FILLMORE COUNTY HOSPITAL

Fillmore County Hospital is committed to providing high quality, personalized healthcare with compassion, dignity, and respect in a cost effective and safe manner - to achieve this we want you to have the opportunity to focus more on receiving treatment for your condition.

As paperwork is also important to your care, we feel that by spending time completing papers prior to your visit will provide accuracy. You can complete them at your own pace in a more private setting by doing these in your own home. This will also save you time when you present to the admission desk at the time of your visit.

Enclosed is information required to be completed prior to your visit with us. Some information is for Fillmore County Hospital and others may be for the specialty physician you are scheduled to see.

Please use the check list below as a 'reminder for your upcoming visit. If you have any questions, please call us at 402-759-4924 or 1-800-277-0706.

If instructions are included for your procedure, please read and follow them accordingly. If you have any questions, please do not hesitate to call. These are yours to keep.

To avoid duplicate work on your part, please fill out the forms in their entirety and bring them to your scheduled visit.

Patient Information Data _ Medicare Questionnaire _ Specialty Physician Questionnaire

☐ Bring insurance card(s). It is your responsibility to contact your insurance company for pre-certification or pre-authorization prior to having procedures/tests that request them. If your pre-certification or pre authorization is not done prior to your procedure/test, your insurance company will penalize you and will not pay their portion of the bill. You will then be responsible for payment.

If you are under the age of 19, a parent/guardian must be present to sign the consent the day of visit or your Parent/ guardian may make arrangements to have the consent signed prior to the visit by contacting the Admission Office.

If no information is given in the scheduled appointment box to the right, someone from Fillmore County Hospital or your specialty physician office will be contacting you.

Sincerely,

The Specialty Clinic Team
Fillmore County Hospital

_____
Name
Your scheduled appointment is:
_____
Day Date Time
_____
Scheduled Physician or Procedure
We will contact you if this changes.

FILLMORE COUNTY HOSPITAL
(402) 759-3167. 1900 F STREET. GENEVA. NE 68361. *www.myfch.org*

Prairie Orthopaedic & Plastic Surgery

History of New Illness or Injury

Patient Name:
Age: DOB:

What are we seeing you for today?

_____

_____

Date of injury/onset? _____ Where did it occur? (Home/work/school) _____

R handed or L handed Who referred you to our office? _____

Please rate and describe your CURRENT pain level.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Worst Pain Imaginable

____ Dull ____ Aching _____ Sharp _____ Shooting _____ Burning _____ Penetrating
____ Tender ____ Numbness ____ Tingling ____ Nagging ____ Throbbing _____Gnawing ____ Constant ____ Occasional ____ Intermittent ____ Day pain ____ Night pain

Have you had x-rays taken? yes or no Where? _____

What makes your symptoms worse? _____ Better? _____

What treatments have you already tried? _____

Do you need a Work Note? yes or no

Any other significant health history we should be aware of? _____

_____

Is it OK for us to obtain your medication history? yes or no

Please list all medications (with dosage) that you currently take including OTC on the reverse side of this paper. If you are not taking any medications, circle: NONE

Prairie

Orthopaedic & Plastic Surgery, PC

Patient Information

Patient Name _____ (First / MI / Last)

Date of Birth _____ **Height** _____ **Weight** _____ **Gender** M F

Social Security Number _____ **Email Address** _____
Patient Portal access available with email address

Address _____ (Street Address / City / State / Zip)

Primary phone _____ ◻ Cell ◻ Home ◻ Work **Secondary Phone** _____ ◻ Cell ◻ Home ◻ Work

How did you hear about our office: ◻ Physician ◻ Patient ◻ Friend/Family ◻ Insurance Company ◻ ER ◻ Media

Employment Status ◻ Employed ◻ Student ◻ Retired ◻ Unemployed ◻ Other _____

Name of Employer _____ **Occupation** _____

Work Phone _____ **Can we contact you at work?** ◻ Yes ◻ No

If referred by a physician, what is name of physician that referred you? _____

Is this physician your primary care physician? ◻ Yes ◻ No, **name of PCP:** _____

Marital Status ◻ Single ◻ Married ◻ Divorced ◻ Separated ◻ Widowed ◻ Common Law ◻ Life Partner

Spouse's Name if applicable _____ Spouse's Last 4 SS# _____

Emergency Contact Name _____ **Relationship** _____

Emergency Contact Phone _____

Is there someone we have permission to contact or share medical information with on the patient's behalf?

