Appointment Date: _____
- ☐ X-Ray
- ☐ MRI
- ☐ CT- Scan

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

Patient information

Name (Last, First, MI)					MR # (Office Use Only)
Patient Email Address:					
Street Address					
City	State	Zip	Gender ☐ Male ☐ Female		Date of Birth
Social Security #		Home phone #			Cell Phone #
Work Phone #		Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		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 ☐ Self ☐Spouse ☐Child Other		Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐Female		Date of Birth
Secondary Insurance Information	Policy #		Group #
Claims Address	City	State	Phone
Patient's Relationship to Insured ☐ Self ☐Spouse ☐Child ☐ Other		Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐ Female		Date of Birth

Assignment of Benefits and Release

Please read the following and sign below
Assignment of Benefits and Release of Information
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.

Medicare Patients
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.

Notice of Privacy practices Acknowledgement
By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

By signing below, I acknowledge that I agree to the financial policy described on the back of this form.

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 AGREEMENT

Dear Patients,
Thank you for choosing Dr. Kelly as your Orthopedic Surgeon. In order to provide the best care, we would like to clearly outline our policy. If at any time you have questions, please contact our office immediately.

Dr. Kelly participates with the following insurance plans:

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

*As of June 30, 2010 Dr. Kelly no longer participates with Workers Compensation and No Fault Insurance
* Dr. Kelly **DOES NOT** participate with any Affordable Care Act or Exchange insurance Plans.
* Dr. Kelly **DOES NOT** participate with United Health Care Community Plan or Compass Plans.

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 will gladly furnish you with a receipt for you to submit to your insurance company for potential reimbursement consideration. Please contact your insurance company to verify your out-of-network benefits and coverage details.

If you require additional treatment and/or a surgical procedure, we will 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 visit. 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 CASE or Worker's Compensation Case _____
Initials

_____
Print Name of Patient Date

_____
Signature of patient/ Guardian/Guarantor Date

Bryan T. Kelly, MD
Center for Hip Preservation, Hospital for Special Surgery
535 E. 70th Street
New York, NY 10021

Please provide us with your preferred Pharmacy and telephone number.

Patient Name_____

Patient Date of Birth_____

Pharmacy Name _____

Pharmacy Address_____

Pharmacy Phone Number _____

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.

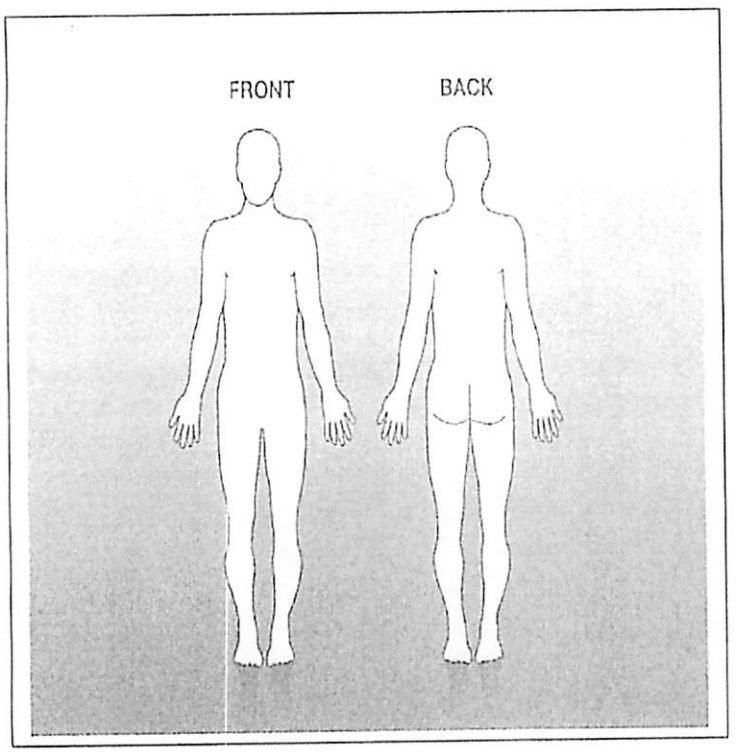
_____

_____

_____

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 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 condition? ☐ Yes ☐ No

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

Have you seen other physicians for your 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? 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 ☐ Yes ☐ No		
Food ☐ Yes ☐ No		
Environment ☐ Yes ☐ No		
Latex ☐ Yes ☐ No		

Medications

Name	Dose
☐ None or not applicable	

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

Disease Name	Date Diagnosed
☐ None or not applicable	

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

Procedure	Date of Procedure	Hospital or Surgeon
☐ 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?_____

Preferred Pharmacy Name and Address: _____