Garden State Orthopaedics & Sports Medicine

Dr. Lawrence I. Barr

Sports Injuries • Spine Surgery • Arthroscopy • Fracture Treatment
Industrial Injuries • Hand Surgery • General Orthopaedics

FELLOWSHIP-TRAINED ORTHOPEDIC SPINE SURGEON | BOARD-CERTIFIED ORTHOPEDIC SURGEON

WWW.GARDENSTATEORTHOPAEDICS.COM

WELCOME TO GARDEN STATE ORTHOPAEDICS!

You are here to undergo an evaluation. This evaluation is being performed at the request of an insurance carrier, an attorney, or another physician. During this evaluation the doctor will take a history and a physical examination will be performed with a medical assistant present. A doctor/patient relationship will not be established on or after this interaction. The forms that you will fill out will be used as part of the final report, providing background about your past medical history, job, prior jobs, education, activities of daily living and leisure time activities.

For the physical examination you may be asked to undress (depending on the nature of your injury) and you will be given a gown to wear. Please put it on with the opening towards your back. The doctor will conduct the exam with a medical assistant present. If at any time throughout the exam you feel discomfort/pain or you are asked to do something that you feel you cannot do, please indicate that to the examiner.

After the examination you will be asked to dress. You may leave at that time. A report will be prepared and sent to the requesting party after the conclusion. The reports usually go out in 2-3 weeks. I have read the above and understand.

_____

Print Name of Examinee

_____

Signature of Examinee

_____

Parent/Guardian Signature (If under the age of 18)

_____

Date

1030 North Kings Hwy., Suite 200 • Cherry Hill, NJ 08034 • 856-616-2999 • FAX 856-616-1437

Billing inquiries: 856-616-2970 • FAX 856-616-1439

GARDEN STATE ORTHOPAEDICS

Chaperone:_____

PATIENT REGISTRATION FORM - Referred by:_____

Name: _____Date of Birth:_____Age:_____Sex:_____

Address:_____

City:_____State:_____Zip:_____

Social Security #: _____-_____-_____Home Phone #:_____ Work Phone #:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer's Name: _____Occupation: _____

Address: _____

City:_____State:_____Zip:_____

Date of Accident/Injury:_____

Type of Claim: ☐ Motor Vehicle Accident ☐ Work related ☐ Other_____

Attorneys' Name:_____ Phone #_____

Address:_____

ACCIDENT INFORMATION:

Insurance Carrier:_____

Name of Insured:_____ Claim/policy #:_____

ADDITIONAL INSURANCE INFORMATION:

Name of Insurance Company:_____

Address:_____

Subscriber's Name::_____ Relationship to Insured_____

ID #:_____Group #:_____

Patient Signature:_____Today's Date:_____

Examination Start Time: _____

Examination Stop Time:_____

If this was a motor vehicle accident, what was your position sitting in the vehicle?

☐ Driver ☐ Front passenger ☐ Rear right ☐ Rear left ☐ Other_____

Were you wearing a seat belt? ☐ YES ☐ NO (☐ harness ☐ lap belt ☐ both)

Was your car ☐ Moving or ☐ Stopped in traffic OR ☐ Stopped?

If moving, what was your approximately speed at the time of impact? _____mph

Were you ☐ hit or did you ☐ hit another vehicle?

If you were hit, where?: ☐ rear ended ☐ back driver's side ☐ back passenger's side ☐ head on

☐ front driver's side ☐ front passenger's side ☐ other_____

If you were the driver, did you have both hands on the steering wheel? ☐ YES ☐ NO ☐ Other_____

If you were the passenger, did you brace with your hands on impact? ☐ YES ☐ NO

Did any part of your body come in contact with any part of the vehicle? ☐ YES ☐ NO

If yes, describe:_____

_____

Describe your body movement at the time of impact:_____

_____

Where did this accident/injury occur?_____

How did it happen?_____

If this was a motor vehicle accident, how many vehicles were involved in the accident? _____

Date of accident:_____

Did you go to a hospital/ER ☐ YES ☐ NO If yes, were you taken by ambulance? ☐ YES ☐ NO

