



535 East 70th Street New York, NY 10021

The Center for Hip Pain and Preservation
541 East 71st Street New York, NY 10021
Bryan T. Kelly, MD Co Director

Patient Information	Name (Last, First, MI)			MR# (Office Use Only)		
	Street Address					
	City	State	Zip	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
	Social Security #		Home phone #		Cell Phone #	
	Work Phone #	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			Occupation	Employer
	Employment Address					
Guarantor	Name			Relationship to Patient		
	Social Security #		Date of Birth		Employer Name and Address	
Physician Info	Referring Physician's Name (if applicable)			Physician Phone #		
	Primary Physician's Name			Physician Phone #		
Insurance Information	Primary Insurance Company		Policy #		Group #	
	Claims Address		City	State	Phone	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)		
	Subscriber's Social Security #		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
	Secondary Insurance Information		Policy #		Group #	
	Claims Address		City	State	Phone	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)		
	Subscriber's Social Security #		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
Assignment of Benefits and Release	<p>Please read the following and sign below <u>Assignment of Benefits and Release of Information</u> I hereby authorize my benefits to be paid directly to the undersigned physician. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.</p> <p><u>Medicare Patients</u> I authorize any holder of medical or other information about me to release for Medicare & Medicaid Services and its agents any information needed to determine benefits for this related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.</p> <p><u>Notice of Privacy practices Acknowledgement</u> By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.</p> <p><u>Financial Acknowledgement</u> By signing below, I acknowledge that I agree to the financial policy described on the back of this form.</p>					
	Signature: _____			Date: _____		

Bryan T. Kelly, MD
Center for Hip Preservation
541 East 71st Street, Ground Floor of Caspary Bldg.
New York, NY 10021
PAYMENT POLICY

Dear Patients,

Thank you for choosing Dr. Kelly as your Orthopedic Surgeon. In order to provide the best care, we would like to establish a clear payment policy. If at any time you have questions, please inform our office immediately.

Dr. Kelly participates with the following insurance plans

- ✓ **Oxford Health Plans**
- ✓ **United Health Care**
- ✓ **Medicare**

***As of June 30, 2007 Dr. Kelly no longer participates with BCBS Plans

***As of June 30, 2010 Dr. Kelly no longer participates with Workers

Compensation and No Fault Insurance

*** Dr. Kelly **DOES NOT** participates with **ANY** Affordable Care Act insurances.

*** Dr. Kelly **DOES NOT** participate with United Health Care Community Plan or Compass Plan

It is **your responsibility** to know and understand your own insurance program.

It is **your responsibility** to know the amount of your insurance deductible.

It is **your responsibility** to know whether this office is participating with your particular insurance plan and program.

It is **your responsibility** to know if you need a valid referral for today or future visits/tests.

Please note that if you DO NOT have one of the above plans, you will be responsible for your visit IN FULL at the time of service unless other definite financial arrangements have been made prior to treatment. Upon payment, we would gladly furnish you receipt for you to submit to your insurance company for reimbursement consideration. Please contact your insurance company to verify your out-of-network benefits and coverage detail.

If you require additional treatment or a surgical procedure, we would gladly get authorization for your procedure and submit on your behalf, but please be informed that you have a patient responsibly due and authorization for your procedure is not a guarantee of payment.

By signing this agreement you understand that Dr. Bryan T. Kelly participates in a limited number of insurance plans and based on the above information, he may not participate in your plan. In the case that he does not participate, you understand that based upon your plan or policy you may require a referral for out-of network care, which needs to be obtained prior to your initial consultation. In the case that Dr. Kelly does participate in your plan you will be responsible for your designated co-pay at the time of service.

By initialing here, you acknowledge that this is not an open NO FAULT or Worker's Compensation case _____

Initials

Print Name of Patient

Date

Signature of Patient/ Guardian/Guarantor

Date

April 14, 2003

Medical Record Number _____

ACKNOWLEDGMENT OF RECEIPT

By signing below, I acknowledge that I have been provided a copy of my physician's 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

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.

