



Pharmacy _____ Phone # _____
Pharmacy Address _____

New Patient Registration Form (PLEASE PRINT) TODAY'S DATE _____

How did you learn about our practice? Physician (PCP) _____
Relative ___ Friend ___ Website ___ Phone book ___ Newspaper ___ Other ___

Patient's Full Name _____ Age _____

Home Address _____
City _____ State _____ Zip _____

Home Phone Number _____ Mobile Phone Number _____

Emergency Contact Person _____ Emergency Phone Number _____

Emergency Person DOB _____ Sex M ___ F ___ Relationship to Patient _____

Patient's Email Address _____

Patient's Date of Birth _____ Social Security Number _____

Sex M ___ F ___ Marital Status (circle one) Single Married Widowed Divorced

Race (optional) Caucasian ___ Hispanic ___ African American ___ Asian ___ Other _____

Nationality American ___ Puerto Rican ___ Italian ___ Indian ___ Other _____

Patient's Employer _____ (if not employed is patient
Retired? ___ Student? ___ Homemaker? ___ Unemployed? ___)

Patient Employer Address _____
City _____ State _____ Zip _____

Employer Phone Number _____ Extension _____

Responsible Party Information (Guarantor)

Who is Financially Responsible for the Account? The responsible party can never be a child.

Is the Responsible Party the same as the Patient information? Yes___ No___ (if no please fill in the information below)

Name _____

Address _____ City _____ State ____ Zip _____

Phone Number _____

Guarantor DOB _____ Social Security Number _____

Email Address _____

If patient is a MINOR, fill in responsible parent or guardian:

Patient/Guardian Name _____

Patient/Guardian Address _____ City _____ State ____ Zip _____

Patient/Guardian Phone Number _____

Patient/Guardian Email Address _____

I acknowledge the above information is correct and I accept financial responsibility
For any services offered for my dependant or myself.

Signature _____

Date _____



Primary Insurance Information

Name of Primary Insurance _____

Primary Insurance Address _____

City _____ State _____ Zip _____

Insurance Phone Number _____

Policy Number _____ Group # _____

Is the Patient the subscriber for the Primary Insurance? Yes ____ No ____

(If no, please complete this section.)

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____

Subscriber Name _____

Subscriber Address _____

Subscriber City _____ State _____ Zip _____

Subscriber Date of Birth _____ Sex M F

Subscriber Social Security Number _____ Subscriber Phone _____

Subscriber Employer _____

Subscriber Employer Address _____

City _____ State _____ Zip _____

Subscriber Employer Phone _____

Secondary Insurance Information (if applicable)

Name of Secondary Insurance _____

Secondary Insurance Address _____

City _____ State _____ Zip _____

Insurance Phone Number _____

Policy Number _____ Group # _____

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____

Subscriber Name _____

Subscriber Address _____

Subscriber City _____ State _____ Zip _____

Subscriber Date of Birth _____ Sex M F

Subscriber Social Security Number _____ Subscriber Phone _____

Subscriber Employer _____

Subscriber Employer Address _____

City _____ State _____ Zip _____

Subscriber Employer Phone _____



INSURANCE AUTHORIZATION FORM

PATIENT ACCOUNT NUMBER

PATIENT NAME

MEDICARE

HIC NUMBER

Statement to Permit Payment of Medicare Benefits to Provider, Physician's and Patient

I request payment of authorized Medicare Benefits to me or in my behalf for any services furnished to me by St. Luke's Health Services. I authorize any holder of medical and other information about me to release to the Health Care Financing Administration (Medicare) and its agents any information needed to determine benefits or benefits for related services. I understand that I am responsible for any health insurance deductibles, co-insurances or other non-covered services.

Date

Signature- Beneficiary

Date

Other Signature

Relationship and Reason

MEDIGAP

HIC NUMBER

MEDIGAP POLICY NUMBER

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to any information needed to determine these benefits payable for related services. (Name of Medigap Insurer)

Date

Signature- Beneficiary

Date

Other Signature

Relationship and Reason

MEDICAL ASSISTANCE

RECIPIENT NUMBER

"My signature certifies that I received a service or item on the date listed below. I understand that payment for services or items will be from Federal and State Funds, and that any false claims, statements or documents, or concealment of material may be prosecuted under applicable Federal and State Laws.

