Shoulder & Elbow Center PSC
Michael J. Moskal, MD
130 Hunter Station Way, Suite 201
Sellersburg, IN 47172
Phone 812.248.4789
Fax 812.248.4773
www.shoulderandelbowcenter.com

Last Name: ______________________ **First Name:** __________________ **DOB:** ___________

PATIENT MEDICAL HISTORY

DATE:

Age: __________ **Sex:** M or F **Dominant Hand:** Left or Right **Did you bring x-rays?** Yes or No

Have you ever seen Dr. Moskal before? YES or NO **If yes, when?** ____

Who referred you to see Dr. Moskal? ☐ Self ☐ Another Doctor ______________________ ☐ Other ____________________

Have you had prior imaging(MRI, X-ray, CT) for this problem? ☐ Yes ☐ No, if yes where and what ______________________

Is this work related or due to an auto accident? YES or NO **If yes, please see receptionist for additional forms.**

Did you have an injury? YES or NO **If yes, date of injury** _______________ **How did it happen?** ______________________

____

____

If no injury, how long have you had pain? _____ Days _______ Weeks ______ Months ______ Years

Have you had a trouble with this same problem in the past? Yes or No

Explain ____

The pain was: ☐ GRADUAL ☐ SUDDEN

The pain is: ☐ SHARP ☐ DULL ☐ STABBING ☐ THROBBING ☐ ACHING ☐ BURNING

The pain is: ☐ CONSTANT ☐ COMES AND GOES

When does the pain occur: ☐ DURING THE DAY ☐ AT NIGHT ☐ AWAKENS ME AT NIGHT ☐ WHILE AT WORK ☐ WITH ACTIVITY

Since the pain started, it is: ☐ GETTING BETTER ☐ GETTING WORSE ☐ UNCHANGED

What other symptoms are associated with your pain? ☐ SWELLING ☐ BRUISING ☐ NUMBNESS ☐ TINGLING ☐ WEAKNESS
Explain: ____

What makes your symptoms worse? ☐ Lifting (floor to waist) ☐ Lifting (waist to shoulder) ☐ Lifting (away from body or above head) ☐ Throwing ☐ Exercise ☐ Working ☐ Lying in bed ☐ Sneezing

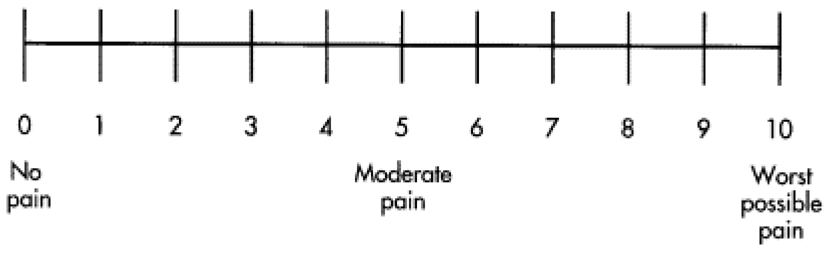
What makes your symptoms better? ☐ Rest ☐ Elevation ☐ Other ____________________________________

Office Notes:

On the diagram below, please CIRCLE where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition. If you have more than one body part, please request additional form from the receptionist.

RIGHT LEFT LEFT RIGHT

Indicate on the line below how you would describe your present pain by placing an "X" on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.



Patient Signature: ______________________________ **Date:**

MEDICAL HISTORY

Have you ever been diagnosed with any of the following medical conditions?

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Alcohol addiction			Hepatitis			Reaction to anesthesia		
Alzheimer’s			High blood pressure			Hypothyroidism/hyperthyroidism		
Anemia			High cholesterol			Rheumatoid arthritis		
Anxiety			HIV			Stomach ulcers		
Depression			Kidney disease			Tuberculosis		
Diabetes			Liver disease			Blood clots (when? where?)		
Drug addiction			Osteoporosis			Blood transfusion (when?)		
Gout			Psoriasis			Cancer (what body part?)		
Heart attack			Stroke					
Heart failure			Seizures					

Please provide details for each medical condition (ex. when diagnosed, treatment, etc.): ______________________________

____

____

____

Any other medical conditions not listed above: ____

____

Do you have sleep apnea? YES or NO If yes, do you wear a CPAP? YES or NO Do you have a machine? YES or NO

What is your setting? _____________

Do you have MRSA? YES or NO Have you ever had exposure to MRSA? YES or NO

SURGICAL HISTORY

Arm Surgeries	Year	Other Surgeries	Year

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following disorders?

