PATIENT REGISTRATION FORM

HOSPITAL FOR SPECIAL SURGERY 535 E 70th Street (MAIN) * 519 E 72nd Street (OFF SITE) New York, NY 10021	MR # DATE OF VISIT HOSPITAL PHYSICIAN DR. ROZBRUCH

PATIENT'S LEGAL FULL NAME (LAST, FIRST, M.I.)	SEX	DATE OF BIRTH	MARITAL STATUS
ADDRESS	SS #		HOME PHONE#
CITY, STATE, & ZIP CODE	RACE	ASSOCIATED ETHNICITY	CELL PHONE #
HAVE YOU BEEN TO THE HOSPITAL FOR SPECIAL SURGERY BEFORE? WHEN?	E-MAIL ADDRESS		

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER	OCCUPATION	❑ F/T ❑ P/T ❑ Retired ❑ Student	RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)		EMPLOYERS' PHONE #	

GUARANTOR (PERSON RESPONSIBLE FOR INSURANCE CLAIM)

❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other

GUARANTOR / EMERGENCY CONTACT

RELATIVE # 1 LEGAL FULL NAME -INSURANCE GUARANTOR ONLY-			RELATIONSHIP TO PATIENT		DATE OF BIRTH
ADDRESS (building #, city, state, zip code)		MARITAL STAT	SEX	HOME PHONE #	SS#
EMPLOYER	OCCUPATION		❑ F/T ❑ P/T ❑ Retired ❑ Student		RETIREMENT DATE
EMPLOYER ADDRESS (building #, city, state, zip code)				EMPLOYER PHONE #	
RELATIVE # 2 FULL NAME -EMERGENCY CONTACT ONLY-			RELATIONSHIP TO PATIENT		DATE OF BIRTH
ADDRESS (building #, city, state, zip code)			SEX	HOME PHONE #	CELL PHONE #

MEDICAL DETAIL

COMPLAINT / REASON FOR VISIT	ALLERGIES ★
REF. PHYSICIAN / ADDRESS & CONTACT #	

PRIMARY INSURANCE: ***PLEASE NOTIFY REGISTRAR IF PRIMARY INSURANCE IS NO FAULT/WORKMAN'S COMP (ADD'L FORMS)

INSURANCE CO. NAME & ADDRESS			POLICY # (or) ID #	GROUP# / ACCOUNT #
NO FAULT OR WORKMAN'S COMP.			INSURANCE CLASS/TYPE	CLAIM #
PLACE OF ACCIDENT	ACCIDENT DATE	ACCIDENT TIME	CONTACT NAME & NO.	WCB CASE #

SECONDARY INSURANCE:

INSURANCE CO. NAME & ADDRESS			POLICY # (or) ID #	GROUP# /ACCOUNT#
NO FAULT OR WORKMAN'S COMP.			INSURANCE CLASS/TYPE	CLAIM #
PLACE OF ACCIDENT	ACCIDENT DATE	ACCIDENT TIME	CONTACT NAME & NO.	WCB CASE #

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

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, 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 X ____________________ DATE ________

S. Robert Rozbruch, MD
Orthopaedic Surgery

Please note that it is a requirement for the physician to document this information. Please answer all questions. Answer "none" if appropriate.

Date: ________________

Name: ____ Email: ______________________________________

Home #: ______________________ Cell # ______________________ Work #: ______________________

Birth Date: ______________ Age: ____ Height: ________ Weight: ________ Blood Pressure: ______________

Chief Complaint: ____

Primary MD (Name, Phone Number): ____

Referral Information:

Who referred you to Dr. Rozbruch? ____

Are they a former patient of this office? ____

Information on the doctor(s) to whom you would like a report sent:

Name: ____

Address: ____

City: ________________________ State: ______________ Zip code: ______________

Telephone: ____

Did this doctor refer you here? _________________________________

History of Present Illness:

Location: Where is the pain? ____

Quality: Circle one or more: sharp dull aching shooting traveling

Timing: When did it first start? ____

Is this a Work, Pedestrian or Motor Vehicle related injury? ____

Context: What causes the pain? ____

Frequency: How many times per week is it a problem? ____

Modifying Factors: What makes it worse? ____

What helps make it better? ____

Prior Treatment: ____

Past Medical History:

Major illness or injury: ____

Past Surgery: ____

Current Medications and what they are used to treat:

____ ______________________________________

____ ______________________________________

____ ______________________________________

Allergies to medications: ____

Other Allergies ie. food: ____

Family History:

Medical Conditions that have been in your family: ______________________________

Social History:

Marital Status: ______________________ Occupation: ______________________

Are you currently working? __________ If No, last date of work: ______________________

Alcohol use: How many drinks per week? ______________________________

Smoking: How many packs per day? ______________________________

Person you wish doctor to call in case of emergency or after surgery:

Name/Relation: ______________________ Telephone: ______________

Person(s) able to be of assistance after surgery (explain): ______________________________

____

Review of Systems:

Please list any problems in the following systems: Indicate "none" if appropriate.