I have read and agree with the above statement."

Date

Signature

WORKER'S COMPENSATION

AUTO

COMMERCIAL

Authorization to Release Medical Information- "I authorize St. Luke's Health Services to release any information required to complete my compensation, auto and/or insurance claim to my employer/insurance company pertaining to my visit(s) of

Date

Signature

Assignment of Insurance Benefits- "I hereby assign to St. Luke's Health Services (SLHS) and authorize and direct that payment be made directly to SLHS, of all benefits otherwise payable to me directly under the terms of my insurance policies (including major medical) by reason of the services described in the statements rendered by SLHS; provide that SLHS shall refund to the persons or persons entitled to receive the same, any payments in excess of its full charges. I understand that I am financially responsible for all charges not covered by this assignment"

Date

Signature



NOTICE OF FINANCIAL POLICY ACKNOWLEDGEMENT

**I HAVE RECEIVED A COPY OF ST. LUKE'S PHYSICIAN GROUP
NOTICE OF FINANCIAL POLICIES AND PROCEDURES**

SIGNATURE _____

PRINT NAME _____

DATE _____

St. Luke's Hospital and Health Network

St. Luke's Physician Group

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of St. Luke's Hospital and Health Network's
Notice of Privacy Practices.

SIGNATURE _____

PRINT NAME _____

DATE _____

COMMUNICATION CONSENT

St. Luke's Orthopaedic Specialists

Patient Name _____

DOB: _____

It is the office policy of the St. Luke's Orthopaedic Specialists and staff not to release confidential and/or unauthorized information on a home telephone, answering machine, work telephone, voice mail, or cell phone. Whenever calling your residence, we will not leave a message if the recorded message does not identify your name or phone number. Information will also not be left with an unauthorized person who may answer the phone.

I authorize the staff of St. Luke's Orthopaedic Specialists to leave medical information pertaining to my care by the following methods and will assume the responsibility to notify the office whenever the information changes.

Please complete the following and include phone numbers:

Home Phone/Answering Machine# _____ ☐ yes ☐ no

Work Telephone/Voicemail # _____ ☐ yes ☐ no

Cell Phone/Voicemail # _____ ☐ yes ☐ no

The following authorizes us to release medical information to someone other than you.

Spouse Name _____ ☐ yes ☐ no

Parent/Guardian Name _____ ☐ yes ☐ no

Other-Please list relationship:

_____ ☐ yes ☐ no

_____ ☐ yes ☐ no

Patient Signature _____
(Parent/Guardian if minor)

Date _____

Patient Name(Print) _____

St. Luke's Warren Orthopedics
Patient Information and Medical History

HT: _____
WT: _____
BP: _____

Dominant Hand: R L

Patient Name: _____ Date of Birth: _____

Family Physician: _____ Phone #: _____

My Problem is: ☐ Work Related ☐ Accident Related ☐ Other: _____

My orthopedic complaint is: _____

Body Area (specify right or left): _____

Description of problem/accident including duration: _____

Date of accident: _____

Were you treated by any other physician for this problem: ☐ yes ☐ no
If yes, name of physician: _____ Phone number: _____

Treatment: _____

Symptoms: ☐ pain ☐ Swelling ☐ Weakness ☐ Instability ☐ Other _____

Past Tests: ☐ X-rays ☐ MRI ☐ CT Scan ☐ None ☐ Other _____

Tests taken at _____

List all other physicians you see (please list names) _____

List Active Medical Problems:

| | | | | | | | | |
|-----------------------|-------|----|--------------------|-----|----|------------------------|-----|----|
| High Blood Pressure | yes | no | Diabetes | yes | no | Thyroid Disease | yes | no |
| Stroke | yes | no | Liver Disease | yes | no | Bleeding Disorder | yes | no |
| Heart Disorder | yes | no | Depression | yes | no | Asthma or COPD | yes | no |
| Seizures | yes | no | Stomach GI problem | yes | no | Kidney/bladder disease | yes | no |
| Skin disorders/ulcers | yes | no | Cancer | yes | no | Arthritis | yes | no |
| High Cholesterol | yes | no | | | | | | |
| Other | _____ | | | | | | | |