CONDITION	YES	NO	WHICH RELATIVE
Diabetes			
High blood pressure			
Heart disease			
Rheumatoid arthritis			

SOCIAL HISTORY

Employer: ____

Occupation or past occupation: ____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Do you live alone? ☐ Yes ☐ No Do you have any children? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No If yes, how much? ____ packs/day for ____ years

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____ drinks/week

REVIEW OF SYSTEMS

Do you CURRENTLY have any of the following:

1. Psychiatric:
- ☐ None
- ☐ Difficulty getting to sleep
- ☐ Nervousness
- ☐ Difficulty getting up
- ☐ Lose of desire to do things that you used to enjoy doing

Explain: ______________________________________

____

2. Musculoskeletal:
- ☐ None
- ☐ Morning stiffness
- ☐ Joint pain
- ☐ Muscle aches
- ☐ Joint swelling
- ☐ Neck pain
- ☐ Back pain

Explain: ______________________________________

____

3. General:
- ☐ None
- ☐ Excessive weight loss without trying
- ☐ Fever
- ☐ Fatigue
- ☐ Weakness

Explain: ______________________________________

____

4. Ears, Nose, Throat:
- ☐ None
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Trouble swallowing
- ☐ Nose bleeds

Explain: ______________________________________

____

5. Cardiovascular:
- ☐ None
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swelling in legs or ankles

Explain: ______________________________________

____

6. Gastrointestinal:
- ☐ None
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in stool or black tarry stools
- ☐ Stomach pain

Explain: ______________________________________

____

7. Skin:
- ☐ None
- ☐ Frequent rashes
- ☐ Itching
- ☐ Sores that won't heal

Explain: ______________________________________

____

8. Endocrine:
- ☐ None
- ☐ Excessive thirst or hunger
- ☐ Hot or cold intolerance
- ☐ Hot flashes
- ☐ Excessive urination

Explain: ______________________________________

____

9. Neurological:
- ☐ None
- ☐ Headaches
- ☐ Dizziness
- ☐ Loss of feeling
- ☐ Pins and needles

Explain: ______________________________________

____

10. Eyes:
- ☐ None
- ☐ Blurred vision
- ☐ Double vision
- ☐ Vision loss
- ☐ Contacts or glasses

Explain: ______________________________________

____

11. Respiratory:
- ☐ None
- ☐ Frequent cough
- ☐ Shortness of breath

Explain: ______________________________________

____

12. Hematological:
- ☐ None
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Bleeding gums
- ☐ Swollen glands

Explain: ______________________________________

____

13. Urinary:
- ☐ None
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Poor/weak stream with urination

Explain: ______________________________________

____

If there is anything you don't understand, please ask.

Any other concerns not listed above?

____

____

____

____

MEDICATIONS
What medications are you currently taking?

MEDICATION	DOSAGE	REASON TAKING

Please list all known medical allergies and describe reaction.

ALLERGY	REACTION

Patient Signature: ____ **DATE:**

Reviewed Pages 1 thru 5 ____, **MD** **DATE:**

Last Name:_______________________First Name:_____________________DOB:_________

CONSENT TO TREATMENT IN OFFICE: I consent to the rendering of care, including diagnostic procedures and treatment, as Doctor Moskal or physician(s) under his supervision or health care person(s) under his supervision consider appropriate.

RECEIPT OF AND CONSENT TO PRIVACY POLICY: I acknowledge that I have been provided and have had an opportunity to review the privacy policy of the Shoulder & Elbow Center, PSC. I understand that my protected healthcare information will be maintained and disclosed consistent with that policy. I consent to disclosure made consistent with that policy.

ANCILLARY SERVICES: I understand that I may be prescribed physical or occupational therapy, corrective appliances, devices and/or braces. Shoulder & Elbow Center, PSC will assume no responsibility for the quality of the delivered product or services.

LEGAL PROCESS: In the event I, on the behalf of myself or my child or ward, pursue personally or through the efforts of an attorney, a claim against any person for personal injuries being treated by Shoulder & Elbow Center, PSC, I will be responsible for notifying the payer and responsible person, that out of the proceeds of any settlement or judgment, Shoulder & Elbow Center, PSC is to be paid for services in full, prior to any other person or entity. I will notify Shoulder & Elbow, PSC of my pursuit of such claim. In the event I obtain an attorney, I agree to notify such attorney of this agreement, which I have made with Shoulder & Elbow, PSC to provide my attorney with a copy of this agreement and any other information requested by said attorney.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize ________________ Insurance Company to pay Shoulder & Elbow, PSC any benefits due for services rendered. I understand that I am financially responsible to Doctor Moskal and the Shoulder & Elbow, PSC for any charges not covered under assignment. *I further understand and agree that I shall cooperate fully with the Shoulder & Elbow Center, PSC and provide all information necessary to the Shoulder & Elbow Center, PSC to complete this assignment of benefits. I further understand and agree that if I fail or refuse to provide the information required, I will be responsible for full payment for services rendered and will be personally responsible for obtaining reimbursement from my insurance carrier of any benefit I am entitled to receive.* A copy of this document is valid.

PAYMENT FOR SERVICES: I agree that I have obtained prior authorization for services provided by the Shoulder & Elbow, PSC, if needed. I will be responsible for payment of services rendered by Shoulder & Elbow Center, PSC in a reasonable and customary time. Services rendered include but are not limited to my office visit, including radiographs, ultrasound, other diagnostic and therapeutic tests, orthotic devices, surgical services, and any clerical work concerning my care. In the event that payment from a third party payer (insurance) does not cover in full for all services rendered by the Shoulder & Elbow Center, PSC herein, I agree to pay in full. I agree to pay all court costs, attorney's fees, collection fees associated with the collection of my account.

All of the provisions of this document are binding until revoked in writing to the Shoulder & Elbow Center, PSC.

Patient Name ____________________________ Address ____________________________________

Social Security No. ____________________________________ **(REQUIRED**)**

Insurance Company Name _________________________ Policy Number ________________________

Subscriber's Name _______________________________ Patient is a minor _________ years of age

Signature ______________________________________ Witness ___________________________
(Signature of the patient or patient's legal guardian if a minor)

Date:

** **Many insurance companies and other payors require this information prior to the payment of claims. The release of this information will be in accordance with Shoulder & Elbow Center, PSC's privacy policy.**

Physical Therapy and Dr. Moskal Office Visits

Appointment Cancellation / No Show Policy

Shoulder and Elbow Center commits a significant amount of time each week to our patients. In order to ensure that we provide the best care for all, we have implemented a 24-hour cancellation policy.

Due to scheduling considerations, you must cancel 24 hours prior to your set appointment during the times of 8:00am and 4:30pm. When canceling please notify the office. If you call after hours, leave a message on our office answering machine with details on why you are unable to attend your appointment. **Please DO NOT call the doctor and leave him a message that you will not be able to attend your appointment.**

We understand that there are certain circumstances in which you may find it impossible to make your scheduled appointment without giving 24 hours notice of cancellation. For these situations, Shoulder and Elbow Center reserves the right to waive the cancellation / no show fee. **We will need you to submit, in writing, your reason for not notifying our office.**

If you do not cancel your appointment and do not arrive on your set time, your account will be subjected to a "cancellation or no show charge" of $20.00.

Shoulder and Elbow Center reserves the right to forfeit rescheduling new appointments for habitual no shows or cancellations, as well as, reserves the right to discharge any patients who fails to give proper notice three consecutive times.

Your welfare is our top priority and we value you as a patient. Please be considerate of our time and services. If you are experiencing additional problems, please speak with our practice administrator.

I have read and understand the 24-hour cancellation policy. I agree to pay a twenty-dollar (20.00) cancellation or no show fee.

____

Signature of Patient/Guardian Date

Shoulder & Elbow Center Driving Sheet

Please read and initial line by each statement

_____ We strive to provide accurate information for our patients. In general, a new drug, injury, or surgery could affect your ability to drive; therefore, it may be unsafe for you to drive. We do not have scientific information to make assessments of safe driving. Guidelines about driving specific to musculoskeletal disorders, injury, or orthopedic surgery do not exist to our knowledge. Drugs may have the potential to impair an individual's ability or capability to perform complex tasks (ie. driving) even without the individual knowing.

_____ We can advise if an orthopedic problem of the limb (arm) needs or does not need specific restrictions on activities based upon reasonable medical probability. We may be able to advise patients, "Do Not Drive" but can not advise if you can drive *safely*.

_____ Medications that may impair your ability to drive safely include, but are not limited to, narcotic analgesics (pain medicines), antiemetics (medicines for nausea), nonnarcotic pain medicines (such as Ultram), or neurological medications (such as gabapentin). Narcotic pain medications include, but are not limited to, the following: oxycodone, hydrocodone, codeine, propoxyphene, OxyIR, Percocet, Lortab, Norco, Darvocet. Always read the instructions and warning labels provided regarding activities and do not drive or operate machinery.

