Protocol for Dr. Kelly's Prospective Patients

We have a review process for all new patients to ensure that Dr. Kelly is the most appropriate practitioner to treat you. Please complete the following checklist when submitting your information:

- ☐ Demographic forms: Please complete the following forms and submit with your material.
- ☐ Copy of Insurance Card: Please send a copy of the front and back of your card.
- ☐ All office notes from physicians that you have seen for your hip(s).
- ☐ Images (x-rays, MRIs, CT Scans) on a **disc**. We do not accept electronic copies, and you must have recent (within the past year) images for review.
- ☐ All imaging reports related to your hip (including x-rays, MRIs, CT Scans, and injections).
- ☐ Physical therapy notes pertaining to your hip.
- ☐ If you have had previous surgery, your operative reports and intra-operative images.

All records must be received before your information can be reviewed or appointments are made. Please send all information together to expedite the review process. We recommend that you send your package by Priority Mail, FedEx, or UPS so that your materials can be tracked.

Please mail information to:

Hospital for Special Surgery
Dr. Bryan Kelly
535 East 70th Street
New York, NY 10021

Phone: (212)606-1159
Fax: (646)797-8865

Bryan T. Kelly, MD
541 East 71st Street
New York, NY 10021

Patient information

Name (Last, First, MI)				Sex assigned at birth: ❑ Male ❑ Female Gender Identity: _____
Patient Email Address:				
Street Address				
City	State	Zip Code:		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
Hospital for Special Surgery
541 East 71st Street, Pavilion 1
New York, NY 10021

PAYMENT POLICY AGREEMENT

Dear Patient,

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 companies:

✓ Medicare Part B	✓ Horizon BCBS	✓ Aetna (effective 9.25.23)
✓ Oxford	✓ Emblem Health	
✓ United HealthCare	✓ NYSHIP	

It is **your responsibility** to know and understand your own insurance program and the amount of your insurance deductible, and co-insurance.
It is **your responsibility** to know whether this office is participating with your insurance plan and if you need a valid referral for today or future visits/tests.

Please note that if you DO NOT have the above plan, 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. 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 it on your behalf, but please be informed that an 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 Worker's Compensation Case No Fault Case or Motor Vehicle case. _____
Initials

Print Name of Patient Date

Signature of patient/ Guardian/Guarantor Date

HOSPITAL
FOR
SPECIAL
SURGERY

OUT OF NETWORK/NON-PAR PROVIDER WAIVER FORM

I, _____, have been advised that Dr. Kelly does not participate with my insurance plan. Therefore, services provided to me, and billed by Dr. Kelly will be considered "out-of-network." Under this acknowledgement, I understand that my insurance carrier may pay for services rendered at a lower rate compared to those considered as "in-network" or may not pay at all. I agree I am responsible for 100% of the total charges today, and on each day of service thereafter. I will assume the responsibility to respond to any financial correspondence furnished by the billing service, and I also agree to pay any outstanding/remaining difference, if my initial out-of-pocket payment is not sufficient to satisfy my account once my insurance company has been billed. The amount estimated to be billed for any particular visit or service is available upon request.

I have read and understand the above and I agree to the terms.

_____
Patient Name (please print)

_____
Patient Signature

_____
Today's Date

Bryan T. Kelly, MD
Orthopaedic Surgery and
Sports Medicine

Office Location:
Center for Hip Preservation
541 East 71st Street, Ground Floor
New York, NY 10021
tel 212.606.1199
fax 646.797.8855

Mailing Address
535 East 70th Street
New York, NY 10021

Please Note: Tests ordered are normally done at the Hospital for Special Surgery (HSS). Please be aware that HSS is a separate entity from the physician's practice and will bill you for any services rendered. HSS lab tests will be billed as "outpatient hospital" service not as drawn in a "doctor's office". Labs done at HSS may not be paid at 100%. It is your responsibility to check with your insurance plan(s) to determine if HSS is a participating provider. Be aware that some insurance companies are imposing in-network deductibles, co-pays and/or co-insurance. For example, you may receive an additional bill for labs done at the hospital even though HSS participates with your plan. Quest can be drawn at HSS for a minimal fee. HSS will not draw for Lab Corp. If you are unsure and do not want to incur additional fees, you may request to do tests outside the hospital.

Effective Date: April 14, 2003
Revision Dre: September 23, 2013

Acknowledgement of Receipt of Notice of Privacy Practices

Respect for our patients' privacy has long been highly valued at Hospital for Special Surgery. Not only is it what our patients expect, it is the right way to conduct health care. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices of our Hospital and its medical staff and affiliated health care providers when providing health care services for our Hospital. Our Notice will be posted in the main entrance area of the Hospital at 535 East 70th Street, New York, New York and in other locations where we provide services. You will also be able to obtain your own copy of the Notice by accessing our website at www.hss.edu, calling Health Information Management at (212) 606-1254, or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me may be used and disclosed by the Hospital, and how I may obtain access to and control this information. I also acknowledge and understand that special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and/or disclosure of my health information as described in this Notice, including to treat me and arrange for my medical care, to seek and receive payment for services given me, and for the business operations of the Hospital and staff.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date

If you have any questions about this Notice or would like further information, please contact HSS ASC's Privacy Officer at (212) 548-2510.