Have you ever had a Bone Density (DEXA) scan: _____ most recent _____

List past surgeries and year of surgery:

| | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

FAMILY HISTORY: Do you have any family members that have now or have had -

Cancer ☐ Yes ☐ No If yes type _____

Arthritis ☐ Yes ☐ No Osteoporosis ☐ Yes ☐ No

Other Musculoskeletal problems ☐ Yes ☐ No If yes -type of problem _____

Patient Name: _____ DOB _____

PERSONAL HABITS:

Smoking Status ☐ Current ☐ Former ☐ Never Smoked

If Current - ☐ cigarettes ☐ Pipe ☐ Cigars ☐ Number per day ☐ Years

Do you drink alcohol? ☐ Yes ☐ No If yes, how often _____ Type _____

Do you drink ☐ Coffee ☐ Regular ☐ Decaf How many cups per day? _____

☐ Tea ☐ Regular ☐ Decaf How many cups per day? _____

☐ Cola ☐ Regular ☐ Caffeine free How many cups per day? _____

Please list all active medications you currently take:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

List Allergies to Medications: _____

Please Circle all that apply

Are you experiencing problems with:

GENERAL: Fever – Chills – Feeling Poorly – Feeling Tired – Weight loss (☐ lbs)– Weight Gain(☐ lbs)

ENT: Eyesight Problems – Red Eyes – Loss of Hearing – Nosebleeds – Sore Throat

CARDIAC: Chest Pains – Palpitations – Leg Pain – Leg Swelling

RESPIRATORY: Shortness of Breath – Wheezing – Cough

ABDOMINAL: Abdominal Pain – Constipation – Diarrhea – Nausea – Vomiting – Bloody Stools

URINARY: Painful Urination – Difficulties Urinating – Urinary Incontinence

MUSCULOSKELETAL: Joint Pain – Joint Stiffness – Joint Swelling – Muscle Pain – Arm/Leg Pain – Arm/Leg Swelling

SKIN: Skin Rashes – Skin Lesions – Itchy Skin – Dry Skin – Open Wounds

NEURO: Headache – Confusion – Dizziness – Numbness – Tingling

ENDOCRINE: Muscle Weakness – Frequent urination – Excessive thirst – Feelings of Weakness

PSYCH: Suicidal – Depression – Anxiety

Reviewed by: _____
Physician/NPP Signature

Date: _____

Patient Name: _____ DOB _____

PERSONAL HABITS:

Smoking Status ☐ Current ☐ Former ☐ Never Smoked

If Current - ☐ cigarettes ☐ Pipe ☐ Cigars ☐ Number per day ☐ Years

Do you drink alcohol? ☐ Yes ☐ No If yes, how often _____ Type _____

Do you drink ☐ Coffee ☐ Regular ☐ Decaf How many cups per day? _____

☐ Tea ☐ Regular ☐ Decaf How many cups per day? _____

☐ Cola ☐ Regular ☐ Caffeine free How many cups per day? _____

Please list all active medications you currently take:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

List Allergies to Medications: _____

Please Circle all that apply

Are you experiencing problems with:

GENERAL: Fever – Chills – Feeling Poorly – Feeling Tired – Weight loss (☐ lbs)– Weight Gain(☐ lbs)

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PSYCH: Suicidal – Depression – Anxiety

Reviewed by: _____

Physician/NPP Signature

Date: _____

ST. LUKE'S HOSPITAL & HEALTH NETWORK

NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. **WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**

We are legally required to protect the privacy of your health information. We call this information protected health information, or PHI for short, and it includes information that can be used to identify you, that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish this purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in the appropriate areas. You can also request a copy of this notice from the contact person listed in Section VI below at any time and can view a copy of the notice on our web site at <http://www.slhnn.org>.

