PATIENT AUTHORIZATION & AGREEMENT

AUTHORIZATION

Patient Name:_____ Date of Birth: _____

Authorization for Medical Treatment: The undersigned will be informed of the treatment procedures considered necessary for the patient and that the treatment / procedures will be directed by a physician and performed by employees of Advanced Orthopedics & Sports Medicine d/b/a Sano Orthopedics. The undersigned understands that no guarantee for assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment. (_____)

INITIAL

Information Privacy: Sano Orthopedics will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed Privacy Policy to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information. (_____)

INITIAL

Release of Information: Sano Orthopedics is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, trainers, DME representatives, physical therapists, rehabilitation nurses, orthopedic technicians and/or coaches. I also authorize Sano Orthopedics to utilize medical information obtained during the course of my treatment in medical research and education programs, provided my name and likeness are not revealed and my privacy is completely protected. (_____)

INITIAL

Assignment of Insurance Benefits: In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Sano Orthopedics for application on the patient's bill. The undersigned and/or patient agrees to be responsible for charges not covered by the assignment, including deductible and co-payment prescribed by law. (_____)

INITIAL

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she individually agrees to be totally responsible for all charges for services, including any non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by a specialist and by physician for whom Sano Orthopedics is authorized to bill. Should the account be referred to an attorney for collection, the undersigned agrees to pay all costs of collections. (_____)

INITIAL

Medicare Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself for to party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in part for my treatment. (Section 11288 of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply. (_____)

INITIAL

Controlled Substance Agreement and Prescription Policy Agreement: Sano Orthopedics has made a copy of the Controlled Substance policy readily available to me. The undersigned acknowledges receipt of this information and agrees to adherence to the policy set-forth by Sano Orthopedics. (_____)

INITIAL

Miscellaneous Provisions: I understand that Sano Orthopedics will not be liable for property of patients. (_____)

INITIAL

The undersigned certifies that he/she has read and understands the foregoing, is the patient or one authorized by the patient to execute the above and accepts the terms thereof.

Patient / Guardian Signature: _____ Date of Birth: _____

Printed Name: _____ Today's Date: _____

SANO ORTHOPEDICS
ADVANCED ORTHOPEDICS & SPORTS MEDICINE EXPERTS

PATIENT REGISTRATION FORM

Today's Date: _____

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI: _____

DOB:_____ Age:_____ SSN:_____ Gender: □ Male □ Female

Race: □ American Indian □ Asian □ Pacific Islander □ African American □ Caucasian □ Hispanic □ Other: _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino Language: □ English □ Other:_____ Marital Status: _____

Address:_____ City:_____ State:_____ Zip: _____

Preferred Phone:_____ Secondary Phone: _____
□ Cell □ Home □ Work □ Cell □ Home □ Work

Email Address: _____ School name (if applicable): _____

Occupation:_____ Employer: _____

Employer Address:_____ City:_____ State:_____ Zip: _____

Employer Contact Person:_____ Employer Phone: _____

EMERGENCY CONTACT

Name:_____ Relationship to Patient: _____

Preferred Phone:_____ Secondary Phone: _____
□ Cell □ Home □ Work □ Cell □ Home □ Work

GUARANTOR INFORMATION

Last Name:_____ First Name:_____ Phone: _____

Date of Birth:_____ SSN:_____ Relationship: _____

Address:_____ City:_____ State:_____ Zip: _____

REFERRING & PRIMARY CARE PHYSICIAN

Referring Physician (if applicable):_____ Phone: _____

Primary Care Physician:_____ Phone: _____

PHARMACY INFORMATION

Preferred Pharmacy:_____ Phone: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

ATTORNEY INFORMATION (if applicable)

Attorney:_____ Phone: _____ Address: _____

Address:_____ City:_____ State:_____ Zip: _____

SANO ORTHOPEDICS
ADVANCED ORTHOPEDICS & SPORTS MEDICINE EXPERTS

PATIENT REGISTRATION FORM

INSURANCE INFORMATION

Primary Insurance Company:_____ Insurance Phone: _____

Policy # /Member ID:_____ Group ID: _____

Policy Holder's Last Name:_____ First Name:_____ Date of Birth: _____

Policy Holder's SSN:_____ Relationship to Patient: □ Self □ Spouse □ Parent □ Other: _____

