



1579 Straits Turnpike, Suite E  
Middlebury, CT 06762  
Phone: 203-598-0700  
www.OrthoNewEngland.com

### Medical History Update

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Handed R/L

Primary Care Physician: \_\_\_\_\_ May we send a letter to your physician? Y / N

Allergies: \_\_\_\_\_

What brings you to the office today?

Follow up from surgery (please specify type): \_\_\_\_\_

New / Follow up fracture (please specify type): \_\_\_\_\_

Follow up painful hip/knee/ankle/elbow/shoulder (please specify location and side):  
\_\_\_\_\_

Other: \_\_\_\_\_

Date of injury or surgery if applicable: \_\_\_\_\_

Is this work related? Y / N

Due to a motor vehicle accident? Y / N

Did you bring x-ray or MRI films with you? Y / N

What severity level would you use to describe your pain? (0-10 scale, 0= no pain, 10=worst pain) \_\_\_\_

Is there anything that makes the pain worse? \_\_\_\_\_

Is there anything that relieves the pain? \_\_\_\_\_

Please list any medications you have tried for this problem:  
\_\_\_\_\_

Have you tried any of the following?

Braces  Cane/Walker  Physical Therapy  Steroid Injection  Synvisc/Supartz/Euflexxa

Since your last visit:

Are you taking any new medications? Y / N Please List \_\_\_\_\_

Have you had any surgical procedures? Y / N Please List \_\_\_\_\_

Do you have any new medical conditions? Y / N Please List \_\_\_\_\_

Patient Signature \_\_\_\_\_



**SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, ACKNOWLEDGEMENT OF PRIVACY PRACTICES, NOTICE OF QUALITY IMPROVEMENT STUDY**

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Orthopaedics New England, P.C. for services furnished by Orthopaedics New England, P.C. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If I have other insurance coverage, my signature authorizes releasing the information to the insurer or agency shown. Orthopaedics New England, P.C. accepts the Medicare allowable determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
2. **PARTICIPATING INSURANCE AND RELEASE OF INFORMATION:** I understand that Orthopaedics New England, P.C. may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or other third party. Orthopaedics New England, P.C. may also tell my health plan and/or referring physician about a treatment I am going to receive to obtain prior approval or to determine whether my plan will cover the treatment, to facilitate payment, or the like.
3. **NON-PARTICIPATING WITH PATIENT'S INSURANCE:** The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to be by Orthopaedics New England, P.C. if I belong to a plan that Orthopaedics New England, P.C. does not participate with.
4. **NON-COVERED SERVICES:** The undersigned accepts full financial responsibility for all items and services which are determined by my insurance plan not to be covered. The undersigned agrees to cooperate with Orthopaedics New England, P.C. to obtain necessary healthcare service plan authorizations.
5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Orthopaedics New England, P.C., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Orthopaedics New England, P.C. for payment.
6. **APPOINTMENT CANCELLATION:** We request that at least 24 hour notice be given if you are unable to keep your scheduled appointment. Cancellations with less than 24 hr notice may be billed \$25 per occurrence.
7. **FINANCE CHARGES:** I agree to pay a finance charge of 1% per month, compounded, for any balance I am responsible for which is over 30 days old. I also agree to pay for any returned check fees incurred by Orthopaedics New England, P.C.  
I also agree that if I am the parent/guardian bringing a child in for treatment that I am responsible for all fees incurred by the child.  
If an account is sent to a collection agency or attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.  
Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Orthopaedics New England, P.C. If co-payments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to Orthopaedics New England, P.C. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
8. **ACKNOWLEDGEMENT OF PRIVACY PRACTICES:** I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Orthopaedics New England, P.C. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified or changed in any way.
9. **NOTICE OF QUALITY IMPROVEMENT STUDY:** Dr. Keggi and Dr. Kennon are committed to promoting the scientific basis for the practice of medicine. Orthopaedics New England, P.C. reviews patient results, surgical techniques, the effects of treatment and other measures. Your signature below indicates you understand that your information & results may be reviewed for scientific purposes. Any distribution or discussion of such information outside of Orthopaedics New England, P.C., whether for publication or presentation is done in a manner that removes your name and any other identifying information in order to protect your privacy.

**PATIENT SIGNATURE** \_\_\_\_\_

**SIGNATURE OF PATIENT'S REPRESENTATIVE** \_\_\_\_\_

**PATIENT NAME (PRINT)** \_\_\_\_\_ **DATE** \_\_\_\_\_

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**For Office Use Only**

To be completed by practice if unable to obtain written acknowledgement from the patient

- \_\_\_\_\_ Patient refused or declined to sign this written acknowledgement
- \_\_\_\_\_ Patient could not understand request to sign written acknowledgment
- \_\_\_\_\_ Other reason (please specify)

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_



John M. Keggi, M.D.  
Robert E. Kennon, M.D.  
Lee E. Rubin, M.D.

### HIPAA RELEASE FORM

Patient Name: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Privacy regulations require us to have releases signed by our patients for us to speak with family members, friends and other relations regarding medical treatment. Each person must be listed individually and by name.

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information.

_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #
_____ Name	_____ Relation	_____ Telephone #

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date