Arthroscopic Surgery
Reconstructive Joint Surgery

10313 GEORGIA AVENUE, SUITE 107
SILVER SPRING, MARYLAND 20902
OFFICE: 301-681-3100
FAX: 301-681-3367

A. ROY ROSENTHAL, M.D., P.A.
ANDREW J. SIEKANOWICZ, M.D., P.L.L.C
ASHOK L. GOWDA, M.D.
PRACTICE LIMITED TO ORTHOPAEDIC SURGERY

Sports Medicine
Physical Therapy

8721 GREENBELT ROAD, SUITE 203
GREENBELT, MARYLAND 20770
OFFICE: 240-784-7730
FAX: 240-764-7732

REGISTRATION FORM

Social Security #____________________ Date____________

Patient Name ____________________ Age _____ Date of Birth ________ ❒ Male ❒ Female

Last First Middle Name

❒ Single ❒ Married ❒ Sep./Div. ❒ Widow ❒ Student ❒ Physician____________

Address____________________ Apt. #______

City & State____________________ Zip____________

Home Phone____________ Work Phone____________ Cell Phone____________

Employed by____________________ Position____________ Student ____________

Address____________________ Bus. Phone____________ Ext.______

Spouse's Name____________________ Social Security #____________

Parent's Name (if minor)____________________ Social Security #____________

Responsible Party Empl. by____________________ Bus. Phone ____________

***Permission to treat minor:** Witness (1)____________ Witness (2) ____________

Health Insurance:____________________ Secondary Ins.:____________

ID#:____________________ ID#:____________

Address:____________________ Address:____________

Pregnant ❒ No ❒ Yes **Any Allergies to Drugs?** ❒ No ❒ Yes Please List:____________

Legal Case?______ Date of Accident______ Ins. Co. of Liable Party____________

PIP Ins. Co.____________ Claim #____________ Policy #____________

Policyholder ____________________

Attorney____________________ Phone____________ Fax____________

Address____________________ City, State & Zip____________

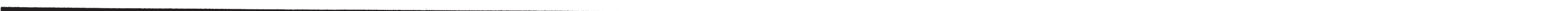
Workman's Comp. Case? ______ Date of Injury______ Time of Injury____________

Reported?______ To Whom? ____________________

Employer at Time of Injury ____________________ Bus. Phone____________ Ext.______

Insurance Carrier____________________ Workmen's Comp. #____________

Address of Carrier____________________



While we will file all necessary insurance in order to expedite payment, all services rendered are the sole responsibility of the patient and or guardian.

I authorize release of medical information to my Attorney/and or my insurance company/workman's compensation company. I assign benefits to be paid directly to the provider of services: ____________________

(signature required)

PATIENT'S ACCOUNT NO.

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Date of Accident/Injury____

Authorization to pay benefits for services directly to provider:

I hereby authorize my insurance carrier to pay and all benefits directly to the provider of services, Drs. Rosenthal & Siekanowicz, L.L.C. (A. Roy Rosenthal, M.D., P.A, Andrew J. Siekanowicz, M.D., P.L.L.C. and Ashok L. Gowda, M.D.)

Authorization to release medical information/records as requested:

I hereby authorize the release of any medical information relating to this injury (see above date) as requested by my insurance carrier (Health/workers comp/Automobile). The release of medical information may be for purposes including but not limited to:

Request for Payment, Pre-authorization, Pre-certification, Medical review.

If I'm represented by an Attorney, I authorize medical information/records be released as requested.

If my Health Plan requires a referral for office visits it is my responsibility to furnish this office with current referrals even in the event my treatment may be covered by another source of payment (workers comp/auto/liability). Failure to provide current referrals as required by my Health Plan may result in my being held responsible for any charges not covered by my Health Plan. This office also reserves the right to reschedule any appointment if a current referral is not provided.

I am responsible for all co-payments/deductibles and any item not covered by my Health plan, as determined my Health Plan Policy Provisions.

Failure to pay the patient portion any balance owed may result in account being forwarded to collection agency/ attorney office for collection purposes. Collection agency/attorney fees may be included in the bill if required.

