our staff prior to checking in if you have been involved in a motor vehicle accident or injured on the job.**

We will call your carrier ahead of time to verify your accident date, claim number, and authorization for services. If we have verified your claim with your insurance carrier, no payment will be necessary from you at the time of your visit. If we are not able to verify your claim prior to your appointment, you may need to be rescheduled.

Uninsured/Non-Covered Services - In the event you are uninsured, a payment will be expected when you check in for your appointment. We do not accept travel insurance or out of country insurance. If you carry insurance we do not accept, payment is expected at the time of your appointment. We will provide you with the necessary information for you to complete and file your claim directly with your insurance carrier after your services are rendered. If you have been referred to us by the Emergency Room, you may be directed to speak with a Patient Account Representative prior to your first visit, to discuss your individual financial situation. A Good Faith Estimate will be provided for all non-covered services.

Balances/Collections - If you have an outstanding balance due, we appreciate prompt payment in full. If you are unable to make payment in full, please contact our billing department to discuss a mutually agreeable payment plan. If you are unable to pay for your services, it is important to inform our Self-pay Account Representative. In addition to payment plans, our office offers and accepts *CareCredit*, a payment option which you can apply for in the office. To ask for additional information, or to apply, please contact our Patient Accounts Department at (508) 568- 3765. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due to a collection agency. Any payment made to us in the form of a check that is returned for insufficient funds will incur a $25.00 fee, per incidence.

Durable Medical Equipment - Your course of treatment may require the use of an orthopaedic soft good, brace, or splint to facilitate your rehabilitation. We will verify your insurance benefits and file a claim with your insurance company when applicable. In cases where your insurance does not cover the required equipment, we require payment in full at the time of service. We also offer cash items, which are to be paid for when dispensed.

Surgery - If your physician recommends surgery, you will be referred to one of our Surgical Coordinators. They will answer specific questions about the surgery scheduling process, discuss paperwork and tests involved, and complete all pre-certification/authorization required by your insurance company.

Additional Bills for Surgery and Services at Another Facility

We do not perform surgery in either of our offices. All surgical procedures will be performed in a hospital or surgical facility setting. You will likely receive bills for services rendered by the facility, anesthesiologist, radiology and/or pathology. Please be sure that you understand your insurance coverage and benefits prior to undergoing surgery.

Physical Therapy (PT), Occupational Therapy (OT) and Work Conditioning

During your initial evaluation, we will discuss your plan of care, specifically tailored to meet your medical needs and goals. Treatment may include, but is not limited to; therapeutic strengthening, functional stimulation, neuromuscular re-education, manual therapy including manipulation and mobilization, therapeutic modalities, including dry needling, gait and balance training and vestibular/sensory treatment, as medically indicated.

CAPE COD ORTHOPAEDICS & SPORTS MEDICINE P.C.
CAPE COD ORTHOPAEDICS PHYSICAL THERAPY

Patient Information (Please Print)

Was your injury due to: Motor Vehicle Accident Y/N Work related Accident Y/N

Last Name: _____ First Name: _____

Middle Initial: _____ Gender: _____ Marital Status: _____ Birth Date: _____

Student: Y/N Veteran: Y/N Email address: _____

Do you have an Advanced Directive? Yes _____ No ____ Do you have Health Care Proxy? Yes ____ No ____

- **If yes**, please provide a copy to the front desk.

Would you like to sign up for the Patient Portal? Yes _____ No _____ Ask the front desk staff how!

PO Box/Mailing: _____ City: _____ State: _____ ZIP: _____

Current address: _____ City: _____State: _____ Zip: _____

Out of State address: _____City: _____ State: _____ Zip: _____

Home Phone (___) _____ Cell Phone (___) _____

Primary Employer: _____ Work number: (___) _____

Emergency Contact: _____ Relationship: _____ Phone: (___) _____

Primary Care Physician: _____

Preferred Pharmacy: _____
Name Town/Address

Who referred you to Cape Cod Orthopaedics? _____

Primary Insurance name: _____ Secondary Insurance name: _____

IF UNDER 18: Guarantor Name & Date of Birth: _____ _____

NOTICE OF AUTHORIZATION AND CONSENT TO TREAT

I hereby authorize Cape Cod Orthopedics and Sports Medicine, P.C. and its entities/affiliates/agents to evaluate and treat my condition and my examination findings as medically necessary. Treatment that I consent to, may include, but not limited to; therapeutic strengthening, functional simulation, neuromuscular re-education, manual therapy including manipulation and mobilization, physical therapy/occupational therapy modalities including dry needling, gait and balance training, and vestibular/sensory treatment, as medically intended.

