CHARLOTTESVILLE
ORTHOPAEDIC
CENTER
Innovation that moves you

David Nielsen, D.O.
Board-certified Orthopaedic Surgeon
Fellowship-trained in Upper Extremity
Certificate of Added Qualification (CAQ):
Hand Surgery

183 Spotnap Road, Suite C | Charlottesville, VA 22911 | 434-244-8412 | www.cvilleortho.com

PATIENT INFORMATION

Patient's last name:	First:	Middle	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid / Partner

Birth date: / /	Age:	Social Security no.:	Sex: ☐M ☐F	Home phone no.: ( )

Physical address:	Email Address:	Cell Phone: ( )

P.O. box/Mailing (if different):	City:	State:	ZIP Code:

PCP/Family Doctor: | Is this visit result of an injury? Y or N | Date/Time of injury_____

INSURANCE/PAYMENT INFORMATION

Is this patient covered by insurance? ☐ Yes ☐ No

Person responsible for bill: Self	Birth date: / /	Address (if different):

Home phone no.: ( )	Work no: ( )	Cell No: ( )	Is this person a patient here? ☐ Yes ☐ No

(Please give your insurance card to the receptionist.)

Primary insurance:	Policy no.:	Group no.:

Subscriber's name: ☐ Self	Subscriber's S.S. no.:	Birth date: / /	Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary insurance:	Policy no.:	Group no.:

Subscriber's name: ☐ Self	Subscriber's S.S. no.:	Birth date: / /	Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

WORKCOMP Patients (You must have proper written authorization or you may be considered a selfpay patient.)

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Authorization for Treatment, Release of Information, Insurance Authorization and Assignment & Financial Agreement:

I hereby authorize treatment. I authorize Charlottesville Orthopaedic Center to furnish to insurance carriers any medical information necessary to process my claims. I hereby assign to Charlottesville Orthopaedic Center all payments, for medical good/services rendered to myself or my dependents. I understand that I am responsible for payment of any amount not covered by insurance. After insurance payment is received, I authorize Charlottesville Orthopaedic Center to bill any remaining balance to the credit card I present and to mail me a receipt. I understand that an additional amount of 1% interest will be added to patient balances every 30 days or more past due. I agree to reimburse any collection agency and legal fees. I acknowledge that if do not provide a 24-hour cancellation notice for a scheduled appointment, I may be charged a $50 No-Show fee. I authorize Charlottesville Orthopaedic Center to download my medication history automatically from pharmacy benefit managers. I consent to receive reminders/messages regarding my care by way of phone call, text, or email.

Patient or Guardian signature *Date*

Last updated 5/2018

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Patient Questionnaire Initial Evaluation

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. ***Mark the word or phrase that best describes your situation. You may select more than one answer per question.*** Answer the question in as much detail as possible. Write additional information in the margins if needed. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. ***THANK YOU.***

Patient name: _____ Date:_____

Family/primary doctor: _____ Phone: _____

Family/primary doctor's address: _____

How were you referred here? Family/primary doctor Other doctor, please name: _____

☐ Family Friend Telephone book ☐ Internet ☐ Referral service Other: _____

Age:_____ Sex: Male Female Are you pregnant? Yes (_____Weeks) No

Are you breastfeeding? Yes No

What are you seeing the doctor for? _____

Is this injury work related? Yes (date/time of injury)_____ No

When did the problem first start or when did the injury occur? _____

Explain in your own words how this problem occurred: _____

_____

_____

Have you seen a doctor for this problem or injury? Yes No If yes, who and when?

_____

What treatments have you had (tests, medication, surgery, therapy, splinting, etc)? Please include everything from previous providers as well as anything you may have done on your own. ☐ None ☐ Yes, please explain: _____

_____

_____

_____

_____

_____

_____

DOYOUCURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS? Please check all that apply:

☐ Fevers
☐ Weight gain
☐ Weakness
☐ Fingers/toes turn colors in the cold
☐ Numbness/tingling
☐ Dental problems
☐ Increased infections
☐ Shortness of breath
☐ Chest pain
☐ Heartburn
☐ Blood clots
☐ Bleeding tendency
☐ Disturbed sleep
☐ ***I do not have any of these symptoms***

PLEASE TELL US ABOUT YOUR PAST ORTHOPAEDIC HISTORY (not including today):

Shoulder fracture Left/Right
Shoulder injury Left/Right
Shoulder dislocation Left/Right
Rotator cuff strain/bursitis Left/Right
Rotator cuff tear Left/Right
☐ Adhesive capsulitis/frozen shoulder Left/Right

☐ Arm fracture Left/Right
☐ Arm injury Left/Right
☐ Elbow fracture Left/Right
☐ Elbow injury Left/Right
☐ Tennis elbow Left/Right
☐ Forearm fracture Left/Right
☐ Forearm injury Left/Right

☐ Finger fracture Left/Right
☐ Finger injury Left/Right
☐ Hand fracture Left/Right
☐ Hand injury Left/Right
☐ Wrist fracture Left/Right
☐ Wrist injury Left/Right
☐ Carpal tunnel syndrome Left/Right
☐ Trigger finger Left/Right
☐ Ganglion cysts Left/Right
☐ Tendon lacerations Left/Right
☐ Nerve or artery injury Left/Right

Hip fracture Left/Right
Hip injury Left/Right
Thigh fracture Left/Right
Thigh injury Left/Right

☐ Knee injury Left/Right
☐ Meniscal tear Left/Right
☐ ACL ligament injury Left/Right
☐ Leg fracture Left/Right
☐ Leg injury Left/Right

☐ Ankle fracture Left/Right
☐ Ankle sprains Left/Right
☐ Foot fracture Left/Right
☐ Foot injury Left/Right
☐ Toe fracture Left/Right
☐ Toe injury Left/Right

☐ Herniated disc
☐ Back fracture
☐ Low back pain
☐ Neck fracture
☐ Neck injury
☐ Other, please specify: _____

_____

☐ ***NO PREVIOUS ORTHOPAEDIC PROBLEMS***

PLEASE TELL US ABOUT YOUR PAST MEDICAL HISTORY:

☐ Coronary arterydisease
☐ Peripheral vascular disease
☐ Past heart attack
☐ Chest pain
☐ Arrhythmia/Irregular heart beat
☐ Heart murmur
☐ Heart valve dysfunction
☐ Pacemaker
☐ Heart failure
☐ Fainting spells

☐ Hypertension/High blood pressure
☐ High cholesterol
☐ Adult onset diabetes
☐ Childhood onset diabetes
☐ Stroke/TIA

☐ DVT/Blood clot
☐ Bleeding problems
☐ Sickle cell disease
☐ Anemia
☐ Blood transfusion

☐ Asthma
☐ Emphysema
☐ COPD
☐ Shortness of breath
☐ Pneumonia

☐ Growth problems
☐ Developmental delay
☐ Congenital anomalies

Stomach ulcer
Reflux/GERD
Gastritis
☐ Hiatal hernia
Colitis
☐ Chron's disease
☐ Irritable bowel syndrome
Diverticulitis
Diarrhea
Pancreatitis
Cirrhosis
☐ Liver disease
Alcoholism
☐ Hepatitis A/B/C
☐ Kidney disease
☐ Kidney stones

☐ Enlarged prostate
Endometriosis
Menopause
☐ Gynecologic problems

Anxiety
Depression
Migraines
Parkinson's
☐ Seizure disorder
☐ Multiple sclerosis

☐ Cancer, specify type:

_____

_____

☐ Head injury
☐ Paralysis/spinal cord injury
☐ Immune disorder
☐ Thyroid disease

Glasses/contacts
Blind
Cataracts
☐ Detached retina
Glaucoma

☐ Deaf/Hard of hearing
☐ Hearing aid use
Vertigo
☐ Seasonal allergies
☐ Nose bleeds
Sinusitis

☐ Osteoarthritis (age related)
☐ Rheumatoid arthritis
Gout
☐ Fibromyalgia/Chronic pain
SLE/Lupus

☐ Bone infections
☐ Chronic/Non-healing wounds
☐ Burn injury
☐ Other condition, please list:

_____

_____

☐ ***NO MEDICAL PROBLEMS***

PLEASE TELL US ABOUT YOUR PAST SURGICAL HISTORY: Place a mark beside any surgery you have ever had.

General Surgery

		YEAR		*YEAR*
☐	Appendectomy	_____	Hernia repair	_____
☐	Cataract extraction	_____	Hysterectomy	_____
☐	Caesarian section	_____	Mastectomy	_____
☐	Angioplasty	_____	Tonsillectomy	_____
☐	Bypass/open heart surgery	_____	Prostate surgery	_____
☐	Peripheral vascular surgery	_____	Other, please specify:	_____
☐	Gall Bladder surgery	_____	***NO PREVIOUS GENERAL SURGERY***	
			☐	

Orthopaedic Surgery

			YEAR		*YEAR*
☐	Shoulder: fracture repair	Left/Right	_____	☐ Hip: fracture repair	Left/Right _____
☐	Shoulder: arthroscopy	Left/Right	_____	☐ Hip: total hip replacement	Left/Right _____
☐	Shoulder: rotator cuff repair	Left/Right	_____	☐ Thigh	Left/Right _____
☐	Clavicle	Left/Right	_____	☐ Knee: fracture repair	Left/Right _____
☐	Arm	Left/Right	_____	☐ Knee: arthroscopy	Left/Right _____
☐	Elbow	Left/Right	_____	☐ Knee: ACL reconstruction	Left/Right _____
☐	Forearm	Left/Right	_____	☐ Knee: total knee replacement	Left/Right _____
☐	Hand/Wrist: fracture repair	Left/Right	_____	☐ Leg	Left/Right _____
☐	Hand/Wrist: carpal tunnel	Left/Right	_____	☐ Ankle	Left/Right _____
☐	Hand/Wrist: nerve repair	Left/Right	_____	☐ Foot	Left/Right _____
☐	Hand/Wrist: tendon repair	Left/Right	_____	☐ Toes	Left/Right _____
☐	Finger	Left/Right	_____	☐ Other, please specify:	_____
☐	Low back	Left/Right	_____	_____	
☐	Neck	Left/Right	_____		
				☐ ***NO PREVIOUS ORTHOPAEDIC SURGERY***	

PLEASE TELL US ABOUT YOUR FAMILY HISTORY:

Has any blood relative had any of the following conditions? Place a mark beside any condition, and fill in type if known

☐	Dysplasia , type: _____	☐	Congenital musculoskeletal , type: _____
☐	Bone diseases , type: _____	☐	Neurologic disorders , type: _____
☐	Connective tissue disorders , type: _____	☐	Bone cancer , type: _____
☐	Mucopolysaccharidosis , type: _____	☐	Other cancer , type: _____
☐	Muscular dystrophies , type: _____	☐	Other please list: _____
☐	Blood disorders , type: _____		***NEGATIVE FAMILY HISTORY***
		☐	

PLEASE TELL US ABOUT YOURSELF:

Occupation:_____ Retired Employer_____

☐ Disabled (cause: _____) Permanent Temporary

Hand dominance: Right Left Ambidextrous

Education completed:

☐ Elementary school
☐ High school
☐ GED
☐ Vocational school
☐ College
☐ Graduate school

Marital status:

☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Partner
☐ Widow

Children:

☐ None

____# son(s)
____# daughter(s)

Home arrangements:

☐ Home, alone
☐ Home with family
☐ Home with roommates
☐ Assisted living, name: _____
☐ Nursing home, name: _____

What best describes your activity level? (Check only one)

☐ 30 minutes of an exercise program less than 1 day a week
☐ 30 minutes of an exercise program 1-2 days a week
☐ 30 minutes of an exercise program 3 or more days a week
☐ Active but no exercise program
☐ Sedentary/sit most of the day
☐ Minimal activity outside of home
☐ Stay at home only
☐ Stay in bed only

What assistive devices do you use? (Check all that apply)

☐ ***None***
☐ Cane
☐ Crutches
☐ One-handed walker
☐ Full walker
☐ Rollator
☐ Wheelchair

Do you now, or have you ever used tobacco? ☐ Yes (years _____) No Quit (year _____)

Type:
Chew
Cigar
Cigarette
☐ Dip
Pipe

Amount: (pack/can/each)
<1
1 2
3 >3

Frequency:
Daily
Weekly
Monthly
Occasionally
Socially

Do you now, or have you ever consumed alcohol? ☐ Yes ☐ No ☐ Quit (year _____)

Type:
Beer
Liquor
Mixed drinks
Wine
Other: _____

Amount: (glasses/servings)
<1
1 2
3 >3

Frequency:
Daily
Weekly
Monthly
Occasionally
Socially

Do you now, or have you ever used recreational drugs? ☐ Yes ☐ No ☐ Quit (year_____)

Type:
Amphetamines
Cocaine
☐ LSD
Marijuana
☐ Other: _____

Amount:
<1
1 2
3 >3

Frequency:
Daily
Weekly
Monthly
Occasionally
Socially

Place a mark beside any medication listed below to which you are allergic:

		Reaction			***Reaction***
☐	Penicillin	_____		Radiographic Dyes	_____
☐	Keflex (Cephalexin)	_____		Adhesive Tape	_____
☐	Sulfa	_____		Latex	_____
☐	Erythromycin	_____		Metal	_____
☐	Morphine	_____		Other, please specify:	_____
☐	Codeine	_____	_____		_____
☐	Iodine/Betadine	_____	_____		_____

☐ ***NO KNOWN ALLERGIES***

Name and location of your pharmacy: _____

What medications are you currently taking? Please include both prescription and non-prescription medications.

▫ I take no prescription or over-the-counter medications

Medication s	**(MG)**	**# Times a Day**

Everything I have answered is true and correct to the best of my knowledge.

Patient Signature

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.

IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD

AT CHARLOTTESVILLE ORTHOPAEDIC CENTER, PLC

Charlottesville Orthopaedic Center, PLC

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests

- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Billfor your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or requiredto share your information in other ways– usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can changethe terms of thisnotice,andthechanges will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice: May 1, 2017
- The Office Manager for Charlottesville Orthopaedic Center also serves as the Privacy Officer. Email address is info@cvilleortho.com. Phone number is 434-244-8412.
- We never market or sell personal information. We do not create or manage a hospital directory. We do not create or maintain psychotherapy notes at this practice.
- We will never share any substance abuse treatment records without your written permission.

PROTECTED HEALTH INFORMATION (HIPAA)

I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BY CHARLOTTESVILLE ORTHOPAEDIC CENTER, PLC AND its MEDICAL STAFF FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I give consent to Charlottesville Orthopaedic Center, PLC and other providers involved in my care to use and/or disclose my protected health information for the purposes of treatment, payment and health care operations. I understand health care operations may include, among others, uses or disclosures relative to quality review, utilization review, medical necessity, or legal review. Protected health information may include medical records, insurance and payment information, and other information used, in whole or in part, to make decisions about me. Charlottesville Orthopaedic Center, PLC Notice of Privacy Practices provides more information about how the Practice, its medical staff, and other providers may use and disclose my protected health information for these purposes. Also I have been provided information about Virginia law about policy for Hepatitis B and C or HIV testing if there is an exposure.

I acknowledge that I have received or been offered a copy of Charlottesville Orthopaedic Center, PLC Notice of Privacy Practices.

Signed by:

- ( ) Patient ( ) Spouse ( ) Parent ( ) Guardian
- ( ) Power of Attorney ( ) Other _____
- ( ) Patient is unable to sign or acknowledge
- ( ) Patient refuses to sign but was given the opportunity to acknowledge and sign

Print: _____

Signed: _____

Witness: _____

Date: _____

Chart Number_____

SHARING INFORMATION WITH FAMILY & FRIENDS

To protect the confidentiality of our patients, we ask you to fill out this section. Please indicate who you will allow us to discuss your medical care with. If you do not let us know who we may talk to, we will not discuss your medical care with them.

People we may talk to about your medical care:

Name Relation

_____

_____

People we may NOT talk to about your medical care:

Name Relation

_____

_____

_____

Signature Date