Name _____ Relationship to Patient _____

Parent/Guardian Information: Is the patient under the age of 19 years? ◻ Yes ◻ No (if no skip to Insurance)

Legal Guardian's Name _____ Relationship to Patient _____

Guardian's Date of Birth _____ Guardian's Social Security # _____

Insurance Information (If no insurance then skip to Billing Information)

Insurance Company Name _____ Policy Holder Name _____

Policy Holder Date of Birth _____ Policy Holder Social Security # _____

Billing Information: ☐ Same as patient

If different, name of responsible party? _____

Is address of patient same as address of responsible party? ☐ Yes (skip to next section) ☐ No

Responsible party address _____

Responsible party phone _____ Responsible party SS# _____

MEDICAL HISTORY:

Latex Allergy ☐ Yes ☐ No
Adhesive Allergy ☐ Yes ☐ No

Nickel Allery ☐ Yes ☐ No
Other Metal Allergy ☐ Yes ☐ No

Allergies to Medications? ☐ Yes ☐ No
Medication: Type of Reaction:

_____

_____

History of adverse reaction to pain medicine? ☐ Yes ☐ No If yes, what med and type of reaction?

_____

History of problems with Anesthesia? ☐ Yes ☐ No If yes, what type of problem? _____

Current Prescription Medications: **Dosage:**

_____

_____

_____

_____

_____

_____

Over the Counter Meds/Herbals: **Dosage:**

_____

_____

_____

Past or Current Medical Issues: (Type)

Arthritis	☐ Yes ☐ No	_____
Asthma	☐ Yes ☐ No	
Bronchitis	☐ Yes ☐ No	
Blood Clots	☐ Yes ☐ No	
Blood Transfusions	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	_____
Heart (a-fib, MI, CHF)	☐ Yes ☐ No	_____
Depression	☐ Yes ☐ No	
Diabetes – Type I	☐ Yes ☐ No	
Diabetes – Type II	☐ Yes ☐ No	
DVT (Deep Vein Thrombosis)	☐ Yes ☐ No	
Emphysema / COPD	☐ Yes ☐ No	
Gastroesophageal reflux	☐ Yes ☐ No	
Gout	☐ Yes ☐ No	
High Cholesterol	☐ Yes ☐ No	
HIV/AIDS	☐ Yes ☐ No	
Hepatitis (Circle: A B C)	☐ Yes ☐ No	
High Blood Pressure	☐ Yes ☐ No	
Kidney disease	☐ Yes ☐ No	
Lung disease	☐ Yes ☐ No	
Osteoporosis	☐ Yes ☐ No	
Prostate	☐ Yes ☐ No	
Ulcers	☐ Yes ☐ No	
Thyroid problem	☐ Yes ☐ No	

☐ Others: _____

Previous Surgeries:

☐ NONE

☐ Tonsils ☐ Appendix ☐ Gallbladder
☐ Cataract ☐ Hysterectomy ☐ Breast
☐ Prostate ☐ Thyroid

☐ Heart Bypass ☐ Heart Valve ☐ Heart Stent

(Please circle side surgery was done on)

☐ Shoulder Surgery	R / L	Date: _____
☐ Carpal Tunnel	R / L	Date: _____
☐ Knee replacement	R / L	Date: _____
☐ Hip replacement	R / L	Date: _____
☐ Knee Scope	R / L	Date: _____
☐ Foot	R / L	Date: _____

☐ Other: Date:

_____

_____

_____

_____

FAMILY HISTORY: (parents/siblings)

Heart Disease: ☐ Yes ☐ No (what kind & who has?) _____
Cancer: ☐ Yes ☐ No (what kind & who has?) _____
Bleeding Tendency ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Osteoporosis ☐ Yes ☐ No
Family History of Problems with Anesthesia: ☐ Yes ☐ No
Family History of Malignant Hyperthermia: ☐ Yes ☐ No
Other: _____

SOCIAL HISTORY:

Has the patient ever smoked cigarettes or used nicotine? ☐ Yes ☐ No (If no, please skip the next four questions.)

