William O. Reed, Jr. M.D., P.A.

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Overland Park, KS 66204
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Workers' Compensation Form

First Name________________________ MI____ Last Name____ Sex______

Date of Birth_____________ Social Security Number _____________________ E-mail address:______________________

Street Address_____________________________________City_________________________State_____Zip__________

Home Phone (_____)______________ Work Phone (_____)______________ Cell Phone (_____)_______________

Name of Employer ____ Supervisor______________________________

Employer's Address __________________________________City______________________ State_____ Zip_________

Occupation: ____ Date of Injury/Accident: _____________________________

Describe accident in your own words: ____

____

____

Are you currently working? Yes____ No___ If no, last date worked: ____

Are you on light duty? Yes___ No___ If yes, specify restrictions: ____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize William O. Reed, Jr., M.D., P.A., to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physicians all payments for medical services rendered to myself or on my behalf.

Patient's Signature:____ Date: _____________________

☐ Kansas ☐ Missouri ☐ __________ST Workers' Compensation Claim

Send bills to: __________________________________

____

____

PPO Network: _________________________________

Claim #: ______________________________________

Adjuster's Name: _______________________________

Adjuster's E-mail: ______________________________

Adjuster's Phone: (_____)_________________________

Adjuster's Fax: (_____)___________________________

Date of Injury: __________________________________

Appointment made by: ____________________________

Phone number (_____)______________________________

Type of Service Authorized: ☐ Eval Only ☐ Eval & Treat

☐ 2nd Opinion ☐ 2nd Opinion & Treat ☐ IME

Body part authorized: ______________________________

Type of problem: __________________________________

Previous Films/Tests: ☐ X-ray ☐ MRI ☐ EMG ☐ CT

Appointment Date: _______________ Time: ___________

Appointment scheduled by: __________________________

Referring Physician: ____________________________ Phone (_____)__________ Fax (_____)___________________

Referring Physician's Address: _________________________________ City __________________ ST _____ Zip_______

Fax/Mail copies of transcription/workstatus to: **Case Manager:** ____

Company Name: _______________________________ E-mail address: __________________________________

Cell Phone (_____)________________Phone: (______)______________Fax: (______)_____________________________

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History and Physical

Name____ Date of Birth _______________

Age______ Sex/Gender _______ Height ________ Weight_______ ☐ Right-handed ☐ Left-handed

Complaint:____

____

Date of Injury or Onset of Illness:____

Previous Test(s): (Mark all that apply) ☐ X-Ray ☐ MRI ☐ EMG ☐ CT Scan Other________________

Past Medical History: Are you now or have you ever been treated for any of the following:

	Yes	No	Explain:
High blood pressure	_____	_____	______________________________
Diabetes	_____	_____	______________________________
Cancer	_____	_____	______________________________
Heart Problems	_____	_____	______________________________
Chest Pain	_____	_____	______________________________
Asthma	_____	_____	______________________________
Epilepsy/Seizure	_____	_____	______________________________
Stroke	_____	_____	______________________________
Thyroid	_____	_____	______________________________
Bleeding Disorder	_____	_____	______________________________
Hepatitis	_____	_____	______________________________
Jaundice	_____	_____	______________________________
AIDS/HIV	_____	_____	______________________________

FEMALES ONLY—Next 2 questions

Could you be pregnant? Yes ______ No______
Date of last menstrual period:________________

ALLERGIES: Are you allergic to any medicine, tapes or iodine? If yes, please list:____________________

____

MEDICATIONS: Are you currently taking any medications? If yes, please list:__________________________

____

PAST SURGICAL HISTORY: Please list previous surgeries (include year):________________________________

____

Do you smoke: ☐ Yes ☐ No If yes, how much per day?____________
Do you drink alcohol: ☐ Yes ☐ No If yes, how much per day?____________

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Name____ Date of Birth ______________

Family History: Is there any family history of health problems, such as:

	Yes	No	Explain:
Diabetes	_____	_____	____
Cancer	_____	_____	____
High Blood Pressure	_____	_____	____
Stroke	_____	_____	____
Other	_____	_____	____

Review of Systems: Do you have any complaints with the following?

	Yes	No	Explain:
Sleep	_____	_____	____
Eyes	_____	_____	____
Heart	_____	_____	____
Lungs	_____	_____	____
Bowels	_____	_____	____
Bladder	_____	_____	____
Skin	_____	_____	____
Headaches	_____	_____	____
Allergies	_____	_____	____
Depression/anxiety	_____	_____	____
Weight loss/gain	_____	_____	____
Numbness/tingling	_____	_____	____

Patient's Signature:____ Date:__________________

DO NOT WRITE BELOW THIS LINE. TO BE COMPLETED BY PHYSICIAN

HEENT ____
Neck ____
Chest ____
Heart ____
Lungs ____
Abdomen ____
Neurologic ____
Extremities____
Other ____

Physician's Signature:____ Date:__________________

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Pain Assessment

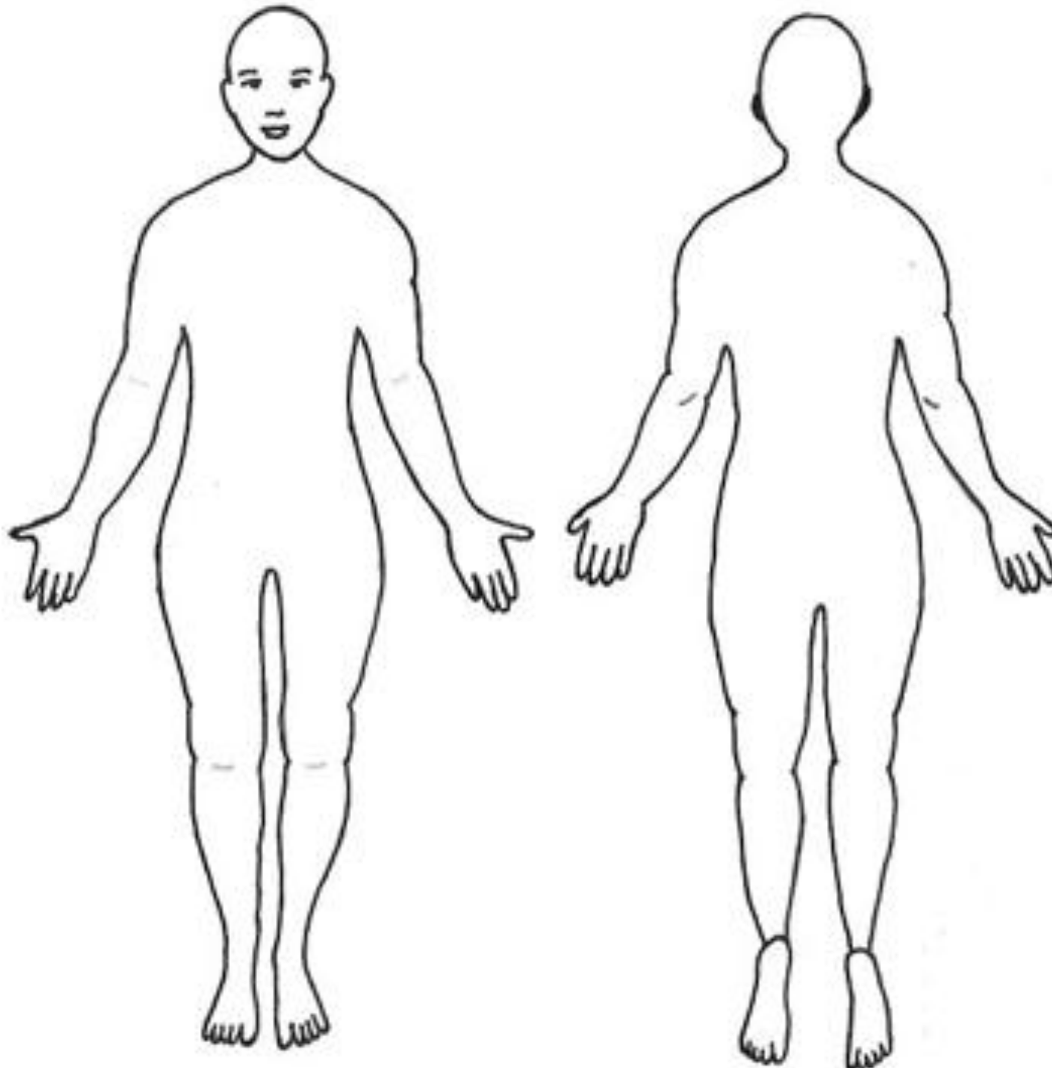
Name____ Date of Birth ______________

Patient Identification Number___________________________ Date of Visit:______________

Where is your pain now?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas. Just to complete the picture, please draw in your face.

	^ ^ ^ ^		0 0 0 0		= = = =		X X X X		/ / / /
Ache	^ ^ ^ ^	Numbness	0 0 0 0	Pins/Needles	= = = =	Burning	X X X X	Stabbing	/ / / /
	^ ^ ^ ^		0 0 0 0		= = = =		X X X X		/ / / /



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Pain Assessment
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Name____ Date of Birth _______________

How bad is your pain now?

Please make an "X" along the line to show how far from normal toward the worst possible situation your pain has taken you.

Question	Scale (left)	Scale (right)
1. How bad is your <u>back</u> pain now?	no pain	worst possible pain
2. How bad is your <u>leg</u> pain now?	no pain	worst possible pain
3. How bad is your pain at <u>night</u>?	no pain	worst possible pain
4. Does the pain interfere with your lifestyle?	no problem	total change in lifestyle
5. How good are pain killers for your pain?	complete relief	no relief
6. How stiff is your back?	no stiffness	worst possible stiffness
7. Does your pain interfere with walking?	no problem	cannot walk
8. Do you hurt when walking?	no pain	worst possible pain
9. Does your pain keep you from standing still?	stand as long as I want	cannot stand at all