Secondary Insurance Company:_____ Insurance Phone: _____

Policy # /Member ID:_____ Group ID: _____

Policy Holder's Last Name:_____ First Name:_____ Date of Birth: _____

Policy Holder's SSN:_____ Relationship to Patient: □ Self □ Spouse □ Parent □ Other: _____

WORKERS' COMPENSATION INFORMATION (if applicable)

Is this a work-related injury? □ Yes □ No Did you report it? □ Yes □ No Did your employer approve this visit? □ Yes □ No

Date /Time of Injury:_____ Date Last Worked: _____

Contact Person at Place of Employment:_____ Phone: _____

Workers' Compensation Carrier:_____ Claim#: _____

Address:_____ City:_____ State:_____ Zip: _____

Adjuster's Name:_____ Phone: _____

ACCIDENT / PERSONAL INJURY INFORMATION (if applicable)

Is this a Motor Vehicle / Personal Injury? □ Yes □ No Date / Time of Accident:_____ State: _____

Insurance Carrier:_____ Claim #:_____ Phone: _____

Address:_____ City:_____ State:_____ Zip: _____

HOW DID YOU LEARN ABOUT US?

□ I've been a patient in the past □ Family / Friend / Other Patient (specify): _____

□ Workers' Compensation Case Manager □ Physician (specify): _____

□ Attorney □ Hospital / Urgent Care (specify): _____

□ Internet (circle below) □ Coach / Athletic Trainer / Physical Therapist (specify): _____
(circle: Google / Facebook / Sano Website / Yelp / Healthgrades) Other : _____

PATIENT AUTHORIZATION

All of the information provided is complete and accurate to the best of my knowledge. I authorize Advanced Orthopedics & Sports Medicine d/b/a Sano Orthopedics to release my personal, confidential health and billing information to my emergency contact, guarantor, referring provider, primary care physician, pharmacy, health insurance(s), workers' compensation carrier / agent and attorney. I understand that my photo identification, insurance card(s) and any applicable co-payment or general deductible payment are required at the time of the visit.

Patient / Guardian Signature:_____ Date of Birth: _____

Printed Name:_____ Today's Date: _____

SANO ORTHOPEDICS
ADVANCED ORTHOPEDICS & SPORTS MEDICINE EXPERTS

PATIENT MEDICAL HISTORY

Today's Date: _____

REASON FOR VISIT

Patient Name: _____ Date of Birth: _____

Reason for Appointment: _____ Date Symptoms Began: _____

Body Part: _____ Location: □ Left Side □ Right Side □ Bilateral

Pain Level (scale of 1-10): _____ Have you seen another physician? □ Yes □ No Name: _____

SOCIAL REVIEW

Height: _____ Weight: _____ Do you Exercise? □ Yes □ No Type: _____

Do you consume Alcohol? □ Yes □ No If yes, please specify the type and frequency: _____

Do you Smoke? □ Yes □ No If yes, please specify the type and frequency: _____

Do you use recreational drugs? □ Yes □ No If yes, please specify the type and frequency: _____

MEDICATION REVIEW

Are you taking any medicine or drugs now? (please include any over-the-counter medicine, vitamins, etc.) □ Yes □ No

If yes, please list the name, the dosage and how many times / day that you take each medication (or attach your own separate list):

Name of Medicine	Dosage	Times Per Day

Do you have any allergies? (please include medication, environmental allergies, etc.) □ Yes □ No □ No Known Drug Allergies

Please list: _____

SURGICAL REVIEW

Please list all previous surgeries:

□ Appendectomy □ Gall Bladder □ Heart Surgery □ Hip Replacement □ Hysterectomy
□ Knee Replacement □ Prostrate Surgery □ Shoulder Replacement □ Tonsillectomy □ Carpal Tunnel Surgery
□ Knee Arthroscopy □ Shoulder Arthroscopy □ Hip Arthroscopy □ Other: _____

