Jim Pappas, MD
Orthopaedic Surgeon

5255 Longley Lane, Suite 140, Reno, Nevada 89511
775-322-1200 office 1-888-757-7375 toll free 775-322-1241 fax
ActiveSportsMedicine.com

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Preferred Name: _____
Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
Sex: ☐ Male ☐ Female
Street Address: _____ Social Security #: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Referring Physician: _____
Cell Phone: _____ Primary Physician: _____
Work Phone: _____ Phone #: _____
E-mail Address: _____ Referring Other: _____
☐ Employed ☐ Retired ☐ Unemployed ☐ Student
Employer: _____

GUARANTOR

☐Same as Patient
Name: _____ Social Security #: _____
Address: _____ Relationship to Patient: _____
_____ Date of Birth: _____
Sex: ☐ Male ☐ Female
Phone: _____
Employer: _____

EMERGENCY CONTACT

Name: _____ Phone: _____
Relationship to Patient: _____ ☐ Home ☐ Cell ☐ Work

PRIMARY INSURANCE AND SUBSCRIBER

Insurance Carrier: _____ ☐ Same as Patient ☐ Guarantor ☐ Other
Insured I.D. #: _____ Name of Cardholder: _____
Group #: _____ Date of Birth: _____
Employer: _____ Relationship to patient: _____
Are you active duty military? ☐ Yes ☐ No Social Security #: _____

SECONDARY INSURANCE AND SUBSCRIBER

Insurance Carrier: _____ ☐ Same as Patient ☐ Guarantor ☐ Other
Insured I.D. #: _____ Name of Cardholder: _____
Group #: _____ Date of Birth: _____
Employer: _____ Social Security #: _____

IF WORK OR AUTO

Insurance Carrier: _____ Claim #: _____
Adjustor Name: _____ Adjustor's Phone #: _____

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COMPREHENSIVE MEDICAL HISTORY

Name: _____ **Age**: _____ **Date**: _____
Height: _____ **Weight**: _____ **BP**: _____ **Advanced Directive**: _____
Date of last influenza vaccine? _____ **Date of last pneumococcal vaccine?** _____
Body Part to be treated: ☐ Right ☐ Left _____ **Is there a chance you may be pregnant?** ☐ Yes ☐ No
How was it injured: _____
Date of injury: _____ Is this a work or auto related injury? ☐ Yes ☐ No
Treatment of current injury/pain: (e.g. E.R., physical therapy, other doctors, etc.) _____
_____
Have you had a previous injury to this body part? ☐ Yes ☐ No
If yes, when and what kind of injury? _____
Have you had previous surgery to this body part? ☐ Yes ☐ No
If yes, performing doctor: _____
Location: _____ Date: _____
What makes it feel better?
☐ Rest ☐ Ice ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Exercise ☐ Pain Pills
Other: _____
What makes it worse?
☐ Sitting ☐ Standing ☐ Exercise Other: _____
Have you missed any work due to this injury? ☐ Yes ☐ No If yes, how many days? _____
Are you working now? ☐ Yes ☐ No
Have you had previous work related injuries to this body part before? ☐ Yes ☐ No
If yes, when? _____ Name of insurance carrier? _____
Have you had any of the following studies for you CURRENT injury/pain?
Diagnostic X-rays ☐ Yes ☐ No Date: _____ Location: _____
MRI ☐ Yes ☐ No Date: _____ Location: _____
Other: _____ Date: _____ Location: _____
Review of Symptoms. If YES, please explain:

Difficulty Sleeping	☐ No ☐ Yes, _____
Chest Pain	☐ No ☐ Yes, _____
Shortness of Breath	☐ No ☐ Yes, _____
Nausea/Vomiting	☐ No ☐ Yes, _____
Loss of bowel/bladder control	☐ No ☐ Yes, _____
Weakness	☐ No ☐ Yes, _____
Skin Rashes	☐ No ☐ Yes, _____
Numbness/Tingling	☐ No ☐ Yes, _____
Depressed Mood	☐ No ☐ Yes, _____
Weight Change	☐ No ☐ Yes, _____
Easy Bruising/Bleeding	☐ No ☐ Yes, _____
Hay fever	☐ No ☐ Yes, _____

Medical History- List ALL medical conditions for which you are currently being treated for (EX: Hypertension):
_____
DO YOU HAVE SLEEP APNEA? ☐ No ☐ Yes If yes, do you use a CPap? ☐ No ☐ Yes
Past Surgical History- List and prior surgeries: _____
_____
Family Medical History- List medical illnesses/diseases affecting your immediate family: _____
_____

Social History:
Tobacco use: ☐ Yes ☐ No Packs per day: _____
Ready to quit? ☐ Yes ☐ No If previous, year quit: _____
Alcohol use: ☐ Yes ☐ No Drinks per day: _____

Active Sports Medicine
MEDICATIONS AND ALLERGIES

Patients Name: _____ **Date of Birth**: _____

☐ **No Medications**

Prescription Medications:	**Dosage:**	**Frequency:**

Over-the-counter/ Herbal/ Vitamin (example: Tylenol, calcium, Echinacea)

	Dosage:	**Frequency:**

☐**No Allergies**

List ALL Allergies:	**Type of Reaction:**

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HIPAA LETTER OF COMPLIANCE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to *Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly and indirectly. *Obtain payment from designated third party payers. *Conduct normal health care operations such as quality assessments or evaluations, and physician certifications. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in office in print form). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, or payment of health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at anytime, except to the extent that the organization has taken action relying on this consent.