Patient's Name:_____________________________________ **Date:**_____________________

Signature: ____ **Date:**_____________________

(If patient is a minor, parent or guardian must sign below to consent for treatment/assignment of benefits and authorization for direct payment from Health Plan)

Parent/Guardian:_______________________________ **Print Name:**_____________________

*MEDICAL INFORMATION/RECORDS MAY CONTAIN INFORMATION RELATED TO PAST HISTORY; INJURIES, SURGERIES, MEDICATIONS & ILLNESSES INCLUDING COMMUNICABLE DISEASES. THEY MAY ALSO CONTAIN PERSONAL INFORMATION INCLUDING BUT NOT LIMITED TO DATE OF BIRTH, SOCIAL SECURITY, EMPLOYMENT INFO, DISABILITY., ATTORNEY ETC.

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ASSIGNMENT & AUTHORIZATION

I hereby authorize Drs. Rosenthal & Siekanowicz, L.L.C. to furnish my attorney(s) and/or Insurance Company any medical reports requested in reference to the injury(ies) sustained by me, my child, or my children.

I further authorize and direct the said attorney(s), or attorney's(s), successor(s), designee(s), or Insurance Company to pay from the proceeds of any recovery in my case to Drs. Rosenthal & Siekanowicz L.L.C. all fees and costs incurred for professional services rendered including reports. I hereby specifically agree to permit and direct any other additional, future or new attorney(s) or representative(s) of mine, my child or children, to do the same.

I UNDERSTAND THAT THIS IN NO WAY RELIEVES ME OF MY PERSONAL PRIMARY RESPONSIBILITY TO PAY DRS. ROSENTHAL & SIEKANOWICZ, L.L.C. FOR SUCH SERVICES WHEN RENDERED, AND I AGREE TO PAY COSTS INCURRED IN THE COLLECTION OF THESE CHARGES INCLUDING REASONABLE ATTORNEY FEES. I HEREBY AGREE TO WAIVE THE DEFENSE OF THE STATUTE OF LIMITATIONS AS IT PERTAINS TO ANY CLAIM FILED AGAINST ME BY REASON OF ANY UNPAID BILL. IF I REQUEST THAT MY MEDICAL INSURANCE COMPANY BE BILLED, THEN I AGREE TO BE RESPONSIBLE FOR ALL SERVICES RENDERED WHICH ARE NOT FULLY REIMBURSED BY ANY PRE-EXISTING PARTICIPATION AGREEMENT WITH INSURANCE COMPANIES. I ALSO UNDERSTAND THAT FEES FOR LEGAL REPORTS AND EVALUATIONS ARE NOT INCLUDED IN ANY PARTICIPATION AGREEMENT. I AGREE TO ALLOW MY ATTORNEY TO FURNISH HOME OR WORK RELATED INFORMATION PERTAINING TO MYSELF OR FAMILY TO AID IN COLLECTION OF THE BILL.

It is very IMPORTANT that ALL of the information below be COMPLETED.
A MEDICAL REPORT CANNOT be prepared without this information.

PATIENT'SNAME________________________________ DATEOFINJURY__________________
please print

ADDRESS____

SIGNATURE OF PATIENT
AUTHORIZED PERSON **X**________________________________ DATE OF SIGNATURE__________________
sign here

NAME OF ATTORNEY____

ADDRESS OF ATTORNEY____

THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFERRED TO HEREINABOVE, HEREBY AGREES TO COMPLY FULLY WITH THE FOREGOING ASSIGNMENT & AUTHORIZATION AND AGREES TO ADVISE THE NAMED DOCTOR(S), IN WRITING, WITHIN TEN DAYS OF THIS REQUEST THEREOF OF THE STATUS OF THE CLAIM OF THE AFORESAID PATIENT(S).

I also agree to withhold any pay from the proceeds from settlement, collection of judgment PIP, med-pay or other insurance proceeds the amount of the doctor's charges after contacting the doctor's office to obtain a current balance.
I agree to notify the doctor immediately of any change in the status of the claim which may preclude payment of the doctor's charges.
I agree to require any attorney to whom the undersigned refers this case, with or outside the firm, to honor this assignment, as a condition of referral.

SIGNATURE OF
ATTORNEY **X**________________________________ DATE OF SIGNATURE__________________

Please SIGN, DATE & RETURN ONE COPY of this Assignment to the doctor's office.
The medical report cannot be released to you until we have two signatures.

