PINNACLE
Orthopedic & Spine Specialists

Welcome to Pinnacle Orthopedics & Spine Specialists

General Information & Policies

Please keep this page for your records

Clinic Office Hours: 7:30 AM – 4:00 PM Mon-Fri
Phone Hours: 7:30 AM – 5:00 PM Mon- Thurs
7:30 AM – 4:30 PM Fri
After-hour call service is available for emergencies outside of business hours

- Co-pays, co-insurance, and deductibles are due at time of check-in for each visit in compliance with federal regulations. High deductible plans which have not yet reached the deductible amount will require payment in full at time of the appointment. Payments are accepted by cash, check, or credit card.

- Insurances- The patient is expected to present valid insurance card and identification at each visit. The patient is responsible to update the practice of any new injuries or insurance coverage at the time of appointment scheduling. If changes need to be made at the time of the appointment and information is not available, you may be asked to reschedule. The patient is responsible to be aware of their insurance coverage, policy provisions, and authorization requirements.

- Cancellations/No shows- Please notify us as soon as possible with any changes to appointments to avoid delays in your care. Cancellations within 24 hours of appointment time will be considered failure to attend appointment, or "no show" as it does not allow us adequate time to fill the appointment slot. A fee of $50 may be charged for any appointment missed or not cancelled before 24 hours of scheduled visit. Three or more missed appointments may result in discharge from the practice.

- Walk-Ins/Same day appointments- Visits are by appointment only. If you require a sooner appointment, please call our scheduling department and we will do our best to accommodate you.

- Reminder Calls/Texts- Automated reminder calls are made 5 days prior to appointments. Texts are sent 2 days prior at which point you will be given the option to confirm or cancel the appointment. Please inform us of any phone number changes to allow us to reach you regarding your care.

- Disability form completion requires a payment of $15 for standard forms, and $20 for FMLA/PFMLA. The fees are due at the time of form submission and cannot be billed to insurance. Please allow 5-7 business days for completion.

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Patient Medical Profile

Patient Name: _____ **Birth Date:** _____/_____/_____
Month Day Year

Patient Contact Information: Primary: (_____)_____-_____ Secondary: (_____)_____-_____

Address: _____

Primary Care Doctor: Name: _____ Phone: (_____)_____-_____

Address: _____

Referring Provider: Name: _____ Phone: (_____)_____-_____

Address: _____

Preferred Pharmacy: Name: _____ Phone: (_____)_____-_____

Address: _____

Personal Health Insurance Plan: _____ Claim #:_____

Primary Complaint ***(What is the reason for your visit today?)***

_____

Is your injury a result of: Work Injury / Car Accident / Other Injury / No Specific Injury
(circle one)

Date the injury occurred (if applicable) _____/_____/_____

Have you had previous treatment for this injury/body part?

☐ YES Where? _____ ☐ No Treatment

Have you had any imaging/testing since onset? (circle all that apply)

☐ YES MRI / CT / EMG / X-Ray Where? _____ ☐ No Testing

Have you had any physical/occupational therapy visits for this injury?

☐ YES Where? _____ ☐ No Therapy

Employer (Worker's Comp only): _____ Occupation: _____

Work Status ☐ Unemployed ☐ Not working due to injury ☐ Not working prior to injury

☐ Working ☐ Working with restrictions ☐ Disabled ☐ Retired

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Medications ***(Please list all OTC and prescription medications)*** ☐ **NO CURRENT MEDICATIONS**

_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergy Information ☐ **NO KNOWN ALLERGIES**

Medication	Reaction/Severity (ex. Mild Rash)	Approximate Date of Onset
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgical History: (*Please list ALL previous surgeries)* ☐ **NO PREVIOUS SURGERIES**

Surgery	Date of surgery	Performing Surgeon/Office
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Problems with Anesthesia? ☐ No ☐ Yes – Describe:_____

Birth Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Smoking: ☐ Non-smoker ☐ No, previous smoker ☐ Yes ____ pack(s) per day for ____ years

Alcohol: ☐ None ☐ Yes _____ Drink(s) per day / week / month
(Circle one)

Patient Medical History: (*Indicate with an "x" for all that apply)* ☐ **NO MEDICAL CONDITIONS**

Lungs/Pulmonary Disorders: ☐ Tuberculosis ☐ Emphysema ☐ Pulmonary Embolism
☐ Pneumonia ☐ Sleep Apnea ☐ Respiratory Arrest ☐ COPD
☐ Asthma- If yes, how many years? _____ Do you use an inhaler? ☐ Yes ☐ No