_____ Wearing a sling will impair your ability to drive.

_____ In our area, you might obtain advice on your ability to safely drive from

1. Department of Motor Vehicles
2. Frazier Rehab Institute Newburg Driver Rehabilitation Specialist
    a. The program includes a pre-driving evaluation and a behind-the wheel evaluation.

Frazier Rehab Institute Newburg
Driver Evaluation and Training Program
3430 Newburg Road, Suite #111
Louisville, KY 40218
Telephone: (502) 451-6886 Fax: (502) 458-2158

The Shoulder & Elbow Center, PSC has no opinion regarding an individual's ability or capability to drive safely, drive in general, or the return to safe driving.

I have read the above and fully understand. I do not have any questions or concerns at this time.

____
Signature of patient or legal guardian Date:

Witness______________________________________ Date:

HIPPA & PRIVACY ACT

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this **authorization** is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient name: ___________________________Date of Birth: _____________ Social Security # _______________

Patient's address: ____

I authorize the release of all my medical record information from the office of Dr. Michael J. Moskal to the following persons for the purpose of the individuals listed below to assist in my care:

_____________________________________ __________________________/________________
(**Please List Emergency Contact here**) Name Relationship

_____________________/_______________ __________________________/________________
Name Relationship Name Relationship

Must be completed for all **authorizations**.

The patient or the patient's representative must read and initial the following statements:

1. I understand that this **authorization** will expire on __ __ / __ __/ __ __ __ __ or 2 years following date signed. Initials: ______

2. I understand that I may revoke this **authorization** at any time by notifying the practice in writing, but if I do, it won't have any affect on any actions they took before they received the revocation. Initials: _____

Do you have a **power of attorney**? **YES** or **NO**

Do you have a **living will?** **YES** or **NO**

Please inform the front desk and give them the appropriate documentation. **If yes please list Power Of Attorney as a person that we may release information to on one of the four above lines.**

____
Signature of patient or legal guardian Date

(Form MUST be completed before signing)

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Michael J. Moskal, MD
www.shoulderandelbowcenter.com

Welcome to the Shoulder & Elbow Center, PSC. We will do our best to discuss your condition as clearly and completely as possible and answer any questions you may have. Questions or problems may arise after you leave and we want to assure you that someone is available to you. Please contact us at the office if you need our help.

Monday & Wednesday: 8:00 AM – 4:30 PM
Tuesday, Thursday, Friday: 8:00 AM – 3:00 PM
Phone: (812) 248-4789 Fax: (812) 248-4773

Emergencies after 3:00 PM, on Weekends and on Holidays

1. If you have recently had surgery by Dr. Moskal and it is an emergency, call the office, listen carefully to the answering service, and leave a message including your name and telephone number. If you do not receive a timely response please refer to number 2.

2. Any other cases, you should go to the closest Emergency Department or call 911.

Medicines

Medicines may be prescribed from 8 AM to2 PM, Monday thru Friday. We will not be able to prescribe medicines over the phone if your chart is not available. Prescriptions CANNOT be refilled after 2 PM Monday through Friday, on Saturday, Sunday, or on Holidays.

We will not refill a prescription if an appointment has been missed or cancelled since the last office visit. Return to the office for lost, stolen, or accidentally discarded prescriptions.

If you have been released from our care, you will need an appointment to determine if medicines are best for you. We will not prescribe medicines if another doctor is prescribing medicines for you.

PATIENT SIGNATURE________________________________ DATE:

Obsidian

Physical Therapy, LLC

Nathan Lynch, PT, CSCS
Whitney Ochsner, MPT
(812) 248-4789 Fax: 812-248-4773

Dear Patient:

Physical therapy plays an important role in rehabilitation of orthopedic injuries to relieve pain, return an individual to a sport or work activities, or to improve a person's quality of life. If your doctor recommends that you would benefit from therapy to help alleviate your problem, one option is to have this performed conveniently within our office by Obsidian Physical Therapy therapists that are contracted by Dr. Michael J. Moskal and the Shoulder and Elbow Center, PSC. It is important that you understand the reasons we provide this for you as an option.

Obsidian's staff is highly skilled and experienced at providing exceptional orthopedic therapy care for you and your family. Other advantages include the therapists' and doctors' ability to work as a team, exchanging information and sharing ideas. The frequency and immediacy of feedback allows for the fine-tuning of therapeutic protocols that we strongly believe improves patient outcomes in a surgical and non-surgical situation.

The services for Physical Therapy and Dr. Moskal are billed separately through the Shoulder and Elbow Center, PSC. We are proud to be able to offer you this convenient, rehabilitative service and want to make sure you know how the two independent companies work together.

Please let us know if you have any questions concerning the therapy services in this facility. Of course, the final choice of where your therapy is performed is entirely up to you. If you want to discuss alternatives, please feel free to ask.

I have read and understand the above and do not have any questions.

Patient Signature/Guardian____________________________ Date:

AUTHORIZATION FOR RELEASE OF SURGERY& TEST DATES AND TIMES

I hereby authorize **Shoulder & Elbow Center, PSC** to record and convey information regarding my appointment date and time and the surgery & test to be performed by designated means listed below. I understand that this **authorization** is voluntary.

Patient Name:______________________________ ID Number:___________________

Patient's Address:____

____

I hereby authorize **Shoulder & Elbow Center, PSC** to leave surgery & test dates and times at the following: **(please check all that apply)**

☐ Home Answering Machine _____________________________________ (number)

☐ Work Voice Mail ____ (number)

☐ E-mail ____ (e-mail address)

☐ Other ____

____

The patient or the patient's representative must read and initial the following statements:

1. I understand that my healthcare and the payment for my healthcare will not be affected if I do not sign this form. Initials:__________
2. The information to be released and the purpose for the release is to communicate to me the date and time of Surgery or medical testing and information regarding the surgery or testing to be performed. Initials: ___________
3. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials:__________
4. I understand that this **authorization** will expire on ___ / ____ / ___________ or 12 months following date signed. Initials:_________
5. I understand that I may revoke this **authorization** at any time by notifying the practice in writing, but if I do, it will not have any affect on any actions they took before they received the revocation. Initials:__________

____

Signature of Patient or Legal Guardian **Date**

(Form **MUST** be completed before signing)

Printed name of Patient's Representative:_____________________________________

Relationship to the Patient:____

Shoulder & Elbow Center PSC

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Phone 812.248.4789
Fax 812.248.4773

Michael J. Moskal, MD

www.shoulderandelbowcenter.com

WELCOME!!

Welcome to the office of **Dr. Michael J. Moskal**.

Enclosed you will find some information about Dr. Moskal and his practice.

For your convenience we have included forms that must be completed and returned to our staff upon your arrival. These forms are required for medical and insurance purposes. We appreciate your cooperation in completing these forms prior to your visit as it shortens your wait time in the office.

In addition, you will need to bring with you any medical records, **especially X-rays and MRI's <u>along with the REPORTS</u>,** from your referring or previous treating physicians. **<u>Please bring only on a DISC</u>. Please bring only the disc and reports of the body part for which you are being seen; no other discs will be reviewed**.

In order for our office to file a claim with your insurance company we must obtain a copy of your insurance card/cards for your medical chart. A referral, if required, needs to be obtained from your Primary Care Physician prior to being seen in our office.

If you do not have medical insurance coverage or your visit is due to a liability claim, such as a motor vehicle accident, you will be expected to pay for services in full at the time of your visit. Please inform the staff prior to your visit if either of these apply.

If you are bringing any children to your office visit, please bring a responsible adult to watch the children while you are being seen by the doctor.

We look forward to seeing you!!!!
Michael J. Moskal MD & Staff

SHOULDER & ELBOW CENTER
MICHAEL MOSKAL, MD

Hunter Station Medical Center
130 Hunter Station Way
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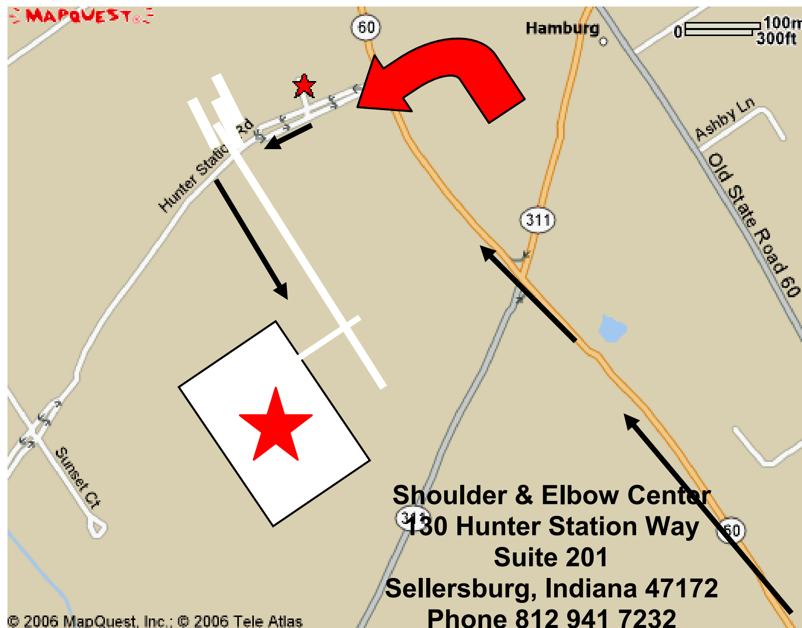
Sellersburg, Indiana 47172
Phone 812.248.4789
Fax 812.248.4773



From Louisville:
Take **I-65 North** toward Indianapolis; take **exit # 7 (Salem)**; turn **Left** at light at top of ramp onto Hwy 60; Go down to **4th Stop Light** (There will be a JayC food store on your right) and turn **Left** onto **Hunter Station Road**; take an immediate **Left** onto **Hunter Station Way**; we are in the **2nd** building on the **Right (Hunter Station Medical Center) (2nd Floor).**

From Indianapolis:
Take **I-65 South** toward Louisville; take **exit # 7 (Salem)*;*** turn **Right** at light off ramp; at **3rd Stop Light** (There will be a JayC food store on your right) turn **Left** on **Hunter Station Road**; take an immediate **Left** onto **Hunter Station Way,** we are in the **2nd** building on the **Right (Hunter Station Medical Center) (2nd Floor).**

From the West:
From **I-64** take **exit # 121** onto **I-265 East (New Albany)**; then merge onto **I-65 North** towards Indianapolis; take the first exit **(exit #7 – Salem);** turn **Left** at light at top of ramp; at **4th Stop Light** (There will be a JayC food store on your right) turn **Left** onto **Hunter Station Road**; take an immediate **Left** onto **Hunter Station Way**; we are in the **2nd** building on the **Right (Hunter Station Medical Center) (2nd Floor).**

Shoulder and Elbow Center, PSC

The Shoulder and Elbow Center is the sole orthopedic practice of Dr. Michael J. Moskal. We proudly serve the Kentuckiana area. Our office is located in Sellersburg, Indiana. At the Shoulder and Elbow Center, we strive to provide the most comprehensive evaluation and treatment opportunities for all of our patients.

Dr. Michael Moskal

Dr. Moskal is board certified in the hand and upper extremity section by the American Board of Orthopedic Surgeons. The Shoulder and Elbow Center provides comprehensive care of the hand, wrist, elbow, and shoulder. We regularly provide care for simple and complex disorders due to sports and other injuries.

Dr. Moskal has lectured and operated around the world. He has written numerous scientific papers and book chapters about the shoulder, elbow, wrist, and hand. Dr. Moskal has been featured on the cover of Louisville Magazine named one of the city's "Top Docs Under 40". He has been the focus of a WHAS Evening News Medical Breakthroughs segment highlighting total shoulder replacement surgery.

Hand and Wrist

Dr. Moskal completed his hand and microsurgery fellowship at the Kleinert Institute in Louisville, KY. He was a partner at Kleinert, Kutz, and Associates until 2001. Dr. Moskal routinely performed complex reconstructive surgeries of the hand including being a member of the surgical team performing the first successful hand transplantation surgery. **A picture of this surgery, including Dr. Moskal, was featured in the Life Magazine 1999 Album, The Year in Pictures.**

Age related and traumatic problems of the wrist are routinely cared for at the Shoulder and Elbow Center. Dr. Moskal is an expert at minimally invasive surgery including wrist arthroscopy. He is the chairman of the wrist arthroscopy education committee for the Arthroscopy Association of North America.

Elbow and Shoulder

Dr. Moskal completed a shoulder and elbow fellowship at the Department of Orthopedic Surgery and Sports Medicine at the University of Washington. Dr. Moskal is a nationally and internationally recognized expert and one of our region's only fellowship trained shoulder and elbow specialist.

Please inquire about our shoulder and elbow joint replacement program. Our program is designed to treat many types of arthritic conditions from initial evaluation to replacement surgery. Dr. Moskal is an expert arthroscopist. Minimally invasive surgery, including arthroscopy, speeds the recovery process after treatment.

Sports Medicine

At the Shoulder and Elbow Center, we strive to provide the most comprehensive evaluation and treatment opportunities for student and adult athletes. We routinely care for athletes at the high school and college level due to such sports as volleyball, baseball, football, and tennis.

Physical Therapy

Expert physical therapists are located on site and are ready to evaluate and treat our patients. To provide excellent and timely service, all of our patients can be seen within the Shoulder and Elbow Center to match the unique needs of each patient and problem even on the day of their visit.

For more information regarding The Shoulder and Elbow Center or Dr. Moskal please visit our website at www.shoulderandelbowcenter.com.

Shoulder & Elbow Center, PSC
Insurance and Payment Policies

1. All co-payments are due at the time of check–in. If you are unable to pay your co-pay, please let us know so that we can reschedule your appointment to a more suitable day and time. However, there are multiple banks with ATM accessibility near the office.

2. Any and all charges subjected to a deductible, co-pay, or cost share will need to be paid at time of service.

3. If your insurance requires a referral it is **your responsibility** to obtain this prior to your appointment. If the referral has not been obtained prior to your scheduled appointment time, this may result in excessive delays and may ultimately result in rescheduling your appointment.

4. Please notify our staff of any policies and procedures that your insurance may have such as preauthorization, use of certain labs, network physicians and hospitals. This will ensure that you receive maximum benefits from your insurance carrier.

5. Your insurance card/cards need to be presented upon sign-in along with a valid photo ID. A photocopy will be obtained and kept in your medical record. If you do not have an insurance card you will be required to pay for services in full on the day they are rendered.

6. Your insurance coverage is **YOUR** responsibility. It is your responsibility to check to see if Dr. Moskal is a participating provider with your insurance and if a referral or co-pay is required for your office visit. It is your Responsibility to know if you have any Therapy Benefits and what those Benefits are.

7. Acceptable methods of payment are cash, check, or credit card (Visa & Mastercard). Please be advised if you choose to pay your co-pay/balance by check there is a $20 fee on all returned checks.

We look forward to seeing you. If you should have any questions please contact us.

SHOULDER AND ELBOW CENTER PSC NOTICE OF PRIVACY PRACTICES

The Shoulder and Elbow Center PSC understands that the privacy of your personal information is important to you. We want you to understand our privacy practices and procedures, as well as answer questions you may have. **This notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, obtain payment for services, run our business, and for other purposes that are permitted or required by law. This notice describes your rights to access and control information regarding your health.**

Although this notice reflects our current privacy practices, we may change them at any time. If we change them, we will provide a new notice to you. In addition, we will post our current privacy practices on our website at shoulderandelbowcenter.com

The term "protected health information" means information about you that may identify you and that relates to your past, present, or future physical or mental health condition or related services we provide.

GENERAL USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by our office or other healthcare providers that are involved in your care and treatment in order to provide health care services to you, to obtain payment of your healthcare bills from you or your insurance carrier or other payment source, and as necessary for the operation and administration of our practice.

ADDITIONAL USES AND DISCLOSURES OF PROTECTED INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

Any other use or disclosure of your protected healthcare information not described above may be made *only with your written authorization*, unless otherwise permitted or required by law such as to report abuse, neglect or domestic violence or for law enforcement purposes or as authorized or required by workers' compensation laws and regulations. If you provide us with an authorization, you may revoke it at any time, in writing, except to the extent that we have taken an action in reliance on the authorization. We may, for example, request your authorization to use your protected healthcare information for research or teaching purposes.

We may use or disclose your protected healthcare information if you agree to such disclosures. If you are not present or able to agree or object to the use or disclosure of your protected healthcare information then we may, in the use of our professional judgement, determine whether the disclosure is in your best interest. If we determine disclosure is necessary we will only disclose the information that is relevant to your current health. This type of disclosure includes disclosures to individuals directly involved in your healthcare including family, close friends, personal representatives, legal guardians, or other persons you identify. We will disclose your protected health information as necessary to comply with Workers' Compensation laws and regulations.

DISCLOSURE IN LEGAL PROCEEDINGS

From time to time our patients are involved in legal proceedings. We will disclose protected healthcare information in the course of any judicial or administrative proceeding in response to an Order of a court or administrative tribunal or in response to a subpoena.

However, we will first give you notice of the subpoena to provide you with an opportunity to object in the court issuing the subpoena.