Does the patient smoke or use nicotine 1 or more days per week? ☐ Yes ☐ No
How many cigarettes (packs) does the patient smoke per day? ☐ Less than 1 ☐ 1 ☐ 2 ☐ More than 2
How long has the patient been using nicotine? ☐ <1 year ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐10-15 yrs ☐ 15-20 yrs
If no longer using nicotine, when did the patient stop? _____

How often does the patient drink alcohol? ☐ Daily ☐ Weekly ☐ Rarely ☐ Never
Number of Alcoholic Drinks per week? ☐ Less than one ☐ 1-4 ☐ 5-7 ☐ 8-14 ☐ 15-21 ☐ 22-28 ☐ More than 28

How many days per week does the Patient get at least 30 min of moderate exercise? ☐ 1 ☐ 3 ☐ 5 ☐ 7

Prairie

Orthopaedic & Plastic Surgery, PC

Review of Systems

Name _____ Date _____

GENERAL:
- ___ change in weight
- ___ fever
- ___ chills
- ___ nausea
- ___ vomiting
- ___ swelling
- ___ fatigue

LUNGS:
- ___ shortness of breath
- ___ wheezing
- ___ coughing blood
- ___ sputum production
- ___ snoring

ENDOCRINE:
- ___ excessive thirst
- ___ excessive urination
- ___ dry skin
- ___ heat/cold intolerance

PSYCHIATRIC:
- ___ stress
- ___ depression
- ___ anxiety
- ___ suicidal thoughts
- ___ sleep disturbance

EYES/EARS/NOSE:
- ___ vision changes
- ___ contact lenses or glasses
- ___ hearing loss
- ___ nasal congestion
- ___ cough
- ___ runny nose

GASTROINTESTINAL:
- ___ abdominal pain
- ___ bloating
- ___ vomiting
- ___ heartburn
- ___ constipation
- ___ diarrhea

SKIN:
- ___ rash/itching
- ___ change in color/temperature
- ___ change in texture
- ___ birth marks

LYMPH/BLOOD:
- ___ lumps or bumps
- ___ easy bruising
- ___ bleeding tendency

CARDIAC:
- ___ chest pain
- ___ palpitations
- ___ racing heart
- ___ ankle swelling

GENITOURINARY:
- ___ urinary frequency
- ___ urinary urgency
- ___ pain with urination

NEUROLOGIC:
- ___ light headed
- ___ dizziness
- ___ seizures
- ___ numbness

MUSCULOSKELETAL:
- ___ joint inflammation
- ___ stiffness
- ___ swelling
- ___ pain
- ___ difficulty with balance
- ___ walk with limp
- ___ weakness
- ___ muscle cramps/aches

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY RIGHTS AND PRACTICES OF PRAIRIE ORTHOPAEDIC & PLASTIC SURGERY, PC

I acknowledge that I have received the Prairie Orthopaedic & Plastic Surgery (POPS), Notice of Privacy Rights and Practices, effective April 14, 2003, which explains how my health information will be handled in various situations. I understand that POPS reserves the right to change the Notice and its Privacy practices at any time. This document in its entirety is available by request, located in the waiting area, or online at www.prairie-ortho.com.

_____ _____

Patient's/Patient's Representative Signature Date

DISCLOSURE OF PHYSICIAN OWNERSHIP - LINCOLN SURGICAL HOSPITAL

Lincoln Surgical Hospital (LSH) meets the definition of "physician-owned" under 42 CFR 489.3. Dr. Hurlbut has a small financial interest in this facility. You have the right to choose the provider of your health care services. Although we believe the LSH will be able to meet your surgical needs, if necessary, you have the option to use a facility other than LSH. You will not be treated differently by your physician if you choose to use a different facility; however, your physician may not be able to perform your procedures at an alternative facility if he does not maintain privileges at such a facility. If desired, your physician or a staff member can provide information about alternative health care options.

By signing this document, you acknowledge that you have read and understand the foregoing notice to patient regarding the HIPAA Privacy Rights and Practices and Physician Ownership Policy of POPS.

