HOSPITAL FOR SPECIAL SURGERY

ANDREW D. PEARLE, MD
Orthopaedic Surgery & Sports Medicine
535 E. 70th Street
New York, NY 10021
(t) 212.774.2878
(f) 212.774.2798

MRN: _____

PATIENT INFORMATION

Name: _____
(last) (first) (M.I.)

Sex: M F

Address: _____

DOB: _____

_____

SS #: _____

City, State, Zip: _____

Marital Status: _____

Phone: _____ H—W—C

Referring MD: _____

Phone: _____ H—W—C

Email Address: _____

PATIENT EMPLOYMENT

[None]

Employed - Retired - Unemployed - Other

Contacts: _____

Phone: _____

_____

Employer: _____

_____

GUARANTOR/SUBSCRIBER

[ ] Same as Patient

Name: _____

DOB: _____

Address: _____

SS #: _____

_____

Phone: _____

_____

PRIMARY INSURANCE

Relationship: Self [ ] Other: _____

Company: _____

ID #: _____

Group #: _____

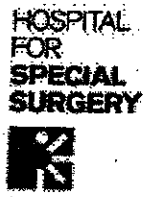
SECONDARY INSURANCE

Relationship: Self [ ] Other: _____

Company: _____

ID #: _____

Group #: _____



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ASSIGNMENT AND RELEASE OF BENEFITS

I certify that the information given by me is correct. I understand that this information is entered into a database, and I authorize the sharing of information with affiliated physicians who are responsible for my care. I hereby also authorize the release of information related to my medical condition, as requested by government agencies and/or insurance carriers. I hereby assign my insurance benefits to the Physician and understand that, in the absence of accepted insurance coverage, my legal guardian or I, 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 and I understand that I am responsible for insurance deductibles on all services, and 20% coinsurance on ancillary services. When Medicare is deemed the secondary insurance, I will follow payment terms specified by the individual Physician's policies.

EFFECTIVE DATE

These statements shall be effective from the date of the signature below until my insurance changes, at which time I understand that I am obligated to notify the Physician.

Signature of Patient or Guardian: _____ **Date:** _____

Relationship to Patient: _____

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FINANCIAL POLICY

We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our office participates with a variety of insurance plans. It is your responsibility to:

  ► Bring your insurance card(s) at every visit.
  ► Be prepared to pay your copay at each visit.
  ► **Make payment in full at the time of visit** for medical care not covered by your insurance.

  * Payment can be made by Cash, Check, or Credit Card

- If you have insurance that we do not participate with, our office is happy to file the claim upon request, however, payment in full is expected at the time of service.

- Referrals: It is your responsibilty to obtain and bring any required referrals for treatment, at or prior to the visit. If you do not have the referral, you may be financially responsible.

- Other documentation: It is your responsibilty to provide our office with certain documentation. Failure to do so may cause you to be financially responsible.

- Your insurance carrier writes and administers your policy. We are happy to answer any insurance questions you have, but specific coverage issues and plan requirement questions should be directed to your insurance carrier.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to this office.

Please sign acknowledging that you have read and agree to the terms of this Financial Policy.

Patient Name: _____ **Date of Birth:** _____
(Please Print)

Patient Signature: _____ **Today's Date:** _____

Parent/Guarantor: _____ **Relationship:** _____
(Please Print)

Parent/Guarantor Signature: _____ **Today's Date:** _____

HOSPITAL FOR SPECIAL SURGERY

For the office of Andrew D. Pearle, MD
Orthopedics Surgery and Sports Medicine

Medical Record Number: _____

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of my physician Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

_____
Signature of Patient or Patient's Personal Representative

DOB: _____
Print name of Patient or Patient's 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 office manager.

FOR OFFICE USE ONLY: If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.

Andrew D. Pearle, 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 financial relationships with the following 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 relationships with these companies:

I am on the Scientific Advisory Board of Blue Belt Technologies and receive compensation for my time.

I am a consultant for Biomet and Stryker-MAKO for which I receive compensation for my time.

I do not receive any payments from this company for use of its 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 David Altchek, MD, Co-Chief of Service, (212-606-1909), 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

Andrew D. Pearle, MD

523 East 72nd Street, 6th Floor
New York, NY 10021
(212) 774-2878

Cancellation Policy for Surgery

In an effort to serve our patients better we have instituted a cancellation policy for scheduled surgery dates.

