



Gerard Librodo, M.D.

Joshua Klemp, M.D.

Patient Information

Patient Name: Last _____, First _____, M.I. _____

Street Address: _____ City _____ State _____ Zip _____

S.S. #: _____ Sex: ___ M ___ F Birth Date: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Email: _____

Employer: _____ Occupation: _____

Spouses Name: _____ DOB: _____ Cell Phone: (____) _____

Emergency Contact:

Full Name: **(NOT SELF)**: _____ Relationship: _____

Street Address: _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

DPOA: () Yes (If yes, Name & Phone #): _____

() No

Health Insurance Information

I do not have health insurance; I will be self-paying. () ****See financial policy for payment details on page 7****

Notice: Be prepared to present insurance card(s) and driver's license upon arrival of your appointment.

Primary Health Insurance	Secondary Health Insurance
---------------------------------	-----------------------------------

Name of Insurance Co. _____

Phone Number: _____

Claims Address: _____

Claims City: _____ Claims State: _____

Claims Zip Code: _____

Policy Holder Name: _____

Member ID of Patient: _____

Group Number of Patient: _____

Employer: _____

Date of Birth: _____

Phone #: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Name of Insurance Co. _____

Phone Number: _____

Claim Address: _____

Claims City: _____ Claims State: _____

Claims Zip Code: _____

Policy Holder Name: _____

Member ID of Patient: _____

Group Number of Patient: _____

Employer: _____

Date of Birth: _____

Phone #: _____ Address: _____

City: _____ State: _____ Zip Code: _____

I ACCEPT PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES FOR SERVICES RENDERED TO ME. I AUTHORIZE PAYMENTS OF MEDICAL INSURANCE BENEFITS TO FLINT HILLS ORTHOPAEDICS I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signature of Patient/Insured: _____

Date: _____

Insured Signature (If other than patient): _____

Date: _____

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE
---------------------	---------	----------	------

Past Medical History

Please check all that apply

Head		Gastrointestinal		Psychiatric	
Trauma		Cirrhosis		Bipolar Disorder	
		GERD		Depression	
Eyes		Gallbladder Disease		Dementia	
Blindness		Heartburn		Hallucination/Delusions	
Cataracts		Hemorrhoids		Suicidal Ideations	
Glaucoma		Hepatitis (Type)		Suicide Attempt(s)	
Glasses/Contacts		Hiatal Hernia			
		Jaundice		Endocrine	
Ears		Ulcers		Goiter	
Hearing aids				Hyperlipidemia	
		Genitourinary		Hypothyroidism	
Nose/Sinuses		Hernias		Hyperthyroidism	
Allergic Rhinitis		Incontinence		Thyroid Disease	
Sinus Infections		Kidney Stones		Type 1 DM	
		Other Kidney Disease		Type 2 DM	
Mouth/Throat/Teeth		STD's			
Dentures		UTI(s)		Heme/Oncology (Cancer)	
				Anemia	
Cardiovascular		Musculoskeletal		Cancer (Type)	
Aneurysm		Arthritis			
Angina		Gout		Infectious Disease	
DVT		M/S Injury		HIV	
Dysrhythmia				STD's	
Hypertension (HTN)		Skin		TB (disease)	
Murmur		Dermatitis		TB (exposure)	
Myocardial Infarction		Mole(s)			
		Others			
Respiratory		Psoriasis			
Asthma					
Bronchitis		Neurological			
COPD		Epilepsy			
Pleuritis		Seizures			
Pneumonia		Severe HA/Migraines			
		Stroke(s)			
		TIA's			

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE
---------------------	---------	----------	------

Past Surgical History

Year	Procedure Type	Year	Procedure Type

Family History

Please Indicate family history of the following where **(M)** = Mother; **(F)** = Father.

	(M/F)		(M/F)		(M/F)
Arthritis		Asthma		Type 1 Diabetes	
Dementia		COPD		Type 2 Diabetes	
Hypertension (HTN)		Cancers (Type)		Kidney disease	
Chest Pain		Seizures		Osteoporosis	
Gout		Congestive Heart Failure		Clotting disorders	

Review Of Systems:

Please check *all that apply* for the PAST MONTH.

- | | | | |
|------------------|-----------------------|-------------------------|---------------------------|
| ◇ Recent illness | ◇ Shortness of breath | ◇ Chest pain | ◇ Change of appetite |
| ◇ Fever | ◇ Bowel incontinence | ◇ Urinary incontinence | ◇ Generalized muscle pain |
| ◇ Rash | ◇ Seizures | ◇ Heat/cold intolerance | ◇ Bleeding tendencies |

Physical Therapy in the past 6 months: () Yes () No

Location: _____ How Long: _____

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE
---------------------	---------	----------	------

SOCIAL HISTORY

What is your smoking status?

- ◇ Current every day smoker
- ◇ Current some day smoker
- ◇ Former smoker
- ◇ Heavy tobacco smoker
- ◇ Never smoker

Alcohol use:

- ◇ Do not drink
- ◇ Drink daily
- ◇ Frequently drink
- ◇ History of alcoholism
- ◇ Occasional drink



Gerard Librodo, M.D.

Joshua Klemp, M.D.

FINANCIAL POLICY

Thank you for choosing *Flint Hills Orthopaedics* as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy. We required you to read and sign this policy before any treatment can be rendered.

MISSED APPOINTMENT: We reserve the right to charge a fee of \$25 for all missed appointments that are not cancelled with a 24-hour advance notice. This fee will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Patients that have **3 "NO SHOWS"** for appointments, without calling prior to the appointment to reschedule may receive notification of termination from the practice and will no longer be scheduled for appointment.

COPAYS: You will be expected to pay your copay prior to seeing your physician. If you are unable to pay, you will be required to reschedule your appointment.

Uninsured Patient: A deposit of \$230.00 will be collected at the time of the patient's first visit. Additionally, patient will be asked to **pay additional deposit of \$80.00 for each subsequent visit plus other possible procedure expenses (i.e. Casting/Splinting Supplies, Braces, Injections, etc.).** You may be asked to reschedule your appointment if your deposit is not received at this time of service.

PAYMENT FOR SERVICES: All patients must complete a patient information form and provide insurance information, if appropriate, or make payment arrangements prior to leaving the clinic.

Payment in full: Payment in full is expected and can be made by cash, check, or credit card. Please remember we accept *Visa, Master Card, or Discover.*

Payment Plan: If you are unable to pay the account in full, financial arrangements will be established based on the following guideline. When establishing a payment plan, the patient (or their guarantor) will sign a contract agreement with the 1st payment due upon signing the contract. This approach requires a minimum payment of \$25. The contract will specify the dollar amount of subsequent payments and the day of the month the payments will be made. When you set up a payment plan, you will continue to receive a monthly statement. If you miss one (1) payment and fail to bring the account current by the due date of the following payment, the account will be referred to the clinic's collection agency.

Patient Due Balances of \$500 or less will be set up on a 90-day payment plan.

Patient Due Balances of \$501-\$1,000 will be set up on a 180-day payment plan.

Patient Due Balances of \$1,000+ will be set up on a 1-year payment plan.

If you anytime you are unable to make payment in full, please contact **Penny Nielsen** at **316-252-8668** to make reasonable payment arrangements.

COMPLETION OF FORMS: (Disability, FMLA, Physician Statements, Etc.) A \$25 charge will be assessed per form. Prepayment is required before the form(s) will be completed.

MINOR PATIENTS: If you are a minor, your parents and/or guardian need to accompany you to our office before treatment can be rendered, you will need to make arrangements prior to being see with your parent and/or guardian for payment to be made at the time of treatment.

LAB: In the event we need to have a lab drawn, our office uses an outside laboratory service. You will receive a separate bill for the lab services.

UNIFORM APPLICATION OF PLOICY: This policy will apply to all patients, employees, or others who present themselves for services (at any time, including any future visits).

It is always your responsibility to see that your account is paid, regardless of insurance or any other circumstances (such as litigation). The patient responsible for costs associated with collecting said owed balances, including but not limited to collection agency fees, attorney fees, and court costs. I have read, understand, and agree to adhere to the above Financial Policy.

Signature of Patient or Responsible Party

Date



Gerard Librodo, M.D.

Joshua Klemp, M.D.

PERMISSION TO GIVE OUT INFORMATION

Please list below only the names of the person and/or persons that you wish to give permission for our staff to speak with regarding your medical and/or financial information.