_____ _____

Patient's/Patient's Representative Signature Date

DISCLOSURE OF PHYSICIAN OWNERSHIP - PRAIRIE ORTHOPAEDIC & PLASTIC SURGERY THERAPY

Prairie Orthopaedic & Plastic Surgery Physical Therapy is a physician-owned rehabilitation facility. Dr. Hurlbut & Dr. Machado have a financial interest in this facility. You have the right to choose the provider of your health care services, including your Physical Therapist. Although we believe that Prairie Orthopaedic & Plastic Surgery Physical Therapy will be able to meet your therapy needs, if necessary, you have the option to use a facility or therapist of your choice. You will not be treated differently by your physician if you choose a different facility. If desired, your physician or a staff member can provide information about alternative options.

By signing this document, you acknowledge that you have read and understand the foregoing notice to patient regarding the HIPAA Privacy Rights and Practices and Physician Ownership Policy of POPS.

_____ _____

Patient's/Patient's Representative Signature Date

****

(To be completed by POPS staff should Acknowledgement Form not be signed)

Does patient have a copy of the Privacy Notice? ☐ Yes ☐ No

Please explain why the patient was unable to sign form and POPS efforts in trying to obtain signature:

_____

_____

Prairie Orthopaedic & Plastic Surgery, PC (POPS)
Financial Policy, Statement of Responsibility and Other Acknowledgements

Assignment of Benefits: I have read and agree to the terms and conditions on the financial policy and I hereby authorize the release of any medical information necessary to process my health insurance claim. I assign all benefit proceeds for services rendered by POPS including health insurance, worker's compensation, third party liability, and other benefit proceeds and request payment of benefits to the provider of services. I understand I am financially responsible to POPS for charges not covered or denied by my insurance company.

Financial Agreement: I hereby certify that I have read, understand, and agree to the information set forth above.

Consent to Treat: I understand by signing this form, I am authorizing POPS to provide treatment for as long as I seek care from Prairie Orthopaedic & Plastic Surgery, PC, or until I withdraw my consent in writing.

The undersigned certifies that he or she has read the foregoing, is the patient or Responsible Party duly authorized by and on behalf of the Patient to execute this document and accept its terms.

_____ Date

Patient's Signature

_____

Responsible Party's Signature

****

For Office Use Only:

Patient was unable to sign consent because:_____

_____ Date

Witness

Prairie Orthopaedic & Plastic Surgery, PC (POPS)
Financial Policy, Statement of Responsibility and Other Acknowledgements

Insurance filing: You are responsible for verifying if providers are in-network with your insurance company. We will submit medical claims to your insurance company. Your insurance policy is a contract between you and your insurance company. **Deductibles, Coinsurance and Co-Payment amounts are established by your health insurance plan and are due at the time of service.** Any remaining balance after the processing of the claim is the patient's responsibility.

Surgery: Arrangements will need to be made to meet your financial responsibilities prior to your surgery. Our financial/surgery coordinator will verify your eligibility and benefits with your insurance plan. **A prepayment of the estimated out- of – pocket expenses, as specified by your insurance plan, will be required one week prior to your surgery.**

Liability and Auto Accidents: We will file any insurance claims for services related to an auto or third party liability. Additionally, we may be required to submit claims to your health insurance and will need your insurance information prior to treatment. **Patients who fail to provide insurance information are directly responsible for payment of their account.** By signing below you agree to assign all benefit dollars to POPS for services provided.

Worker's Compensation: If your injury is work-related, we will need the case number, carrier name and information prior to your visit in order to bill the worker's compensation insurance company or your employer. The patient is ultimately responsible for all professional fees if a worker's compensation claim is denied.

Liens: Liens may be placed on accounts related to auto accidents, liability or denied worker's compensation with attorney coverage. The lien will be placed on the person causing the accident, the patient's attorney, the patient, the attorney of the person causing the injury (if known) and the insurance company. We MAY choose to not accept health insurance payments or take contractual adjustments unless required to do so by your personal health insurance carrier.

Self Pay Accounts: Payment is due at the time of service. If surgery is recommended, we expect payment in full one week prior to the procedure.

Forms: There will be a charge for the completion of medical forms filled out by your provider and/or staff, $15 /Disability forms. Please allow 7-10 days for the completion of these forms. If you would like the forms mailed to you or your insurance company, payment will be due prior to mailing of the forms.