If yes, name of hospital and when did you go?_____

Were x-ray-rays taken? ☐ YES ☐ NO If yes, of what body part(s)?_____

Due to your injuries, what symptoms did you initially experience?_____

☐ Nausea ☐ Vomiting ☐ Dizziness ☐ Fainting ☐ Nervousness

Do you have pain in your: ☐ Head ☐ Neck ☐ Chest ☐ Abdomen ☐ Mid back ☐ Low back

☐ R shoulder ☐ L shoulder ☐ R arm ☐ L arm ☐ R hand ☐ L hand ☐ R wrist ☐ L wrist

☐ R leg ☐ L leg ☐ R knee ☐ L knee ☐ R foot ☐ L foot ☐ R ankle ☐ L ankle

Numbness_____ Tingling_____ Weakness_____
Where Where Where

How frequent is your pain? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

What makes the pain worse? _____

What makes the pain better? _____

Describe your pain_____
(e.g., sharp, dull, pins and needles, numbness, burning)

On a pain scale from 0 (no pain) to 10 (excruciating pain), rate your pain:

Now_____ High_____

Average_____ Low_____

ACTIVITY QUESTIONNAIRE:

Since the occurrence, are you having difficulty with any of the following?

Activities of daily living: (please check all that are appropriate)

☐ bathing ☐ dressing ☐ combing hair ☐ toileting ☐ eating

☐ cutting food ☐ brushing teeth ☐ cooking ☐ other_____

House and yard work: (please check all that are appropriate)

☐ mowing lawn ☐ washing car ☐ fixing/repairing cars ☐ yard work

☐ house painting ☐ laundry ☐ grocery shopping ☐ cleaning

☐ vacuuming ☐ opening jar/cans ☐ mopping floors ☐ making beds

☐ carrying laundry ☐ stair climbing ☐ activities with children ☐ shoveling

☐ digging ☐ climbing ladders ☐ gardening

☐ other (please list):_____

Do you have trouble with the following? (please check all that are appropriate)

☐ physical exercise ☐ sitting ☐ walking ☐ kneeling ☐ getting up in the morning

☐ bending ☐ stiffness ☐ standing ☐ sleeping

☐ crawling ☐ driving ☐ lifting ☐ overhead work

List all doctors seen since the accident/injury (M.D., D.O., D.C.):

Name of Doctor	Specialty	Date of first visit	Date of last visit

---

Have you ever injured these body parts previously? ☐ YES ☐ NO

When?_____

How?_____

Treatment received:_____

If injured previously, were you having difficulty at the time of the new injury? ☐ YES ☐ NO

If yes, what problems were you experiencing?_____

_____

Have you ever had a motor vehicle accident or other accident? ☐ YES ☐ NO

If so, when?_____

Any injuries sustained?_____

Details of injuries:_____

Have you ever seen a chiropractor or physician for any type of injury or condition? ☐ YES ☐ NO

Physician(s) name:_____

MEDICAL HISTORY:

Height:_____feet _____inches Weight:_____

☐ Right handed ☐ Left handed ☐ Ambidextrous

Current medical problems: ☐ Hypertension ☐ Diabetes ☐ Asthma ☐ Epilepsy/seizure disorder

☐ Heart attack ☐ Migraines ☐ Stroke ☐ Cardiac disease ☐ Ulcers ☐ Cancer

☐ Anemia ☐ Thyroid disease ☐ Other_____

Past surgeries/Dates performed:_____

List current medications:_____

Have you taken any pain medication today? ☐ YES ☐ NO

If yes, what medication(s) did you take?_____

Are you allergic to any medications? ☐ YES ☐ NO

If yes, please list medications:_____

Who lives with you? _____

Have you had any household help?_____

Describe:_____

EMPLOYMENT HISTORY (must be filled out):

When the accident/injury occurred, where you employed? ☐ YES ☐ NO

Job title:_____

Job description:_____ ☐ Full time ☐ Part time_____hrs/wk

Job duties: Lifting/carrying_____lbs. Sitting_____hrs/wk

Standing_____hrs/wk Walking_____ hrs/wk

Did you miss time from work due to accident/injury? ☐ YES ☐ NO Date first missed work:_____

