St. Cloud Orthopedics • 1901 Connecticut Avenue South • Sartell, MN 56377
(320) 259-4100

MEDICATION LIST

PATIENT NAME: _____

Date of Birth: _____ Chart # _____

ALLERGIES: _____

_____

Nurse Update/initials:						
MEDICATIONS	Dose	MEDICATIONS	Dose			

Signature _____

Date _____

031B

ST. CLOUD ORTHOPEDIC ASSOCIATES , LTD.

1901 Connecticut Avenue South • Sartell, Minnesota 56377
320-259-4100

Authorization for Release of Protected Health Information

PATIENT NAME _____ DATE OF BIRTH _____ CHART NUMBER _____

I authorize:
(NAME AND ADDRESS)

_____
_____
_____
_____

To release my health information to:
(NAME AND ADDRESS)

_____
_____
_____
_____

Purpose of Release:

_____ PATIENT'S OWN REVIEW
_____ CONTINUING CARE
_____ INSURANCE CLAIM
_____ LITIGATION
_____ OTHER_____

Extent of Information to Release:

_____ ALL DATES OF TREATMENT
_____ DATES OF TREATMENT FROM
_____ TO_____
(MONTH / DAY / YEAR) (MONTH / DAY / YEAR)
_____ ONLY FROM DR _____

Information to be released: (Please check all that apply)

___ PHYSICIAN NOTES
___ HOSPITAL/SURGICAL REPORTS
___ X-RAY / DIAGNOSTIC REPORTS
___ X-RAY / DIAGNOSTIC FILMS
___ PHYSICAL THERAPY NOTES
___ LABORATORY REPORTS
___ ITEMIZED BILLING STATEMENTS
___ OTHER _____

I understand that any documentation of substance abuse (drugs or alcohol), psychological or psychiatric conditions, sexually transmitted diseases, and HIV / AIDS will be released as part of my record UNLESS I INITIAL BELOW:

DO NOT RELEASE: (INITIAL TO PROHIBIT RELEASE)

_____ DRUG / ALCOHOL ABUSE
_____ STDs
_____ MENTAL HEALTH
_____ HIV / AIDS

By signing below, I understand the following:
Once my information is released, my records may not be protected under federal privacy regulations, and may be subject to re-disclosure. I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may revoke this authorization at any time by writing to St Cloud Orthopedic Associates, LTD, Attn: ROI Dept., but revocation will not apply to information that has already been released. This authorization will automatically expire 1 year from the signature date below unless an earlier date is specified here_____

_____ _____
SIGNATURE OR MARK OF PATIENT, PARENT OF MINOR, OR LEGAL REPRESENTATIVE TODAY'S DATE

DECLARE LEGAL AUTHORITY TO SIGN AND ATTACH DOCUMENTATION IF APPROPRIATE _____

_____ _____
WITNESS SIGNATURE REQUIRED IF PATIENT UNABLE TO SIGN BUT USES X OR A MARK TODAY'S DATE

The requesting party may be subject to a charge for the release of information. Please contact the St Cloud Orthopedic Associates, LTD, Release of Information Department for fee information.

St. Cloud Orthopedics
1901 Connecticut Ave S, Sartell, MN 56377 (320) 259-4100

Patient's Name: _____ Date-of-Birth: _____ Chart ID: _____

I. Consent and Authorization for Release of Information

1. Release of Information. I consent to the release and use by St. Cloud Orthopedic Associates, Ltd. (referred to as "SCOA") of medical and other information about me to the extent permitted by law to the following:

   - To a health care provider being advised or consulted in connection with my treatment or care;
   - To a health plan, insurer, third party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews; and
   - To a person or organization in connection with SCOA's health care operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.
   - To the following individuals (name spouse or family member, coach, trainer, employer or others): _____

2. Revocation. I understand that this consent shall continue until I revoke it, which I may do at any time by giving written notice to SCOA.

