1450 E Zion Rd
Fayettville, AR 72704
Suite 6 & 10

PowellOrthopedics
Knee & Shoulder / Sports Medicine

P:479-582-4647
F: 479-582-4660

Date:_____

NEW PATIENT INFORMATION

Name: _____ DOB: _____ Age: _____

Email:_____ Chart # _____ Height _____ Weight _____

Referring Physician:_____ M__ F__ Dominant Hand: R L BOTH

TELL US ABOUT YOUR ORTHOPEDIC PROBLEM:

When did it begin? _____ What caused it? _____

Previous treatment? Y N By whom? _____ When? _____

PAST MEDICAL HISTORY: (Circle all that apply)

Heart disease Heart attack Congestive Heart Failure High Blood Pressure Stroke

Lung Disease COPD Emphysema Bleeding disorder Blood Clots Plulmonary Embolus

Kidney Disease Liver Disease Diabetes Seizure Disorder Covid Cancer- Type:_____

Other Health Problems:

_____

_____

_____

PAST SURGICAL HISTORY (PLEASE LIST)

1) _____ Dr. _____ Date:

2) _____ Dr. _____ Date:

3) _____ Dr. _____ Date:

4) _____ Dr. _____ Date:

5) _____ Dr. _____ Date:

6) _____ Dr. _____ Date:

LEGAL

Problem due to an accident? Y N

Auto Accident? Y N

Do you have an attorney? Y N

Is it Litigation planned? Y N

Attorney's Name: _____

Address/Phone: _____

PERSONAL

Do you use tobacco? Y N Amt. per day? _____ Since? _____

Do you use alcohol? Y N Amt. per day? _____ Since? _____

Most physically demanding activity? _____ How often?_____

Occupation: _____ Time @ current employer?_____

Martial status: Single Married divorced Widowed

Living status: Alone Spouse Children Parents Friend(s)

Family health (list, if deceased, please note age of death)

Father: Mother:

Siblings: Children:

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Name: _____ Date: _____ Chart # _____

MEDICINES: (PRESCRIPTION AND NON) PLEASE LIST

I take no medications _____ **See attached** _____

1) _____	_____ mg	1 2 3 4	times a day
2) _____	_____ mg	1 2 3 4	times a day
3) _____	_____ mg	1 2 3 4	times a day
4) _____	_____ mg	1 2 3 4	times a day
5) _____	_____ mg	1 2 3 4	times a day
6) _____	_____ mg	1 2 3 4	times a day
7) _____	_____ mg	1 2 3 4	times a day
8) _____	_____ mg	1 2 3 4	times a day
9) _____	_____ mg	1 2 3 4	times a day
10) _____	_____ mg	1 2 3 4	times a day
11) _____	_____ mg	1 2 3 4	times a day
12) _____	_____ mg	1 2 3 4	times a day
13) _____	_____ mg	1 2 3 4	times a day
14) _____	_____ mg	1 2 3 4	times a day
15) _____	_____ mg	1 2 3 4	times a day

Allergies: _____

_____

_____

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Have you recently experienced any of the following? Check if "yes"

HEENT

___Eye pain or glaucoma
___Require glasses
____Visual Impairment not corrected by glasses
___Cataracts
___Trouble hearing
___Ringing of ears
___Repeated noses bleeds
___Trouble breathing through nose
___Difficulty swallowing
___Hoarseness
___other difficulty speaking
___Salivary gland problem

Cardiopulmondary

___Coughing up phlegm
___Pneumonia
___Collapsed Lung
___Tuberculosis
___Asthma
___Hay fever
___Shortness of breath
___Shortness of breath walking
___Shortness of breath lying down
___Chest pain
___Heart Attack
___Dizziness
___Loss of consciousness
___Rapid heart beat
___Irregular heart beat
___Rheumatic Fever
___Blood clot in legs
___Phlebitis
___pain in legs with walking
___Painful whitening of fingers