YOUR RIGHTS

1. You have a right to inspect and copy your protected healthcare information. This means you may inspect and obtain a copy of protected healthcare information about you that is contained in our records for as long as we maintain such records. However, there are certain restrictions upon this right under federal law. You may *not* inspect or copy certain records including psychotherapy notes, information compiled in reasonable anticipation of or use in civil, criminal, or administrative proceedings or protected healthcare information that is subject to a law which prohibits access to it.

If you wish to inspect your medical records, please contact our privacy contact about access to your records.

2. You have a right to request a restriction on your protected healthcare information. You may ask us not to use or disclose any part of your protected healthcare information for purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected healthcare information not be disclosed to family members or friends who may be involved in your healthcare. In order to do this, you must provide us with a letter that describes the specific restriction you desire and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we believe that it is in your best interest to permit use or disclosure of the information, it will not be restricted. If we agree to the requested restriction, we will not use or disclose your protected healthcare information in violation of that restriction unless it is needed to provide emergency treatment.

3. You have a right to request or receive confidential communications from us by an alternative means (e.g. not by mail) or at an alternative location other than your home (e.g. to your place of work) address. We will accommodate reasonable requests when possible. We may also condition this accommodation by asking you for information as to how payment will be handled **or for specification of an alternative address or other method of contact.** We will not request an explanation from you as to the basis of the request. If you have such a request, please make this request in writing to our privacy contact. Because of privacy concerns we will not communicate by email.

4. You have the right to ask your physician to change your protected healthcare information, for example, if you believe that something in our records is incorrect. If we grant your request, we will make the change and notify you and others who may need to know of the change. If we deny your request, we will tell you in writing why and give you the opportunity to submit a statement disagreeing with us. We will then attach your original request and statement of disagreement with your protected health information and make it part of your record. Please contact our privacy contact in writing if you wish to have an amendment made to your medical record.

5. You have a right to receive a detailed accounting of certain disclosures that we have made, if any, of your protected healthcare information. This right applies to disclosures for purposes *other than* treatment, payment, or healthcare operations as described above. For example, this also excludes disclosures we have made to you, to family members, or to friends involved in your care or for notification purposes. **The right**

to receive this information is subject to certain exception, restrictions and limitations. You have a right to obtain a paper copy of this notice from us upon request.

6. You may complain to us or to the **Secretary of Health and Human Services**, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our privacy contact, Dr. Mike Moskal, at (812) 248-4789 or **info@shoulderandelbowcenter.com** for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

Shoulder & Elbow Center, PSC
PATIENT INFORMATION

PATIENT:

Name (First, Middle, Last): ________________ **Age:**_____ **Sex: M F**

Date of Birth:__________ **Social Security Number:**__________ **Marital Status: Single Married Other**

Address:__________ **City:** __________ **State** _____ **Zip Code** _____

Home Phone:__________ **Cell/Alternate Phone**__________ **E-mail:** __________

Employer: __________ **Address:** __________

City: __________ **State** _____ **Zip Code** _____ **Phone** __________

RESPONSIBLE PARTY (IF PATIENT IS A MINOR):

Name (First, Middle, Last): ________________ **Age:**_____ **Sex: M F**

Date of Birth:__________ **Social Security Number:**__________ **Marital Status: Single Married Other**

Address:__________ **City:** __________ **State** _____ **Zip Code** _____

Home Phone:__________ **Cell/Alternate Phone**__________ **E-mail:** __________

Employer: __________ **Address:** __________

City: __________ **State** _____ **Zip Code** _____ **Phone** __________

PRIMARY CARE PHYSICIAN:

Name: __________ **Phone** __________

REFERRING PHYSICIAN:

Name: __________ **Phone** __________

INSURANCE INFORMATION:

Primary Insurance: __________ **Subscriber's Name:** __________

Date of Birth:__________ **Social Security Number:**__________ **Relationship to Patient:**__________

Policy Number __________ **Group Number**__________ **Co-pay Amount:** __________

Secondary Insurance: __________ **Subscriber's Name:** __________

Date of Birth:__________ **Social Security Number:**__________ **Relationship to Patient:**__________

Policy Number __________ Group Number__________ Co-pay Amount: __________

EMERGENCY CONTACT INFORMATION:

Name:__________ **Relationship:**__________ **Primary Phone** __________ **Other:** __________

Pharmacy:__________ **Phone** __________

Address: __________

Patient Release: I certify the information I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owed to the provider that are past due.
I permit a copy of this release to be used in place of the original.

Signature of Patient, Authorized person, or Parent of minor: __________ **DATE:**