Cardiovascular, Heart: ______________________________

Ear, Nose, Throat: ______________________________

Endocrine, Hormonal, Diabetes: ______________________________

Eyes: ______________________________

Gastrointestinal, Digestive system, Liver: ______________________________

Genitourinary: ______________________________

Hematologic, Blood: ______________________________

Immunologic, Immune compromise: ______________________________

Integumentary, Skin: ______________________________

Neurologic: ______________________________

Peripheral circulation: ______________________________

Psychiatric: ______________________________

Renal, Kidney: ______________________________

Respiratory, Lungs: ______________________________

Do you have Sleep Apnea? __________ If Yes, do you use a CPAP/BIPAP? __________

Other:

Infection History-

Do you have a history of infection? ______________ If Yes, what kind/When? ______________

Name/Type of Antibiotics used, Duration? ______________________________

Infectious Disease MD (Name, Phone Number): ______________________________

Pain Management History-

Have you been followed by a Pain Management MD? __________ If Yes, current or past? __________

Name of Pain Medications and for how long? ______________________________

____

Pain Management MD (Name, Phone Number): ______________________________

Effective Date: April 14, 2003
Revision Date: September 23, 2013

Acknowledgement of Receipt of Notice of Privacy Practices

Respect for our patients' privacy has long been highly valued at Hospital for Special Surgery. Not only is it what our patients expect, it is the right way to conduct health care. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices of our Hospital and its medical staff and affiliated health care providers when providing health care services for our Hospital. Our Notice will be posted in the main entrance area of the Hospital at 535 East 70th Street, New York, New York and in other locations where we provide services. You will also be able to obtain your own copy of the Notice by accessing our website at www.hss.edu, calling Health Information Management at (212) 606-1254, or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me may be used and disclosed by the Hospital, and how I may obtain access to and control this information. I also acknowledge and understand special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and/or disclosure of my health information as described in this Notice, including to treat me and arrange for my medical care, to seek and receive payment for services given me, and for the business operations of the Hospital and its staff.

____
Signature of Patient or Personal Representative

____
Print Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

____
Date

If you have any questions about this Notice or would like further information, please contact the Privacy Officer at (212) 774-7500.

For Office Use Only: If the patient does not sign this acknowledgement form, record here the good faith efforts made to obtain this acknowledgement and consent.

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HOSPITAL FOR
SPECIAL SURGERY

OUT PATIENT INTAKE FACE SHEET R/E/L Query

As part of a national initiative and rules enacted by the federal government, intended to insure that all patients receive the highest quality care, HSS will ask all of our patients to self report their race, ethnicity and preferred language for healthcare.

If You Have Provided This Information To A Registrar Prior To This Visit Then You Do Not Have To Complete This Survey For Subsequent Visits To HSS.

Thank you.

1. Do you consider yourself to be Hispanic/Latino?

   ❑ Yes ❑ No

2. Which one or more categories best describes your race? Please check up to two only.

   ❑ American Indian/Alaska Native ❑ Asian ❑ Black or African American

   ❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Some Other race

3. Please further describe your race or ethnic background? Please provide up to two responses.

   (For example: Mexican and Polish, Chinese and Caribbean American, Puerto Rican and Russian)

   ____________________ ____________________

4. How would you rate your ability to speak and understand English?

   ❑ Very Well ❑ Well ❑ Not Well ❑ Not at all

5. What is your preferred spoken language for discussing healthcare?

   (Provide one only.) ____________________

6. Would you like an Interpreter offered free of charge?

   ❑ Yes ❑ No ❑ Not Applicable

7. In what language would you prefer reading medical or healthcare instruction?

   (Provide one only.) ____________________

S. Robert Rozbruch, MD

Financial Interest Disclosure Form
Medical Staff, Allied Health Professional Staff,
Residents, and Fellows