For Office Use Only: If the patient does not sign this acknowledgement form, record here the good faith efforts made to obtain this acknowledgement.

_____
_____
_____

Bryan T. Kelly, MD
Hospital for Special Surgery
541 East 71st Street, Pavilion 1
New York, NY 10021

Preferred Pharmacy

Please provide us with your preferred Pharmacy and telephone number.

Patient Name: _____

Patient Date of Birth: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

HIPAA Privacy Act Patient Consent Form

The Health Insurance Portability and Accountability Act, H.I.P.A.A requires that all medical providers, Insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Our office requests that each patient sign this consent form which allows us to share protected health Information with other physician offices, your hospital and Insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.
Our Notice of Privacy Practices provides Information about how we may use and disclose protected health Information about you. You have the right to review our notice before signing this consent.

Name of Patient: _____ Patient Date of Birth: _____
Signature of Patient or Guardian: _____Date: _____

Authorization to Release Information to Family Members and/or Friends

Many of our patients allow family members such as their spouse, parents or others such as friends to call and request appointment times, rescheduling of appointment times for the patient, to go over insurance benefits, and/or the request results of tests and procedures. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have the Information released to family members and/or friends you must sign this form. Signing this form will only give consent to release appointment times, rescheduling of patient appointment times, to go over Insurance benefits, and/or the results of tests and procedure to the family members and/or friends Indicated below. This consent form will not allow our office to release any other information about you. This H.I.P.A.A consent is valid for up to one year. However, you have the right to revoke this consent, in writing prior to expiration of that one year, except where we have already made disclosures in reliance on your prior consent.

I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling of appointment times, to go over insurance benefits, and/or the results of tests and procedures.

1. Individual Name: _____Relation to Patient: _____
2. Individual Name: _____Relation to Patient: _____

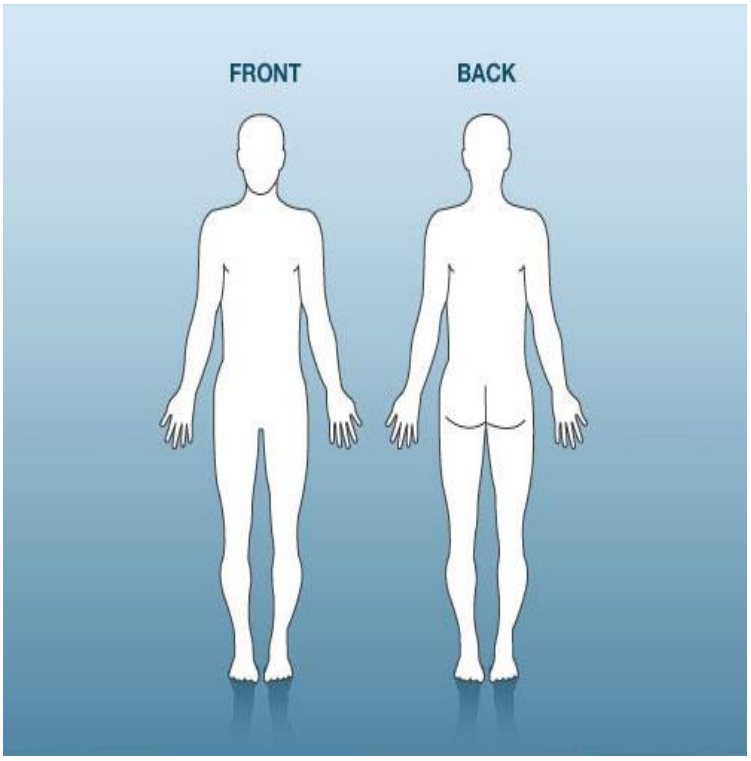
Signature of Patient or Guardian: _____ Date: _____

Leaving Messages with Household Members/Answering Machine

From time to time it is necessary for our office to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to go over Insurance benefits, to notify the patient that we would like to discuss lab or procedure results, or to ask a patient to call us regarding an issue or concern. At no time will our office discuss your medical circumstances or condition without your consent. The purpose of this consent la to leave messages with members of your household or on your answering machine.

Bryan T. Kelly, MD
Hospital for Special Surgery
541 East 71st Street, Pavilion 1
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:_____Gender Identity_____Preferred Pronoun_____
☐ Right Handed ☐ Left Handed
What brings you in today? (Chief Complaint)_____
Which hip is hurting you? ☐ Right ☐ Left ☐ Both
Which side is worse? ☐ Right ☐ Left ☐ Equally painful
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 so, 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? ☐ Acupuncture ☐ Acupressure ☐ 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 ☐ 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 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		
Drug or Substance Abuse					
History or thoughts of self-harm or suicide					

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

_____