Bryan T. Kelly, MD
 Center for Hip Preservation
 Hospital for Special Surgery
 541 East 71st Street
 New York, NY 10021
 Tel: 212.606.1159 Fax: 646.797.8865

Date _____
 Name _____ Age _____ Birthdate _____ Height _____ Weight _____
 Contact: Home: _____ Work: _____ Cell: _____ Email: _____
 Occupation: _____ Referred by: _____

Right Handed Left Handed

What brings you in today? (Chief Complaint) _____

Which side of the hip is hurting you? Right Left Both

Which side is worse? Right Left Equally painful

If you are in pain, how long have you been in pain? _____ days weeks months
 years

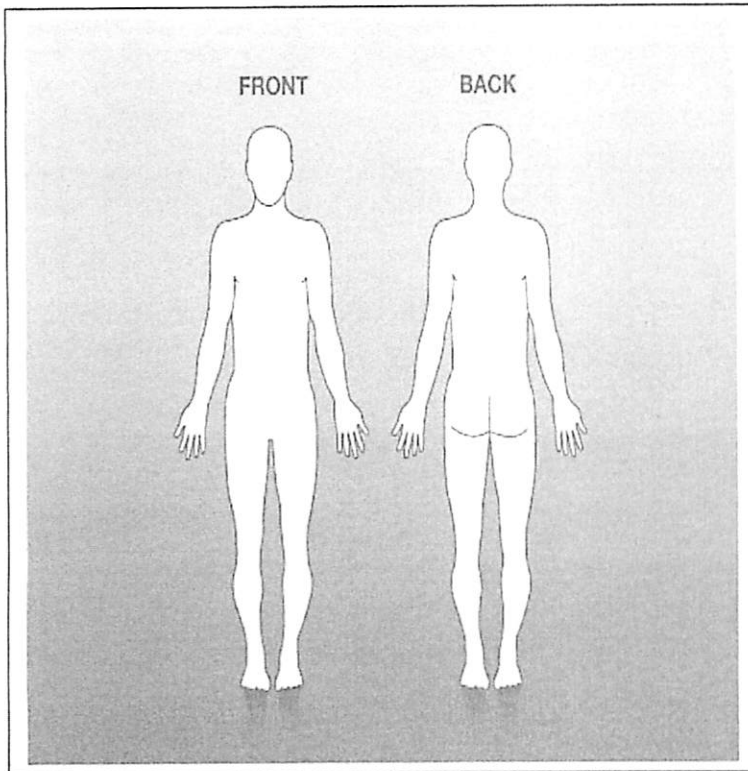
How did it start? Gradually Suddenly

Describe the injury or problem: Trauma/injury No trauma/no injury Unsure

Other, please specify: _____

Do you have any of the following? Snapping Popping Clicking Catching

Where is your pain? Please place an "x" mark in the drawing for the location of your pain



Please rate your pain:

Legend: 0 = No pain 10 = Extreme pain

1. Right now

0 1 2 3 4 5 6 7 8 9 10

2. At worst

0 1 2 3 4 5 6 7 8 9 10

3. At Best

0 1 2 3 4 5 6 7 8 9 10

Please describe the quality of your pain:

Sharp Stabbing Dull Nagging Burning
 Others, please specify: _____

Please describe the intensity of your pain?

Mild Mild-Moderate Moderate
 Moderate-Severe Severe

When do you experience pain?

Continuously Intermittent Daily
 Weekly Other, please specify: _____

What aggravates the pain or what makes it worse?

Running Sitting Walking Standing Kicking Sports Driving Flexion
 Other, please specify: _____

What makes it better?