Scheduling surgery is a time consuming and complicated process, and the office understands that it is very disruptive to patient's normal lives. 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. Ahead of your surgery, the office commits many hours of work to ensure that all aspects of your care are prepared for- including, but not limited to: pre-certification and follow up with your insurance plan, coordination of your care with related caregivers (including other physicians when indicated, allied health professionals, and anesthesiologists), and post-operative care in the form of rehabilitation preparation.

From time to time, extenuating circumstances cause a surgery to be canceled. However, in situations when the patient electively cancels a procedure within 14 business days of the scheduled surgery, a non-refundable cancellation fee of $500 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 surgery date.

I _____, have received and reviewed the surgery cancellation policy of Dr. Andrew D. Pearle. I hereby accept and agree to adhere to the above policy.

_____
Patient Signature or Parent/Guardian (if patient is a minor)

_____
Date

ANDREW D. PEARLE, MD

ORTHOPAEDIC SURGERY & SPORTS MEDICINE

HOSPITAL FOR SPECIAL SURGERY
535 EAST 70TH STREET
NEW YORK, NY 10021

Please provide us with your pharmacy information so that we may comply with New York State regulated use of ePrescribe. Thank you.

Patient Name:_____

Pharmacy Name:_____

Pharmacy Location:_____

Phone number:_____

City/State:_____

New Patient Questionnaire

Orthopedic Sports Medicine and Shoulder

HOSPITAL FOR SPECIAL SURGERY

Name:	DOB:	Date:
Height:	Weight:	Age:

Referring Physician: _____ Phone Number: _____

Chief Complaint

What is the reason for your visit? _____

Please describe your symptoms:

Pain	Stiffness	Locking/Catching	Instability
Swelling	Clicking	Weakness	Numbness/Tingling

Current Pain Level (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10

When did your symptoms start? _____

Have you had or tried any of the following (please select and describe)?

Type	Effective?
□ Acupuncture Treatment □ When?	Yes No
□ Anti-Inflammatory Medications: Which Brand(s)?	Yes No
□ Other Medications: Please specify?	Yes No
□ Chiropractic Treatment	Yes No
□ Injections Type: □ Hyaluronic Acid (Orthovisc, Synvisc, Euflexxa, Other): When? _____ Please specify which brand name(s): _____ □ Cortisone: When? _____ □ Platelet Rich Plasma (PRP): When? _____	Yes No
□ Physical Therapy □ When? _____ □ For how long? _____	Yes No
□ Massage Therapy/Deep Tissue	Yes No
□ Brace/Cane	Yes No

Have you had surgery related to this condition? Yes / No

Please specify type of surgery: When?

_____ _____

_____ _____

Do you participate in sports/recreational activities? Please Specify:

_____

Occupation: _____ Employer _____

What is your dominant hand? Right Left Ambidextrous

Screening Questions (Coordination of Care)

Do you have any sensitivity/allergies to metal? Yes No

Are you currently on any blood thinners? Yes No

Have you ever had a MRSA Infection? Yes No

Have you had Deep Vein Thrombosis (DVT)? Yes No

Have you had a Pulmonary Embolism (PE)? Yes No

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

Have you ever had complications from prior surgery? Yes No Problem:_____

Have you had surgery for this same condition before? Yes No

Do you have any of the following medical devices? (Mark all that apply)

Pain Pump	Neurostimulator	Pacemaker and/or Defibrillator	Shunt for hydrocephalus

Do you have diabetes? Yes No

If yes, do you have an insulin pump? Yes No

Have you been taking opioids for 6 months or more (e.g. codeine, percocet, morphine, Vicodin, etc.)?

Do you take birth control, hormone replacement therapy, or testosterone? Yes No

If yes, please specify: _____

Please list any allergies below (**including medications, metals, adhesives, latex, foods**, etc.):

Allergy	Reaction
1.	
2.	
3.	