GI

__Abnormal pain
__Indigestion, Heartburn
__Nausea
__Vomitiing
__Diarrhea
__Constipation
__Black stools
__Blood in stools
__Loss of appetitie
__Ulcers
__Hiatal Hernia
__Other hernia
__Jaundice
__Hepatitis
__Colitis or enteritis
__Cirrhosis
__Panceratitis
__Loss of coordination
__tremors, shaking
__Confusion
__Spells
__Seizures
__Stroke
__Traumatic Brain injury
__Gonorrhea
__Other venereal disease
__Bladder not emptying
__Decreased urinary stream

For Men

__Discharge from penis
__Difficulty with erection
__Prostatitis
__Enlarged prostate
__Decreased sex drive

GU

__Urinary tract infection
__Burning with urination
__Dark or bloody urine
__Kidney stones
__Syphillis
__Gonorrhea
__Other venereal disease
__Trouble starting urination
__Bladder not emptying
__Decreased urinary stream

Neuro

__Headaches
__Back pain
__Neck pain
__Weakness
__Numbness

Other

__Weight loss
__Weight gain
__Joint stiffness
__Joint pain
__Joint swelling
__Poor sleeping
__Depression
__Anxiety
__Crying Spells

For Women

__Birth control pills/shots/implants
__Are you Pregnant?
__pain or other problems with intercourse
__Decreased sex drive
____ Date of Last menstrual period

PLEASE READ: The patient is responsible for all fees, regardless of insurance coverage. PAYMENT IS REQUESTED AT TIME OF SERVICE.

A photocopy of this authorization shall have the same effect as thr original.

X _____ Date: _____

Parent/ Guardian Signature

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Chart # _____

Patient Name: Email:
Address:

Home Phone: Cell: Work:
DOB: SSN: M F
Employer: Primary Ins Carrier:
Member ID: Group #:
Secondary Ins Carrier:
Member ID:

Please fill out the name of the priamry cardholder of your insurance if it is different from the patient above.

Name: DOB:
SSN: M F
Employer: Work #:

PERMISSION TO GIVE MEDICAL INFORMATION

I, _____, hereby authorize the physician and staff of Powell Orthopedics, PA to contact in case of emergency, or to discuss any information about health, wellbeing, or appointments concerning the patient, with myself or spouse or with the following person or people.

1) Name _____ Phone _____ Relation _____
2) Name _____ Phone _____ Relation _____

This is also an agreement to obtain medical services, assignment of benefits and authorization to release medical information. I authorize any holder of medical information about me to release it to Powell Orthopedics P.A. and or staff, any informatioin needed. I also agree to an automated telephone system to call and remind me of scheduled appointment and I acknowledge receiving a copy of the HIPAA notice of privacy practice today. Powell Orthopedics P.A. is also authorized to furnish to any insurance company, 3rd party player, hospital or physician any and all perscriptons, treatments, X-rays, and all other requested information or documentation pertaining shall be considered valid and effective as the orignal.

X _____ Date _____
Parent/ Guardian Signature

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PT CLINIC WAIVER

Chart #: _____

Welcome to Powell Orthopedics! We are happy that you have chosen us for your rehabilitation needs. We will do everything in our power to make your physical therapy experience a positive one. Please take a few moments to review some information about our clinic.

Powell Orthopedics is a physician- owned facility and as a patient, you have the right to choose your own physical therapy provider. We feel that our team –based approach to rehabilitation involving physicians, nurses and physical therapist provides the highest quality of care. However, you are free to pursue your rehabilitation at a clinic of your choosing.