FAMILY REVIEW

Please mark any condition(s) that have been diagnosed in biological relation(s) such as parents, grandparents & siblings. Please select all that apply:

Father: □ High Blood Pressure □ Stroke □ Heart Disease □ Obesity □ Bleeding / Clotting Disorder □ Cancer □ Diabetes □ Thyroid

Mother: □ High Blood Pressure □ Stroke □ Heart Disease □ Obesity □ Bleeding / Clotting Disorder □ Cancer □ Diabetes □ Thyroid

Siblings: □ High Blood Pressure □ Stroke □ Heart Disease □ Obesity □ Bleeding / Clotting Disorder □ Cancer □ Diabetes □ Thyroid

Children: □ High Blood Pressure □ Stroke □ Heart Disease □ Obesity □ Bleeding / Clotting Disorder □ Cancer □ Diabetes □ Thyroid

SANO ORTHOPEDICS
ADVANCED ORTHOPEDICS & SPORTS MEDICINE EXPERTS

PATIENT MEDICAL HISTORY

SYSTEM REVIEW

Yes	No	GENERAL / CONSTITUTIONAL
		Fatigue
		Fever
		Weight Gain
		Weight Loss

		OPHTHALMOLOGIC
		Corrective Lens
		Eye Problems
		Vision Changes

		EAR – NOSE – THROAT
		Ear Problems
		Nose / Throat Problems

		ENDOCRINE
		Diabetes
		Thyroid Problems

		RESPIRATORY
		Chronic Dry Cough
		Coughing-up Blood / Mucus
		Waking at Night Coughing / Choking
		Asthma
		Breathing Problems
		Shortness of Breath

		CARDIOVASCULAR
		Changes in Heartbeat / Palpitation
		Chest Pain
		Heart Problems
		High Blood Pressure
		Irregular Heartbeat / Murmur
		Palpitation

		GASTROINTESTINAL
		Abdominal Pain
		Change in Bowel Habits
		Nausea
		Stomach Problems
		Vomiting

Yes	No	HEMATOLOGY
		Bleeding / Clotting Tendency
		Anemia

		GENITOURINARY
		Difficulty Urinating
		Kidney Problems
		Painful Urination

		MUSCULOSKELETAL
		Arthritis
		Back Problems
		Carpal Tunnel
		History of Gout
		Joint Stiffness
		Leg Cramps
		Muscle Aches
		Pain in Shoulder(s)
		Painful Joints
		Swollen Joints
		Weakness

		NEUROLOGIC
		Balance Difficulty
		Coordination
		Difficulty Speaking
		Dizziness
		Fainting
		Headache
		Tingling / Numbness
		PSYCHIATRIC
		Depression
		Anxiety
		Eating Disorders

All of the information provided is complete and accurate to the best of my knowledge.

Patient / Guardian Signature: _____ Date of Birth: _____

Printed Name: _____ Today's Date: _____

SANO ORTHOPEDICS
ADVANCED ORTHOPEDICS & SPORTS MEDICINE EXPERTS

CONTROLLED SUBSTANCE AGREEMENT & PRESCRIPTION POLICY

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____

OBJECTIVE

The staff of Advanced Orthopedics and Sports Medicine d/b/a Sano Orthopedics ("Sano") is dedicated to providing each of our patients with the most appropriate and complete treatment for the injuries they suffer from.
If you do not agree with or do not think that you can comply with our Controlled Substance Agreement and Prescription Policy, please notify us. Sano will do our best to devise a plan for you, which may include, but is not limited to, referral to a pain management specialist or referral to another providing physician. By signing this agreement, you are agreeing to abide by the following agreement and policy.