As your treating physician and as a member of the Medical Staff of Hospital for Special Surgery (HSS), I would like you to know that I have a financial relationship with Small Bone Innovations, and Smith & Nephew, orthopedics device companies whose products I may use, or prescribe, for you in your care at HSS. The following will provide you with information about my financial relationship with these companies:

> I am a consultant and designer of the Rozbruch Ankle Distraction Frame (RAD™) for Small Bone Innovations for which I receive royalties.
>
> I am also a consultant, designer and a Speakers Bureau participant for Smith & Nephew for which I receive compensation for my time, and may receive royalty earnings for designing an internal lengthening nail device.
>
> I DO NOT RECEIVE ANY PAYMENTS FROM THESE COMPANIES FOR USE OF THEIR PRODUCTS FOR YOUR CARE AT HSS OR FOR THE CARE OF ANY OTHER PATIENTS AT HSS.

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with me, you may contact the Hospital's Office of Corporate Compliance (212-774-2398) or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship I have disclosed to you, you choose to refuse a particular treatment, or would like to revoke any informed consent you have previously given for a particular operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that I have discussed the financial interest or relationship described above. You also confirm that you have read and fully understand this document, and that you have been given the opportunity to ask questions about my financial interest or relationship and your questions have been answered to your satisfaction.

Signature____
Patient/Parent/Guardian/Health Care Agent **Date**

Print Name____
Patient/Parent/Guardian/Health Care Agent

____
Relationship to Patient

PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD

OXFORD
HEALTH PLANS®
A UnitedHealthcare Company

Member Authorization Form for a Designated Representative to Appeal a Determination

TO: Clinical Appeals Department
48 Monroe Turnpike
Trumbull, CT 06611

DATE: ______________________________

Member Name: ______________________________

Member ID #: ______________________________

I hereby authorize __Dr. Robert Rozbruch/ PMI Medical Mngt.__ to appeal Oxford's determination
(print name)

concerning ____on my behalf, as my
(description of service and date of Oxford's determination or reference number)

Designated Representative, and, as part of the appeal, I hereby authorize Oxford in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative concerning the following:

> All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this Authorization. This authorization is valid for a period of one year.

____
Signature of Member or Legal Guardian/Representative

____
___Signature of Witness ___Designated Representative (Check One)

____
Name of Witness/Designated Representative (Please Print)

____
Title (if on provider's staff) or Relationship to Member

MS-04-1227
7322 R2

HOSPITAL
FOR
**SPECIAL
SURGERY**

S. Robert Rozbruch, MD
Chief, Limb Lengthening & Complex Reconstruction Service
Professor of Clinical Orthopaedic Surgery
Weill Cornell Medical College

E-mail Communication Guidelines for Patients/Parents/Guardians

We believe e-mail communication with your healthcare team offers an efficient and effective means of communication. The following guidelines must be met in order to communicate by e-mail.

1. The patient or parent/guardian must give prior written consent (below) to engage in e-mail communication, including e-mail about privileged medical information.
2. Always insert the patient name into the subject line of all e-mails.
3. E-mail should be used for practical, concise communication with your healthcare team. Avoid long narratives. Clear and direct questions should be used.
4. E-mail should never be used for a medical emergency or other time-sensitive issues. If you require immediate attention please call the office or answering service, or if a medical emergency call 911.
5. Do not abuse email communication. Examples of email abuse include excessive emailing, long wordy emails, and confrontational emails. If you abuse email communication, we will terminate this form of communication with you.

We will typically answer your questions in a succinct fashion within the body of your email. Email will typically be answered within 24 hours. If you do not get a response to a first time email, then your email may have gone to our spam filter. Call the office with your email address and we will email you to open the line of communication.

By consenting to e-mail communication you agree and understand that our response to you will typically be copied to the rest of our team in order to improve communication and keep everyone advised and up to date about your condition.

Print Patient name: ______________________________

I ____ (Print name of Patient/Parent/Guardian) would like to communicate with my healthcare team via email. I understand that privileged medical information may be copied to other members of our team. Additionally, I understand that there is always a risk of email being seen by unintended persons. I understand that if I do not follow the guidelines as outlined above, I may lose the ability to use email to communicate with the healthcare team. I understand that I may revoke this consent for e-mail communication at any time.

Patient/Parent/Guardian signature: __________________________ Date: ________________

Mailing Address:
535 East 70th Street
New York, NY 10021
email: RozbruchSR@hss.edu

LIMB LENGTHENING.COM
www.hss.edu/limblengthening

Office Location:
519 East 72nd Street
New York, NY 10021
tel 212.606.1415
fax 212.774.2744