In order to more effectively treat our patients, we have implemented the following clinical guidelines:

1) **Appointment Times**- Please try to arrive several minutes prior to your scheduled appointment time. We reserve the right to reschedule your appointment if you are more than 20 minutes late.
2) **Cancellations-** Please notify us in advance if you know you can't make an appointment. We realize situations arise that necessitate cancellations. We would just like to know as soon as possible so that we can schedule other patients.
3) **No Shows-** We reserve the right to discharge patients from physical therapy if that patient fails to show for 3 scheduled appointments without notification.
4) **Children-** We recognize that there are times when patients must bring young children to treatment sessions with them. Please note that we have a number of equipment pieces that can seriously injure a small child. Additionally, with the number of patients that are usually in the clinic, our therapist and other staff members aren't generally able to oversee your children. Please remember that your children are your responsibility.

Again, welcome to our clinic and we look forward to serving your rehabilitation needs! If you have questions or concerns regarding your treatment, please bring them to our attention.

I have read the above information and I understand that Powell Orthopedics is a physician- owned facility, and that I have the right to attend physical therapy at any clinic I choose. Furthermore, I understand the clinical guidelines set forth above and agree to adhere to them.

Signature: _____ Date: _____

Mark W. Powell, M.D. Orthopedic Surgery / 1450 E. Zion Rd, Suite 6 &10 / Fayetteville, AR 72703
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Mailing address: 9688 Fayetteville, AR 72703

PowellOrthopedics

PAYMENT POLICY

Chart #: _____

CO PAYS & CO INSURANCE: Your copay or deductible/ co-insurance (whichever applies) is due at the time of your office visit. Please understand that some co-pays only pay for the office visit and other services such as X-rays, Injections, etc. may apply to your deductible/ co- insurance. We contact your insurance to get explanation of benefits, however, the information we are given is **NOT** always accurate. You may want to call your insurance to confirm your benefits. After filing your claims sometimes, we are informed by your insurance that you may owe more than what was collected at the time of your visit. If this is the case, we will send you a statement for the balance due.

SELF PAY: If you are not using insurance, full payment is due the same day as your visit.

LIABILITY OR 3RD PARTY INSURANCE: We do **NOT** file 3rd party insurance. If your primary insurance will not pay due to an accident of any kind, you are responsible for the bill in full at time of service.

SCHOOL INSURANCE: We accept school insurance. We will **NOT** file school insurance unless we have the filled out and signed documents on the day of the visit and only up to 4 days after visit. **IF** we do not get these insurance documents from you in the allotted time, you will responsible for filing it. Please understand, most school insurance does NOT pay the full amount of medical services, we must have the PCP referral on or before the day of your visit.

MEDICAID & ARKIDS PLANS OR INSURANCE REQUIRING A REFFERAL: Getting a referral is the patients' responsibility. **IF** a primary care referral is required, we must have the PCP referral on or the day before your visit.

PAYMENT PLAN: We offer CARECREDIT, 6 MONTHS, O PERCENT PAYMENT PLANS for all balances over $200.00. CareCredit can also be used for balances under 200.00 but there is no discount and interest is charged by CareCredit. If you would like to qualify for CareCredit card please call 1-800-365-8295 or contact them online.

PAYMENT OF ANY BALANCE DUE/COLLECTIONS: If you receive a bill please pay as indicated on the statement to avoid collections. All billing for Dr. Powell and physical therapy is filed and sent out by a 3rd party for us. Not paying your bill when due is not calling Powell Orthopedics, P.A. to discuss this matter can result in your account being sent to collections. Please understand we don't want to send our patients to collections but unfortunately, we have to do this sometimes. If we send your account to collections, we will never see you again as a patient and this may go against your credit rating.

MESSAGES LEFT ON YOUR PHONE REGARDING INSURANCE, BALANCE, OR SCHEDULED APPOINTMENTS: Sometimes we need to call patients/ responsible party and discuss insurance requests or balance due and we get a voicemail. We also have an automated message that may call to inform you of your appointment or we may need to reschedule your appointment. If this happens, we would like your permission to leave you a voicemail or text message about this matter to inform you of what is going on. Please sign and print your phone number so we may leave a message.

Signature: _____ Date: _____

I HAVE READ AND UNDERSTAND AND WILL ABIDE BY THIS POLICY.

Print Full Name: _____

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