Signature of Patient (or Guardian) _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT PATIENT CONSENT FORM

I understand that, under the Health Insurance and Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this 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 directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I understand that Cape Cod Orthopaedics & Sports Medicine, P.C. has the right to change its "Notice of Privacy Practices" from time to time and that I may contact Cape Cod Orthopaedics & Sports Medicine, P.C. at 508-775-8282 or by mail at 130 North Street, Hyannis, MA 02601 any time to obtain a current copy of the "Notice of Private Practices".

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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

This authorization will remain in effect until revoked by the patient.

I also authorize this practice to disclose my medical information

To my Current Primary Care Physician: Yes _____ No _____

On my answering machine/voicemail: Yes _____ No _____

To my spouse: If yes Name _____ No _____

To my adult children, additional family and or friend(s): if yes Name(s) _____

_____No _____

_____ _____

Signature of **Patient** (or Guardian / Personal Representative) Date

Print Patient's Name: _____

CAPE COD ORTHOPAEDICS & SPORTS MEDICINE P.C.

By signing below, I hereby acknowledge I have read and understand the entirety of this document.

STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS ***(Medicare Patients Only)***

I request payment of authorized Medicare benefits be paid on my behalf to Cape Cod Orthopaedics and Sports Medicine, P.C. for any services furnished by their physicians and providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits, or the benefit payable for related services.

To get Medicare payments and benefits we may need your SSN# _____

STATEMENT OF FINANCIAL RESPONSIBILITY (***Must be 18 years of age TO SIGN***)

I authorize Cape Cod Orthopaedics & Sports Medicine P.C. to release any information required during this examination and my treatment to my insurance company, primary care physician or other third party as requested by me. I also authorize and direct payment of all medical/surgical benefits directly to Cape Cod Orthopaedics & Sports Medicine, P.C. I understand my insurance and/or Medicare may not cover all charges and agree to accept responsibility for payment of those charges.

BALANCES/COLLECTIONS

If you have an outstanding balance due, we appreciate prompt payment in full. If you are unable to make payment in full, please contact our billing department to discuss a mutually agreeable payment plan. If you are unable to pay for your services, it is important to inform our Self-pay Account Representative. In addition to payment plans, our office offers and accepts *CareCredit*, a payment option which you can apply for in the office. To ask for additional information, or to apply, please contact our Patient Accounts Department at (508) 568- 3765. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due to a collection agency. Any payment made to us in the form of a check that is returned for insufficient funds will incur a **$25.00** fee, per incidence.

NO SHOW/CANCELLATION POLICY ACKNOWLEDGEMENT

I understand that Cape Cod Orthopaedics and Sports Medicine may charge a

- **$75.00** No Show/Cancellation Fee if I do not show up for an appointment & fail to cancel any office appointment within **24 hours** of the scheduled visit,
- ****$250.00** Cancellation Fee if I fail to cancel any scheduled surgery **within 7 days** of the date of surgery.

MEDICAL RECORD/ FMLA REQUEST FEE ACKNOWLEDGEMENT / MEDICAL RECORDS/XRAY RELEASE

Medical Records and Radiology Imaging - Copies of any pertinent medical records exceeding 101 pages in length may incur a $25.00 fee. If you request your x-ray on a CD, there may be a charge of $15.00. Patients and/or authorized representatives may pay prior to, or at the time of pick-up. If requested by me, I do hereby authorize release of my medical record, to me. If records or X-rays are to be released to anyone other than me, I understand that an additional authorization may be required. There may be a $35.00 fee for FMLA and/or disability paperwork to be completed by your provider. You may pay for this in advance by calling our Patient Accounts Department or pay in-person when you drop your forms off.

DURABLE MEDICAL EQUIPMENT RETURN/RESTOCKING FEE ACKNOWLEDGEMENT

I understand I will be responsible for a $15.00 Restocking Fee in the event my durable medical equipment is to be returned and condition has been inspected and approved for return, within 14 days of dispense.

Signature of Patient or Guardian _____**Date:** _____

Print Patient's Name: _____ Date of Birth_____

HISTORY OF PRESENT ILLNESS (PLEASE PRINT)

Patient Name_____ Date of birth_____ Today Date _____

Body part(s) to be evaluated: _____

Was your injury due to a: ○ Motor vehicle accident ○ Work related injury ○ Liability ○ Other

If yes, Date of injury _____ Where and how did your injury occur? _____

Have you been treated by a physician for THIS problem? ○ No ○ Yes Dr. Name_____

Was an MRI and /or X-Ray taken for THIS problem? ○ No ○ Yes If Yes, Where _____ When _____

What treatments have you had to date for THIS problem: ○ Physical Therapy ○ Splints ○ Medication

○ Surgery ○ Exercise ○ Injection ○ Chiropractor ○ Podiatrist

Preferred Pharmacy: _____

Name Town/Address

SOCIAL HISTORY

Occupation _____ Education _____

Smoke ○ Never ○ Yes ○ Former **Recreational drugs** ○ No ○ Yes **Marijuana (any form)** ○ No ○ Yes

Caffeine ○ No ○ Yes ○ **Lt handed** ○ **Rt handed** **Pacemaker** ○ No ○ Yes

Metal Foreign Object in/on your body ○ No ○ Yes **Height** _____ **Weight** _____lbs.

Did you have a drink containing alcohol in the past year? ○ **No** ○ **Yes** *If yes please answer below

- **How often did you have six or more drinks on one occasion in the past year?**

○ Never ○ Less than Monthly ○ 2 or 4 times a month ○ 2 or 3 times per week ○ 4 or more times a week

○ Declined to Specify

- **How many drinks did you have on a typical day when you were drinking in the past year**?

○ 1 or 2 drinks ○ 3 or 4 drinks ○ 5 or 6 drinks ○ 7 to 8 drinks ○ 10 for more drinks

○ Declined to Specify

- **How often did you have a drink containing alcohol in the past year?**

○ Never ○ Monthly or Less ○ 2 to 4 Times a Month ○ 2 to 3 Times a Week ○ Daily or Almost Daily

○ Declined to Specify

If over the age of 65, how many falls within the last 12 months? _____

Exercise Frequency_____ **Type of Exercise**_____

CURRENT MEDICATIONS (PLEASE PRINT) DOSAGE REASON FOR TAKING (Please provide list if apply)

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

Patient Name_____ Date of birth_____ Today Date _____

All Allergies	Reaction (Please provide list if apply)
_____	_____
_____	_____
_____	_____

SURGERIES (Side if applicable) and YEAR:

_____(_____) _____(_____) _____(_____) _____(_____)

PAST MEDICAL HISTORY & ILLNESS (PLEASE CHECK)

○ Alcoholism	○ Alzheimer's	○ Anemia	○ Arthritis	○ Asthma	○ Blood Clots
○ Cancer (TYPE)	○ Depression	○ Diabetes	○ Drug Abuse	○ High Cholesterol	○ Hypertension (HighBP)
	○ Heart Disease	○ Hepatitis	○Kidney Disease	○ Osteoarthritis	○ Seizures
○ Ulcers	○ Gout	○	○	○	○

FAMILY MEDICAL HISTORY (PLEASE CHECK)

DISEASE:	**FAMILY MEMBER(S)**
○ CANCER (TYPE) _____	○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather Maternal/Paternal Maternal/Paternal
○ DIABETES	○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather Maternal/Paternal Maternal/Paternal
○ HEART DISEASE	○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather Maternal/Paternal Maternal/Paternal
○ HYPERTENSION (HIGH BLOOD PRESSURE)	○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather Maternal/Paternal Maternal/Paternal
○ OSTEOPOROSIS	○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather Maternal/Paternal Maternal/Paternal
○ OSTEOARTHRITIS	○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather Maternal/Paternal Maternal/Paternal
○ OTHER _____	○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather Maternal/Paternal Maternal/Paternal

Please mark if you have any of these symptoms TODAY:

CONSTITUTIONAL: ○ Fever ○ Fatigue ○ Night Sweats	**SKIN:** ○ Rashes ○ Changes Skin ○ Changes Hair
HEENT: ○ Vision ○ Headaches	**NEUROLOGICAL/PSYCHIATRIC:** ○ Dizziness ○ Emotional Disturbances
CARDIOVASCULAR: ○ Chest Pain ○ Palpitations	
RESPIRATORY: ○ Cough ○ Shortness of Breath	**METABOLIC/ENDOCRINE:** ○ Cold Intolerance ○ Heat Intolerance
GASTROINTESTINAL: ○ Vomiting ○ Diarrhea ○ Constipation	**GENITOURINARY:** ○ Urinary Difficulty ○ Pain ○ Blood