

PATIENT REGISTRATION FORM

HOSPITAL FOR SPECIAL SURGERY
535 East 70th Street NEW YORK, NY 10021

MEDICAL RECORD NUMBER (FOR OFFICE USE ONLY)

DATE OF VISIT

LEGAL ID TYPE DRIVER'S LIC. PASSPORT BIRTH CERT. SSN GREEN CARD OTHER

HOSPITAL PHYSICIAN

PATIENT'S FULL NAME (Last, First, MI.)

DATE OF BIRTH

BIRTH PLACE

STREET ADDRESS

CITY

STATE

ZIP CODE

COUNTRY

HOME PHONE

SEX

RACE

MARITAL STATUS

SOC. SEC. NUMBER

CELL PHONE (if applicable)

TEMPORARY ADDRESS #1

E - MAIL ADDRESS

ARE YOU CURRENTLY RESIDING IN A SKILLED NURSING FACILITY OR INPATIENT REHAB FACILITY? YES NO

IF YES, PROVIDE NAME OF FACILITY

SKILLED NURSING FACILITY/REHAB FACILITY ADDRESS

PHONE NUMBER OF FACILITY

HAVE YOU EVER BEEN TO HSS FOR A DOCTOR OR HOSPITAL VISIT ? YES NO

IF SO, WHAT DOCTOR AND WHEN WERE YOU SEEN?

EMPLOYMENT (If full-time student provide information on school)

PATIENT'S EMPLOYER

PATIENT OCCUPATION

FULL-TIME PART-TIME

RETIRED STUDENT

RETIREMENT DATE

EMPLOYER ADDRESS (no., street, city, state, zip code)

EMP PHONE

E - MAIL ADDRESS

GUARANTOR (The person responsible for the bill)

SELF SPOUSE PARENT/GUARDIAN OTHER (If guarantor other than self, provide person's information below)

EMERGENCY CONTACT

PERSON # 1 FULL NAME (Complete this section for Spouse, Parent, Legal Guardian, etc.)

RELATIONSHIP TO PATIENT

DATE OF BIRTH

ADDRESS (no., street, apt#, city, state, zip code)

SEX

HOME PHONE

SOC. SEC. NUMBER

EMPLOYER

OCCUPATION

FULL-TIME PART-TIME

RETIRED STUDENT

RETIREMENT DATE

EMPLOYER ADDRESS (no., street, city, state, zip code)

EMP PHONE

PERSON # 2 FULL NAME

RELATIONSHIP TO PATIENT

DATE OF BIRTH

ADDRESS (no., street, apt#, city, state, zip code)

SEX

HOME/WORK/CELL PHONE

MEDICAL DETAIL

REASON FOR VISIT OR CHIEF COMPLAINT

ALLERGIES

IF YOUR SERVICE IS RELATED TO AN INJURY OR ACCIDENT - HOW DID YOUR INJURY OCCUR?

DATE OF INJURY

TIME OF INJURY

PLACE OF INJURY

REFERRING PHYSICIAN & ADDRESS

PRIMARY INSURANCE

INSURANCE COMPANY NAME

PHONE NUMBER

INSURANCE COMPANY ADDRESS

NAME OF CLAIMS ADJUSTER (if applicable)

POLICY NUMBER

GROUP/PLAN NUMBER

CLAIM NUMBER (if applicable)

WCB CASE NUMBER (if applicable)

SECONDARY INSURANCE

INSURANCE COMPANY NAME

PHONE NUMBER

INSURANCE COMPANY ADDRESS

POLICY NUMBER

GROUP/PLAN NUMBER

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT - I certify that the information given by me is correct. I understand that this information is entered into a database, and I hereby authorize the sharing of such information with Hospital affiliated physicians who are responsible for my care and their offices. I hereby also authorize the release of information related to my medical care, as requested by government agencies and/or insurance carriers. I hereby assign benefits to the Hospital and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of services rendered.

MEDICARE PATIENTS - I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles on all services and a 20% co-insurance on ancillary services. When Medicare is deemed the secondary insurance, I will follow payment terms under Hospital policies.

EFFECTIVE DATE - These statements shall be effective from the date of the signature below until December 31 of the current year, unless you notify HSS otherwise in writing at the address written above.

PATIENT OR GUARDIAN SIGNATURE _____

DATE _____

John D. MacGillivray, M.D.

Medical Profile

Name: _____ Today's Date: _____

Social Security #: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ *****REQUIRED*****

Referring Physician Address: _____ *****REQUIRED*****

Chief Complaint

Why are you seeing the doctor today? _____

Current problem is the result of a(n): Check all that apply

- Car Accident Work Accident Accident Other _____

This occurred during: Check all that apply

- Lifting Pulling Twisting Falling Bending Reaching Squatting
 Hit by Object Not known

List all medications you are currently taking:

Medication	Dose	How long?	Side Effects

ALLERGIES TO MEDICATION: YES NO

Name of Medication: _____ Reaction: _____

Review of Systems

Are you currently having or have you had problems with your:

	Circle	Describe all <u>Yes</u> responses
Eyes	No Yes	_____
Ears, Nose, Throat	No Yes	_____
Lungs, Breathing	No Yes	_____
Digestion	No Yes	_____
Bowel movement	No Yes	_____
Bladder problem	No Yes	_____
Diabetes	No Yes	<u>Controlled: No Yes</u>
High blood pressure	No Yes	_____
Bleeding problems	No Yes	_____
Balance problems	No Yes	_____
Numbness/tingling	No Yes	_____
Blackout/fainting	No Yes	_____
Psychological problems	No Yes	_____
AIDS/HIV	No Yes	_____
Cancer	No Yes	_____
Arthritis	No Yes	_____
Polio	No Yes	_____
TB	No Yes	_____
Epilepsy	No Yes	_____

Current Specialists None _____

Cardiologist _____

Rheumatologist _____

Hematologist _____

Oncologist _____

Pain Management _____

Current Medical Conditions

Sleep Apnea _____ HepC _____

Pacemaker _____ Hemophilia _____

Insulin Diabetic _____ Coumadin _____

Liver Disease _____ Heparin _____

Sickle Cell _____

Reviewed By: _____ MD

Date: _____

(NEXT PAGE)

Name: _____ Today's Date: _____

Social Security #: _____ Date of Birth: _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Temperature _____

Treatment to Date

Medication: Name _____ **Physical Therapy:** _____

Cortisone: Effect _____ **Surgery:** Type _____

Past Surgical History

List Type of Surgery	Year	Complications

Have you ever had general anesthesia? No Yes
Have any problems with anesthesia? No Yes Describe: _____

Family History

Loose Joints:	
Arthritis:	
Diabetes:	
Gout:	

Social History

Exercise? Daily Weekly Monthly Rarely Never
What type of exercise? _____
History of substance abuse? No Yes **What?** _____
Smoke currently? No Yes _____ Packs per day for _____ years
Quit smoking? This year >1 year >5 years >10 years
Previously smoked _____ Packs per day for _____ years
Drink alcohol? Daily 1-2x/week 1-2x/year

Medical Information Release: I authorize the staff of Dr. John D. MacGillivray, MD to discuss my medical history and medical condition with the following persons:

_____ Relationship _____
_____ Relationship _____
_____ Relationship _____

Patient's Signature _____

Date: _____

John D. MacGillivray, M.D.
Hospital for Special Surgery
535 East 70th Street
New York NY 10021
(212) 606-1896

FINANCIAL POLICY

Thank you for choosing John D. MacGillivray, M.D. as your health care provider. We are committed to your treatment being successful. All patients must read and sign our Financial Policy before seeing Dr. MacGillivray.

Patients with Non Participating Plans

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA OR MATERCARD.

Patients Enrolled in Participating Plans

The billing office will submit to your carrier, however, you will be responsible for all deductibles and co-pays.

