**Name: _____** **Date of Birth: _____**

**Address: _____**

**Cell Phone: _____** **Home Phone: _____**

**Email: _____**

**Sex:** □ M □ F □ T **Ethnicity:** □ Hispanic/Latino □ Non-Hispanic/Latino

**Race:** □ White □ Black/African-American □ American Native/Alaska Native □ Asian □Native Hawaiian/Pacific Islander

**Marital Status:** □ Single □ Married □ Divorced □ Widowed

**Language**: _____ **Occupation:** _____

**Pharmacy**:_____ **Address/City:**_____ **Phone Number:**_____

**Who referred you to Dr. Talmo?:**_____

**Previous Surgeries (within the last 5 years):**

**Type of Surgery** **Year**

1. _____
2. _____
3. _____
4. _____

**Allergies:**

□ No known drug allergies

□ Nickle/Metal □ Latex □ Tape

Known Penicillin Allergy Nature of reaction

_____

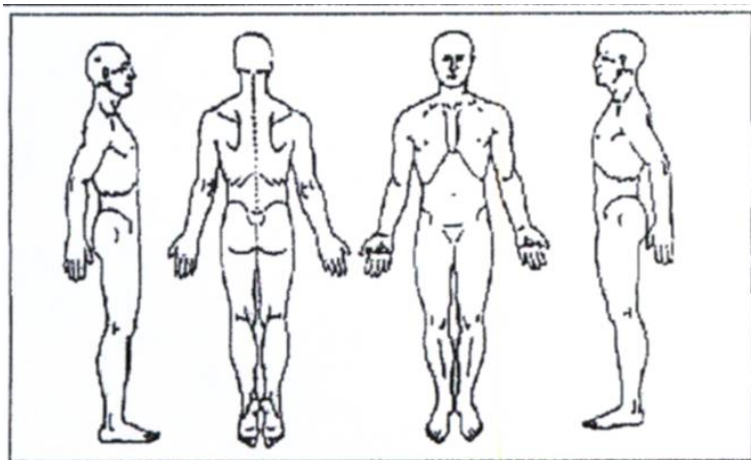
Other Antibiotic Allergies Nature of reaction

_____

**What is your current activity level? (**Check box that best applies)

□ Walk w/o stopping for ½ mile □ Walk w/o stopping 200 feet □ Walk w/o stopping for ¼ mile □ Very restricted, wheelchair

**Using the diagram below, please indicate where you are having pain:**



**Height: _____**

**Weight: _____**

**Using the scale, please indicate how severe your pain is**:

No Pain (0) 1 2 3 4 5 6 7 8 9 Severe Pain (10)

Patient Name: _____Date of Birth: _____

**Current Medication List:**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

| | | | |
|---|---|---|---|
| **Primary Care Physician** | Name: | Phone: | Fax: |
| **Cardiologist (Heart)** | Name: | Phone: | Fax: |
| **Nephrologist (Kidneys)** | Name: | Phone: | Fax: |
| **Endocrinologist (Diabetes)** | Name: | Phone: | Fax: |
| **Circle if applies: Hematologist, Neurologist, Rheumatologist, Pulmonologist** | Name: | Phone: | Fax: |

**Medical History:**

Do you consume alcoholic beverages? ☐ No ☐ Yes If yes, _____ # of drinks per week Tobacco Use ☐ No ☐ Yes

Have you ever been treated for/experienced alcohol withdrawal? ☐ No ☐ Yes If yes, when? _____

Are you currently taking ☐ Methadone or ☐ Suboxone/Buprenorphine? If yes, dose _____

**Cardiovascular**
☐ Coronary Artery Disease
☐ Coronary Bypass Surgery
☐ Heart Attacks/Stents
☐ Heart Failure (CHF)
☐ Heart Valve Problems
☐ Heart Valve Surgery
☐ Cardiomyopathy
☐ Pacemaker/ICD
☐ Other _____

**Pulmonary**
☐ COPD/Emphysema
☐ Asthma
☐ Sleep Apnea
☐ Recurrent Bronchitis
☐ Pneumonia
☐ Other _____

**Hematologic**
☐ DVT/PE
☐ Clotting Disorder
☐ Abnormal Blood Counts
☐ Other _____

**Rheumatology**
☐ Rheumatoid Arthritis
☐ Lupus
☐ Use of Biologics/Steroids
☐ Other _____

**Neurological**
☐ Stroke
☐ Seizure
☐ Parkinson's disease
☐ Dementia/Alzheimer
☐ History of Post-Op Confusion
☐ Other _____

**Endocrine**
☐ Diabetes
☐ Steroid Dependence
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Insulin Pump
☐ Other _____

**Cancer**
☐_____

**Renal**
☐ Dialysis
☐ Chronic Kidney Disease
☐ Kidney transplant
☐ Other _____

**Gastrointestinal**
☐ Cirrhosis
☐ GI Bleeding
☐ GERD/Reflux
☐ Other _____

**Infectious Disease**
☐ History of Joint/Spine Infection
☐ History of Osteomyelitis
☐ HIV Positive
☐ Other _____

**Other**
☐ Glaucoma
☐ Difficulty with Anesthesia
☐ Anxiety/Depression
☐ Bipolar Disorder
☐ Dental Issues

## Authorization/Consent

I hereby authorize Carl T. Talmo, M.D., to furnish information to my insurance carrier in the course of my treatment, and further authorize payment of surgical and/or medical benefits to the physician(s). In consideration of medical services to be rendered, I understand I am responsible for any unpaid balances, including co-payments and/or deductibles and payment is due within ten (10) days of the billing date.

I give permission to Carl T. Talmo, M.D., to check my prescription eligibility and history.

_____ _____/_____/_____

**Patient's Signature** **Date**

## BILLING POLICY: CARL T. TALMO, M.D.

HEALTH INSURANCE CARD: Please have your insurance card with you when you register with the office. If your insurance should change, please notify the office as soon as possible.

INSURANCE BENEFITS: It is your responsibility to verify your medical benefits with your insurance company. Benefits are subject to the provisions of your policy.

REFERRALS: If your insurance requires referrals, you are responsible to provide one at the time of your visit. You will be responsible to obtain future referrals as needed for your treatment(s). You will also be responsible for payment of any visit that does not have a referral at the time of service.

MOTOR VEHICLE ACCIDENTS: We will not bill MVA insurance carriers and/or attorneys for services rendered. All visit(s) are to be paid in-full at the time of visit(s). Our office will assist you in obtaining payment from the insurance company by providing any necessary documentation at your request.

WORKERS COMPENSATION: Please provide the office with your date of injury, claim number, and your case adjuster's name and telephone number. We reserve the right to cancel your appointment(s) until the workers compensation claim is verified and approved.

CONSENT TO RENDER PAYMENT: You hereby authorize the payment of medical benefits to this office for services rendered. We agree to bill your insurance company, however, should the insurance company delay payment or deny claims beyond 60 days of submission; you will be responsible for making the payment in-full after receiving notification from your insurance company.

DEDUCTIBLE, CO- INSURANCE, CO-PAYMENT: You hereby agree to pay all copayments, deductibles, and co-insurances if required by your insurance company at the time of your visit. This is your contractual obligation with your insurance company, and we are mandated to collect this.

PATIENT STATEMENTS: All bills are to be paid within thirty (30) days of receipt.

I have read the Billing Policy and understand my responsibilities as a patient.

_____ _____/_____/_____

**Patient's Signature** **Date**

**OPIOID AGREEMENT**

This is an agreement between _____ (Patient Name) and Carl T. Talmo, M.D. concerning the use of opioid analgesics (Narcotic Pain Medication) for the treatment of pain management. The medication will not completely eliminate my pain, but reduce it.

1. I understand that opioid analgesics are strong medication for pain relief and have been informed of the risks and side effects involved. Such as nausea, vomiting, diarrhea, constipation.
2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal can be uncomfortable, but not life threatening.
3. I understand if I'm pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life threatening for a baby.
4. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a car or operate machinery that could put my life or someone else's life in danger.
5. Overdose of this medication may cause death.
6. I understand it is my responsibility to inform the doctor of any side effects I have from this medication.
7. I agree to take this medication as directed and not increase the frequency or dose without discussing it with the doctor. Running out early, needing early refills, escalating doses without permission and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.
8. I agree that the opioids will be prescribed by **one** doctor and I agree to fill my prescriptions at only **one** pharmacy. I agree not to take any pain medication or mind altering medication without first discussing it with the Dr. Talmo. I give permission to Dr. Talmo to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.
9. I agree to keep my medication in a safe and secure place. Lost, stolen or damaged medication will not be replaced.
10. I agree not to sell, lend or in any way give my medication to any other person.
11. I agree not to drink alcohol or take other mood altering drugs while I am taking opioid analgesic medication.
12. I agree that I will attend all follow-up appointments and understand that failure to do so will result in discontinuation of medication. I also agree to participate in chronic pain treatment modalities recommended by my doctor.
13. People with a history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred for help with this.

I have read the above and understand the agreement. If I violate this agreement, I know that Dr. Talmo may discontinue this treatment.