10. Does your pain keep you from twisting?	no problem	cannot twist
11. Does your pain allow you to sit in an upright hard chair?	sit as long as I like	cannot use a hard chair at all
12. Does your pain allow you to sit in a soft chair?	sit as long as I like	cannot use a softchair at all
13. Do you have back pain when lying in bed?	no pain	no relief at all
14. How much does your pain limit your normal lifestyle?	no limit	cannot do anything
15. Does your pain interfere with your work?	no problem	totally cannot work
16. How much have you had to change your work place because of back pain?	no change	constantly changing

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Medication Refill Policy

Prescription refills are NEVER available on weekends or holidays.

The patient is responsible for planning his/her medication needs so as not to run out on weekends, long weekends or holidays.

Use of the answering service over weekends and holidays is reserved for emergency medical needs.

We require a 48-hour notice for all prescription refills.

I have read and understand the above policy regarding medication refills.

______________________________________ ______________________

Patient’s or Guardian’s Signature Date

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OFFICE POLICIES

Name____ Date of Birth _______________

Payment in full is due at time of service. It is not our policy to bill. We accept Cash, Check, MasterCard and Visa.

Thank you for choosing Dr. William O. Reed, Jr., M.D., as your orthopaedic provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Office Policy that we require you read and sign prior to any treatment. All patients must complete our demographic, insurance and medical forms prior to seeing a provider. Remember that appointment times are guidelines only. The physician will spend as much time as needed to fulfill each individual patient's needs. This and emergency cases can lead to a slight delay in the daily schedule.

Medication Refills: Our office WILL NOT refill any prescriptions *after 4:30 p.m., on weekends, or on holidays.* If you are taking any pain medication, we cannot give out any more than 30 pills in a 7-day period.