If you do not bring in your insurance identification card with you, payment in full is expected the day of service. Your insurance card must contain your policy, group or plan numbers, also the correct mailing address for claims to be submitted and the telephone number of the insurance company for verification.

If a referral is required and not presented at the time of service you understand that you will be responsible for any charges incurred at time of service.

In the event that your insurance changes to a plan in which Dr. MacGillivray does not participate, refer to the above paragraph concerning Non-Participating Plans. It is your responsibility to notify our office of any insurance changes. Failure to do so may result in being responsible for the services that incur under new insurance policy.

Minor Patients

The adult accompanying a minor to this office is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless payment has been pre-authorized to an approved health care carrier. Visa, MasterCard, cash or checks are acceptable at the time of service.

I have read Dr. MacGillivray's Financial Policy and agree to be bound to this Financial Policy.

X _____
Signature of Patient or Responsible Party

Date _____

X _____
Signature of Co-Responsible Party

Date _____

John D. MacGillivray, M.D.
Hospital for Special Surgery
535 East 70th Street
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Cancellation Policy for Surgery

In an effort to serve our patients better we have instituted a cancellation policy for scheduled surgery dates. Surgery cancellations should be done more than 7 days prior to surgery.

Scheduling surgery is a time consuming and complicated process, and the office understands that it is very disruptive to your normal life. Likewise, when surgery is indicated, the office invests a considerable amount of time and effort beforehand, to ensure that the day of surgery goes as smoothly as possible.

From time to time, extenuating circumstances cause a surgery to be cancelled. However, in situations when the patient electively cancels a procedure within 7 days of the scheduled, **a non-refundable cancellation fee of \$250 will be charged to the patient.**

If your surgery is cancelled for a medical reason this charge does not apply. Please keep this in mind when scheduling your surgical date.

I, _____ have read and understand the surgical cancellation policy of Dr. John MacGillivray and I hereby accept and agree to adhere to the conditions of this policy.

Patient Signature or Parent/Guardian

Date

It is understood and agreed that my purpose of requesting examination and treatment is for medical purposes only and **NOT** in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate **IN ANY WAY** in the litigation, except to provide a true and accurate copy of any medical records and x-rays in the possession and control of this office pursuant to an authorization by the undersigned. *

* Upon payment of usual copying charges

Additionally, any forms that may be required by employers in connection to FLMA/Short Term Disability or for the purposes of transportation/travel accommodations are subject to an administrative charge of \$10.00 per packet. This charge is the patient's responsibility due at the time the forms are submitted.

John D MacGillivray, MD, PC
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021
Telephone: 212-606-1896

I. Insurance Status:

Patient Insurance Plan _____

___ Participating ___ Non-Participating

*A complete list of insurances with which I participate is available at www.hss.edu/macgillivray

II. I am affiliated with **Hospital for Special Surgery** and the following hospitals:

- a. New York Presbyterian Hospital

III. During your procedure and/or hospital stay, we may request consultations by physicians who will also follow your case. These doctors will bill you separately.

IV. We recommend that you call each provider listed to confirm their participation status with your insurance company.

Below is a list of providers who may provide services as part of your prescribed treatment. Their contact information is also included

Name	Address	Telephone #
East River Medical Anesthesia*	535 East 70th Street, NYC	212-606-1206
HSS Radiology*	535 East 70th Street, NYC	212-774-2607
HSS Pathology*	535 East 70th Street, NYC	212-774-2607
East River Medical Imaging	519 East 72nd Street, NYC	212-288-1575
Park Avenue Orthotics	155 East 55th Street, NYC	212-297-0362

*Anesthesia, Radiology and Pathology participate in the same insurance plans as Hospital for Special Surgery. You can find a list of participating plans at www.hss.edu/insurance.

V. Estimated charges for out of network service are available upon request.

VI. I have been informed of the insurance participation status of John D. MacGillivray, MD. I have reviewed the information provided to me and understand that the above providers may be involved in my care. I understand that it is my responsibility to contact each provider to determine participation status with my health plan.

Patient Name

Signature

Date