



Patient Information

Office:		<input type="checkbox"/> Little Silver	<input type="checkbox"/> Freehold	
PATIENT NAME (First, M., Last)		PATIENT ID (Office Use Only)	DOB	AGE
SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Married; <input type="checkbox"/> Single; <input type="checkbox"/> Other	HOME	CELL	SS #
ADDRESS			EMAIL	
CITY, STATE, ZIP				
PRIMARY CARE PROVIDER (PCP) NAME			EMERGENCY CONTACT NAME	
PCP PHONE			EMERGENCY CONTACT RELATIONSHIP	EMERGENCY CONTACT PHONE
RACE			ETHNICITY	
NAME OF AUTHORIZED PARTIES THAT MAY DISCUSS MEDICAL CARE		RELATIONSHIP	PHONE	
		RELATIONSHIP	PHONE	
IS IT OKAY TO LEAVE TEST RESULTS ON VOICEMAIL?		HOME: <input type="checkbox"/> YES <input type="checkbox"/> NO	CELL: <input type="checkbox"/> YES <input type="checkbox"/> NO	

Employer Information

COMPANY / EMPLOYER NAME	
OCCUPATION	EMPLOYER PHONE #
EMPLOYMENT STATUS: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Work at Home <input type="checkbox"/> Retired <input type="checkbox"/> Student	

Referring Physician

NAME		
ADDRESS		
CITY	STATE	ZIP

Responsible Party (Billing) Same as patient Different from patient (fill out below, if different)

RESPONSIBLE PARTY NAME (First, M., Last)		HOME	CELL
ADDRESS		DATE OF BIRTH	SS #
CITY, STATE, ZIP		SEX <input type="checkbox"/> M <input type="checkbox"/> F	PATIENT'S RELATION TO RESP
EMPLOYER	OCCUPATION	RESP PARTY ID (Office Use Only)	

Primary Insurance		Who is the primary insured party / subscriber (check one): <input type="checkbox"/> Patient <input type="checkbox"/> Responsible Party <input type="checkbox"/> Other (complete below)	
INSURANCE COMPANY NAME	CO-PAY AMOUNT	INSURED'S NAME (If "other," complete this column in addition to left column)	
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP	
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH	
INSURANCE COMPANY PHONE NUMBES		INSURED'S SS #	SEX <input type="checkbox"/> M <input type="checkbox"/> F PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBES	INSURED'S GROUP #	INSURED'S EMPLOYER	INSURED'S OCCUPATION

Secondary Insurance		Who is the secondary insured party / subscriber (check one): <input type="checkbox"/> Patient <input type="checkbox"/> Responsible Party <input type="checkbox"/> Other (complete below)	
INSURANCE COMPANY NAME	CO-PAY AMOUNT	INSURED'S NAME	
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP	
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH	
INSURANCE COMPANY PHONE NUMBES		INSURED'S SS #	SEX <input type="checkbox"/> M <input type="checkbox"/> F PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBES	INSURED'S GROUP #	INSURED'S EMPLOYER	INSURED'S OCCUPATION

Tertiary Insurance		Who is the tertiary insured party / subscriber (check one): <input type="checkbox"/> Patient <input type="checkbox"/> Responsible Party <input type="checkbox"/> Other (complete below)	
INSURANCE COMPANY NAME	CO-PAY AMOUNT	INSURED'S NAME	
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP	
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH	
INSURANCE COMPANY PHONE NUMBES		INSURED'S SS #	SEX <input type="checkbox"/> M <input type="checkbox"/> F PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBES	INSURED'S GROUP #	INSURED'S EMPLOYER	INSURED'S OCCUPATION

Responsible Party		
I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize ORTHOPAEDIC AND SPORTS MEDICINE SPECIALISTS, INC, to release any information acquired in the course of my treatment to my insurance company, employer, physicians, institutions, or third party payers, as required for certain claims filed.		
_____	_____	_____
Signature of Patient / Parent / Guardian	Printed Name	Date
I / We authorize direct payment to ORTHOPAEDIC AND SPORTS MEDICINE SPECIALISTS, INC for any and all medical surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.		
_____	_____	_____
Signature of Patient / Parent / Guardian	Printed Name	Date



Patient Information					
PATIENT NAME					TODAY'S DATE
DOB	AGE	HEIGHT	WEIGHT	BP /	BP TAKEN BY
PHARMACY NAME			PHARMACY TOWN		PHARMACY PHONE

Description of Injury	
DATE OF INJURY / SYMPTOM ONSET	SIDE INVOLVED: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> BOTH
TYPE OF INJURY / ILLNESS	
THE COMPLAINT IS A RESULT OF: <input type="checkbox"/> FALLING <input type="checkbox"/> TWISTING <input type="checkbox"/> SQUATTING <input type="checkbox"/> LIFTING <input type="checkbox"/> PUSHING <input type="checkbox"/> PULLING <input type="checkbox"/> OTHER (PLEASE EXPLAIN):	
HAVE ANY TEST(S) OR TREATMENT(S) BEEN PERFORMED FOR THIS PROBLEM? <input type="checkbox"/> YES (PLEASE LIST) <input type="checkbox"/> NO	

