Nirschl Orthopaedic Center

Thank you for scheduling an appointment with Nirschl Orthopaedic Center.

This e-mail contains important instructions. Please read the e-mail in its entirety before proceeding with the registration forms.

ALL registration documents **MUST** be completed prior to seeing the physician you are scheduled with no later than the business day before your scheduled appointment. Failure to do so may result in the appointment being cancelled.

You **DO NOT** need to print these forms. Once you have completed the forms, you will be prompted to electronically sign them. Once the forms have been successfully submitted, you will receive a confirmation email.

The day of your visit:
Please bring your picture ID, insurance card, and any records that you would like reviewed during your appointment. (Ex: MRI reports & discs, x-ray discs, EMG reports, etc.) You **MUST** arrive 15 minutes prior to your appointment, or your appointment will be rescheduled. If you are going to be late, please call the office at (703) 525-2200. **If you are more than 15 minutes late, your appointment will be rescheduled.**

OFFICE ADDRESS:
1715 North George Mason Drive, Suite 504, Arlington, VA 22205
(Medical Office Building "D" located on the Virginia Hospital Center Campus)
We are located on the 5th Floor.

PARKING:
Parking Garage "C". There is a flat rate fee of **$7.00** for parking.
You can purchase discounted validations at the Cashier's Office. They ONLY come in a pack of 5 for $30.00 ($6.00 each).

Important COVID-19 office policies for visiting our office:

1. Masks are optional and available upon request.
2. Patients that have a scheduled appointment are allowed one patient care companion during their visit.
3. Please reschedule your appointment if you are experiencing any COVID symptoms such as: coughing, fever (100.4 or higher), loss of smell/taste, chills, or other flu like symptoms. Telemedicine appointments will be offered on a case-by-case basis.

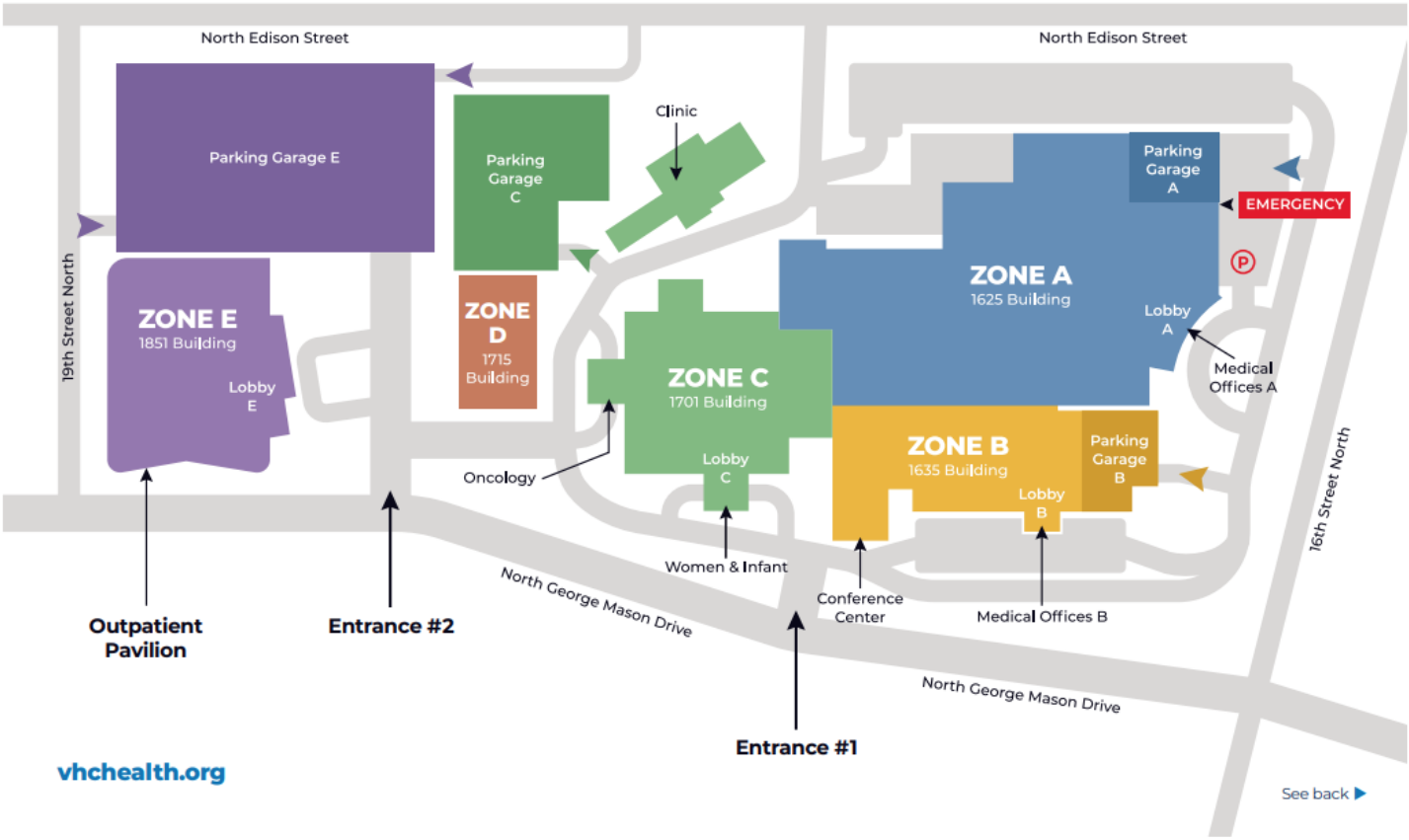
These precautions are being implemented for both the safety and well-being of all the Nirschl Orthopaedic Center patients and Team Members. Please call if you have any questions regarding any of the information above. Again, thank you for choosing Nirschl Orthopaedic Center, and we look forward to seeing you!