Divorce: The parent signing this Financial Policy and Statement of Responsibility is responsible for any and all payments for services. Any legal agreement, or other disagreement, between two parties in a divorce must be dealt with between those parties and does not involve POPS.

Medical Records: POPS may transfer copies of your medical record, or portions thereof, to you or a third party, including but not limited to your personal representative, your health insurance carrier, attorneys, physicians involved with your care, your workers compensation carrier, and/or liability carriers. **The minimum charge to copy records is $0.50 per page plus a handling fee and any applicable sales tax.**

Payment: WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER AND CARE CREDIT. Interest at 18% APR will be charged on balances 60 days or older. If your check is returned due to insufficient funds, a **$30 returned check fee** will be added to your account balance. An account representative can be reached at **402-489-4700.**

Delinquency: Accounts will be considered delinquent if not paid in full within 60 days of initial billing or if acceptable payment arrangements have not been made and will be considered for collection or legal action. In the event of nonpayment, you are responsible to pay the cost of collection and/or court costs and reasonable fees should they be required.

Medical Consent: By signing below you hereby request and consent to medical care including all examinations, tests, and other procedures which the health care providers of Prairie Orthopaedic & Plastic Surgery, PC and such assistants and staff may deem necessary or appropriate. You are aware that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to you as a result of treatment or procedures performed. In addition, you consent to prescription history and/or narcotic history reconciliation by your provider via the electronic history provided through Surescripts and/or the state controlled substances database.

Consent to Contact: By signing below you hereby consent to receive communications from POPS staff or contractors, including collection agents to any landline, cell number, or email address provided. This information may be used to contact you live, via voicemail, text, email, by pre-recorded message, or auto-dialer in regards to appointments, treatment, marketed services or billing/collection services.

Prairie Orthopaedic & Plastic Surgery, PC (POPS)
Financial Policy, Statement of Responsibility and Other Acknowledgements

Detailed Payment Information

Office Visits: Office charges will be determined by your physician following your exam today. Office charges may include: initial exam, x-rays, injections, fracture care with casting, and any supplies. Upon completion of your visit, staff will work with you to determine your portion of the bill which is payable today.

Global Periods or Fracture Care: Any patient that undergoes a surgical procedure or is in a fracture care category will be billed using a global period. This means that for 90 days (10 days for Medicaid recipients) following your surgery all follow-up care with the physician is already covered. This does **not** include further needed x-rays, supplies, therapy or injections.

Surgery: Since you (or your employer) have chosen an insurance carrier with particular benefits and because insurance coverage is a complicated business with no fixed rules, please check with your insurance carrier in regard to the specifics of your proposed surgery. Also, please note that the hospital bill is not something we can control, so please direct any questions regarding the specifics of the hospital, lab and anesthesia bill to the hospital billing office where your surgery was or will be performed.

Arthroscopic operations and total joint replacements are complex and require a trained surgical team. Dr. Hurlbut, Dr. Machado, Dr. Krejci and Dr. Byington work with fully trained physician assistants/nurse practitioners who assist them during the operation. You will receive a bill for their services as well.

Our Financial or Surgery Coordinator will verify your eligibility and benefits and work with you to determine your out-of-pocket expense for your particular surgery. Financial arrangements will need to be made to meet your financial responsibilities prior to your surgery.

Frequently Asked Questions

What is a co-pay? Typically, the co-pay is a set amount the consumer will pay to see a physician. For example, an office visit to your physician might have a co-pay of $30; Dr. Hurlbut, Dr. Machado, Dr. Krejci and Dr. Byington are physician specialists so therefore your specialist co-pay would apply to your visit here, e.g., $60. Your carrier requires that all co-pays be paid prior to any services being rendered. This co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.

What is co-insurance? Co-insurance is a percentage of the allowed cost either the insurance or consumer will pay. For example an 80/20 plan typically represents that the insurance will pay 80% of the allowed cost and the consumer is responsible for the remaining 20% of the allowed cost, after the consumer's deductible has been paid.

What is a deductible? A deductible is an annual dollar amount established by your insurance plan the consumer must pay before insurance benefits are applied. This amount is your obligation and must be paid prior to having surgery.

What are out of-pocket expenses? All expenses not covered by insurance that you are responsible for paying for via cash, check, credit or debit.