Surgical and Medical History	
Do you have or have you previously had:	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Diabetes (Type: ___)	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer Type:
<input type="checkbox"/> Stroke	<input type="checkbox"/> Emphysema / COPD
<input type="checkbox"/> Stomach Problems	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Arthritis
	<input type="checkbox"/> Other:
<input type="checkbox"/> HIV / AIDS	
<input type="checkbox"/> Liver / Kidney Disease	
<input type="checkbox"/> Hepatitis	
Any Allergies to Medications? <input type="checkbox"/> YES (PLEASE LIST. NOTE ANY SERIOUS EFFECTS) <input type="checkbox"/> NO	
Current Medications (include dosage and strength; include supplements / vitamins): _____ _____	
Surgical History (include date and, if applicable, which side): _____ _____	
For Women Only: Are you on birth control pills? <input type="checkbox"/> YES <input type="checkbox"/> NO; Are you pregnant? <input type="checkbox"/> YES (# of weeks: _____) <input type="checkbox"/> NO	

Do you have a family history of:				
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Emphysema / COPD	<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Stomach Problems	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Liver / Kidney Disease
<input type="checkbox"/> Diabetes (Type: ___)	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer Type:		<input type="checkbox"/> Other:	

Social History	
Do you drink alcohol?	Yes No If yes, how often? _____
Do you smoke?	Yes No Formerly If yes, how often? _____ If formerly, how long ago did you quit? _____
Do you take any illicit drugs?	Yes No

Orthopaedic and Sports Medicine Specialists, Inc – Financial Policy

WELCOME, and thank you for choosing Orthopaedic and Sports Medicine Associates, Inc, for your medical care. We are committed to providing you with quality medical care. Our professional fees have been determined through careful consideration and we believe are reasonable and in line with other area physician charges.

INSURANCE: The patient or their guarantor is responsible for payment for services provided by Dr. Lopez at the time of service. Orthopaedic and Sports Medicine Specialists, Inc, will file claims directly with your insurance carrier for services verified under your plan. Verification does not guarantee your insurance will pay for services. Payments of co-pays, co-insurance, deductibles, or fees for non-covered services are required at the time of service.

HMO / PPO OR CONTRACTED INSURANCE PLANS: Each time you make an appointment with Dr. Lopez, it is your responsibility to make sure that he is currently contracted with your plan and that you have obtained the necessary referrals. We will bill your plan and allow 45 days for payment. If the services are not paid the balance will become your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, pre-existing conditions, or “reasonable and customary” charges.

IF YOU DO NOT HAVE MEDICAL INSURANCE: We request payment at the time of service or satisfactory payment arrangements made prior to service. If you are unable to pay for non-emergent services and do not have insurance, the service or treatment may be delayed until acceptable payment arrangements can be made. If you have any questions about your account balance, please call Maureen at our billing office at 732-888-2100, Ext. 612, between 8:30 a.m. and 4:00 p.m., Monday – Friday.

MEDICARE: If you are a Medicare patient, we ask that you pay the Medicare deductible at the time of service only if you have not met the deductible and your 20% co-insurance. If you have a supplemental policy, then you will only be required to pay the Medicare deductible. As a courtesy to you, Orthopaedic and Sports Medicine Specialists, Inc., will file Medicare and any supplemental insurance claims to your insurance carrier(s).

INSURANCE ASSIGNMENT & AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize ORTHOPAEDIC AND SPORTS MEDICINE SPECIALISTS, INC, to release any information acquired in the course of my treatment that may be necessary to process my claim. I permit a copy of this authorization to be used in place of the original. In consideration of services rendered, I authorize payment to be made directly to ORTHOPAEDIC AND SPORTS MEDICINE SPECIALISTS, INC. Please be aware that we will not forgive patient deductibles, co-payments, or co-insurance payments, as it is against the law to do so.

COLLECTION. In the event that this account is placed with an attorney or collection agency because of an unpaid balance remaining on my account, I agree & promise to pay a collection fee of \$50.00 or 20% of the total balance due, whichever is greater. I agree if my account balance is over 90 days old, I will be responsible for a late fee \$50.00.

NO SHOW POLICY I understand that a charge of \$50.00 will be made for broken and/or no show appointments unless 24 hour notice given, which I agree to pay.

MEDICARE PATIENTS. I hereby acknowledge that I am not a member of any Medicare HMO plan.

REFFERALS / AUTHORIZATIONS. It is the patient’s responsibility to make sure that a referral has been obtained from their Primary Care Physician and to bring a copy of that referral to our office. If you do not have the referral you may be asked to reschedule your appointment or you may choose to pay in full for services that day.

CO-PAYS, CO-INSURANCE, AND DEDUCTIBLE. Co-pays are the fixed amount that your insurance plan has designated as your responsibility for each office visit. This amount will be collected prior to your office visit. If a coinsurance or deductible is applied to your responsibility instead, you will be billed for the additional amount once your insurance processes the claim.