Nirschl Orthopaedic Center

Campus Directory

VHC Health Main Campus

VHC HEALTH™



Patient Registration

Patient Name: _____
Last **First** **Middle**

Date of Birth: _____ Sex: ☐Male ☐Female ☐Other: _____

Cellphone: _____ Home: _____ Work: _____

Address: _____ Zip Code: _____

Email: _____

Primary Insurance

Ins Company: _____ Address: _____

Member ID: _____Group/Enrollment #: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Secondary Insurance

Ins Company: _____ Address: _____

Member ID: _____Group/Enrollment #: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Emergency Contact

Name: _____ Relationship: _____Phone#: _____

I acknowledge that I was made aware of Nirschl Orthopaedic Center's Privacy Policy and a copy was available for my review (online and in the office).

I authorize the following person(s) to have access to my protected health information (PHI):

Name:	Relationship to patient:
_____	_____
_____	_____

I HEREBY AUTHORIZE NIRSCHL ORTHOPAEDIC CENTER/VIRGINIA SPORTSMEDICINE INSTITUTE TO SUBMIT FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED. I REQUEST PAYMENT FROM INSURANCE COMPANIES TO BE MADE DIRECTLY TO THE NIRSCHL ORTHOPAEDIC CENTER. PAYMENT OF SERVICES: I REALIZE THIS MAY NOT REPRESENT THE FULL PAYMENT FOR SERVICES RENDERED AND I WILL BE RESPONSIBLE FOR BALANCE DUE. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I FURTHER ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCES, DEDUCTIBLES, CO-PAYS, AND MISSED APPOINTMENT FEES NOT COVERED BY MY INSURANCE PLAN. ANY ACCOUNTS NOT PAID IN A TIMELY FASHION WILL BE REFERRED TO AN OUTSIDE COLLECTION AGENCY. I UNDERSTAND I WILL BE RESPONSIBLE TO PAY COLLECTION AGENCY FEES AND/OR ATTORNEY FEES IN THE AMOUNT OF 33% OF THE OUTSTANDING BALANCE AS WELL AS ANY COURT COSTS ASSOCIATED WITH THE COLLECTION PROCESS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL ASSIGNMENT. THIS AUTHORIZATION IS IN EFFECT FOR ALL FUTURE CLAIMS UNTIL I GIVE WRITTEN NOTICE TO REVOKE IT.

Patient Signature (Parent/Legal Guardian if patient is a minor): _____ **Date:** _____

Nirschl Orthopaedic Center

Patient Health History

Patient's Last Name: _____ **First:** _____ **MI:** _____
Date of Birth: _____ **Height:** _____ **Weight:** _____ **Sex:** ☐ Male ☐ Female ☐ Other
Primary Care Physician: _____
Pharmacy Name & Phone: _____
Current or recent occupation: _____
How did you hear about us? PCP/Friend/Internet? _____
Activities/Goals/Hobbies: _____

CHIEF COMPLAINT

What are you seeing the doctor for today? _____ ☐ **Left** ☐ **Right**
When did this problem start? _____
Have you been treated for this problem before? ☐ **Yes** ☐ **No** **If yes, when, and where?** _____
Have you had any of the following for THIS problem? Please list facility/doctor for each:
☐ **EMG/NVC** _____ ☐ **MRI** _____ ☐ **CT** _____ ☐ **X-ray** _____
Have you been diagnosed with any medical conditions? ☐ **No** ☐ **If YES, please list the condition(s) below:**

_____

The following questions are regarding different tests and immunizations that may or may not apply to you/the patient. If you are not sure of the exact date of the test, procedure, or immunization, please list at least the year to the best of your recollection.

