

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 copy of front and back.
- All office notes from physicians that you have seen for you 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
c/o Eilish O'Sullivan
535 East 70th Street
New York, NY 10021

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

(Office Use Only)

Appointment Date: _____

X-Ray L / R

MRI L / R

CT- Scan L / R

Bryan T. Kelly, MD
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 <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"/> 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 <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	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: _____	
Office use only: OSIRIX: _____				MD Notes <input type="checkbox"/> Radiology Reports <input type="checkbox"/> No PT / PT Notes <input type="checkbox"/>		

Bryan T. Kelly, MD
Hospital for Special Surgery
541 East 71st Street, 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 Medicare only.

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 particular 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 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 initialling 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 212.605.1159
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.

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 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 its 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 the Privacy Officer at (212) 774-7500.

<p>For Office Use Only: If the patient does not sign this acknowledgement form, record here the good faith efforts made to obtain this acknowledgement and consent.</p> <p>_____</p> <p>_____</p> <p>_____</p>

Bryan T. Kelly, MD
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 _____

HIPPA Privacy Act Patient Consent Form

The Health Insurance Portability and Protection Act, H.I.P.P.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.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have this 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.P.A consent is valid 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 is 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 Pronouns: _____

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

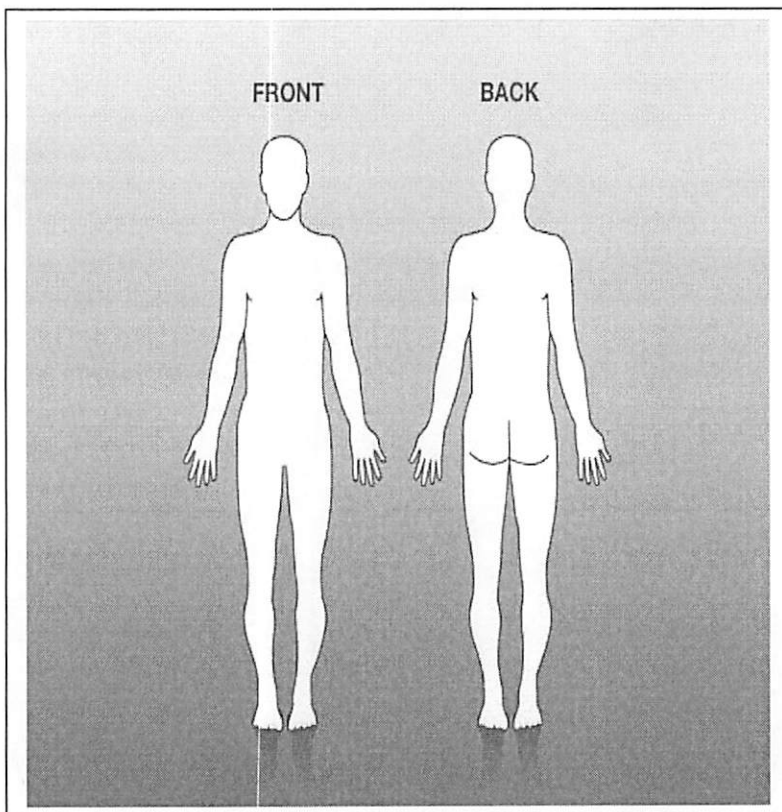
How did it start? Gradually Suddenly

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

PRP injection Yes No If yes, please specify area _____

Do you have a primary care physician? No 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		
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?