X-Rays: All x-ray requests need to be made at least 72 hours in advance. This includes x-rays taken here as well as x-rays brought or sent here from another facility. All x-rays taken at this facility are a part of our permanent records and are the property of this office. If you wish to take your x-rays to another licensed physician, copies will be made available at a charge of $17 per film to be paid in advance. This assures payment is received prior to copies being made and will give our radiology technician adequate time to get your films copied.

Medical Records: Original records WILL NOT leave this office. A release must be completed and signed by the patient or guardian of the patient prior to copies of records being sent.

Workers' Compensation Patients: You must fill out your portion of the forms completely in order for us to file to your Workers' Compensation insurance. Social Security Number, Date of Injury, and a description of the injury is a must in order for the insurance to recognize our billing. The case manager, insurance company or your employer must make all appointments that are not scheduled immediately following each visit. This includes any changes in scheduled appointments.

Regarding Insurance: We may accept assignment of insurance benefits. However, we do require any co-pay or remaining portion of the bill to be paid in full at the time of service. We cannot bill your insurance company unless you give us accurate insurance information in full, including a copy of your card at or before your first visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance is your responsibility, whether your insurance company pays or not. Please be aware that some supplies that are used are considered non-covered by many insurance plans and will be your responsibility. Regarding insurance plans in which we are a participating provider, all co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, payment for additional services or any remaining balance will become your responsibility. If your balance becomes delinquent and we are forced to turn your account over to collections, you can be terminated from the practice.

Release of Information and Authorization to Pay Insurance Benefits: This facility may disclose all or any part of the record of the patient to any group or organization which is or may be liable for or responsible for payment of all or part of the facility's charges, including but not limited to, insurance companies, medical or hospital service companies, Workers' Compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized Basic Benefits, as well as Major Medical Benefits, be made on behalf of the patient directly to said providers.

Pre-certification/Authorization/Referrals: Referrals for office visits and radiology is the patient's responsibility. Our staff will assist you in any way we can, but if you are seen without referral, payment will be expected from you. Pre-certification for surgery will be done by our staff providing we have all of your insurance information. Our office will initiate authorization for additional tests or therapy and we will assist you in scheduling these tests and/or therapy.

Usual and Customary Rates: You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients: The adult (parent or guardian) accompanying the minor is responsible for the bill and/or getting the correct insurance information to our office. We do not contact or bill third parties. Unaccompanied minors here for non-emergency treatment will be rescheduled, unless consent form and payment arrangements have been taken care of prior to treatment.

Disability/Insurance Forms: There is a $35.00 fee for filling out a Disability Form. These are done in the order they are received and will be sent to the patient or insurance when completed.

Patient's Signature:____ Date:____________________

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RADIOLOGIC STUDIES

Dear Valued Patient:

The physician you are visiting must have all radiology studies performed in the past five years available at your appointment.

You must personally pick up and bring the actual films or CD's containing all performed studies when you come to the office. The reports alone are not satisfactory for diagnosis and decision-making purposes. Your physician must have the actual films or CD's with the relevant studies and the radiologist's interpretation.

This means you must either leave the facility with the studies in hand after your tests, or return to the facility later to pick up the studies and bring them to the office upon your scheduled visit.

Do not, under any circumstances, allow or believe that the facility will see to the delivery of your studies. Do not delegate this responsibility, or you will risk the next appointment with your physician being unproductive.

If you can obtain the radiologist's report, please do so. However, we can usually obtain the report by fax or e-mail quickly. The more important files you must carry yourself to the appointment to be sure they are available for your physician.

Please acknowledge the understanding of this important request by signing below.

____ ______________________

Patient's Signature Date

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MISSED APPOINTMENT FEE

There will be a $50.00 charge for appointments that are not rescheduled or canceled within 24 hours prior to the appointment.

MISSED APPOINTMENT FEE AGREEMENT

I understand that I am responsible for the $50.00 fee to Dr. William O. Reed, Jr., M.D., if I do not give a 24-hour notice prior to my appointment.

____
Patient's Name (Printed)

____
Patient's Signature

____
Date

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