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In order for us to obtain a complete medical history, it is important for you to fill out this form in its entirety. **Every item needs to be filled out.** This information will be entered into our Electronic Medical Records and you are welcomed to request a copy of this report for your records.

Please sign all designated areas.

Patient Information:

Name: ____ Date of Birth: ______________________ MM/DD/YYYY

SS#: _______-_______-________ Sex: ☐ Male ☐ Female

Mailing Address: ____ OWN RENT

Street/ PO Box City State Zip Please circle one

Home Phone: (______) __________________ Cell: (______) __________________

Email Address:__________________________________

Primary Language:______________________ **Secondary Language:**___________________________

Primary Care Physician: ____________________________________ **Phone Number:**_______________________

Pharmacy Preference (include location): ____

Emergency Contact Name and Phone: ____

I give Ackland Sports Medicine **permission** to speak with ______________________________________ regarding my health information.

Who can we thank for sending you here today? ____

Insurance Information: **This section needs to be filled out in its entirety**

1.) Worker's Compensation: <u>Health Ins not needed</u>

Insurance Name: _____________________________________ Claim# ____________________ DOI:______________

Billing Address:____

Adjuster:________________________________P) __________________F) ________________EMAIL:___________________

Nurse Case Manager:______________________P) __________________F) _________________ EMAIL: __________________

2.) Motor Vehicle: <u>Health Ins Information and copy of insurance card mandatory</u>

Insurance Name: ___________________________________ Claim# ____________________ DOI: _____________

Adjuster:________________________________P) __________________F) ________________EMAIL:___________________

Health Insurance: _____________________________________ ID# ___________________ Group # ____________

<u>FINANCIAL RESPONSIBILITY</u> *Must be signed by financially responsible person

All professional services rendered are the responsibility of the patient/guarantor. The patient/guarantor is responsible for all fees, regardless of insurance coverage. If for any reason the account should become delinquent, I agree to any collection costs including reasonable legal fees. Acceptable methods of payment are cash, check, and money order. I authorize the release of any medical/financial information required to process claims to my insurance company, any managed care entity, my primary care physician, or other third party payer. I permit a copy of this authorization to be used in place of the original. I authorize Ackland Sports Medicine and their agents to contact me on my cell phone. *** Ackland Sports Medicine, Inc. does not accept or bill any personal health insurance, State, or Federal Plans. In the event WC denies the claim patients are responsible for payment of all medical bills. MVA patients are responsible for payment of all medical bills, personally or out of any settlement received from the accident.**

****By signing below I agree to full payment of all medical bills as stated above.****

Patient/Guarantor Signature: ____ **Date:** ___________________

A photocopy of this document shall be considered as effective and valid as the original.

INJURY INFORMATION

*****This section must be completed in its entirety. Information needed for billing purposes*****

This injury is due to: (please circle one)

Workmen's Compensation

Motor Vehicle Accident- Were there others in the car? Y N -How many?________

Slip/fall

****EMPLOYER:** ____

Human Resource Contact: Name:__________________________ **Phone:**______________________________

Date of Injury: _________/________/__________ **** (Month, day, and year must be completed)****

Month Day Year

Date last worked:______________________________

Injury: Body Part:_______________________ LEFT RIGHT BILATERAL

What **city/ town** did the accident take place in?

____

Please describe how your injury occurred (In as much detail as possible- Were you taken by ambulance?, etc.):

____

____

____

____

Did police respond? YES NO if yes, Do you have a copy of the report? YES NO

Have you retained an Attorney regarding this injury? YES* NO

***Attorney Name:** ____ Phone: _________________________

Are you currently treating with another provider (PT, Chiro, Orthopedic Surgeon, etc) Y** N

** If yes, please list provider name:____

THE FOREGOING IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE:

Patient Name: ____ Date of Birth: __________________
MM/DD/YYYY

Signature of patient or guardian: ____ **Date:** ________________

A photocopy of this document shall be considered as effective and valid as the original.

PRESENT HEALTH:

Please list any and all Medications you are taking (Include all prescriptions, herbal remedies and OTC medications)
If more room is needed please list on the back of this sheet.

Name	Dosage	How Often	Purpose

Please List ALL Medication Allergies.

Name	Type of Reaction

Please list any NON-Medication Allergies such as: pollen, dust, food, latex, etc.

If yes, please indicate what you are allergic to and type of reaction: ____

____

Surgeries and Hospitalizations:

Have you ever had surgery? ☐ **Yes** ☐ **No** **If yes, please describe and indicate when they were done:**

____

____

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **Yes** ☐ **No** **If yes, please describe:**

____

Past Health: Have you ever been **diagnosed** with:

Cancer ☐Yes, type ________________ When diagnosed? _____________ Current status? _______________ ☐No

High/Elevated Cholesterol ☐Yes ☐No

Diabetes ☐Yes type: **I** **II** ☐No

Blood Pressure ☐ High ☐ Low ☐ Not Diagnosed

Hepatitis ☐Yes type: **A** **B** **C** ☐No

Stomach Ulcer ☐Yes ☐No

Rheumatoid Arthritis: ☐Yes ☐No

HIV ☐Yes ☐No

Are you pregnant? ☐Yes ☐No

DVT ☐Yes ☐No

Heart Conditions: ☐Yes **Please circle one**: Heart attack, stroke, failure ☐No

****** Cardiologist Name:________________________________Phone:____________________________*******

Lung Conditions: ☐Yes **Please circle one:** Asthma, COPD, Sleep Apnea ☐No

***** Pulmonologist Name: ______________________________ Phone: ______________________________*******

Metallic foreign body in the eye ☐ **Yes** ☐ **No**

SOCIAL HISTORY

Do you use: Tobacco in any form? □ Yes □ No **Alcohol**? □ Yes □ No **Recreational Drugs**? □ Yes □ No

FAMILY HISTORY

Heart disease □Yes □No Diabetes □ Yes □No Cancer □Yes type:____________ □ No

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REVIEW OF SYSTEMS

(List any problems you have or have had recently in the following areas.)