III. **HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

A. **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**

We may use and disclose your PHI for the following reasons:

1. **For Treatment.** We may disclose your PHI to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical rehabilitation department in order to coordinate your care.
2. **To Obtain Payment for Treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided for you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies, and others that process our health care claim.
3. **For Health Care Operations.** We may disclose your PHI in order to operate this provider. For example, we may use your PHI in order to evaluate the quality of health care services that you received or evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

B. **Certain Uses and Disclosures Do Not Require Your Consent.** We may use and disclose your PHI without your consent or authorization for the following reasons:

1. **When a Disclosure is Required by Federal, State, or Local Law, Judicial or Administrative Proceedings, or Law Enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; or when ordered in judicial or administrative proceedings.
2. **For Public Health Activities.** For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.
3. **For Health Oversight Activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **For Purposes of Organ Donation.** We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.
5. **For Research Purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.
6. **To Avoid Harm.** In order to avoid serious threat to health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
7. **For Specific Government Functions.** We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
8. **For Workers' Compensation Purposes.** We may provide PHI in order to comply with workers' compensation laws.
9. **Appointment Reminders and Health-Related Benefits or Service.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.
10. **Fundraising Activities.** We may use PHI to raise funds for our organizations. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed in Section VI below.

C. Two Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Patient Directories.** We may include your name, location in this facility, general condition, and religious affiliation, in our patient directory for use by clergy and visitors who ask for you by name, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
2. **Disclosures to Family, Friends, or Others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. All Other Uses and Disclosures Require Your Prior Written Authorization.

In any other situation not described in sections IIIA, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

IV. WHAT RIGHT YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

- A. The Right to Request Limits on Uses and Disclosures of your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.
- B. The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.
- C. The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within thirty days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request copies of your PHI, there will be a charge based on state and federal regulations.
- D. The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of whom we have released your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or healthcare operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14, 2003.

We will respond within sixty days of receiving your request. The list we will give you will include releases made up to the last six years. The list will include the date of the release, to which PHI was released (including their address, if known), a description of the information released, and the reason for the release. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you in accordance with the state and federal regulations.
- E. The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within six days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not request a statement of disagreement, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.
- F. The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact

Chief Compliance & Privacy Officer
St. Luke's Hospital & Health Network
801 Ostrum Street
Bethlehem, PA 18015
484-526-3100

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

FINANCIAL POLICY

It is the policy of this practice as a member of St. Luke's Physician Group, to have a Financial Policy that clearly outlines patient and practice responsibilities. We are committed to providing our patients with the best possible medical care while minimizing administrative costs. This Policy has been developed with these objectives in mind, and to avoid any misunderstandings or disagreements concerning payment for professional services.

Please read the following carefully:

For patients who do not have insurance:

- Patients who do not have any insurance coverage are expected to pay for services rendered at the time of the visit. Financial assistance may be available for qualified patients. If a patient feels that he or she may qualify for assistance, the practice receptionist should be notified at the appointment check in.
- Payment plans are available for patients who meet the minimum requirements.

For patients who are currently covered by insurance:

- The patient is responsible to provide us with valid health insurance information, and should bring their insurance card to each visit.
- Our office participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services using a standard CMS 1500 claim form.
- St. Luke's Physician Group bills secondary insurances as a courtesy to our patients.

If you have a plan that our practice participates with:

- The patient is responsible to pay any co-payment or any portion of the charges as specified by the plan at the time of the visit
- Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of the visit. Specific coverage issues should be addressed by the insurance company's member services department (telephone number is on the insurance card).

If you have a plan that our office does not participate with:

- If a patient has insurance that we do not participate in, our office will file a claim upon request, but payment is expected at time of service.

If you are covered by an HMO or Managed Care Plan:

- The patient is responsible to pay any co-payment or any portion of the charges as specified by the plan at the time of the visit.
- The patient is responsible to ensure that any required referrals for treatment are provided to the practice **at the time of visit**. Non-emergent visits may be rescheduled, or the patient may be financially responsible due to the lack of the referral.

Other:

- The office reserves the right to charge for the completion of forms. For example, insurance, disability or medication programs, and the copying of medical records.
- Any outstanding patient balance that is either not paid in full or under a payment plan agreement will be transferred to an outside collection agency.