If yes, how much time?_____days/months Date returned to work:_____

Employer for work comp claim at time of injury:_____

Current employer:_____

Hours worked weekly:_____ Years at job:_____

Are you actively working now? ☐ YES ☐ NO

If yes: ☐ same job (same duties) ☐ same job (different duties) ☐ new job ☐ side jobs

☐ Any work restrictions?_____

☐ List duties_____

Employment history (last five years):

Employer's Name	Job Description	Years Worked

EDUCATION:

High School ☐ YES ☐ NO Year graduated_____

Vocational School ☐ YES ☐ NO Year graduated_____

College ☐ YES ☐ NO Year graduated_____

Other (please list):_____

SOCIAL HISTORY:

Do you use tobacco? ☐ YES ☐ NO Do you drink alcohol? ☐ YES ☐ NO

How many packs of cigarettes per day?_____ How many drinks per day?_____

How many years have you smoked?_____ If you quit, when?_____

Do you or have you in 6 months before participate in any sports or hobbies?

_____

_____

FAMILY HISTORY:

Have any family members had the following:

☐ diabetes, who?_____ ☐ cancer, who?_____

☐ heart disease, who?_____ ☐ arthritis, who?_____

☐ other disease, who?_____

FAMILY PHYSICIAN: Name:_____

Address:_____

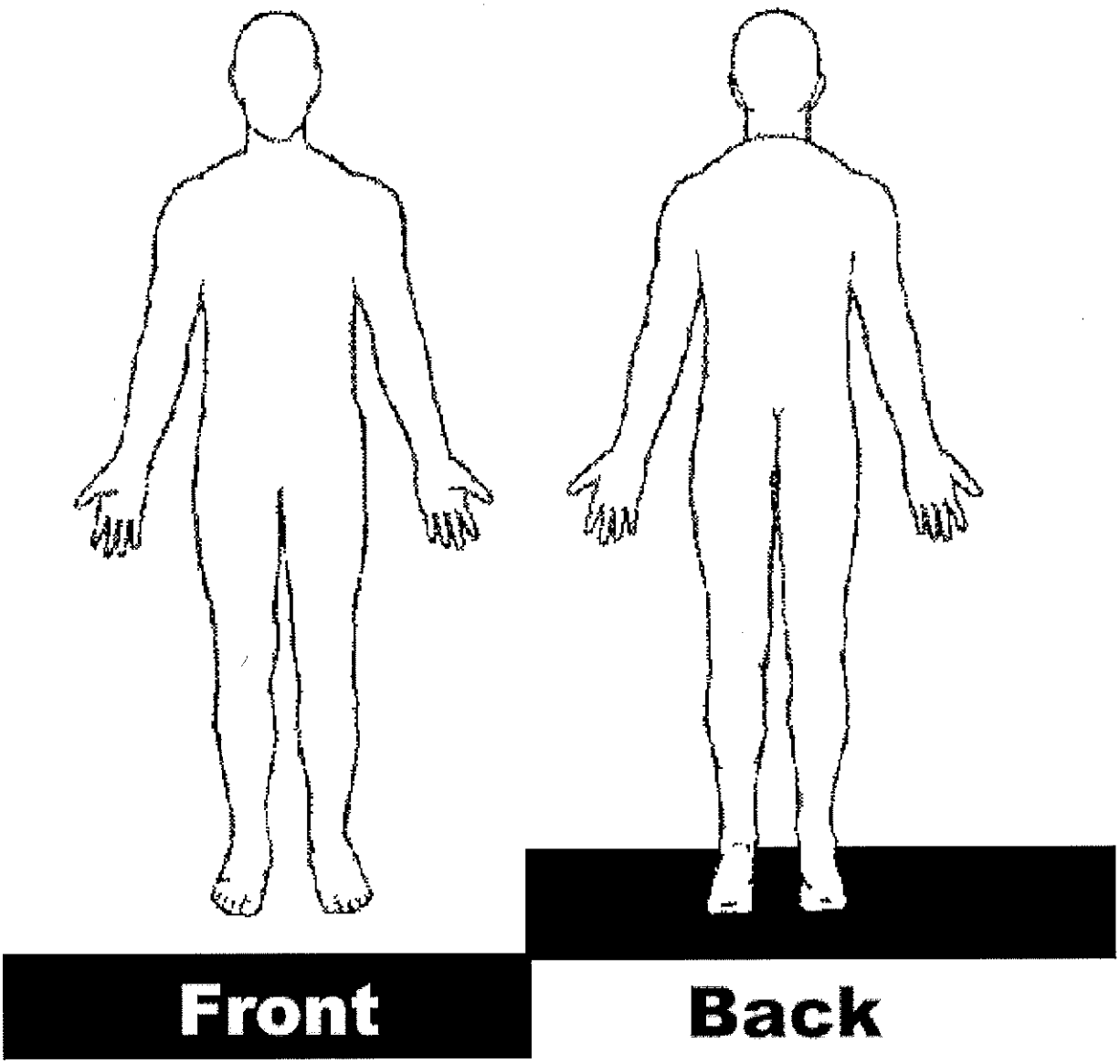
_____

Phone #:_____

PAIN DRAWING

Using the symbols giving below, mark the area(s) on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
^ ^ ^	= = =	o o o	x x x	/ / /	. . .



Pain in the arm(s) compared to the neck: ☐ worse ☐ same ☐ less

Pain in the leg(s) compared to the back: ☐ worse ☐ same ☐ less

I understand that I am being seen for an independent medical examination and no treating physician/patient relationship is established. I understand that the information I discuss will be included in a report, which is prepared for the requesting client. I consent to this report being sent to this client and to participating in the assessment. I agree to advise the physician immediately if I experience any difficulties during the examination.

Signed:_____

Today's Date:_____

Witness:_____

HIPPA Notice of Privacy Practices

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.

The Health Insurance Portability and Accountability act of 1996 and its implementing regulations (HIPAA), as amended, is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of your upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected heath information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Heath and Human Services to investigate or determine our compliance with the requirements of HIPAA

