ORTHOPAEDIC ASSOCIATES OF MARLBOROUGH

Markian Stecyk, M.D. | Donald Hangen, M.D. | Paul Pongor, M.D.
Steven Sewall, M.D. | Kathryn Fischer, P.A.-C.
65 Fremont Street | Marlborough, MA 01752 | 508.485.3665

Dear HMO member:

We are always happy to submit a claim to your HMO for services rendered. However, in most cases, your HMO does not cover any services which is not approved, arranged, or provided by your Primary Care Physician. (please consult your Member Handbook for a list of services which do not require a referral from your Primary Care Physician)

Your signature below indicates that, if you receive specialty care services without the consent of your Primary Care Physician, you will assume financial responsibility for such services.

_____ _____

Signature of Patient/Guardian if under 18 **Date**

_____

Patient

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Dear PPO and/or HMO member:

We are always happy to submit a claim to your PPO for services rendered. However, we are not members of your health insurance network. In most cases, your insurance does not cover, in full, services provided by an out-of-network provider. Please consult your Member Handbook for an explanation of patient responsibility.

Your signature below indicates that you will assume financial responsibility for any and all balances not paid by your insurance company.

_____ _____

Signature of Patient/Guardian if under 18 **Date**

_____

Patient

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PATIENT REGISTRATION FORM

PLACE CHECK NEXT TO DOCTOR YOU ARE SEEING

- □ Markian Stecyk, M.D.
- □ Donald Hangen, M.D.
- □ Paul Pongor, M.D.
- □ Steven Sewall, M.D.
- □ Kathryn Fischer, P.A.-C.

PERSONAL INFORMATION

Name of Patient: _____ Date of Birth: _____
Social Security No.: _____ Marital Status: _____ Male: ____ Female: ____
Home Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Mobile Phone: _____
Employer Name: _____ Work Phone: _____
Employer Address: _____ City: _____ State: ____ Zip: _____
Primary Care Physician: _____ Phone: _____
Name & Phone of Nearest Relative/Friend to Contact in Case of Emergency: _____
_____

IF UNDER 18, PERSON(S) LEGALLY RESPONSIBLE FOR PATIENT

Name: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone: _____ Mobile Phone:_____

INJURY INFORMATION

Date of Injury: _____
Is this injury the Result of: Auto Accident? _____ Work Injury? _____ Other Accident/Injury? _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____ Subscriber DOB: _____
ID or Member Number: _____ Group or Policy Number: _____
Subscriber Name: _____ Relation to Patient: _____
Subscriber Employer Name: _____

SECONDARY INSURANCE

Secondary Insurance Company Name: _____ PCP Name: _____
ID or Member Number: _____ Group or Policy Number: _____
Subscriber Name: _____ Relation to Patient: _____
Subscriber Employer Name: _____ Subscriber DOB: _____

ASSIGNMENT OF BENEFITS

I hereby authorize assignment of payments directly to Orthopaedic Associates of Marlboro, P.C. for any surgical and/or medical benefits, which are payable to me for this service described above. I understand that I am financially responsible for the charges not covered by this assignment of benefits or my insurance. I hereby authorize Orthopaedic Associates of Marlboro, P.C. to release any information related to medical care received by me for purposes of treatment and/or payment. Furthermore, by signing below, I declare that I have received a copy of Orthopaedic Associates of Marlboro, P.C. privacy precautions.

_____ _____
Signature of Patient/Guardian if under 18 **Date**

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HEALTH ASSESSMENT QUESTIONNAIRE

Name of Patient: _____ Date: _____
Age:_____ Occupation/ Work: _____
Primary Care Physician: _____ Phone: _____
Referred By (ER, Primary Care, Clinic, Employee Health, Med Works, Patient, Etc.): _____
Current Orthopedic Problem (Why are you here today?): Date of Injury:_____
#1_____
#2_____
History of Current Problem (Location, Severity, Timing, Duration): Work Related? Yes___ No___
_____
_____
_____
How long have your symptoms been present?_____

General Medical Condition
Height:_____ Weight: _____

Yes__ No__ Heart Trouble _____
Yes__ No__ Cancer _____
Yes__ No__ Stomach Ulcers _____
Yes__ No__ Diabetes _____
Yes__ No__ Stroke _____
Yes__ No__ Bleeding Tendency _____
Yes__ No__ Osteoporosis _____
Yes__ No__ High Blood Pressure _____
Yes__ No__ Blood Clots _____
Yes__ No__ Asthma _____
Yes__ No__ Fibromyalgia _____
Other Medical Conditions/Illnesses/Arthritis:_____
_____
Current Medications:_____
_____
_____
Previous Surgery:_____
List Drug Allergies:_____

Recreational & Social History
Yes___ No___ Alcohol Use _____
Yes___ No___ Tobacco Use _____
Yes___ No___ Nonprescription Drug Use _____
Yes___ No___ Nonprescription Drug Use _____
Current Sports/Activities:_____

Family History (Ages, Major Medical Problems, if Deceased, Cause of Death):
Mother:_____
Father: _____
Siblings: _____
Children:_____
Spouse: _____

Yes___ No___ Previous Questionnaire Reviewed
Yes___ No___ Change in Health Status

_____
Signature of Patient/Guardian if under 18

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RECEIPT OF PRIVACY PRACTICES & DISCLOSURE AUTHORIZATION

Date: _____

Patient Name: _____
Patient Phone: _____

DO WE HAVE PERMISSION TO:

Yes___ No___ Leave a message on your answering machine at home?
Yes___ No___ Leave a message at your place of employment or voice mail?
Yes___ No___ Discuss your condition with spouse, partner or children?
Yes___ No___ Can your interpreter or friend receive verbal communication from physician?

If yes, Please List whom the Disclosure May be Made:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

My signature below certifies that I have been provided with a written copy of the above named practice's notice of privacy practices.

_____ _____
Signature of Patient of Guardian if under 18 **Date**

FOR OFFICE USE ONLY

☐ **Lic/Photo ID:** _____ ☐ **Lic/Photo ID:** _____
_____ _____