Cardiac/Heart Disorders: ☐ Congestive Heart Failure ☐ Irregular Heart Beat ☐ Deep Vein Thrombosis (DVT)
☐ Bleeding Problems ☐ Heart Attack ☐ Chest Pain/Angina ☐ Heart Murmur/Valve disorder
☐ High Blood Pressure ☐ Mitral Valve Prolapse ☐ Peripheral vascular disease

Neurologic Disorders: ☐ Parkinson's Disease ☐ Cerebral Palsy ☐ Peripheral Neuropathy
☐ Stroke/TIA ☐ Polio ☐ Multiple Sclerosis (MS)

Bone & Joint Disorders: ☐ Scleroderma ☐ Osteoarthritis ☐ Ankylosing Spondylitis
☐ Rheumatoid Arthritis ☐ Osteomyelitis ☐ Gout ☐ Lupus

Gastrointestinal Disorders: ☐ Peptic/Stomach Ulcer ☐ Liver Disease ☐ GI Bleed/Bleeding Ulcer
☐ Diverticulitis ☐ Hepatitis- Type _____ ☐ Acid Reflux/GERD ☐ Colitis/ IBS

Genitourinary Disorders: ☐ Kidney Issues ☐ Kidney Stones ☐ Bladder Issues
☐ Dialysis (Kidney Failure) ☐ Chronic UTIs

Metabolic & Other Disorders: ☐ Depression ☐ Anxiety ☐ Psoriasis
☐ Thyroid Problems ☐ Sickle Cell Disease ☐ Alcohol Dependency ☐ Drug Dependency
☐ Tooth Abscess ☐ High Cholesterol/Lipids ☐ HIV+ / AIDS ☐ Cancer _____

Other Medical Problem not listed above: _____

Family Medical History: (*Indicate with an "x" for all that apply)* ☐ **NO MEDICAL CONDITIONS**

☐ Asthma ☐ Tuberculosis ☐ Sleep Apnea ☐ COPD/Emphysema
☐ Irregular Heartbeat ☐ Bleeding Problems ☐ Heart Attack ☐ Peripheral Neuropathy
☐ MS or Parkinson's ☐ Osteoarthritis ☐ Lupus ☐ Rheumatoid Arthritis
☐ Gout ☐ Acid Reflux/GERD ☐ Hepatitis _____ ☐ Inflammatory Bowel (IBS)
☐ Liver Disease ☐ Diabetes ☐ Kidney Problems ☐ Kidney Failure/ Dialysis
☐ Psoriasis ☐ Thyroid Problems ☐ High Blood Pressure ☐ High Cholesterol/ Lipids
☐ Sickle Cell Disease ☐ Skin Ulcer ☐ Anesthesia Issues ☐ Malignant Hypothermia
☐ Congestive Heart Failure ☐ Cancer- type(s)_____

Other Medical Problem not listed above: _____

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HIPPA Protection/Authorization to Disclose Health Information

We will not divulge any information regarding your treatment, appointment dates/times etc. without your written consent. By completing and signing this form you authorize your healthcare provider to file medical reports with the parties you choose by checking the boxes below or naming them individually. Failure to execute this authorization may interfere with your ability to obtain any benefits such as Social Security, Disability, or Worker's Compensation benefits.

*Please note, a copy of your narrative note(s) will not automatically be sent to contacts listed.

_____	_____-_____-_____	_____/_____/_____
Patient Name	Social Security Number	Date of Birth

I authorize my treating healthcare provider to disclose my health information, including billing records to the following parties:

( ) Worker's Compensation Board

( ) Worker's Compensation Carrier & representatives thereof (Adjusters/Nurse Case Managers)

( ) Current/Former Employer

( ) No-Fault Insurance Carrier

( ) Current/Former Private Health Insurance Company

( ) Individuals listed on the lines below

In the space provided below, please print clearly any person(s) to whom we may provide information. In this space you may choose to include **family members, treating physicians, and attorney** if applicable.

_____	_____/_____/_____
Patient Signature	Date of Birth

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Provider Notice of Privacy Policies

This notice describes how medical information about you may be used and disclosed, and how you may access this information.

Uses and Disclosures: We use health information about you for treatment, to obtain payment or treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your Rights: In most, cases, you have the right to look at or get a copy of health information about you. If you request your medical records and come to the office to pick them up, we will provide you with a CD at no cost. You also have the right to receive a list of list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request corrections to the existing information.

