PATIENT REGISTRATION FORM

HOSPITAL FOR SPECIAL SURGERY

535 E 70th Street (MAIN) * 519 E 72nd Street (OFF SITE)

New York, NY 10021

MR #

DATE OF VISIT ★

HOSPITAL PHYSICIAN DR. METZL

PATIENT'S LEGAL FULL NAME (Last, First, MI.) ★		SEX ★	DATE OF BIRTH ★	MARITAL STATUS ★
ADDRESS ★		SS # ★		HOME PHONE# ★
CITY, STATE, & ZIP CODE ★		RACE ★	ASSOCIATED ETHNICITY ★	CELL PHONE # ★
HAVE YOU BEEN TO THE HOSPITAL FOR SPECIAL SURGERY BEFORE? WHEN? ★	E-MAIL ADDRESS			

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER ★	OCCUPATION ★	❑ F/T ❑ P/T ❑ Retired ❑ Student	RETIREMENT DATE ★
EMPLOYER ADDRESS (no., street, city, state, zip code)		EMPLOYERS' PHONE #	

GUARANTOR (PERSON RESPONSIBLE FOR INSURANCE CLAIM)

❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other

GUARANTOR / EMERGENCY CONTACT

RELATIVE # 1 LEGAL FULL NAME -INSURANCE GUARANTOR ONLY- ★			RELATIONSHIP TO PATIENT ★		DATE OF BIRTH ★
ADDRESS (building #, city, state, zip code) ★	MARITAL STAT	SEX ★	HOME PHONE #★		SS# ★
EMPLOYER ★	OCCUPATION ★	❑ F/T ❑ P/T ❑ Retired ❑ Student			RETIREMENT DATE ★
EMPLOYER ADDRESS (building #, city, state, zip code) ★		EMPLOYER PHONE # ★			
RELATIVE # 2 FULL NAME -EMERGENCY CONTACT ONLY- ★			RELATIONSHIP TO PATIENT ★		DATE OF BIRTH
ADDRESS *(no., street, apt#, city, state, zip code)* ★		SEX ★	HOME PHONE # ★		CELL PHONE # ★

MEDICAL DETAIL

COMPLAINT / REASON FOR VISIT ★	ALLERGIES ★★★
REF. PHYSICIAN / ADDRESS & CONTACT # ★	

PRIMARY INSURANCE: ***PLEASE NOTIFY REGISTRAR IF PRIMARY INSURANCE IS NO FAULT/WORKMAN'S COMP (ADD'L FORMS)

INSURANCE CO. NAME & ADDRESS			POLICY # (or) ID #	GROUP# / ACCOUNT #
NO FAULT OR WORKMAN'S COMP.			CLASS*(PPO / EPO / HMO / POS)*	CLAIM #
ACCIDENT DATE & TIME	ACCIDENT PLACE		CONTACT NAME & NO.	WCB CASE #

SECONDARY INSURANCE:

INSURANCE CO. NAME & ADDRESS			POLICY # (or) ID #	GROUP# /ACCOUNT#
NO FAULT OR WORKMAN'S COMP.			CLASS *PPO / EPO / HMO / POS)*	CLAIM #
ACCIDENT DATE / TIME	ACCIDENT PLACE		CONTACT NAME & NO.	WCB CASE #

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT - I certify that the information given by me is correct. I understand that this information is entered into a database, and I hereby authorize the sharing of such information with Hospital affiliated physicians who are responsible for my care and their offices. I hereby also authorize the release of information related to my medical care, as requested by government agencies and/or insurance carriers. I hereby assign benefits to the Hospital and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment

MEDICARE PATIENTS - I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles on all services, 20% co-insurance on ancillary services. When Medicare is deemed the secondary insurance, I will follow payment terms under Hospital policies.

EFFECTIVE DATE - These statements shall be effective from the date of the signature below until December 31 of the current year, unless you notify HSS otherwise in writing at the address written above.

PATIENT OR GUARDIAN SIGNATURE X _____ DATE _____

PATIENTS THAT HAVE MEDICARE, PLEASE TURN & COMPLETE

TURN

Effective Date: April 14, 2003
Revision Date: September 23, 2013

Acknowledgement of Receipt of Notice of Privacy Practices

Respect for our patients' privacy has long been highly valued at Hospital for Special Surgery. Not only is it what our patients expect, it is the right way to conduct health care. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices of our Hospital and its medical staff and affiliated health care providers when providing health care services for our Hospital. Our Notice will be posted in the main entrance area of the Hospital at 535 East 70th Street, New York, New York and in other locations where we provide services. You will also be able to obtain your own copy of the Notice by accessing our website at www.hss.edu, calling Health Information Management at (212) 606-1254, or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me may be used and disclosed by the Hospital, and how I may obtain access to and control this information. I also acknowledge and understand that special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and/or disclosure of my health information as described in this Notice, including to treat me and arrange for my medical care, to seek and receive payment for services provided to me, and for the health care operations of the Hospital.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date

If you have any questions about this Notice or would like further information, please contact the Hospital's Privacy Officer at (212) 774-7500.

For Office Use Only: If the patient does not sign this acknowledgement form, record here the good faith efforts made to obtain this acknowledgement and consent.

_____

_____

_____

HOSPITAL FOR
SPECIAL SURGERY

OUT PATIENT INTAKE FACE SHEET R/E/L Query

As part of a national initiative and rules enacted by the federal government, intended to insure that all patients receive the highest quality care, HSS will ask all of our patients to self report their race, ethnicity and preferred language for healthcare.

If You Have Provided This Information To A Registrar Prior To This Visit Then You Do Not Have To Complete This Survey For Subsequent Visits To HSS.

Thank you.

1. Do you consider yourself to be Hispanic/Latino?

   ❑ Yes ❑ No

2. Which one or more categories best describes your race? Please check up to two only.

   ❑ American Indian/Alaska Native ❑ Asian ❑ Black or African American

   ❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Some Other race

3. Please further describe your race or ethnic background? Please provide up to two responses.

   (For example: Mexican and Polish, Chinese and Caribbean American, Puerto Rican and Russian)

   _____ _____

4. How would you rate your ability to speak and understand English?

   ❑ Very Well ❑ Well ❑ Not Well ❑ Not at all

5. What is your preferred spoken language for discussing healthcare?

   (Provide one only.) _____

6. Would you like an Interpreter offered free of charge?

   ❑ Yes ❑ No ❑ Not Applicable

7. In what language would you prefer reading medical or healthcare instruction?

   (Provide one only.) _____

PATIENT'S NAME: _____

TURN

HOSPITAL FOR SPECIAL SURGERY

JORDAN D. METZL, M.D.

Confidential Medical History

Name _____ Age _____ Birthdate _____

Occupation _____ Referred by _____

Chief complaint: _____

Date of injury or onset of symptoms: _____

Describe the injury or problem: _____

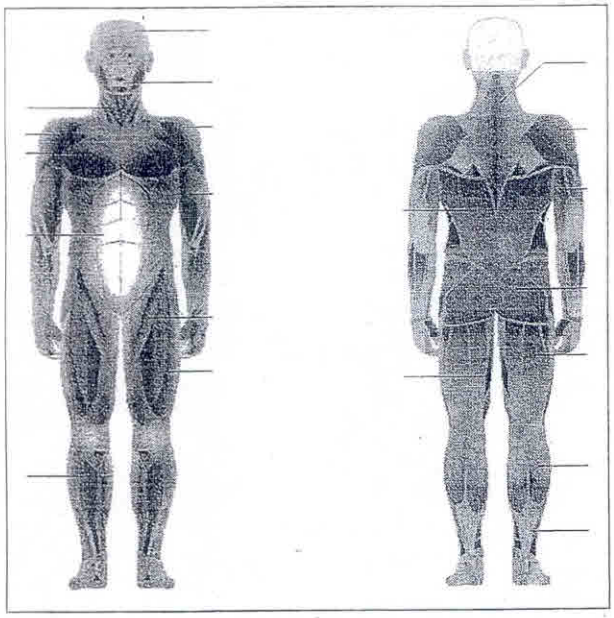
_____

_____

_____

_____

Where is your pain? Mark the drawing.



