

Dr.Gornet

_New patient _Update

Date:_____

Patients LEGAL Name:

(First)_____ (Middle)_____ (Last)_____ Sex: M F

Social Sec.#_____ DOB:_____ Age:_____ Marital Status M S W D

Address:_____ City, State, and Zip: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Employer:_____ Occupation:_____

School Name (if student): _____

Primary Physician Name and Phone:_____

E-mail address:_____

Emergency

Contact:_____ relationship_____ phone_____



David M. Brown, M.D.
Matthew F. Gornet, M.D.
Lyndon B. Gross, M.D., Ph.D.
John O. Krause, M.D.
Paul S. Lux, M.D.

Mark D. Miller, M.D.
Michael J. Milne, M.D.
George A. Paletta, Jr., M.D.
Mitchell B. Rotman, M.D.
Brett A. Taylor, M.D.

Consent to Release Information

I, _____, authorize The Orthopedic Center of St. Louis staff to discuss my medical treatment and any billing issues with the following people: (Please list any family members, friends or legal counsel that we are allowed to discuss your treatment or billing issues with.)

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

Patient Signature: _____ Date: _____

(Parent or Guardian Signature if a minor)



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Dear Friends and Patients,

Welcome. Thank you for choosing **the Orthopedic Center of St. Louis**.

The Orthopedic Center of St. Louis constantly strives to provide the highest quality comprehensive care for you and your family.

We have organized this building to include providers that complement our services so that you can get the care you need in one convenient location. This includes:

- 10 Fellowship Trained Orthopedic/Plastic & Reconstructive Surgeons with subspecialty training in specific areas.
- Digital xrays and electronic medical records in our state of the art facility
- High resolution digital MRI and MR Arthrograms on the 1st floor at **Imaging Partners of Missouri**
- **CT Partners of Chesterfield** provides state of the art CT scanning on the 1st floor
- Electrodiagnostic testing on the 3rd floor at the **Neurological & Electrodiagnostic Institute**
- **ProRehab** on the 3rd floor provides physical therapy and custom splinting, often the same day as your appointment at **The Orthopedic Center of St. Louis**
- Medical Equipment (DME) is available on-site through our office and the **Corner Pharmacy** delivers medications to each of the following surgical facilities to save you a trip to the drugstore after surgery.

If surgery is required, **Timberlake Surgery Center** is located on the 1st floor. **The St. Louis Spine and Orthopedic Surgery Center** and **Advanced Surgery Center** are located nearby and provide additional locations for outpatient surgeries, spine patients, and patients who require an overnight stay. These facilities are staffed with experienced nurses and staffs that work closely with our physicians to provide the highest quality specialized care in an efficient and personalized fashion.

Financial Disclosure

Some of the individual physicians at the Orthopedic Center of St. Louis have ownership in some of the surgical and imaging facilities listed above as permitted by both state and federal law.

You have complete freedom of choice as you select your providers and facilities.

Our physicians and staff are happy to provide you with the names of other service providers and will help coordinate your appointments with your provider of choice.

For more information, visit our website www.TOC-STL.com

We appreciate the opportunity to serve you and your family.

Signed: _____

Date: _____

Printed Name: _____

TOC: _____

**The Orthopedic Center of St. Louis
Notice of Health Information Practices**

This notice describes how your medical information may be used or disclosed and how you can access this information. Please review it carefully.

Uses and Disclosures:

We will use and disclose elements of your protected health information (PHI) in the following ways.

- Basis for planning your care and treatment
- Communication among the health professionals who may contribute to your care
- Legal document describing the care you receive
- Means that you, your insurance company or a third party payor can verify that services billed were actually provided
- Source of data for medical research
- Source of information for public health officials charged with improving the health of the nation
- Source of data for facility planning
- Source we can assess our data to improve the care we render and the outcomes we achieve
- In emergency situations or to avert serious health/safety situations
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties
- To organ, tissue and other donations organization, upon or proximate to your death, if we have no indication on hand about your donation preferences
- To use an automated telephone system to use my name, address, and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine

All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights:

- Request a restricted access to all or part of your private health information as provided by 45 CFR 164.522, if we are unable to abide by this request we will notify you
- Inspect or receive a copy of your medical record as provided by 45 CFR 164.524
- To get updates or reissue of this notice, at your request
- To request a list of disclosures of your medical records as provided by 45 CFR 164.528
- To receive correspondence of confidential information by alternate means or location as long as the request is reasonable
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken

Our duties:

We are required by law to maintain the privacy of your private health information. We must abide by the terms of this notice or any update of this notice. If this notice is updated we will notify you by mail to the address you've supplied us.

To obtain more information or report problems please contact The Orthopedic Center of St. Louis's HIPAA Compliance Officer at 314-336-2555. **Full explanation of notice is posted in our waiting room. To request your own copy, please see our receptionist.**

If you believe your privacy rights have been violated, you can file a complaint with the administrator or operations manager. If, after contacting, The Orthopedic Center of St. Louis, you are not satisfied with the response you may contact the U.S. Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Effective date of this notice is April 14, 2003.

Acknowledgement:

Signature: _____ Date: _____

Print the name of the Patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

Assignment of Benefits

Please Read:

Some insurance companies will not pay your bill if you do not select one of their participating doctors. It is the patient's responsibility to determine if our doctor participates in your plan. Payment or co-payment is due at the time of service. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. In the event of legal action for collection, patient agrees to pay all costs of collection, including reasonable attorney fees. By signature below, the patient or guardian agrees that the jurisdiction and venue for said action shall be the County of St. Louis and State of Missouri. Any balances due from patients or guardians that are outstanding for over 90 days may have an automatic monthly finance charge of 1.5% (18 annual rate).

SIGNED (Patient or Guardian): _____ Date: _____

Authorization and Assignment

I authorize The Orthopedic Center to release information regarding my treatment to my insurance company, to health care providers who have referred me to The Orthopedic Center and to parties who are involved in my treatment if I have a work-related injury. I also authorize my insurance benefits to be paid directly to The Orthopedic Center. This is an authorization for medical treatment of a minor if signed by a parent or guardian. In addition to the above and in the event The Orthopedic Center is served a Subpoena for production of records, the undersigned authorizes The Orthopedic Center to produce such records under a Business Records Affidavit without the necessity of attendance at a deposition. This above Authorization can only be withdrawn or revoked by written notification to The Orthopedic Center.

SIGNED (Patient or Guardian): _____ Date: _____

Consent for Outcome Studies

With the patients' knowledge and consent, our policy at The Orthopedic Center of St. Louis is to choose the best method of treatment for each person and each condition. Knowing the results of these treatment methods helps us evaluate how well our treatment programs are working. This information is especially interesting to other health care professionals because it helps them decide whether to learn and adopt similar treatment methods for their patients.

We are asking for permission to include your clinical results in our computerized database and to report them in medical journals or at medical conventions. Complete privacy will be maintained. No individual person will be identified, names are not used in these professional meetings.

Although we would appreciate your help in this important endeavor, you are ***not*** required to consent to this request in order to receive care at The Orthopedic Center of St. Louis.

I, _____, consent to have my clinical information included in the database of Matthew F. Gornet, M.D. at The Orthopedic Center of St. Louis. I understand that this information will be presented at medical meetings and published in medical journals and may be included in other larger studies involving several clinics.

Signature of Patient or Parent/Guardian

Date

PATIENT'S NAME _____

DATE _____ / _____ / _____

DOCTOR _____

HEIGHT _____ WEIGHT _____

MEDICAL INFORMATION

It is important for us to have this information in your file, in case you need emergency care or hospitalization.

GENERAL MEDICAL (Have you had any of the following?)

Diabetes	Yes	No	Cancer	Yes	No
Heart Disease	Yes	No	Kidney Disease	Yes	No
High Blood Pressure	Yes	No	Liver Disease	Yes	No

Other Medical Problems _____

Surgery (Type) _____

Surgery (Type) _____

Surgery (Type) _____

Surgery (Type) _____

List any medications that you currently take:

1) _____

3) _____

2) _____

4) _____

Drug Allergies: _____

Do you smoke? Yes No

Have you ever been treated by any of our physicians? _____

Is this a work-related injury? Yes No Date & Time of Injury _____

Was an automobile involved? Yes No

Describe accident or illness: _____

◆ First date of treatment _____

◆ Type of Treatment _____

◆ Were x-rays taken? Yes No

If yes, when and where were they taken? _____

Are you currently disabled? Yes No

If so, when did your disability begin? _____

Patient's Signature

PATIENT PAIN DRAWING

Name: _____

Date: ____ / ____ / ____

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.

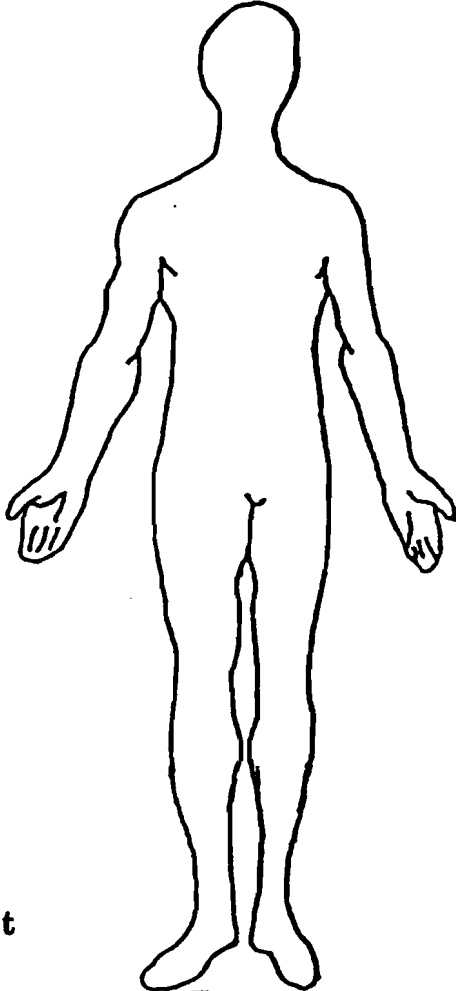
ACHING
▲▲▲▲

NUMBNESS
====

PINS & NEEDLES
OOOO

BURNING
XXXX

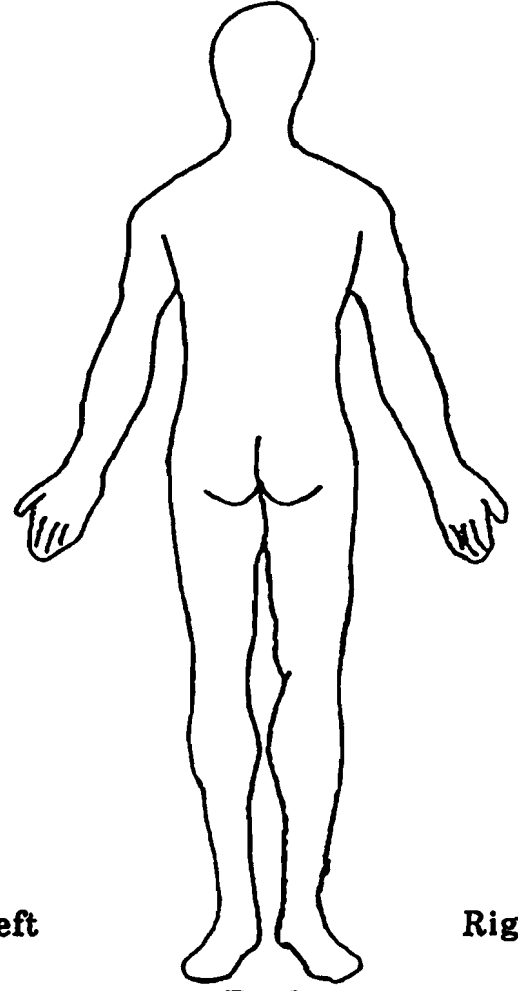
STABBING
/////



Right

Left

Front



Left

Right

Back

How bad is your pain now?

Please mark with an X on the **BODY** diagram above where your pain is the worst now.

Please mark on the line below how **BAD** your pain is now.