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorizations, or Opportunity to Object unless required by law. Use and disclosures of PHI for marketing purposes, as well as disclosures that constitute and sale of PHI, require an authorization from you.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. If such information is maintained in an Electronic Health Record (EHR), your access rights include the right to a copy in electronic format. We have the right to charge you a fee for the copying of paper records, and in the case of a request for and electronic copy of your PHI maintained in and EHR (or a summary or explanation of such information) we have the right to charge you the amount of labor costs in responding to your request. Your right to inspect and obtain a copy of your PHI extends only to your PHI contained in our Designated Record Set for you. A "Designated Record Set" is the HIPAA term for medical and billing records and any other records that we use for making health care decisions about you.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved with you care or for notification purposes described in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Any such request for restrictions must be in writing, be addressed to the Privacy Officer, and state the specific restriction requested and to whom you want the restriction to apply. However, we are not required to comply with your request, unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or heath care operation purposes and such information you wish to restrict pertains solely to a heath care item or service for which you have paid us "out-of-pocket" in full.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. However, we may condition this accommodation by asking you for information as to how payment will be handled or a specification of an alternate address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must be in writing, be addressed to the Privacy Officer, and state the specific alternate means or location.

You have a right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information contained in your Designated Record Set if you believe it is incorrect or incomplete. However, we are not required to make any such amendments. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. All of these documents will be placed in the appropriate part of your Designated Record Set. If you are requesting that we amend your records because you believe that you are a victim of medical identity theft, we will use reasonable efforts to assist you in making corrections to your record which are determined to be appropriate under the circumstances.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Affected individuals have the right to be notified in the event of a breach of unsecured PHI.

We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

To exercise any of your rights above, please contact our privacy officer in writing.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint.**

This notice was originally published and became effective on April 14, 2003, as amended from time to time.

Garden State Orthopaedics & Sports Medicine, P.A.

HIPAA Notice of Privacy Practices
Patient Acknowledgement

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____