_____ _____

**Patient's Signature** **Date**

# NOTICE OF PRIVACY PRACTICES: CARL T. TALMO, M.D.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.**

**INTRODUCTION:**

We believe that your health information is personal. We keep records of the care and services that you receive at our facilities. We are committed to keeping your health information private, and we are also required by law to respect your confidentiality. This notice describes the privacy practices of the office of Carl T. Talmo, M.D. This Notice applies to all of the health records that identify you and the care you receive. We are legally required to give you this Notice and to follow the terms of the Notice that are currently in effect.

**HOW WE MAY USE/DISCLOSE YOUR HEALTH INFORMATION:**

When you become a patient of Carl T. Talmo, M.D., we will use your health information within NEBH and disclose your health information outside NEBH for the reasons described in this Notice. The following categories describe some of the ways that we will use and disclose your health information:

- As a basis for planning your care and treatment.
- As a means of communication amount the various healthcare professionals who contribute to your care.
- A means by which you or a third party payer can verify that services billed were the services provided.
- A source of data used for medical research, education, planning and marketing.
- A tool in which we can assess and continually work to improve the care we render and the outcomes we achieve.
- Legal: we will disclose your health information when required to do so by federal, state, or local law, or by the court process. It also serves as a legal document stating the care you have received.

**YOUR HEALTH INFORMATION RIGHTS:**

Although your record is the physical property of our office, the information belongs to *you.* You have the right to:

- Obtain a paper copy of this notice upon request.
- Inspect and obtain a copy of your health records. Your request to inspect/obtain a copy of your records must be submitted in writing, signed, and dated.
- Amend your medical record, should you feel that the information is incorrect or incomplete. Your request for an amendment must be in writing, signed, and dated.
- Request a restriction on the uses and/or disclosures of your health information for treatment, payment, or healthcare operations. Such restrictions must be submitted in writing, signed, and dated.
- Request that we communicate with you about your health in a certain way, i.e. you may ask that we only contact you at your work or by mail. Your request must be submitted in writing, signed, and dated.

**OUR RESPONSIBILITIES:**

We reserve the right to change our practices and to make new provisions effective for all protected health information that we maintain. Should our Privacy Practices change, we will mail a revised notice to the address you have supplied us.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

I have been presented with a copy of this provider's Notice of Privacy Practices, which details how my health information may be used and/or disclosed as permitted under federal and state law. I understand the contents of this notice. Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself, or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

_____ _____/_____/_____

**Patient's Signature** **Date**

Beth Israel Lahey Health
New England Baptist Hospital

OFFICIAL HOSPITAL

125 Parker Hill Ave Boston, MA 02120

Phone: 617-754-5498 Fax: 617-754-6437

**This form is to be used at your pre-screening appointment if you elect to have surgery. Please complete the following release of medical information form by providing the name of your doctors or hospital you are regulary seen at. This allows NEBH to obtain your past medical history and test results. Thank you.**

## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

**Patient Name: _____ DOB: _____**

I authorize _____

to use or disclose my health information:

To: **New England Baptist Hospital Attn: High Risk Team**

**Specific Information to be released**: Office notes, testing results, health history

**For the following purpose:** Pre-operative screening

I understand that this authorization is voluntary and the hospital will not condition treatment on completion of this authorization. I authorize this use, disclosure and release with the understanding that it may include specifically protected or privileged information in one or more of the following categories: information relating to alcohol or drug use, communications between the patient and social worker, information relating to sexually transmitted diseases, communication between the patient and psychotherapists (including psychiatrists, licensed psychologists).

I have placed a line through and initialed any portion of the paragraph above that lists information which I do not want released to the above referenced organization.

I understand that once my information is disclosed to the recipient, the hospital cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of the health information.

**Authorization expires on: _____ or six months after the date below**. I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to the hospital's health information management department at the address listed above. The revocation will be effective immediately upon the hospitals receipt of my written notice, except that the revocation will not have any effect on any action taken by the hospital in reliance on this authorization before it received my written notice of revocation.

**I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use of and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize New England Baptist Hospital to use or disclose my health information in the manner described above.**

_____ _____

**Signature of Patient or Legal Representative**** **Date**

**Description of Legal Representative: _____

# HOOS, JR. HIP SURVEY

**INSTRUCTIONS:** This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.
Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

**Pain**
What amount of hip pain have you experienced the **last week** during the following activities?

1. Going up or down stairs

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

2. Walking on an uneven surface

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Function, daily living**
The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

3. Rising from sitting

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

4. Bending to floor/pick up an object

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

5. Lying in bed (turning over, maintaining hip position)

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

6. Sitting

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |