BCOS BURLINGTON COUNTY ORTHOPAEDIC SPECIALISTS, P.A.

2059 Briggs Road
Suite 304
Mt. Laurel, NJ 08054
856-235-7080 (Office) 856-235-0992 (fax)

Please complete the enclosed forms and bring them with you to your appointment.

If you are being evaluated for Low Back Pain please download and complete page 1 of this additional form.

Click to download the Back Pain form.

If you are a patient of Dr. Bowers please complete the form that is specific to the reason for your visit.

Click to download the shoulder form.
Click to download the knee form.
Click to download the general form for all other concerns.

Please be sure to bring the following with you to your appointment:

- Insurance card and/or secondary insurance card.
- Photo ID – will be copied and becomes part of your permanent medical record.
- List of all current medications.
- Referral – if your insurance carrier requires a referral please be sure to bring it with you.
- X-rays or MRI's – if you had an x-ray or MRI please be sure to bring the films and report.
- Co-payments – must be made at the time of your appointment. We accept cash, check, Visa, MasterCard, and debit cards.

If the above is not presented at the time of your appointment we will need to reschedule your appointment.

All minor children under the age of 18 must be accompanied by a parent or legal guardian.

BCOS BURLINGTON COUNTY ORTHOPAEDIC SPECIALISTS, P.A.

Name

Home Phone **Cell** **Work Phone**

May we leave messages/detailed medical information on voicemail/answering at any of these phone numbers? **Home** **Cell** **Work** **(circle all that apply)**

☐ ☐ ☐

To whom, other than yourself, may we speak to regarding your **Medical Condition**?

Name **Relationship** **Date of Birth**

Phone #

If you have any **Billing Issues**, do you give anyone else permission to act on your behalf?

Yes ☐ No ☐

If yes, please provide:

Name **Relationship** **Date of Birth**

Phone #

I hereby give permission to discuss my health and billing information with the above. I have received a copy of the Burlington County Orthopaedic Specialists, PA **"Notice of our Privacy Practices"**.

_____

Patient Signature **Date**

Patient Information Record

PLEASE PRINT Date: _____

Patient's Name: _____ Soc. Sec. # _____
Last First Middle Initial

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Birth Date: _____ Age: _____ Sex: _____ Race: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino Language _____ Email: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced Cell Phone: _____

Injury occurred at: ☐ **Work** ☐ **Auto** ☐ **School** ☐ **Other** Date of Injury: _____

Name and Address of Referring\Family Physician or Other Appropriate Source: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Employed by: _____ Employers Address: _____

City: _____ Zip Code: _____ Employer Telephone: _____

INSURANCE INFORMATION

Holder of Primary Insurance: _____

Employer: _____

Address: _____

_____

Telephone: _____

Insured's S.S. Number _____

Insured's Date of Birth _____

Holder of Secondary Insurance: _____

Employer: _____

Address: _____

_____

Telephone: _____

Insured's S.S. Number _____

Insured's Date of Birth _____

Relationship of Insured to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Dependent ☐ Other _____

RESPONSIBILITY FOR CHARGES:

I agree that in consideration of Burlington County Orthopaedic Specialists, P.A. furnishing services or care, I obligate myself to, pay the account in accordance with regular rates and terms of the doctors upon receipt of the bill. Should the account be referred to an attorney or collection, I shall pay the reasonable attorney's fees and collection expense.

I understand the doctors may disclose all or any part of my medical record to any person or corporation which is or may be liable under a contract to the doctors or to the patient or to a family member or employer of the patient for all or part of the doctor's charge, including but not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or my employer.

MEDICARE: PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, PAYMENT REQUEST — I certify that the information given to me in applying under the title XVIII of the Social Security Act is correct. I authorize any holder of medical or any other information about me to release it to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

PERMISSION FOR TREATMENT:

Permission is hereby granted to Burlington County Orthopaedic Specialists, P.A. to perform such procedure(s) as may be indicated or necessary.

I HAVE READ THIS FORM. IT HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY AND ACKNOWLEDGE THAT I UNDERSTAND ITS CONTENTS.

ADVANCE DIRECTIVE (LIVING WILL) YES _____ NO _____

SIGNATURE: _____ DATE: _____

If patient is a minor, incompetent, or unable to sign:

Signature, Responsible Party: _____ Relationship: _____ Date: _____

CHILD
Patient Information Record

PLEASE PRINT

Date: _____

Patient's Name: _____ Soc. Sec. # _____
Last First Middle Initial

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Birth Date: _____ Age: _____ Sex: _____ ☐ Full Time Student

Race: _____ Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino Language _____

Injury occurred at: ☐ Work ☐ Auto ☐ **School** ☐ Other Date of Injury: _____

Name and Address of Referring\Family Physician or Other Appropriate Source: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Responsible Party/relationship: _____ Birth Date: _____ Soc. Sec. #: _____

Address: _____ Telephone: _____ Email: _____

Employed by: _____ Telephone: _____

Employer's Address: _____ City: _____ Zip Code: _____

INSURANCE INFORMATION

Holder of Primary Insurance: _____

Employer: _____

Address: _____

_____

Telephone: _____

Insured's S.S. Number _____

Insured's Date of Birth _____

Holder of Secondary Insurance: _____

Employer: _____

Address: _____

_____

Telephone: _____

Insured's S.S. Number _____

Insured's Date of Birth _____

Relationship of Insured to Patient: ☐ Parent ☐ Step-Parent ☐ Custodial Parent ☐ Legal Guardian ☐ Financial responsibility by divorce decree

IS HOLDER OF PRIMARY INSURANCE RESPONSIBLE FOR ANY BALANCE, COPAYS OR DEDUCTIBLES? YES _____ NO _____. If you answered NO, please indicate the name and address of the responsible party.

Name: _____

Address: _____

RESPONSIBILITY FOR CHARGES:

I agree that in consideration of Burlington County Orthopaedic Specialists, P.A. furnishing services or care, I obligate myself to, pay the account in accordance with regular rates and terms of the doctors upon receipt of the bill. Should the account be referred to an attorney or collection, I shall pay the reasonable attorney's fees and collection expense.

I understand the doctors may disclose all or any part of my medical record to any person or corporation which is or may be liable under a contract to the doctors or to the patient or to a family member or employer of the patient for all or part of the doctor's charge, including but not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or my employer.

MEDICARE: PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, PAYMENT REQUEST — I certify that the information given to me in applying under the title XVIII of the Social Security Act is correct. I authorize any holder of medical or any other information about me to release it to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

PERMISSION FOR TREATMENT:

Permission is hereby granted to Burlington County Orthopaedic Specialists, P.A. to perform such procedure(s) as may be indicated or necessary.

I HAVE READ THIS FORM. IT HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY AND ACKNOWLEDGE THAT I UNDERSTAND ITS CONTENTS.

ADVANCE DIRECTIVE (LIVING WILL) YES _____ NO _____

SIGNATURE: _____ DATE: _____

HEALTH HISTORY
(Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

Height _____ Weight _____ Right or Left Hand Dominant _____ Race _____

Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino Preferred Language _____

What is your reason for visit? _____

SYMPTOMS/REVIEW OF SYSTEMS Check (✔)symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms R/L
- ☐ Back
- ☐ Feet R/L
- ☐ Hands R/L
- ☐ Hips R/L
- ☐ Legs R/L
- ☐ Neck
- ☐ Shoulders R/L

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Rectal bleeding
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ Swelling of extremities

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Sinus problems

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Sore that won't heal

RESPIRATORY
- ☐ Bloody Sputum
- ☐ Difficulty breathing
- ☐ Difficulty breathing on exertion
- ☐ Snoring
- ☐ Wheezing
- ☐ Persistent Cough

WOMEN only
Date of last menstrual period _____
Are you pregnant? _____
Number of children _____

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

PAST MEDICAL HISTORY/CONDITIONS Check (✔) conditions you have or have had in the past.

- ☐ ADHD
- ☐ Alzheimers
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia or Bulimia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Cancer: be specific _____
- ☐ Cataracts
- ☐ CHF
- ☐ Clots: DVT or PE
- ☐ Diabetes
- ☐ Dementia
- ☐ Emphysema or COPD
- ☐ Epilepsy
- ☐ GERD
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease: be specific _____
- ☐ Hepatitis A, B or C
- ☐ Hernia
- ☐ **High Blood Pressure**
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ IBD: Crohn's or Ulcerative Colitis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lyme's Disease
- ☐ Migraine Headaches
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psoriasis
- ☐ Psychiatric Care
- ☐ Rheumatologic problems: be specific _____
- ☐ **Sleep Apnea**
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems: be specific _____
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Tract infections
- ☐ Varicose veins
- ☐ Venereal Diseases
- ☐ Other: _____

MEDICATIONS List medications you are currently taking.

Pharmacy Name_____ Phone_____

Address_____ Fax _____

ALLERGIES List medications or substances including metal & jewelry, and include reaction.

Allergies to any Medications ☐ Yes ☐ No

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Medical Illness
Father			
Mother			
Brothers			
Sisters			

Check (✔) if your blood relatives had any of the following:

☐ Arthritis ☐ Strokes
☐ Diabetes ☐ Kidney Disease
☐ Gout ☐ High Blood Pressure
☐ Cancer ☐ Trouble with Anesthesia
☐ Heart Disease ☐ Clotting Disorder
☐ Rheumatologic Disorder: (RA, Lupus, Sjogren's, other) ☐ Other

HOSPITALIZATION / SURGERIES

Year	Hospital	Reason for Hospitalization and Outcome

SOCIAL HISTORY Check (✔) which substances you use and describe how much you use.

☐ Caffeine_____
☐ Coffee ☐ Carbonated Beverages ☐ Tea
☐ Tobacco How much? _____ For how many years? _____
☐ Drugs Any prior drug use? _____
☐ Alcohol How much? _____
☐ Other _____

Your Occupation:

_____

Date of Last Flu Shot:

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____
Reviewed By Date

BURLINGTON COUNTY ORTHOPAEDIC SPECIALISTS, P.A.
NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Protected Health Information.

How We May Use or Disclose Your Protected Health Information

1. **We May Use or Disclose Your Protected Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization.**
2. **Protected Health Information Will Also Be Used Without Prior Authorization Under the Following Circumstances:**

   To Notify and/or Communicate with your Family - Unless you inform us of your objection in writing, we will use or disclose your Protected Health Information in order to notify your family or assist in notifying your family, your personal representative or another person responsible for your care about your location, your condition or of your death.

   As Required by Law - Protected Health Information will be used and disclosed, to the extent that law requires such use or disclosure.

   For Public Health Purposes - As required by law.

   For Health Oversight Activities - Protected Health Information will be used and disclosed to health agencies during the course of audits, investigations, surveys, accreditation, certification and other proceedings.

   In Response to Subpoenas or for Judicial and Administrative Proceedings

   To Law Enforcement Personnel - Protected Health Information will be used and disclosed to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person, or, in some cases, to comply with a court order or subpoena and for other law enforcement purposes.

   For Public Safety - Protected Health Information will be used and disclosed in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

   To Aid Specialized Government Functions - Protected Health Information may be used and disclosed for military or national security purposes.

   For Worker's Compensation - Protected Health Information may be used and disclosed as necessary to comply with worker's compensation laws.

   To Correctional Institutions or Law Enforcement Officials - If you are an inmate, Protected Health Information may be disclosed to the correctional institution or law enforcement officials.
3. **Required Uses and Disclosures:** Under the law, disclosures must be made to you, upon your request (unless medically contraindicated) and when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance with HIP AA regulations.
4. **For All Other Circumstances, We May Only Use or Disclose Your Protected Health Information After You Have Signed an Authorization.** If you authorize us to use or disclose your Protected Health Information for another purpose, you may revoke your authorization in writing at any time.
5. **We May Also Use or Disclose Your Protected Health Information for the Following Purposes:**

   Appointment Reminders - To contact you with appointment reminders or to provide information on other treatments or health-related benefits and services that may be of interest to you.

   Change of Ownership - In the event that Burlington County Orthopaedic Specialists. P.A. is sold or merged with another organization, your Protected Health Information will become the property of the new owner.

Your Rights with Respect to Your Protected Health Information

1. You have the right to request restrictions on the uses and disclosures of your Protected Health information. Your request must be in writing, be addressed to the Privacy Officer and state the specific restriction requested and to whom you want the restriction to apply. However, we are not required to comply with your request.
2. You have the right to request your Protected Health Information through confidential means. However, we may condition this accommodation by asking you for information as to how payment will be handled or a specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must be in writing, be addressed to the Privacy Officer and state the specific alternate means or location.
3. You have the right to inspect your Protected Health Information. You may also obtain a copy of your Protected health Information (unless medically contraindicated). B.C.O.S. will charge a reasonable fee for the copying of records. You have a right to request that we amend the Protected Health Information contained in your designated records if you believe it is incorrect or incomplete. However, we are not required to make any such amendments.
4. You have a right to receive an accounting of disclosures of your Protected Health information made by us, except that we do not have to account for disclosures: made prior to to April14, 2003; authorized by you; made for treatment, payment, health care operations: provided in response to an Authorization; made in order to notify and communicate with family; for certain government functions, and/or disclosures provided to you, to name a few. The right to receive an accounting is subject to exceptions, restrictions and limitations.
5. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Privacy Officer.

Our Duties to You

We are required by law to maintain the privacy of your Protected Health Information and to provide you with a copy of this Notice.

How You May Complain to the Government About our Privacy Practices

You may make complaints to the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

How You May Contact us About our Privacy Practices

You may contact us about our privacy practices by calling the Privacy Officer at: (856) 235-7080

_____ _____

Signature Date

BCOS BURLINGTON COUNTY ORTHOPAEDIC SPECIALISTS, P.A.

Briggs Road Professional Campus
2059 Briggs Road, Suite 304, Mt. Laurel, NJ 08054
856-235-7080

Directions

From 295 North: Take Exit 40A (Route 38 East) Mt. Holly
Follow 38 East for 1 mile to Briggs Road. Turn Right at Briggs Road.
We are located on the right hand side – Briggs Road Professional Campus.

From 295 South: Take Exit 40B (Route 38 West) Moorestown. Merge onto 38 West.
Take Marter Avenue exit on the Right. Turn Left onto Marter Avenue.
Use left 2 lanes to turn left onto 38 East. Follow 38 East for 1 mile to Briggs Road.
Turn Right at Briggs Road.
We are located on the right hand side – Briggs Road Professional Campus.

Betsy Ross Bridge: Take Route 90 East to Route 73 South to Route 38 East.
Follow Route 38 to Briggs Road. Turn Right at Briggs Road.
We are located on the right hand side – Briggs Road Professional Campus.

Tacony Palmyra Bridge: Take 73 South to Route 38 East.
Follow Route 38 to Briggs Road. Turn Right at Briggs Road.
We are located on the right hand side – Briggs Road Professional Campus.

Burlington Bristol Bridge: Take Rt. 130 North Rt. 541 North.
Take 295 South to Exit 40B (Route 38 West) Moorestown. Merge onto 38 West.
Take Marter Avenue exit on the Right. Turn Left onto Marter Avenue.
Use left 2 lanes to turn left onto 38 East. Follow 38 East for 1 mile to Briggs Road.
Turn Right at Briggs Road.
We are located on the right hand side – Briggs Road Professional Campus.

Mt Holly/Browns Mills: Take Route 38 West to Briggs Road exit on the right. Turn left onto Briggs Road to cross Route 38. Continue on Briggs Road .7 mile.
We are located on the right hand side – Briggs Road Professional Campus.