Rest Ice Stretching Yoga Physical therapy Active release therapy

Other, please specify: _____

Do you participate in sports? Yes No

Level: High school College Professional Recreational

If yes: Soccer Football Tennis Lacrosse Baseball Field Hockey Ice Hockey Squash

Other, please specify: _____

Do you exercise? Yes No

If yes, how often? _____

Have you modified your activities due to your hip condition? Yes No

Are you still able to play sports or exercise with your hip condition? Yes No

Have you seen other physicians for your hip pain? Yes No

Did they diagnose your problem? Yes No

If yes, please specify? _____

Have you tried the following treatments?

Physical therapy? Yes No If yes, how long? ___ days weeks months years

Active release therapy? Yes No If yes, how long? ___ days weeks months years

Alternative therapy? Accupuncture Accupressure Cupping Other and specify _____

Non-steroidal anti-inflammatory? Aleve Motrin Naprosyn Voltaren Mobic Celebrex

Indocin Other and please specify _____

Pain medication? Yes No If yes, please specify _____

Cortisone injection into the hip? Joint Bursa Other _____ Did you get pain relief? Yes No

Do you have a primary care physician? Yes No

If yes, Name: _____ Phone: _____

Allergies:

Allergen	List Names	Reaction
Medications <input type="checkbox"/> Yes <input type="checkbox"/> No		
Food <input type="checkbox"/> Yes <input type="checkbox"/> No		
Environment <input type="checkbox"/> Yes <input type="checkbox"/> No		
Latex <input type="checkbox"/> Yes <input type="checkbox"/> No		

Medications

Name	Dose
<input type="checkbox"/> None or not applicable	

Medical History (example: diabetes, hypertension, gastric reflux disease, etc)

Disease Name	Date Diagnosed
<input type="checkbox"/> None or not applicable	

Surgical History (example: appendectomy, tonsillectomy, hip arthroscopy, etc)

Procedure	Date of Procedure	Hospital or Surgeon
<input type="checkbox"/> None or not applicable		

Did you receive anesthesia in the past? Yes No

If yes, what type: Epidural Spinal General Regional Local Unsure

Have you been hospitalized in the past? Yes No

Is yes, please specify: _____

Family History

Does anyone in your family have any of the following problems?

- Heart disease High blood pressure Anesthesia complications Osteoporosis Cancer
 Nerve problems Blood problems Hip fracture Stroke Diabetes Osteoarthritis
 Other: _____

Social History

Do you smoke? Yes No If yes, how many packs per day? _____ How long? _____

Do you drink alcohol? Yes No If yes, how much? _____

Health Assessment

GENERAL	Yes	No	BLOOD	Yes	No
Fever			Low blood count		
Chills			Bruise easily		
Recent weight loss or weight gain			Blood clots		
EENT			Use of blood thinners		
Glaucoma			Blood transfusion in the past?		
Cataract			GENITOURINARY	Yes	No
CARDIOVASCULAR	Yes	No	Kidney disease		
Irregular heartbeat			Painful urination		
High blood pressure			Dialysis		
High cholesterol			Kidney failure		
Heart attack			METABOLIC	Yes	No
Heart failure			Diabetes		
Heart surgery			Thyroid disease		
RESPIRATORY	Yes	No	Liver disease		
Shortness of breath			NEUROLOGIC	Yes	No
Smoker or smoked in the last year			Stroke		
Oxygen use at home			Seizures		
Sleep apnea			Numbness or tingling		
Blood clot in the lung			MUSCULOSKELETAL	Yes	No
FOR FEMALES ONLY			Osteoporosis		
Are you pregnant?			Back pain		
Last menstrual period date: / /			Neck pain		
Do you use oral contraceptives?			Head injury		
Date of menopause: __/__/__			COMMUNICABLE DISEASE	Yes	No
PSYCHIATRIC	Yes	No	Herpes/HIV/SARS		
Anxiety			Travelled outside of the US the last month?		
Depression					
Attention Deficit Disorder			CANCER	Yes	No
Schizophrenia			History of cancer		
Psychiatric disorder			Received chemo or radiation		

What is your primary concern at this time with regards to your hip condition? _____