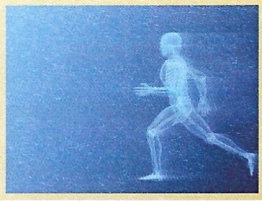
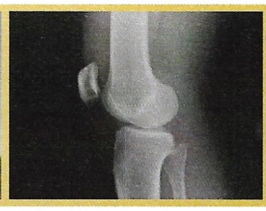
Vipul Dua, M.D.
Orthopedic Surgery
Joint Reconstruction
Hip & Knee Surgery
Arthroscopic Surgery






PATIENT INFORMATION:

Date:

Last Name:	First Name:		Middle:
Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Social Security #:	
Sex: M F	Marital Status: M S W D	Birthdate:	Age:
Employ Status: F/T P/T Not Employed Self Employed Retired Military		Student Status: F/T P/T Not a Student	
Employer:		Occupation:	
Employer's Address:		Work Phone#:	ext:
Financially Responsible Person (over 18-self: under 18-guardian):		Driver's License #:	
Street Address:	City:	State:	Zip:
Employer:		Phone#:	
Emergency Contact:		Phone#:	
PRIMARY CARE PHYSICIAN	**ADDRESS**		

Please present insurance cards and photo identification to receptionist

INSURANCE INFORMATION:

Primary Insurance	Secondary Insurance
Insurance Company	Insurance Company
Company Address	Company Address
Card Holder's Name	Card Holder's Name
Card Holder's SocSec #	Card Holder's SocSec #
Card Holder's Birthdate	Card Holder's Birthdate
Patient's ID# Group#	Patient's ID# Group#
Card Holder's Employer	Card Holder's Employer
Relationship to Insured: Self____Spouse____Dependent____	Relationship to Insured: Self____Spouse____Dependent____

COMPLETE THIS SECTION ONLY FOR WORK RELATED INJURY OR MOTOR VEHICLE ACCIDENT

Worker's Compensation Carrier	Auto Insurance Carrier
Did you fill out first report of Injury? Y N	Do you have medical coverage on your Auto Insurance? Y N
Date of Injury	Date of Accident
Insurance Company	Insurance Company
Company Address	Company Address Phone#
Contact Person Phone#	Insured's Name
Claim#	Claim/Policy#

Vipul Dua, M.D.
PATIENT FINANCIAL POLICY

Thank you for choosing Vipul Dua, M.D. for your orthopedic care.

We sincerely hope that by sharing our financial expectations we will strengthen the practice-patient relationship and keep the lines of communication open. This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the below policies, please feel free to contact our Billing Company 860-282-4103.

Patient Cancellation & Missed Appointment Policy

- In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.
- If you need to reschedule or cancel an appointment, we require a minimum of 24 hrs. notice. Please call the office at (860) 644-5900.
- Missed appointments or last-minute cancellations leave empty appointment times; as well as other patients waiting to receive medical care. For that reason, patients that do not notify the office of a cancellation and are not present for their scheduled appointment will be charged a $25 fee. We realize that on a rare occasion, emergencies may arise, and we will address these situations with you at that time. We thank you for working with us to ensure services are provided to you in the best possible way.

Self-Pay Accounts

We designate accounts, Self-Pay, under the following circumstances: (1) patient is covered by an insurance plan that our provider(s) do not participate in, (2) patient does not have a current, valid insurance card on file, (3) patient does not have a valid insurance referral on file, or (4) patient does not have health insurance coverage.

Payment is Due At the Time of Service

- We accept cash, checks and credit cards.
- All co-payments, deductibles and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.
- Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule.
- If your co-payment is based on a percentage and you do not have a secondary policy, please be prepared to pay the percentage required by your plan on the date of service.
- Patient-responsible balances from prior visits are due at the time of check in.
- In the event that you need surgery and you do not have health insurance coverage, we require a down payment of 50% of the estimated doctor's fees before we can schedule the surgery.

Proof of Insurance

- Please bring your insurance card(s) with you to each appointment.
- It is your responsibility to inform the reception staff when the cause of treatment may be the responsibility of an auto insurance, liability insurance company, worker's compensation – instead of your regular health insurance carrier. You are responsible to provide the office with all information required to bill the carrier responsible in these cases when you check in for your appointment.
- We do not accept Letters of Protection from Attorney offices for possible litigation cases.
- It is your responsibility to notify the practice of changes in your health insurance.