I, _____, hereby grant the physicians and staff of Flint Hill Orthopaedics permission to speak with the following people about my health and well-being.

Effective Date: _____

Name: _____

Relationship: _____

Telephone Number: _____
Home Work Cell

The following information may be given to the above individual (check all that apply):

- Appointment Time
- Financial Information
- Test/Lab Results
- Medications
- Procedures
- Other Information Regarding My Health

Name: _____

Relationship: _____

Telephone Number: _____
Home Work Cell

The following information may be given to the above individual (check all that apply):

- Appointment Time
- Financial Information
- Test/Lab Results
- Medications
- Procedures
- Other Information Regarding My Health

I understand I may revoke this consent at any time by giving written notice to Flint Hills Orthopaedics.

Signed: _____

Date: _____

Informed Consent and Risk/Benefits Notice for Treatment of Chronic, Non-Malignant Pain with Controlled Substances

Your doctor may diagnose you having a condition that causes you pain. Your doctor may recommend that you treat your painful condition with opioids to reduce your pain and improve your infection. Your doctor wants you to know that there are alternatives to the proposed medications therapy, including physical therapy, chiropractic therapy, acupuncture, psychotherapy, percutaneous neuromodulations therapy, and interventional modalities (such as epidural steroid injections, etc.). There are also other types of medications such as NSAIDS, Cox 2 inhibitors, muscle relaxants, antidepressants, antiseizure medications, and certain blood pressure medications. Your doctor wants you know that as with the use of any medication, there are potential side effects and risks associated with the use of the above – named controlled substances, including:

- Sleepiness, confusion, difficulty thinking
- Nausea, vomiting, constipation
- Difficulty breathing, shortness of breath, wheezing
- Rash, itching
- Potential for allergic reaction
- Potential for interaction with other medications (increasing effects or side effects of drugs taken together)
- Potential for dose escalation/tolerance (need to higher doses for the same effect may occur with long term use)
- Potential for dependence (after the body adjusts to these medications, they cannot be stopped abruptly without causing physical symptoms)
- Potential for withdrawal (stopping medications abruptly may cause nausea, vomiting abdominal pain, sweating, aching, abnormal heartbeat or other symptoms that can be life threatening; medications changes should be under provider supervision)
- Potential for addiction (compulsive drug use not related to pain relief)
- Potential for impaired judgment and/or motor skills (driving or operating machinery may be hazardous due to effects on the brain and nerves)
- Potential overdoses from fentanyl patch if they are used in a Jacuzzi or other environment.

This treatment agreement is a platform for communication allowing us to work together in good faith and for you to understand the importance of this medication in allowing you to function better.

NOTE: Flint Hills Orthopaedics normally prescribes pain medication ONLY for post-operative patients for 6 weeks post-op and then you will have to contact your PCP for any further medications.

1. You will take the medication exactly as prescribed and will not change the medication dosage and/or frequency without the approval of your physician, physician assistant, and/or nurse practitioner.
2. The controlled substance pain medication prescribed is being given in order to control pain and allow you to function better. If there are any changes to your activity level or physical condition, the treatment may be changed or discontinued.
3. You agree to act responsibly, including protecting and limiting access to these medications, and to dispose of any unused medication in a proper manner.
4. We expect you not to accept or seek controlled substance medications from other physicians or healthcare providers outside of our practice during your 6-week POST OP care with care.
5. You agree that Flint Hills Orthopaedics may request and use your prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.
6. You understand that it is important to use one pharmacy for all prescriptions in order to provide consistency.
7. You understand that lost, stolen, or misplaced prescriptions will not be replaced. All patients are expected to act responsibly with medication. This medication is prescribed for you and only your needs for pain control. To allow others to use your pain medication is illegal and will not be tolerated by your physician or our practice.

Patient Signature: _____

Date: _____

Patient Signature (Print Name): _____

Witness Signature: _____



Gerard Librodo, M.D.

Joshua Klemp, M.D.

**Acknowledgement of Receipt of Privacy Notice
(HIPAA Brochure)**

I acknowledge that I have received the attached Privacy Notice.

PATIENT

DATE

In the event the patient is unable to sign, a signature by the designated personal representative is acceptable.

Personal Representative

Date