	Not Applicable	Date
If you are a **female** patient between the ages of 51-74, when was your most recent **Breast CA screening (mammogram)**?	☐	
If you are a **female** patient between the ages of 23-64, when was your most recent **Cervical CA screening (pap test)**?	☐	
If you are a patient between the ages of 50-70, when was your most recent **Colorectal CA screening (Colonoscopy, Sigmoidoscopy or FOBT)**?	☐	
For patients 6 months and older, when was the most recent **influenza immunization** administered?	☐	
If you are a patient **65 or older**, when was your most recent **pneumonia vaccination** administered?	☐	

Do you have any GENERAL ALLERGIES and/or ALLERGIES to MEDICATIONS?
☐No ☐ Yes - If yes, please list the **GENERAL ALLERGIES and/or ALLERGIES to MEDICATIONS below:**

Allergy	Reaction

Nirschl Orthopaedic Center

Patient Health History Continued

Patient Name: _____
Last **First** **Middle**

Date of Birth: _____ Sex: ☐Male ☐Female ☐Other: _____ Date: _____

Please list ANY MEDICATIONS you are CURRENTLY taking.		
Name of Medication	Dosage	How Often Taken

SURGERIES and/or HOSPITALIZATIONS	
Have you ever had any problems with anesthesia (being numbed or put to sleep)?	☐ No ☐ Yes - If yes, please list type of problems below:
Have you ever been hospitalized for non-surgical reasons?	☐ No ☐ Yes - If yes, please list the reasons below:

Please list ANY SURGERIES and/or PROCEDURES you have had including the specific body part and date		
Surgery or Procedure	Specific Body Part	Date

Notice of Disclosure of Ownership Interest

Virginia Sportsmedicine Institute (VSI) is wholly owned by Nirschl Orthopaedic Center; however, you may seek physical therapy treatment at outside facilities.

By my signature below, I am acknowledging this Notice of Disclosure of Ownership Interest.

_____ _____

Patient Signature (Parent/Legal Guardian if patient is a minor) **Date**

_____ **DOB:** _____

Patient Name Printed

Financial Policy Statement

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of the charges incurred. The office will file verified insurance for payment of bills as a courtesy to the patient, but not all services are covered by all insurance companies. *It should be understood that by accepting the services, the patient is responsible for payment.* We do not submit to third-party payors.

Co-payments and deductibles must be paid upon the patient's arrival. If you have an outstanding balance, we appreciate prompt payment in full. If you are unable to make payment in full, please inquire about arranging a payment plan with our billing department. Additionally, it is your responsibility to provide any necessary referral information to us that your insurance company requires prior to your visit. It is extremely important that you notify us of any changes to your insurance information prior to each visit. Failure to do so can lead to unpaid/denied claims that the patient will be responsible for.

Our staff may assist you with insurance questions; however, it is your responsibility as the patient to know and understand your medical benefits.

There may be occasions when your course of treatment requires the use of an orthopedic appliance or brace to facilitate your rehabilitation. Some insurance companies do not cover durable medical equipment. If you have any questions regarding this appliance or brace, do not leave the office with it in your possession. Due to health regulations braces, shoe inserts, gloves, putty, or any other such item cannot be returned.

If you fail to provide us with a 24-hour notice of cancellation or no-show to your scheduled appointment, we reserve the right to charge you a $50 no show fee.

Surgery Deposit Policy: Our office requires a $250.00 surgical deposit to reserve your procedure(s) time with your surgeon. If you are unable to keep a scheduled surgery appointment you must provide us with 7 business days' notice. If you fail to do so, we reserve the right to charge you a $250.00 fee.

The administrative staff and management welcome the opportunity to discuss any aspect of our financial policy. We appreciate your confidence and strive to provide quality healthcare.

_____ _____

Patient Signature (Parent/Legal Guardian if patient is a minor) **Date**

_____ **DOB:** _____

Patient Name Printed

Dr. Root's New Patient & New Complaint Upper Extremity History Form

Patient Name: _____
Last **First** **Middle**

Date of Birth: _____ Sex: ☐Male ☐Female ☐Other: _____ Date: _____

Why are you seeing Dr. Root today? ☐ Right ☐ Left

_____

Date of onset of your upper extremity problem: _____

Describe your symptoms:

_____

_____

Please check your level of pain: ☐0 ☐1 ☐2 ☐3 ☐4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐9 ☐ 10

What makes your symptoms better?

_____

What makes your symptoms worse?

_____

Please provide details of any prior:

Treatment by another medical provider(s)?

_____

_____

☐ X-Rays ☐ MRI ☐ CT ☐ EMG/NCS – Please provide the facility & the date:

_____

_____

☐ Physical/Occupational Therapy – Please provide the location & the # of visits:

_____

☐Injections – Please provide the number & date of the most recent:

_____