Billing, Payments and Refunds

- All balances are due in full within 14 days of the statement date.
- If you cannot pay the balance in full within 14 days, please contact our Billing Company (860-282-4103) to see if you qualify for possible payment options.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.

We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or discharge your care as a patient of this practice.

Referrals

If your insurance plan has a designated primary care physician (PCP) and you are required to obtain a written referral from that doctor, you must provide the office with that referral at the time of check-in. If you do not have a current valid referral, we may ask you to either reschedule your appointment or pay for the visit at the time of service.

Legal Guardianship

If you have legal guardianship over a minor, you must provide the office with a copy of the appropriate guardianship papers so that we may examine and treat the patient and release medical information to you.

* **Patient Signature:**_____ **Date:**_____

Consent for Care:

I hereby authorize Vipul Dua, M.D. or their assistants to perform diagnostic and therapeutic measures on

* **Patient Signature:**_____

If the patient is a **MINOR**:

Patient Name:_____ **Signature of Parent or Guardian:**_____

Medical History Form **Vipul Dua MD Alexandr Tarasyuk PA-C**

Patient Name: _____ Date: _____
Age:_____ Sex: ☐F☐M Dominant Hand ☐Right ☐Left **Height**_____ **Weight**_____
Who referred you to our office?_____ Who is your **Primary Care** Physician?_____
Are you **ALLERGIC** to or **have reactions** to any **medications, latex, metal or food**? No ☐ Yes ☐ If YES, Describe:
_____
List **ALL** medications, herbs, supplements you take **now**: _____
_____

Are you on any **BLOOD THINNERS, NSAIDs or ASPIRIN**? If Yes, which ones_____
Which body part are we seeing you for? ☐ **Right** ☐**Left**
☐**Shoulder** ☐ **Elbow** ☐**Wrist** ☐**Hand** ☐**Hip** ☐**Knee** ☐**Ankle** ☐**Foot** ☐**Neck** ☐**Back** ☐**Other**_____
What is the reason for you visit? ☐Pain ☐Numbness ☐Weakness ☐Swelling ☐Stiffness
How long has this pain been bothering you? _____days/ weeks/ months /years
Have you had a problem like this before? ☐No ☐Yes If yes, how long ago? _____
Check the **ONE** box that best described how your problem started:
☐**No Injury** Onset was ☐gradual ☐sudden
☐**Injury** ☐ accident ☐sport Date: _____ Describe_____
☐**Injury at work** Date: _____ ☐lift ☐twist ☐fall ☐bend ☐pull ☐reach☐other_____
☐**Work related** (but NO injury) Date: _____ How did your job cause the problem? _____
☐**Auto Accident** Date: _____ How was your car hit? _____
Describe Symptoms

On a 1-10 scale (10 is worst) how **severe** is your pain? (circle) 1 2 3 4 5 6 7 8 9 10
What is the QUALITY of the pain? ☐ sharp ☐ dull ☐ stabbing ☐ throbbing ☐ aching ☐ burning
The pain is: ☐constant ☐comes and goes (intermittent) Does the pain wake you from sleeping?☐Yes☐No
Since it **started**, the pain is: ☐getting better ☐getting worse ☐unchanged
Do you **now** have: ☐swelling ☐ bruising ☐numbness ☐tingling ☐weakness ☐loss of bowel or bladder control
☐ locking ☐catching ☐giving away ☐stiffness/pain when standing
What makes the pain **worse**?☐ standing ☐walking ☐lifting ☐exercise ☐twisting ☐lying down☐bending ☐stairs
☐ squatting ☐kneeling ☐sitting ☐coughing ☐sneezing ☐reaching over head
Which of these makes symptoms **better**?☐rest ☐ice ☐heat ☐elevation☐other_____
Have you had any of these treatments? ☐ injection ☐brace ☐ therapy ☐cane/crutches ☐medication ☐none
Were you seen in the ER for this problem? ☐ yes ☐no Which ER? _____ Date:_____
What tests have you had for this problem?☐ X-rays ☐MRI ☐CT ☐Bone Scan ☐nerve test (EMG) ☐lab work
Where were they done? _____ Did you bring them today? ☐Yes ☐No

Have you ever had surgery for a problem in the same area?☐ No☐Yes Please list below if yes.
Procedure: _____ Date: _____ Surgeon: _____ City: _____
Procedure: _____ Date: _____ Surgeon: _____ City: _____

Current work status: ☐regular duty ☐light duty- (how long) _____☐Disabled ☐Retired ☐Student
When was the last date you worked your regular job? _____
Are you currently receiving or applying for: ☐ Disability ☐Worker's Comp ☐Unemployment ☐None
Have you had a prior problem with the same orthopedic condition in the past? ☐ Yes ☐No
If yes, describe: _____

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS

Do your <u>other joints</u> have: ☐ morning stiffness over 30 minutes ☐joint pain or swelling ☐back pain ☐Gout ☐Rheumatoid arthritis ☐ osteoporosis ☐prior fracture (which bone) _____ ☐ none of these

Do you have any of these symptoms? If none, please check the box labeled "NONE".

GI	☐heart burn/ ulcers/ reflux ☐ IBS/ Crohn's ☐ blood in stool ☐hepatitis ☐liver disease	☐none
ENDO	☐thyroid disease ☐ heat or cold intolerance	☐none
CON	☐weight loss ☐loss of appetite	☐none
EYE	☐blurred vision ☐double vision ☐vision loss	☐none
ENT	☐hearing loss ☐hoarseness ☐trouble swallowing	☐none
CV	☐chest pain ☐palpitations ☐cardiac stents ☐pacemaker	☐none
RS	☐chronic cough ☐shortness of breath ☐asthma	☐none
GU	☐painful urination ☐blood in urine ☐kidney problems	☐none
SK	☐frequent rashes ☐skin ulcers ☐lumps ☐psoriasis	☐none
NEU	☐headaches ☐dizziness ☐seizures ☐MS	☐none
PSY	☐depression/anxiety ☐drug/alcohol addiction ☐sleep disorder	☐none
HEM	☐easy bleeding ☐easy bruising ☐anemia ☐blood clots	☐none

ARE YOU HIV POSITIVE? ☐yes ☐no

PAST MEDICAL HISTORY

Are you diabetic?☐ yes ☐no If yes, treatment: ☐insulin ☐oral meds. ☐ diet ☐none

Please list any **surgeries/ hospitalizations** for illness or injury, you have had and when they were done. ☐none list if yes _____

_____

_____

Have you or a family member had a reaction to anesthesia? ☐ no ☐yes explain_____

Have you been on blood thinners in the past? ☐ No ☐ Yes If yes, which one(s)_____

Have you ever had any of the following:☐heart attack (year_____) ☐high blood pressure(year____)

☐blood clots(year____) ☐stroke ☐heart failure ☐ankle swelling ☐kidney failure ☐cancer(location_____)

☐stomach ache while taking anti-inflammatories (ex. Advil/Aleve/ Motrin) If yes, which one_____

☐I do not have any of these conditions

Family History- Have any of your direct relatives had any of the following disorders? If so which relative?

☐ diabetes ☐high blood pressure ☐rheumatoid arthritis ☐none If yes, who_____

_____

Social History- Do you smoke? ☐no ☐yes If so, how much per day? _____

Use other tobacco products? ☐yes ☐no Has patient been informed of smoking risks? ☐yes ☐no

Do you drink alcohol? ☐yes ☐no If yes, how much, how often? _____

Marital status: ☐married ☐single ☐widowed ☐divorced How many people live with you? _____

Occupation: _____ Employer: _____☐student

Please sign: The information on this form is accurate to the best of my knowledge.

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

MD NOTES:

Provider Signature:_____ **Vipul Dua MD Alexandr Tarasyuk PA-C Date:**_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Cell Phone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number _____

We will not be able to discuss your care without written consent. If you wish for us to be able to discuss your medical care with someone, please provide us written permission by listing this person's name.

_____ _____

_____ _____

_____ _____

* _____ _____

Patient/Parent or Guardian Signature — Date

_____ _____

Print Name — Birthdate

☐ Your preferred day time contact telephone number
- ☐ Home
- ☐ Work
- ☐ Cell