Rate your pain:

0 = No pain *10 = Extreme pain*

1. Right now 0 1 2 3 4 5 6 7 8 9 10

2. At best 0 1 2 3 4 5 6 7 8 9 10

3. At worst 0 1 2 3 4 5 6 7 8 9 10

4. What makes it better? _____

_____

5. What makes it worse? _____

_____

Medical History

Do you have any ongoing medical problems (diabetes, high blood pressure, etc.? _____

_____

Have you ever been hospitalized? Y N If yes, why? _____

Have you ever had surgery? Y N If yes, why and when? _____

Current medications: _____

Are you allergic to any medication? Y N If yes, list _____

Family History

Does anyone in your family have any of the following problems? (please circle)

Heart disease	High blood pressure	Anesthesia complications
Cancer	Nerve problems	Blood problems (anemia, abnormal bleeding)
Stroke	Diabetes	Other: _____

TURN

Current Symptoms or Problems

Please check any of the following that apply to you:

◊ Recent weight change
◊ Fatigue / weakness
◊ Fever, chill
◊ Skin rash / disease
◊ Vision problems / eye disease
◊ Nose / throat problem
◊ Hearing problems / ear disease
◊ Frequent headaches
◊ Fainting spell
◊ Seizures
◊ Problems with coordination
◊ Depression
◊ Thyroid problems
◊ Change in appetite or thirst
◊ Shortness of breath or wheezing
◊ Frequent cough
◊ Chest pain
◊ Heart murmur
◊ Irregular heart beat
◊ Heart disease
◊ Swollen legs or feet
◊ Stomach pain or heartburn
◊ Ulcers
◊ Hepatitis or gallbladder disease
◊ Change in bowel habits (also blood in stools)
◊ Blood disorder or blood transfusion
◊ Easy bleeding or bruisability
◊ Change in urinary habits (including pain, blood in urine, trouble stopping/starting your urine)
◊ Kidney disease or kidney stones
◊ Sexually transmitted disease
◊ Joint stiffness, pain or swelling
◊ Difficulty in moving an arm or leg

Health Habits

Do you smoke cigarettes? Y N packs/day _____ For how long? _____yrs
Do you drink alcohol? Y N drinks/wk _____
How would you describe your level of leisure physical activity over the past six months?

____ Inactive - just daily activity
____ Light - some walking, gardening, occasional weekend recreational activity
____ Moderate - regular (3x week) moderate exercise and occasional weekend sports
____ Vigorous - regular (3-5x week) vigorous exercise and/or sports activity
____ Intense - competitive vigorous sports training

Height _____ feet/inches Weight ____ lb
Do you consider your current weight ideal? Y N
If no, list your ideal weight: _____

Would you like us to send copies of your notes to your primary care physician? Y N
Primary Care Physician: _____
Address: _____
Phone #: _____ Fax #: _____

INSURANCE WAIVER

Print Name_____ DOB: ____/_____/_____

With healthcare changing rapidly, we want to provide as much information in advance to help you navigate this process. Please contact your insurance ahead of time if you are unsure of the details of your policy. Even if we participate with your plan, the only way to know your responsibility with certainty is to contact your insurance. Some questions you may want to ask about are defined below.*

Please note: At present, we now participate with the following Affordable Care Act/Health Exchange insurances:

Empire Blue Cross Blue Shield- Pathway Enhanced

***If you are unsure if your insurance is a part of the Affordable Care Act, we advise you call your insurance or your employer to check on benefits and coverage.**

Dr. Metzl is **In Network** with the following insurance plans:

- Aetna- All plans (except Aetna Medicare, and Aetna Signature), Referral Required for HMO and Student Health plans
- Empire Blue Cross Blue Shield PPO and HMO, Anthem BCBS PPO, Horizon BCBS PPO (except: Blue Cross Prism EPO, and Blue Priority)
- Medicare (Government Issued)

Radiology: Please be aware that ALL radiology, x-rays, MRI, ultrasounds, etc…are billed by the main hospital. If you do get x-rays at the time of your visit you will receive a separate bill from the Hospital for Special Surgery.

Radiology in CT: All x-rays performed in the CT office are billed through Dr. Metzl and you will be receiving a separate bill after the visit. We do not collect x-ray fees at the time of the visit. If you are in network, then the x-rays are in network, if you are out of network, then your x-rays are considered out of network. We do hold you responsible to call your insurance and check your benefits for radiology coverage.

Signed Acknowledgement _____

***Coinsurance** is the term used by health insurance companies to refer to the amount that you are required to pay for a medical claim, apart from any co-payments or deductible. For example, if your health insurance plan has a 20% coinsurance requirement (and does not have any additional co-payment or deductible requirements), then a $100 medical bill would cost you $20, and the insurance company would pay the remaining $80. The amount of your co-insurance will vary depending on your particular plan.

****Deductible:** The amount you owe for health care services before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services. The deductible may not apply to all services and the amount varies according to your plan.

*****Referral**: An order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (**HMOs**), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services. These are done electronically or on a referral form and a copy should be presented at the time of your visit.