ALL PAGES MUST BE COMPLETED AND SIGNED PRIOR TO ARRIVAL

SECKLER ORTHOPEDICS & SPORTS MEDICINE
2444 HIGHWAY 34-SUITE B, MANASQUAN NJ 08736
WWW.SECKLERORTHO.COM **Phone: 732-528-4407** **Fax: 732-528-4525**

PATIENT LAST NAME_____ FIRST NAME_____ MI_____

ADDRESS_____ CITY_____ STATE_____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

BIRTH DATE _____ AGE _____ □ MALE □ FEMALE □ Single □ Married □Widowed □ Separated □ Divorced

SOC SEC # _____ DRIVERS LICENSE # _____ STATE_____

EMPLOYER NAME, ADDRESS, PHONE _____

OCCUPATION _____ E-MAIL ADDRESS (To access your medical records) _____

□ FULL TIME STUDENT □ PART TIME STUDENT PATIENT RESIDES WITH: □ SELF □ PARENT/GUARDIAN □ SPOUSE □ OTHER_____
EMERGENCY CONTACT NAME & RELATION_____PHONE _____

PRIMARY INSURANCE- CARD MUST BE PRESENTED AT VISIT, **IF UNINSURED, INITIAL HERE _____**

INSURANCE COMPANY_____ ADDRESS _____

EFFECTIVE DATE _____ PLAN TYPE: [ ] HMO [ ]POS [ ]PPO [ ]EPO [ ]Other_____ (**Patient responsible for referrals if required**)

POLICY HOLDER LAST NAME _____ FIRST NAME _____ MI _____

BIRTHDATE _____ RELATIONSHIP TO PATIENT: □ SPOUSE □ PARENT/GUARIDAN □ OTHER_____

EMPLOYER NAME, ADDRESS, PHONE _____ OCCUPATION _____

SECONDARY/SUPPLEMENTAL INSURANCE – CARD MUST BE PRESENTED AT VISIT, **IF NO OTHER INSURANCE, INITIAL HERE _____**

INSURANCE COMPANY_____ ADDRESS _____

EFFECTIVE DATE _____ PLAN TYPE: [ ] HMO [ ]POS [ ]PPO [ ]EPO [ ]Other_____(**Patient responsible for referrals if required**)

POLICY HOLDER LAST NAME _____ FIRST NAME _____ MI _____

BIRTHDATE _____ RELATIONSHIP TO PATIENT: □ SPOUSE □ PARENT/GUARIDAN □ OTHER_____

EMPLOYER NAME, ADDRESS, PHONE _____ OCCUPATION _____

MINORS MUST BE ACCOMPANIED BY PARENT OR LEGAL GUARDIAN TO ALL APPOINTMENTS.
⬇ PARENT/GUARDIAN MUST SIGN ALL PAGES IF PATIENT (18-26) RESIDES WITH YOU AND IS COVERED UNDER YOUR PLAN:
□PARENT □LEGAL GUARDIAN SIGNATURE: _____ PHONE _____

Any person who knowingly or with intent to defraud any insurance company or other persons, provides false or misleading information, therefore commits an act of insurance fraud, which is a crime, subject to prosecution and or civil penalties. The information contained herein, is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to MARK M. SECKLER, M.D. and understand that I am financially responsible. I authorize the release of the above information required to process medical claims.

➡**GUARANTOR SIGNATURE _____ DATE_____**

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732-528-4407
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PATIENT NAME _____ **BIRTHDATE**_____

PAIN – INJURY – ACCIDENT ASSESSMENT

NOT FOR WORK OR MOTOR VEHICLE

NAME, ADDRESS PHONE OF YOUR FAMILY DOCTOR_____

PHARMACY NAME, STREET/TOWN, PHONE _____

WHO/HOW WERE YOU REFERRED TO OUR OFFICE _____

REASON FOR APPOINTMENT TODAY: □KNEE □SHOULDER □OTHER _____**□RIGHT □LEFT □BILATERAL**

□ Sudden Pain □ Gradual onset □ INJURY or □ ACCIDENT Details: _____

WHAT DO YOU THINK CAUSED THIS? _____

List any other treatment past or present you have had on this same body part _____ **When** _____

How long have you had any symptom(s) _____ **List all symptoms** _____

Where were you when you first noticed symptoms? □ HOME □ SCHOOL □ OTHER_____ **This form is NOT for Work or MVA**

List any other Physician(s)/Hospital you saw for this problem _____

Did you have x-rays or MRI taken? □NO □YES: When _____ **Where** _____

List any medications you are or have taken for this problem

Name of Medication	Dosage	Frequency	Last Dose Date/Time

On a scale between 0 (least) and 10 (worst), how severe is your pain _____

0 1 2 3 4 5 6 7 8 9 10

What relieves your pain/discomfort _____

What aggravates your pain/discomfort _____

Have you contacted any attorney □NO □YES, Name and Address _____

Please note: the Doctor will not complete disability forms during your visit. All Forms will be completed and mailed 7-10 working days from the date of your surgery, or from the date which the Doctor renders you disabled. There may be a fee for completing forms. Medication requests and or prescription refills will be taken Monday through Friday *during office hours only*.

➡**Signature**_____ **Date**_____

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PATIENT NAME _____ **BIRTHDATE**_____

Patient Medical History

Please check if you have had any of the following:

□ Alcoholism	□ CVA	□ Liver Disease
□ Anemia	□ Dementia / Alzheimer's	□ Migraine
□ Anxiety	□ Disc Disease	□ Multiple Sclerosis
□ Arrhythmia	□ DJD	□ Nephrolithiasis
□ Arthritis	□ Depression	□ Obesity
□ Asthma	□ DM Type I	□ Osteoarthritis
□ Atrial Fibrillation	□ DM Type II	□ Osteoporosis
□ Bronchitis	□ Emphysema	□ Prior MI
□ CAD	□ Epilepsy	□ Pulmonary Disease
□ Cancer Type:_____	□ Fracture	□ Rheumatoid Arthritis
□ Cardiovascular Disease	□ GERD	□ Seizures
□ CHF	□ Glaucoma	□ Sickle Cell Disease
□ Crohn's Disease	□ Hepatitis	□ STD
□ Cirrhosis	□ High Cholesterol	□ Thyroid Disease
□ Colitis	□ Hyperlipidemia	□ TIA
□ Constipation	□ Hypertension	□ Tuberculosis
□ COPD	□ Implanted Medical Devices	□ Ulcers
□ CRF	□ Kidney Disease	□ Valve Problems

□Other_____

FEMALES: Is there any chance you may be pregnant? □ Yes □ No Last date of menses:_____

Past Surgical History: □ No prior surgical history Sign here: _____

□ Shoulder Surgery	Date_____	□ Appendectomy	Date_____
□ Spinal Surgery	Date_____	□ D & C	Date_____
□ Knee Surgery	Date_____	□ Hysterectomy	Date _____
□ Total Knee Replacement	Date_____	□Tonsillectomy	Date_____
□ Total Hip Replacement	Date_____	□ Tubal Ligation	Date_____
□ Other _____	Date_____	□ Mastectomy	Date_____

□ **ANY/ALL Surgical Complications: □ NO □ YES, describe_____ Date_____**

□ **ANY/ALL Infections: □ NO □ YES, describe:**_____ **Date**_____

□ **DVT (BLOOD CLOT) □ NO □ YES Date**_____

Any problems with anesthesia? □ NO □ YES, describe:_____

PLEASE DESCRIBE ALL COMPLICATIONS/INFECTIONS/PROBLEMS ON THE BACK OF THIS PAGE ➡

➡**Signature**_____ **Date**_____

FOR OFFICE USE ONLY:

HT _____ ***WT***_____ ***PULSE***_____ ***BP***_____ ***Note:***_____

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PATIENT NAME _____ **BIRTHDATE**_____

LIST ALL CURRENT MEDICATIONS & DOSAGE

□ Initial here if taking NO MEDICATIONS _____

MEDICATION	***DOSE***	***FREQUENCY***

LIST ALL ALLERGIES & REACTION

□ Initial here if NO KNOWN ALLERGIES _____

ALLERGY	***REACTION***

Health Habits

Caffeine: _____cups/day

Alcohol: □ Never □ Social: ____ drinks per week: □ Beer □ Wine □Other:_____

Tobacco □ Never □ Currently □ Previously pack(s)/day for _____years □ Cigarette/Cigar □ Pipe □ Chew/ Smokeless □ Quit: When_____

Drug Use: Prescription □ Never □ Recovering □ Current Specify:_____
Recreational □ Never □ Recovering □ Current Specify:_____

Signature_____ **Date**_____

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PATIENT NAME _____ **BIRTHDATE**_____

R.O.S. -Please check if you have the following:

□ Joint Pain	□ Radiculopathy	□ Fractures
□ Back Pain	□ Joint Stiffness	□ Sudden unexplained fractures
□ Loss of appetite	□ Recent change in weight	□ Fatigue (Tired)
□ Fever	□ Chills	□ Night Sweats
□ Headache	□ Vision Problems	□ Ear pain
□ Hearing difficulty	□ Sinus Problems	□ Neck Stiffness
□ Chest Pain	□ Ankle swelling	□ Cold hands or feet
□ Palpitations	□ Heart murmur	□ Persistent cough
□ Shortness of breath	□ Difficulty Breathing	□ Chest congestion
□ Nausea	□ Vomiting	□ Diarrhea
□ Constipation	□ Abdominal Pain	□ Polyuria (Frequent Urination)
□ Excessive Thirst	□ Heat intolerance	□ Cold intolerance
□ Seizures	□ Dizziness	□ Numbness
□ Tingling	□ Confusion	□ Sensory Disturbances
□ Anxiety	□ Depression	□ Panic Attacks
□ Suicidal Thoughts/Attempts	□ Sleep Disturbances	□ Mood Disorders
□ Emotional Problems	□ Depression Screening Completed	□ Easy Bleeding tendency
□ Easy Bruising tendency	□ Frequent Infections	
□ Food Allergy	□ Environmental Allergies	

Preventive Care: ***Have you had any of the following? If so, please provide the date.***

□ Last Complete Physical Exam	___/___/___	□ Bone Density	___/___/___
□ Colonoscopy	___/___/___	□ Mammography	___/___/___
□ Flexible Sigmoidoscopy	___/___/___	□ Chlamydia Screening	___/___/___
□ PSA	___/___/___	□ HIV Testing	___/___/___
□ Stool Occult Blood	___/___/___	□ Flu Vaccine	___/___/___
□ Stress Test	___/___/___	□ Pneumovax	___/___/___
□ Routine Eye Exam	___/___/___	□ Zoster Vaccine	___/___/___
□ Dilated Eye Exam	___/___/___	□ Tdap Vaccine	___/___/___
□ Foot Exam	___/___/___	□ TD	___/___/___
□ HPV	___/___/___	□ Tuberculin PPD	___/___/___

General Family History (Please Circle: Mother, Father, Sibling)

Mother □ Living □ Deceased Age_____ Cause_____ **Father** □ Living □ Deceased Age_____ Cause_____

□ Ankylosing Spondylitis	M	F	S	□ Colitis	M	F	S	□ Kidney Disease	M	F	S
□ Arthritis	M	F	S	□ COPD	M	F	S	□ Liver Disease	M	F	S
□ Alcoholism	M	F	S	□ Crohn's Disease	M	F	S	□ Osteoarthritis	M	F	S
□ Anemia	M	F	S	□ CVA / TIA	M	F	S	□ Osteoporosis	M	F	S
□ Anxiety	M	F	S	□ Depression	M	F	S	□ Psoriasis	M	F	S
□ Asthma	M	F	S	□ Diabetes	M	F	S	□ Pulmonary Disease	M	F	S
□ Bleeding Disorder	M	F	S	□ Epilepsy	M	F	S	□ Renal Disease	M	F	S
□ CAD	M	F	S	□ GERD	M	F	S	□ Rheumatoid Arthritis	M	F	S
□ MI's	M	F	S	□ Gout	M	F	S	□ SLE	M	F	S
□ CHF	M	F	S	□ Hypertension	M	F	S	□ Thyroid Disease	M	F	S

Signature_____ **Date**_____

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SECKLER ORTHOPEDICS & SPORTS MEDICINE
WWW.SECKLERORTHO.COM
FINANCIAL POLICY

Patient Name:_____ Date of Birth: _____

The undersigned guarantor acknowledges and agrees to the following:

Your **original insurance card**(s) (no photo copy) and a Government issued **PHOTO ID** (driver's license, etc.) is **required** in accordance with FTC Red Flag Regulations. Letters or receipts of premium payments will not be accepted as proof of insurance. It is the patient or guarantor's responsibility to provide **current, complete and accurate information**, and to **notify us immediately of any changes** such as insurance, address, phone numbers, etc. If you neglect to do so within the time limits for filing, you will be held liable for any balance due caused by such omission. Our office will bill only those insurance carriers with whom we participate. **If we do not participate with your insurance plan(s), you are expected to pay for services at the time of your appointment**. We will provide you with an itemized receipt for you to submit your own claim(s) at the time of service; we will not bill you after the fact. ***It is your responsibility to retain your itemized receipts, as they will not be re-printed for tax or other purposes***. **We will not bill tertiary (3rd) insurance plans**, and we do not accept attorney letters of protection and or case settlement agreements.

If your plan requires a **referral** from your Primary Care Physician, **it is your responsibility to know, and to obtain one**. If required and you do not present one at the time of your appointment, you shall be responsible for payment. It is your responsibility to know your plan's requirements.

Copays are **expected at each visit**; otherwise your appointment may be rescheduled. **Copays not paid at the time of service are subject to a $5 per month outside billing service fee.** We may bill secondary insurance(s) for coinsurance and deductibles only (not copays), provided that we participate with your secondary plan**.** **Balances** that are not satisfied and or covered by insurance(s) are the responsibility of the patient and or guarantor, and **are due in full within 30 days of the billing cycle. Partial payment agreements must be made with the billing manager and approved by the Doctor within 10 days** of the 1st billing cycle, and must equal 25% of the original balance and or will not exceed 6 months. Non-payment or take-backs by your insurance plan as a result of inaccurate and or invalid information, lapse or termination of coverage, and or policy exclusions, will be the responsibility of the patient or guarantor. The patient or guarantor also acknowledges full responsibility for payment to Mark M. Seckler resulting in balances due for non-payment of market place health insurance premiums and or take backs. All payments are due for the amount billed within 30 days of billing statement date. It is your responsibility to know and understand the provisions of your insurance plan, and any questions or concerns should be directed to your employer's health benefits coordinator, or your insurance company.

We accept VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, PERSONAL CHECKS, AND CASH. When you present a personal check, debit or credit card, you authorize Wells Fargo to use the information to make an electronic fund transaction from your account. Funds may be withdrawn as soon as the same day. Wells Fargo. requires: **checks must be U.S. Bank, first party only (no business or third party), Name and street address must be printed on the check, NO P.O. Boxes, and the Phone number and Driver's license number of checking account holder must be on the check.** We must see the driver's license of the person presenting the check, and the check date must not differ more than 1 day. **Checks returned by the bank for any reason are subject to $25 bank fee penalty**. ALL further payments must be made by cash or certified cashier's check only. If your account falls more than 90 days into arrears, we shall refer your account to a collection agency, and shall seek reimbursement for all costs incurred including but not limited to filing fees, agency fees, and legal fees. We reserve the right to charge and collect interests at the maximum amount allowed by the laws of this State.

There is a **fee for copies of medical records**, x-rays, and or chart notes in accordance with N.J.S.A. 47:1A-5b, 5c, and or completion of insurance and or disability forms. A copy of our "Fees Policy" will be provided at your request.

IMPORTANT: While we do understand true emergencies, we request the courtesy of a phone call if you are unable to keep your appointment. You will be responsible to pay $50 each time you NO SHOW or fail to provide us with at least 1 FULL business day- advanced notice of cancellation. After 2 such occurrences, no further appointments shall be given. We do not make appointment reminder calls. Any person who knowingly or with intent to defraud any insurance company or other persons, provides false or misleading information concerning any fact(s), therefore commits an act of insurance fraud, which is a crime, subject to criminal prosecution and or civil penalties.

➡ **Guarantor Signature: _____ Date: _____**

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USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
HOW WE PROTECT YOUR MEDICAL IDENTITY

YOU MAY REQUEST A COPY OF THIS DOCUMENT

The privacy of your medical record is important to us, and we are committed to the privacy of your information. We only share your PHI between our providers and facilities as necessary to carry out treatment, payment or health care operations related to the services our physician(s) render. We do so by means of electronic exchange through a secure-encrypted network.