3. By signing this consent form, you are agreeing that SCOA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

II. Payment Authorization

1. Payment Responsibility. I agree to pay for all services furnished to me by SCOA, including, but not limited to, charges that are not paid in full by my insurance, government program benefits or other third-party payors, upon receipt of a statement, except as prohibited by SCOA's contract with my health plan or applicable law. I further agree that an interest charge of 1/2% per month (equaling an annual rate of 6%) may be applied to my account balance if I do not pay charges within 90 days of the posting date. I also agree to pay or reimburse SCOA for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees. I have received a copy of SCOA's Credit Policy and agree to its terms. I understand and authorize a creditor and/or debt collector to pull my credit report.

2. Payment Authorization. I authorize SCOA to directly bill my health plan or third-party payor for services rendered to me by or on behalf of SCOA, but acknowledge that SCOA is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a particular third party payor. I also authorize any third-party payor through which I may have benefits to make payment directly to SCOA for such services. If I have a Medigap policy, I request that payment of authorized Medigap benefits be made to SCOA directly on my behalf by my Medigap insurer. I understand and agree that SCOA is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.

3. Statement to Permit Payment for Medicare Benefits to SCOA. If I am entitled to Medicare benefits, I request payment of authorized Medicare benefits to me, or on my behalf to SCOA, for any services furnished to me by or in SCOA, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

III. Notice of Privacy Practices

1. Confidentiality. It is the policy of SCOA to protect the privacy and confidentiality of patients' medical information.

2. Notice of Privacy Practice. SCOA's Notice of Privacy Practices explains how SCOA may use and disclose my medical information. It also explains my rights regarding this kind of information. SCOA may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices at my request. SCOA's Notice of Privacy Practices is available at the Reception Desk.

3. Acknowledgment of Receipt. I acknowledge that I have received SCOA's Notice of Privacy Practices.

Signature of Patient (if applicable): _____ Date: _____

Signature of Legal Guardian (if applicable): _____ Date: _____

PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient Name : Chart # : Resource :

Date of Birth : Appt Time this Visit :

Patient medical history:

Diabetes *(type 1or 2)*	No	Yes
High Blood Pressure	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart Trouble	No	Yes
Convulsions	No	Yes
Acute Infections	No	Yes
Bleeding tendency	No	Yes
Blood clots	No	Yes
Shortness of Breath	No	Yes
Arthritis/gout	No	Yes
Multiple Sclerosis	No	Yes

Have You Had Previous Hospitalizations/Surgeries/Serious Injuries? No Yes

Explain :

Do you have problems with pain medication? No_____ Yes_____

Explain:

Are you or could you be pregnant? Yes (how many weeks)

No

Other personal medical conditions:

ALLERGIES

Food	NO _____	YES (type)
Latex	NO _____	YES
Medication	NO _____	YES (type)

Patient social history:

Marital status:	Single:_____	Married:_____	Separated:_____	Divorced:_____	Widowed:_____
Use of alcohol:	Never:_____	Rarely:_____	Moderate:_____	Daily:_____	
Use of tobacco	Never:_____	Previously, but	quit:_____	Current packs /	day_____
Use of illegal drugs	Never:_____	Type/Frequency:			

Family medical history: **Who:**

Lupus:

Rheumatoid Arthritis:

Anesthesia problems:

Bleeding problems:

Diabetes:

Other family medical conditions:

Review of systems

(Circle any that apply to your current condition)

General	None	Fever, Chills, Headaches, Unexplained weight loss or gain
Respiratory	None	Cough, Wheezing
Gastrointestinal	None	Nausea, Vomiting, Stomach ulcers
Cardiac	None	Swelling in the legs or ankles, Varicose veins, Cold feet, Leg cramps when walking
Genitourinary	None	Loss of bowel or bladder control, Constipation, Blood in urine, Diarrhea
Musculoskeletal	None	Joint pain, Back pain, Neck pain, Difficulty walking, Stiffness in joints
Skin	None	Rash, Lumps, Sores, Change in size or color of mole
Psychiatric	None	Depression, Paranoid, Anxiety
Blood problems	None	Easy bruising, Anemia, Leukemia
Neurological	None	Numbness or tingling in arms or legs, Blackouts, Seizures, Paralysis

SIGNATURE OF PERSON COMPLETING / RELATIONSHIP:	DR. INITIAL & DATE:		