WORKERS COMP AND MOTOR VEHICLE ACCIDENT. We will bill the insurance carrier directly. You are responsible for providing the complete claim information, claim address, and adjuster’s contact information. If your worker’s comp or PIP insurance denies your claim, we will then bill your medical insurance if the appropriate information and referrals needed were provided in a timely manner. We will **NOT** await the results of any litigation to receive payment. We do **NOT** accept “Letters of Protection.” You will be billed for any patient co-insurance and deductible or if the claims are denied. You will be responsible for payment in **FULL**.

SELF PAY. If you do not have medical insurance coverage, payment in full is required at the time of service.

RETURNED CHECKS. If a check you issued as payment is returned by your bank (for any reason), you will be charged the bank fee. Any future payments to our office must be made by cash or credit / debit card **ONLY**.

I have read all of the information above and agree that, regardless of my insurance status, I understand I am responsible for the balance on my account for any professional services rendered.

Patient Signature: _____ **DOB:** _____ **Date:** _____



Orthopaedic & Sports
Medicine Specialists, INC.

PHONE: 732-888-2100

www.lopezortho.com

David V. Lopez, M.D.

BOARD CERTIFIED ORTHOPAEDIC SURGEON

BOARD CERTIFICATION IN ORTHOPAEDIC SPORTS MEDICINE

DIPLOMATE OF THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY

FELLOW OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

ASSISTANT PROFESSOR IN THE DEPARTMENT OF ORTHOPAEDIC SURGERY

AT THE SETON HALL - HACKENSACK MERIDIAN SCHOOL OF MEDICINE

Contract for Opioid Therapy

My policy regarding the prescription of opioids for nonmalignant pain is strict and non-negotiable. Narcotics should only be used as an adjunct to other therapies and as a last resort after other treatment modalities have failed.

My objectives when prescribing narcotics are:

- To provide adequate analgesia with the least dose possible.
- To minimize side effects.
- To allow you to become more functional.
- To avoid abuse and addiction.

Please read the following 20 statements listed below

1. The goal of my medication plan is to discontinue the use of short action opioids (Vicodin, Lortab, Lorcet, Norco, and Percocet) for chronic pain conditions.
2. Prescription refills will be done on an as needed basis, but no sooner than 10 (ten) days.
3. No refills will be made after clinic hours and on weekends or holidays.
4. I will use my medication only as prescribed. I will not take more than the amount indicated. Any evidence of such may result in termination of patient-physician relationship with Dr. Lopez.
5. I will not share my medications with anyone.
6. If I lose my medication, my prescription will not be replaced. Only in the event of extraordinary circumstances will an exception be made (ie. Your house burns down or you have a police report).
7. If my prescription is not refilled, I might experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, irritability, aches throughout my body, and a flu-like feeling. I am aware the opioid withdrawal is uncomfortable but not life threatening. I may choose to seek medical attention at an emergency room.
8. While being a patient of Dr. Lopez, I will not receive prescriptions for opioids or other sedatives from any other licensed prescriber, unless it is authorized by Dr. Lopez. Any evidence of such will result in termination of the patient-physician relationship with Dr. Lopez.
9. I will not alter nor forge my prescriptions. Any evidence of such will result in termination of patient-physician relationship with Dr. Lopez.
10. I will use only **1 (one)** pharmacy to fill my medication.
11. I agree to provide a sample of my urine, and in some cases blood, for drug screening at my physician's request. Failure to do so will result in termination of the patient-physician relationship with Dr. Lopez.



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12. Findings of other non-prescribed drugs in my urine or blood will result in termination of the patient-physician relationship with Dr. Lopez.
13. I am aware that **addiction** is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug, and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medication is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest drug history and that of my family to the best of my knowledge.
14. I understand that physical **dependence** is a normal and expected result of using medicines for a long time. Dependence is not the same as addiction. I am aware that physical dependence means that if pain medicine use is markedly decreased, stopped, or reversed by some agents (nalpuphine, buprenorphine, or stadol) I will experience withdrawal symptoms.
15. I am aware that **tolerance** to analgesia means that I may require more medicine to get the same amount of pain relief. Tolerance does not seem to be a big problem for most patients. If it occurs, increasing doses may not always help and may cause unacceptable side effects. This may cause my doctor to switch to another opioid or choose another form of treatment.
16. I am aware that the use of opioids has been associated with the following side effects:
 - Sleepiness and drowsiness
 - Nausea and/or Vomiting
 - Constipation
 - Urinary retention
 - Dizziness
 - Itching
 - Allergic reaction
 - Slow breathing / Slow reflexes and reaction times
 - Low testosterone levels in males
17. If the medications cause dizziness, sedation, or drowsiness, I understand I must not drive a motor vehicle or operate machinery that could put my life or someone else's in jeopardy.
18. Overdose of this medication may cause **death** by stopping my breathing.
19. I have read this contract or had it read to me. I understand all of it. I have had the chance to have all of my questions regarding this statement answered to my satisfaction. By signing this form voluntarily, I give Orthopaedics and Sports Medicine Specialists, Inc, my consent for the treatment of pain with opioid medications.
20. If I violate this agreement, my doctor will discontinue this form of treatment.

Patients Name: _____

Patient's Signature: _____ Date signed: _____

Pharmacy: _____ Phone #: _____