General Constitutional (Fatigue, Fever, unintentional weight loss/gain, or other) □ **Yes** □ **No**
If yes, please describe: ____

Ear, Nose, Mouth, Throat (Hearing/visual loss, ringing in ears, allergies, nose bleeds, sore throat, or other) □ **Yes** □ **No**
If yes, please describe: ____

Heart & Blood Vessels (Chest pain, irregular heart beat, shortness of breath, or other) □ **Yes** □ **No**
If yes, please describe: ____

Lungs & Respiratory System (Shortness of breath, coughing up blood/sputum, wheezing, or other) □ **Yes** □ **No**
If yes, please describe: ____

Stomach & Digestive System □ **Yes** □ **No**
(Difficulty swallowing, heartburn, nausea, vomiting, Diarrhea, Abdominal Pain, Constipation, Blood in stool, or other)
If yes, please describe: ____

Bones, Joints & Muscles □ **Yes** □ **No**
(Cramping, weakness, fatigue of muscles, change in size of muscles, joint pain, inflammation, or other)
If yes, please describe:____

Kidneys, Bladder, or Sexual Health □ **Yes** □ **No**
(Frequency and/or pain with urination, Difficulty passing or blood in urine, sexual dysfunction, abnormal menstrual cycles, testicular pain or masses, sexually transmitted disease, or other)
If yes, please describe: ____

Skin & Breasts (Rashes, masses, lumps, or other) □ **Yes** □ **No**
If yes, please describe: ____

Brain & Nervous System □ **Yes** □ **No**
(Fainting, blackouts, seizures, paralysis of limbs, speech difficulty, memory loss, pain and/or numbness of spine, arms, or legs, or other)
If yes, please describe: ____

Mental & Emotional Health (Nervousness, tension, mood swings, depression, or other) □ **Yes** □ **No**
If yes, please describe: ____

Blood & Lymph Nodes (Anemia, easy bruising, spontaneous bleeding, prior transfusion, or other) □ **Yes** □ **No**
If yes, please describe: ____

Allergies, Infections, Immune System (Hives, frequent colds, unusual infections, or other) □ **Yes** □ **No**
If yes, please describe:____

NEW ENGLAND BAPTIST HOSPITAL

ACKLAND SPORTS MEDICINE
Stay in the Game™

Michael Ackland, M.D.
Orthopedic Surgeon

Your Rights
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 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.

You have the right to request a restriction of your protected 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 protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the 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. You have the 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. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

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

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 contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ____

Signature: ____ **Date:** ________________

A photocopy of this document shall be considered as effective and valid as the original

NEW ENGLAND BAPTIST HOSPITAL

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Orthopedic Surgeon

ACKLAND SPORTS MEDICINE
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ACKLAND SPORTS MEDICINE POLICIES

APPOINTMENT POLICIES

If a patient misses three appointments regardless of the reason without 24 hour notice, Ackland Sports Medicine Inc. reserves the right to consider patient to be noncompliant. Therefore, as office policy dictates, no more appointments will be scheduled.

MEDICATION CONTRACT

Ackland Sports Medicine recognizes that we see patients who are in pain and need help. The primary focus of our practice is to investigate and treat the underlying cause of the pain. This is a surgical reconstructive practice. Long-term pain management is not the focus of the practice, but we will refer a patient when necessary to pain management physicians who do specialize in this area.

No prescriptions will be given to any patient prior to surgery.

After surgery, you will receive **one** prescription for pain medication. Use it carefully, and as directed. It is expected that you will need only one prescription after surgery as this is adequate for the majority of patients.
Under no circumstances will a second narcotic prescription be given. If a second prescription is deemed necessary it will be for a lesser strength medication.

If you need, or anticipate a need for medication, it MUST be addressed during office hours. **Under no circumstances will medication be prescribed over the phone at other times.** All requests for medication are expected to be handled at your appointment when you see the Physician or Physician's Assistant (PA).We WILL NOT PERFORM telephone requests for medication.

Inform all your physicians what medications you are taking, and who is prescribing these medications. All patients should have a primary care physician, and we urge you to discuss your medications and long-term pain management with them.

If after hours there is an absolute need for medication you should go, in person, to the nearest Emergency Room for assessment.

______________________________________ ________________
Patient or Guardian Signature **Date**

____
Print Patient Name

New England Baptist Hospital

Michael Ackland, M.D.
Orthopedic Surgeon

ACKLAND SPORTS MEDICINE
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REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: ________________

I, ______________________________ D.O.B.: ____________,
(Patient Name)

authorize the release of my medical records to______Ackland Sports Medicine_________

Signature: ________________________________
Patient/ Guardian

Print Name: ______________________________

Phone Number: ___________________________

____

____

____

125 Parker Hill Ave. – Boston, MA 02120
P) 781-278-9711 F) 781-278-9710
www.acklandsportsmedicine.com

Ackland Sports Medicine
125 Parker Hill
Boston, MA 02120
(781) 278-9711 Fax (781) 278-9710

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Ackland Sports Medicine for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Ackland Sports Medicine to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Ackland Sports Medicine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

__________________________________ ________________________
Patient/Responsible Party Signature Date

____
Print Patient Name

__________________________________ ________________________
Witness Date