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CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

• Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.

• Fill status notification - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

• Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Drs. Rosenthal & Siekanowicz, LLC. as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form you are agreeing that your provider at Drs. Rosenthal & Siekanowicz may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Drs. Rosenthal & Siekanowicz, LLC. to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name ____________________________ Patient DOB ________________

Signature of Patient or Guardian ______________________ Today's Date ________________

Relationship to Patient __________

EMERGENCY CONTACT SHEET

DATE____

PATIENTøS NAME____ACCT#____________

In an emergency where I am unconscious to communicate, please notify the persons below.

NOTIFY PERSON #1: ____

HOME PHONE: ____

CELL PHONE: ____

EMAIL: ____

NOTIFY PERSON #2: ____

HOME PHONE: ____

CELL PHONE: ____

EMAIL: ____

En caso de emergencia donde yo este inconsciente o no pueda comunicarme, Por favor notifique a las siguientes personas.

NOTIFIQUE A PERSONA #1: ____

TELEFONO DE CASA: ____

TELEFONO CELULAR: ____

CORREO ELECTRONICO: ____

NOTIFIQUE A PERSONA #2: ____

TELEFONO DE CASA: ____

TELEFONO CELULAR: ____

CORREO ELECTRONICO: ____

Drs. Rosenthal, Siekanowicz & Gowda PATIENT NAME: ______________________________ **DATE:** ____

REVIEW OF SYMPTOMS

SYMPTOMS YOU PRESENTLY HAVE	YES	NO	**GASTROINTESTINAL**	YES	NO
BALANCE PROBLEMS			DIFFICULTY SWALLOWING		
DIFFICULTY WALKING			ULCERS OR GASTRITIS		
USE OF A CANE/WALKER					
DIZZINESS			**CARDIOVASCULAR**		
HEADACHE			CHEST PAIN/COUGHING		
LOSS OF WEIGHT			PAIN WITH BREATHING		
LOSS OF CONSCIOUS					
VISUAL DISTURBANCE (blurred or double)			**SKIN**		
			BRUISE EASILY		
ALLERGIES			CUTS OR ABRASIONS		
LATEX/NICKLE					
MEDICATIONS			**FEMININE**		
			PREGNANT		
PAIN OR WEAKNESS IN			DUE DATE		
NECK					
ARMS			FAMILY INHERITABLE DISEASES		
SHOULDERS			(heart, lungs, neurological etc.)		
HANDS					
BACK					
GROIN					
HIPS			MEDICAL CONDITIONS		
KNEES					
LEGS					
FEET					
NUMBNESS			MEDICATIONS		
DO YOU HAVE PAIN WITH					
BENDING OF LIFTING					
PUSHING OR PULLING					
SITTING OR STANDING			PREVIOUS INJURIES		
STAIR CLIMBING					
WEATHER CHANGES					
OVERHEAD ACTIVITIES					
			SURGERIES AND DATES		
HAVE YOU BEEN TESTED					
HEPATITES circle one + -					
HIV circle one + -					
DO YOU USE					
TOBACCO if yes, how many					
ALCOHOL if yes, how many					
GENITO-URINARY					
LACK OF BLADDER / BOWEL CONTROL					
DIFFICULTY / PAIN URINATING					

SIGNATURE: ________________________________

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As part of the Federal Government's requirements for Electronic Medical Records, we are obliged to ask you for the following demographic information:

Name: ____

Date Of Birth: __________________________

Ethnicity: Please check all that apply:

- ☐ Hispanic Or Latino
- ☐ Not Hispanic Or Latino

Race: Please check all that apply:

- ☐ American Indian Or Alaska Native
- ☐ Asian
- ☐ Black Or African American
- ☐ Native Hawaiian Or Other Pacific Islander
- ☐ White

Preferred Language: ____

Signature: ____

Date: _____________________

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Use and Disclosure of Protected Health Information

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Acknowledgement of Notification

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Drs. Rosenthal & Siekanowicz, L.L.C. may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our Notice of Privacy Practices.