POLICY

Controlled medications that are prescribed by Sano physician include but not limited the Schedule II narcotics Tramadol, Hydrocodone and Oxycodone. In order to help prevent dependency, abuse or overuse of such medications, Sano will follow the prescribing policy listed as follows:

- Tramadol and/or Hydrocodone and/or Oxycodone will initially be prescribed for severe, acute, traumatic injuries (broken bone, laceration, ligament / tendon rupture, etc.) or for post-operative pain control, if indicated clinically necessary. The choice of medication and the amount prescribed will be the physician's decision.
- Sano will not prescribe any Schedule II narcotic medications for chronic conditions.
- If prescribed oxycodone, it will only be used for a maximum period of six-weeks after the injury or post-operatively. Sano will only consider alterations to this policy if there has been a documented allergic reaction to tramadol and hydrocodone.
- Sano will not prescribe any Schedule II narcotic medication (tramadol, hydrocodone or oxycodone) for a period longer than three months after a traumatic injury or post-operatively. Sano will help provide a plan to gradually decrease and discontinue the use of narcotics at the end of the three-month period and will provide non-narcotic medications to help this transition.

ACKNOWLEDGEMENT

- I understand this agreement is essential to the trust and confidence necessary in a doctor / patient relationship and that my doctor undertakes to treat me based on this agreement.
- I understand that due to potential abuse or diversion of medications, strict accountability is necessary.
- I understand that if I break this agreement, my doctor will stop prescribing controlled substances.
- I will only take the prescribed medication as instructed and not change the directions without the consent of my doctor or other staff member(s) working with my physician.
- I understand that if I am suspected of diverting or distributing my medications, my doctor will cease prescribing effective immediately. In this case, my doctor will be required to comply with local, state and federal reporting requirements.
- I will not share, sell or trade prescription medication.
- I will not attempt to obtain any controlled medications from another doctor while Sano is prescribing me with a controlled medication.
- I will safeguard all prescribed pain medications / controlled substances from loss or theft. I understand lost or stolen medications will not be replaced by an Sano physician or staff member.
- I understand that refills will be made only during office hours Monday-Friday and may take 24 - 48 hours. Refills will not be available during the evenings, weekends or on any federally recognized holidays that Sano's office is closed.
- I agree that prescriptions for controlled substances will not be refilled earlier than the agreed renewal date.
- I understand that altering a prescription in any way is against the law. Forged prescriptions or signatures are also against the law. If any of these instances occur, it will results in an immediate termination from Sano.
- I will inform the doctor of all medications that I currently take as well as new prescribed medications.
- I understand that all refills of controlled substances must be picked up during regular office hours. If a person other than myself is picking up my prescribed medication, a driver license must be scanned and a signed copy of the script must be obtained before leaving.
- I agree to follow all guidelines that have been fully explained to me in this agreement. All questions and concerns have been adequately addressed.

The undersigned certifies that he/she has read and understands the foregoing, is the patient or one authorized by the patient to execute the above and accepts the terms thereof.

Patient / Guardian Signature:_____ Date of Birth: _____

Printed Name:_____ Today's Date: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: _____SSN: _____Phone: _____

PATIENT AUTHORIZES:

Facility: Advanced Orthopedics & Sports Medicine d/b/a Sano Orthopedics_____

Address: 2000 SE Blue Parkway, #230, Lee's Summit, MO 64063_____

Phone: (816) 525-2840_____Fax: (816) 525-2841_____Attention: Medical Records_____

TO: □ RELEASE □ OBTAIN Health Information to/from

□ SELF □ PHYSICIAN □ FACILITY □ OTHER

Information to be released / obtained:

□ Complete Records	□ Pathology Reports	□ Hospital Reports	□ Orders
□ Progress Notes	□ Operative Reports	□ Medication Reports	□ Other:_____
□ Radiology Reports	□ Lab Reports	□ Work Status Notes	□ Other:_____

NAME:_____ ATTENTION:_____

ADDRESS:_____CITY_____STATE_____ZIP_____

PHONE:_____ FAX:_____

The information about you is protected under federal law and you have the right to revoke this authorization in writing. Please be advised that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. This authorization expires on the following date: . If left blank, I agree this authorization shall be valid for a period of twelve (12) months from today's date. All patients requesting medical records are required to show current identification for signature verification for the release of medical records.

Patient / Guardian Signature:_____Date of Birth:_____

Printed Name:_____Today's Date:_____