Please list all current medication:

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	

Social History

Are you a tobacco user? Yes No

Do you consume alcohol? Yes No

If yes, how many drinks per week? _____

Past Medical History

Please select any past medical conditions below (please circle):

Condition		Condition	Yourself?
Anxiety	Heart Attack	Open Wounds/Ulcers	Reflex Sympathetic Dystrophy
Arrhythmia (Irregular heartbeat)	Heart Disease	Osteoarthritis	Reflux
Asthma	High Blood Pressure	Osteoporosis	Rheumatoid Arthritis
Bleeding Problems	High Cholesterol	Peripheral Vascular Disease	Seizures
Blood Clots (DVT)	Infection	Pneumonia	Stroke
Cancer	Kidney Disorders	Psychiatric Illness (Depression)	Ulcers
Diabetes	Lung Disease	Pulmonary Embolus	Other:

Do any of your family members (father, mother, sibling, etc.) suffer from the above mentioned medical conditions? If yes, please specify the condition and relationship?

_____

_____

Review of Systems

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	ENT	Eyes	Respiratory
Activity Change	Congestion	Dryness	Chest tightness
Appetite Change	Ear pain	Discharge	Choking
Chills	Nosebleeds	Itching	Cough
Fatigue	Sinus pressure	Pain	Shortness of breath
Fever	Sore throat	Redness	Wheezing
Weight Change			
Cardiovascular	**Gastrointestinal**	**Endocrine**	**Genitourinary**
Chest pain	Abdominal pain	Cold intolerance	Difficult urination
Leg swelling	Blood in stool	Heat intolerance	Flank pain
Palpitations	Constipation	Excessive thirst	Frequent urination
Poor circulation	Heartburn	Excessive hunger	Painful urination
	Nausea		
Musculoskeletal	**Skin**	**Environmental Allergies**	**Neurological**
Joint pain	Color change	Pollen	Dizziness
Joint stiffness	Hair loss	Dust Mites	Headaches
Joint swelling	Rash	Pets/Animals	Light-headedness
Joint warmth/heat	Skin tightening	Mold/Mildew	Memory loss
Muscle pain	Wound		Numbness
			Weakness

Hematologic	Psychiatric
Enlarged lymph nodes	Agitation
Bruises	Hyperactive
Clotting problem	Nervous/anxious
Excessive bleeding	Depression

HSS Department of Medicine
HOSPITAL FOR SPECIAL SURGERY

STOP-BANG Sleep Apnea Questionnaire

Name: _____

Height:_____ Weight:_____ Age: _____ Sex: ☐ Male ☐ Female

PATIENT RESPONSES

STOP	YES	NO
Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed door)?		
Do you often feel **TIRED**, fatigued, or sleepy in the daytime?		
Has anyone **OBSERVED** you stop breathing during your sleep?		
Do you have-or are you being treated for high blood **PRESSURE**?		
TOTAL		

DOCTOR'S OFFICE USE ONLY

BANG	YES	NO
BMI higher than 35kg/m2?		
AGE over 50 years old?		
NECK circumference greater than 16 inches (40cm)?		
GENDER: MALE?		
TOTAL		

sk of OSA:
High Risk: 5 - 8 "Yes" ☐ **Intermediate:** 3 - 4 "Yes" ☐ Low Risk: 0 - 2 "Yes"

HOSPITAL FOR SPECIAL SURGERY

GENERAL CONSENT/ PERMISSION FOR TREATMENT FINANCIAL AGREEMENT

I authorize and consent to performance upon _____
(Insert "me" or Name of Patient)
by Hospital for Special Surgery (HSS) and its staff of such physical examinations, diagnostic imaging procedures (such as x-rays, CT scans, and/or magnetic resonance imaging (MRI)), laboratory tests, and other non-invasive diagnostic and therapeutic procedures and/or treatments, as my/the patient's physician or others on HSS's medical staff consider to be necessary or appropriate for the purpose of diagnostic and/or treatment of my/the patient's condition.

I understand that for each procedure/treatment the following will be explained to and discussed with me/the patient: the nature, intended purpose, anticipated benefits, material risks, and possible complications of such procedure/treatment; the alternative procedures/treatments if such procedure/treatment is not performed; and the probable consequences if such procedure/treatment or alternative procedures/treatments are not performed.

I give this consent with full knowledge and understanding that medicine is not an exact science, that there is the possibility that the procedure/treatment may not have the benefits or results intended, and that there are always risks and dangers to life and health associated generally with medical procedures and treatments that can cause adverse consequences not ordinarily anticipated in advance.

I consent to the diagnostic study by HSS of any blood, urine or other bodily fluids, stool specimens, or tissues that are obtained in the performance of such procedures/treatments, and to the disposal of such fluids/ specimens/tissues by HSS in accordance with its customary practice. I further grant permission for HSS to use such fluids/specimens/tissues for medical, scientific and/or educational purposes.

I consent to the photographing, videotaping, televising, or other observation of the procedures/treatments as HSS or its surgeon(s)/physician(s) may deem useful or appropriate for scientific and/or educational purposes, with the understanding that my/patient's identity will remain confidential.

I consent to the presence during the procedures/treatments of a visitor or visitors, which may include any visiting physician(s) and/or vendor representative(s) whose presence has been requested by the above named surgeon(s)/ physician(s). I understand that the visitor(s) will at all times be under the supervision and direction of the above named surgeon(s)/physician(s) and other HSS personnel, and subject to all relevant HSS policies and procedures.

I understand that information about me/the patient will be disclosed as required by applicable law, including reporting mandated by the federal, state and local governments to oversight agencies such as Centers for Disease Control and Prevention, the New York State Department of Health, and the New York City Department of Health and Mental Hygiene. Examples of such mandated reporting include reporting of suspected or confirmed communicable diseases, child abuse, firearm wounds, and certain knife wounds and burns.

For patients age 19 and older only: I consent to the submission of information about my/the patient's immunizations to the New York Statewide Immunization Information System (NYSIIS), the New York City Citywide Immunization Registry (CIR), and any other federal, state or local immunization registry. I

Guarantee of Hospital Charges

I agree to be responsible for payment in full of the charges for all hospital services and other medical care rendered to me/the above-named patient for this period of care. I understand that even if I have/the patient has domestic or international health insurance coverage accepted by HSS, I will be responsible for payment in full of unpaid balances after insurance company payment to HSS, to the full extent permitted under federal, state and local laws. I understand that my responsibility also includes payment for charges not ordinarily covered by health insurance, such as private room charges.

Personal Property; Release of Liability

I understand that (i) I am solely responsible for any and all costs of items of personal property that I choose to keep with me and/or use while at HSS; (ii) HSS strongly recommends that I either send home or check with HSS Security Department all personal property of value to me, including but not limited to money, checks, jewelry, credit cards, and clothing; and (iii) any items of personal property that I leave behind after my discharge from HSS will not be HSS's responsibility; if HSS finds any items, they will be sent to the HSS Security Department (212-606-1207). I hereby release HSS and its medical staff members, employees and agents from any and all liability and claims arising from my keeping personal property with me while I am at HSS.

For Inpatients Only

Caregiver Designation

The New York State Caregiver Advise, Record and Enable Act, or CARE Act, provides that all inpatients who are 18 years old or older must be given the opportunity to designate a family member, friend, or other person to serve as a caregiver. The role of the designated caregiver is to assist with after-care tasks when the patient is discharged to the patient's home. Most often this will include information about the medications you will be taking at home, how you might need help in moving, with exercises or with managing pain, and information about your surgical site and appointments after discharge. The CARE Act requires that hospitals notify the designated caregiver of the expected discharge or transfer of the patient, and instruct the designated caregiver regarding after-care tasks that are part of the patient's discharge plan. A patient may change his/her designated caregiver(s) at any time.

_____ I do not consent to the release of my medical information by HSS and its staff to my designated caregiver(s).
(Initial)

I confirm that I have read and fully understand this General Consent/Permission for Treatment & Financial Agreement, that I have been given the opportunity to ask questions and have had my questions answered satisfactorily, and that I am eligible to give this consent and agreement. I further confirm that I understand that I have the right to revoke this consent, or any part of it, at any time during my/the patient's treatment by HSS.

Signature of Patient/Parent/Guardian/Health Care Agent/Other Surrogate _____ _____ _____
Date *Time*

Relationship to Patient _____

Witness Certification: I certify that I have witnessed the person whose signature appears above signing this General Consent/Permission for Treatment & Financial Agreement.

Signature of Witness _____ _____ _____
Date *Time*