____

Patient's Signature Date

Consent for Use and Disclosure of Information

By signing below, 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 trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to **Drs. Rosenthal & Siekanowicz, L.L.C.** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and it's agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

____

Patient's Signature Date

____

Print Full Name

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

DLH-AC1:2.5M-05/03

ARTHROSCOPIC SURGERY
RECONSTRUCTIVE JOINT SURGERY

SPORTS MEDICINE
PHYSICAL THERAPY

A. ROY ROSENTHAL, M.D., P.A.
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**PATIENT IS IN THE OFFICE NOW.
PLEASE FAX ASAP. **

PATIENT NAME: ____

DATE OF BIRTH: ____

I, ____**AUTHORIZE**

FACILITY/PROVIDER: ____

PHONE#: ______________________________ **FAX#:** ______________________________

TO RELEASE:

______________ **X-RAY REPORTS**
______________ **CT SCAN REPORTS**
______________ **MRI REPORTS**
______________ **OTHER:** ____
______________ **ALL MEDICAL RECORDS**

FOR DATE OF SERVICE OF: ____

RELEASE THESE RECORDS TO:
A. ROY ROSENTHAL, ANDREW J. SIEKANOWICZ AND ASHOK L. GOWDA, MD

VIA FAX ______________________ **(301) 681-0800 OR (301) 681-3367**

VIA MAIL _____________________ **10313 GEORGIA AVE., SUITE 107 SILVER SPRING, MD 20902**

ONCE THE RECORDS ARE RECEIVED, THEY WILL BECOME PART OF THE PATIENTS' PERMANENT MEDICAL RECORDS.

____ ________________________
PATIENT SIGNATURE: **DATE**

UNDERSTANDING YOUR HEALTH RECORD & INFORMATION: Each time you visit the hospital, physician, or other healthcare provider, a record of your visit is made: typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as basis for planning your care and treatment and serves as a means of communication among the many health professionals who attribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS: unless otherwise required by law your health record is the physical property of the healthcare practitioner or facility that complied it; the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. You may obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to he extent that action has already been taken.

OUR RESPONSIBILITIES: this organization is required to maintain the privacy of your health information, and in addition, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice; notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided. If we maintain a Web site that provides information about our customer services or benefits we will post new notice on the Web site. We will not use or disclose your health information without your authorization, except as describe in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We will use your health information for treatment. For example: Information obtained by a health care practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. By way of example, your physician will document in your record their expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations (example varies by practitioner type). We will also provide your other practitioners with copies of various reports that should assist them in treating you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular heath operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates. There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory test, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job weqve asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Directory (inpatient settings): Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends or any other person you identity, health information relevant to that persong involvement in your care or payment related to your care.

Research (inpatient): We may disclose information to researchers when an institutional review board, that has reviewed the research proposal and established protocols to ensure the privacy of your health information, has approved their research.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as a part of fundraising effort.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As require by law we may disclose your health information to public health or legal authorities charged with tracking births and deaths, ad well as with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your heath and the heath and safety of other individuals. An inmate does not have the right to the Notice of Privacy Practices.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate heath oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Notice of Practices availability: This notice will be prominently posted in the office where registration occurs and patients will be provided with a hard copy.

Effective Date: This notice will be effective form April 14, 2003.

Modification & Amendment: This notice may be modified or amended by other documents, upon notification from your healthcare provider

We believe that your health information is private to you. We make every effort to protect your information from unnecessary disclosure. Some of the characteristic of our practice include the following procedures:

We may use sign-in sheet to facilitate patient visits.

When legally appropriate, we shred information that may contain protected healthcare information.

We employ firewalls and passwords to protect your information form unauthorized individuals.

We educate our staff as to the importance of protecting healthcare information.

We require your written authorization prior to disclosing information to sources not defined in this document.

You may revoke your written authorization at any time by sending us a written request.

This educational publication is licensed and authorized by the Montgomery County Medical Society (Montgomery County MD. http://www.mcmedsoc.org) and is certified to be HIPPA complaint at the time of printing (March 2003)

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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.

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have question or would like additional information, please contact the HIPPA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filling a complaint.

Drs. Rosenthal & Siekanowicz, L.L.C.

10313 Georgia Ave. Suite 107
Silver Spring, MD 20902-5006
301-681-3100 * 301-681-3367(fax)

Notice of Our Privacy Practices