PRIVACY AUTHORIZATION FORM

Authorization for Use of Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act-45 CFR Parts 160 and 164)

1. I hereby authorize James Pappas, MD, LTD to use and/or disclose the protected health information described below to: (list individuals) _____

_____

2. Authorization for release of information, covering all past, present and future medical records

☐a. I hereby **authorize the release of my complete health records**

OR

☐b. I hereby **authorize the release of my complete health records with the exception of the following information:**

☐Communicable diseases (including HIV and AIDS)

☐Other: (please be specific) _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. I understand that information used or disclosed by the recipient and may no longer be protected by federal or state law.

By signing below it indicates that you have read and understood the above terms and conditions

Patient Name: (please print) _____

Patient Signature: (Or legal representative) _____ Date: _____

If signed by legal representative, state relationship to patient: _____

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Our mission is to provide friendly, quality orthopaedic care in a modern, but smaller environment. Our smaller size ensures our patients receive the personal attention and care they deserve.

Disability Forms
We will make every effort to generate insurance forms, disability paperwork, work comp letters and attorney letters in an efficient and timely matter. There is a **$10 charge for the completion of FMLA or disability forms** that will be billed directly to the patient. These do take up to 10 business days from the date they arrive in our office. The patient must fill out their portion of the form ahead of time and provide all information including a destination fax number. _____ **Initial**

Cancellation Policy
In order to provide the best care and service to our patients, we ask that you notify us **24 business** hours in advance to cancel or reschedule your appointment.

Please be aware that failure to do so could result in a missed appointment fee of $35. Insurance companies cannot be billed for this charge; it will be billed directly to the patient.

We value our patient/doctor relationships as well as their time and will do everything we can to accommodate you. Your communication and compliancy are not only very much appreciated but will help us to help you (and others) achieve a positive outcome.
_____ **Initial**

Surgery Policy
Should you have to schedule a surgery, our office will verify your insurance benefits and coverage (that does not guarantee payment from your insurance) and obtain an estimate of what you are going to owe our office for the surgery. **Our office will then require you to pay your estimated surgery cost at your pre-op appointment.** If a first assistant is required during surgery, the first assistant may be an out-of-network provider. Statements for the first assistant will be received through a third party billing service.
_____ **Initial**

One Body Part per Appointment
Each appointment must be booked for one body part only. Due to billing guidelines, time constraints and in effort to limit radiation we can only treat one problem at a time. If a patient is having multiple problems our goal is to focus on the one that is most problematic to the patient and a separate appointment may be booked for additional problems. _____ **Initial**

Off Hour Call
We occasionally work with other physicians in our community to provide the best care and most coverage for our patients. Occasionally, off hours and weekend calls may be answered by other physicians who will work with Dr Pappas in your care. We do ask that you only call for **urgent/emergent** situations only.
_____ **Initial**

Ownership
Dr Pappas has shared ownership of Surgery Center of Reno. We believe in full disclosure of this ownership in order to avoid any conflicts. When physical therapy and/or surgery are recommended, our staff makes every attempt to find your best fit, regardless of ownership. Your insurance carrier's restrictions may play a role in the assignment of these locations. Keep in mind that our goal is to provide the best care possible for our patients, if for any reason, your physical therapy or surgery center does not meet your expectations; please contact the office so that we can amend the situation.
_____ **Initial**

Billing
Any billing questions should be directed to (775) 322-1200.
_____ **Initial**

In Office Injections
We ask that if you have a planned injection in our office, no other person/persons be present in the exam room. This includes underage children. Various members of our clinical staff may be in the room.

If you have an unplanned injection during your visit we ask that any person/persons, other than our clinical staff, please step out of the exam room at the time of injection. _____ **Initial**

By signing below I acknowledge that I have read and understand this information
I have discussed any concerns regarding the mission and policies with the staff at Active Sports Medicine

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My signature below hereby authorizes any insurance company(s) given to pay for all medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance company. I authorize the release of medical information to the insurance company(s). Additionally, my signature provides willing consent to procedures which may be performed, including emergency treatment or procedure, anesthesia, or services rendered to the patient under general and special instructions of the physician or his designate. **I hereby agree to notify the staff of any chance of pregnancy due to the safety of the pregnancy.** I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and legal fees should this be required. Additionally, I have read and understood James Pappas, MD, LTD's current HIPAA letter of compliance and Active Sports Medicine's Mission and Policies and agree to my responsibilities.

Patient Name: (please print) _____ Date: _____

Patient signature: (Or Legal Representative _____