I authorize MARK M. SECKLER, M.D., to discuss with and or release my medical and or billing information to:

NAME:_____ Relationship:_____

ADDRESS: _____ Phone # _____

Treatment: We may use and disclose your PHI to provide, coordinate and or manage your health care and related services. We may also disclose your PHI to other physicians who may be treating you, or whom you may have been referred to, to ensure that the physician has adequate information to diagnose and treat you. We may also disclose your PHI to other providers such as laboratory, specialist, etc., who at the request of the physician, becomes involved in your care.

Payment: Your PHI will be used as needed, to obtain payment for the health care services our physician provided to you.

Health Care Operations: We may disclose, as needed, your PHI in order to conduct certain operational activities, such as quality assessment activities.

Most people think the risk of identity theft is related only to their financial records or social security number. However, you need to be aware of the risk of someone acquiring your insurance information to receive medical services under your insurance coverage. If someone uses your insurance identity to obtain services, your medical record could be compromised in a way that would be contradictory to your health history.

The FTC (Red Flag Rules) requires physician's offices to have in place, measures to ensure the protection of a patient's health record. This is the reason we compel our patients to show photo identification at the time of your visit. Please be accommodating to our staff when they ask, as this is part of the process in helping to protect your information.

You should contact the Federal Trade Commission @ 877-FTC HELP to report suspicious activity.

Because we are a Medicare Provider, the government requires us to collect certain data about our patients for statistical reasons. When providing it to the government, it does not contain your name, address or any other contact information. Your answers are completely voluntary. ***Please initial here if you choose not to disclose this information _____***

WHAT IS YOUR PRIMARY LANGUAGE? □ English □ Spanish □ Other _____ (specify)

YOUR RACE: □ American Indian or Alaskan Native □ Asian □ Black or African American
□ Native Hawaiian or Pacific Islander □ White

Your Ethnicity: □ Hispanic or Latino □ NOT Hispanic or Latino

➡**Patient/Guardian/Guarantor Signature: _____ Date: _____**

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PATIENT NAME _____ BIRTHDATE_____

***MEDICARE LIFETIME SIGNATUIRE ON FILE**

I request payment of authorized Medicare benefits to be made on my behalf to the rendering physician for any services furnished to me by the physician. I authorize any holder of medical information about me to be release to Medicare and its agents in order to determine benefits.

➡ **MEDICARE** BENEFICIARY SIGNATURE_____ DATE_____

PRIVATE INSURANCE AUTHORIZOATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits to the physician. I understand I am financially responsible for any amount not covered by my insurance. I also authorize the physician to release to my insurance company, any information concerning health care advice, treatment, or supplies provided to me. I permit a copy of this authorization to be used in place of the original.

MEDICAL RECORDS RELEASE

I authorize release of my medical records to MARK M. SECKLER, M.D., and permit a copy of this authorization to be used as the original. I authorize the rendering physician to release information and photocopies of the course of my treatment with the understanding that it will be used for the

CONSENT

I consent to INTRA-OPERATIVE photographs that may be taken for medical, insurance and or legal purposes, provided that my name is neither revealed nor listed in any medical publication.

RECENT CHANGES IN THE HEALTHCARE INDUSTRY REQUIRE YOU TO SIGN AND DATE

I understand and agree that it is my responsibility to know my specific insurance coverage, including but not limited to, obtaining and providing SECKLER ORTHOPEDICS with referrals, and to notify his office of any changes to the aforementioned information, including but not limited to: Name, address, telephone, and or insurance coverage. I understand and agree that if I fail to do so, any charges resulting from such will become my financial responsibility.

I acknowledge and accept supplemental financial responsibility for any or all of the following:

□ I am uninsured □ I cannot show proof of insurance □ Seckler Orthopedics not a network provider with _____Insurance

□ No insurance referral from my PCP on file □ Insurance has lapsed/expired □ Workplace/Work related , no claim on file

® Services not covered by the provisions of my health insurance policy.

Any person who knowingly or with intent to defraud any insurance company or other persons, provides false or misleading information, therefore commits an act of insurance fraud, which is a crime, subject to prosecution and or civil penalties. The information contained herein, is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to MARK M. SECKLER, M.D. and understand that I am financially responsible. I authorize the release of the above information required to process medical claims.

➡ PATIENT/GUARDIAN/GUARANTOR SIGNATURE_____ DATE_____