Our Legal Duty: We are required by law to protect the privacy of your information, provide this notice about our informational practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to U.S. Department of Health and Human Services (65 Court Street, Suite 506, Buffalo NY 14202)

If you have questions or complaints, please contact:
CEO- Brent T Boeing, MBA
Address- 700 Michigan Ave, Buffalo NY 14203

_____ _____/_____/_____

Patient Signature Date

_____

Patient Printed Name

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Patient Treatment Waiver

Patient Name: _____ Date: ____/____/_____

Provider Name(s): Dr. A. Marc Tetro, MD, Dr. Zair Fishkin, Dr. Cameron Huckell, Dr. Graham Huckell, Dr. Matthew Rubacha, Dr. Meghan Richli

I understand that the physician I am seeing today is a specialist, not my Primary Care Physician and it is my responsibility to verify that this provider participates with my healthcare plan. If the provider does not, I assume the resulting financial responsibility for services rendered.

Additionally, if a referral letter or authorized referral number is required and has not been provided at time of scheduling assuring it is a covered benefit, and I agree to continue with today's visit, I therefore assume responsibility for paying the bill for services rendered.

_____

Patient Signature

Insurance Authorization

I authorize the release of any of my medical information necessary to process my insurance claims. I also authorize that this authorization will cover all medical services rendered until such authorization is revoked by me. I understand that I am financially responsible for any balance not covered by my insurance carrier. In the event of my failure to pay any sums due and my account is referred to a collection agency, I agree to be responsible for all applicable fees. A copy of my signature below is as valid as the original. I agree that a photocopy of this form may be used in lieu of the original.

_____

Patient Signature

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No-Fault Questionnaire

To be completed for automobile- related accidents

Patient Name: _____ Date of Birth: ____/____/_____

Adjuster Name: _____ Adjuster Phone:(____) _____ -_____

Insurance Carrier:_____ Claim Number:_____

Date of Accident: ____/____/_____ Time: _____ AM / PM Location of Accident: _____

1. Number of occupants in the vehicle: _____
2. Where were you positioned in the vehicle?
   - ☐ Driver seat
   - ☐ Front Passenger Seat
   - ☐ Back seat- Driver side
   - ☐ Back seat, Middle
   - ☐ Back seat- Passenger side
3. Please check all that apply:
   - ☐ Airbag deployed
   - ☐ Airbag did NOT deploy
   - ☐ Lap belt ONLY
   - ☐ No Seatbelt worn
   - ☐ Seatbelt & Shoulder belt
   - ☐ Headrest Present
   - ☐ No Headrest
   - ☐ Loss of Consciousness
4. What kind of car were you in? _____ (Make) _____ (Model) _____ (Year)
5. Other vehicle(s) involved? ☐ No ☐ Yes- Describe: _____
6. List all injuries you sustained in the accident: _____
7. Did you receive medical care following the accident for the specific body part we are seeing you?
   - ☐ **No- skip to question 8**
   - ☐ Yes- complete the section below

7a. When did you receive treatment? _____

7b. Where did you receive treatment?_____

7c. What was the given diagnosis? _____

7d. What testing/treatment was ordered?_____

7e. Was medication prescribed? ☐ No ☐ Yes- _____

7f. Was surgery performed? ☐ No ☐ Yes- _____

7g. Have you had the following? ☐ Physical Therapy ☐ Chiropractic ☐ Other: _____

Location(s): _____

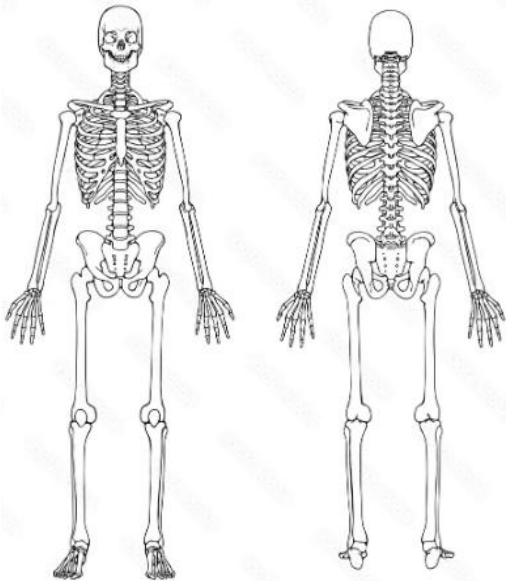
8. Were you employed at the time of accident? ☐ **No- Skip to question 9**
☐ Yes- Complete the following section

8a. Did you lose any time from work? ☐ No ☐ Yes- Dates: _____
8b. Have you returned to work? ☐ No ☐ Yes- Light Duty ☐ Yes- Full duty

9. Do you have any hobbies/recreational activities? List even if unable to do since the accident.

☐ No ☐ Yes- Describe: _____

10. Using the diagram below, draw an arrow to any area(s) you had pain IMMEDIATELY FOLLOWING the accident:



11. Using the diagram below, draw an arrow to any area(s) you had pain in the DAYS AFTER the accident: