WNY KNEE AND ORTHOPEDIC SURGERY, PC
WILLIAMSVILLE - 180 PARK CLUB LANE STE 225 WILLIAMSVILLE, NY 14221
ORCHARD PARK - 3085 SOUTHWESTERN BLVD STE 203 ORCHARD PARK, NY 14127
****Non ambulatory patients must bring someone with them. Our office does not transport or lift.****

PLEASE PRINT
Date: Full Mth day, Year **Acct #** **SS#:** _____

Name: Pat Whole Name (First Name First) **DOB:** Pat DOB **Sex:** ☐Male ☐ Female
Address: Pat Address Full
Home Phone:Pat H Phone Work Phone:Pat W Phone Cell Phone:Pat Cell Phone

Patient's Email Address: _____

Primary Care Physician: PCP Whole Name (First Name First)
Referring Doctor: First name: _____ Last name: _____
Cardiologist: _____ Nephrologist (Kidney) _____
Rheumatologist: _____ Infectious Disease: _____
Wound Care: _____ Other specialist: _____

Pharmacy Name/Address: _____ Phone _____

Race: ☐Caucasian ☐ African American ☐Native American ☐Asian ☐ Hispanic
Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic ☐Declined Language _____

Insurance Information
Primary Insurance Pat Prim Ins Carr Name Insurance ID # Pri Ins Pol #

Group # _____ Effective date of insurance: _____

Policy Holder Name(skip if same as patient): _____ DOB _____

Secondary Insurance:Sec Ins Pln Name

Policy Holder Name (skip if same as patient): _____ DOB _____

Effective date of insurance: _____

Employer: _____ Address: _____ Phone: _____
****Is this visit related to an automobile or work accident? ☐No ☐Yes If yes please indicate ☐Auto ☐Work**
If yes please complete No fault/Workers Comp form attached.

Responsible Party ☐(if same as patient, check and skip to next section)
Name _____ Date of Birth _____ SSN: _____-_____-_____

Address _____
(Street) (City) (State) (Zip)
Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact/HIPAA Contact _____ **Phone** _____
Relationship to Patient _____

The information on all forms has been completed accurately to the best of my knowledge. I understand that it is my responsibility to notify the doctor's office of any changes in my information. I also understand that this information will also be used for billing purposes and that I authorize the WNY KNEE AND ORTHOPEDIC SURGERY, PC to bill my insurance.

Printed name of patient or guardian: _____ Signature: _____
(if patient is under 18 years of age)

Patient Name: Pat Whole Name (First Name First)
Patient DOB: Pat DOB
Account #: Acct #

*YOU WILL NOT BE SEEN WITHOUT AN UPDATED REFERRAL IF ONE IS REQUIRED BY YOUR INSURANCE COMPANY. IF WE DO NOT HAVE A REFERRAL, YOUR APPOINTMENT MAY BE RESCHEDULED. IT IS YOUR RESPONSIBILITY TO CALL YOUR MEDICAL DOCTOR TO OBTAIN A REFERRAL.

***CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF APPOINTMENT.**
WE ACCEPT CASH, CHECK, OR CHARGE (MASTER CARD, VISA, AND DISCOVER CARD)

*IF YOU ARRIVE MORE THAN 15 MINUTES LATE, YOUR APPOINTMENT MAY BE RESCHEDULED TO THE NEXT AVAILABLE APPOINTMENT.

*IF YOU NEED TO CANCEL YOUR APPOINTMENT, WE REQUIRE A 24-HOUR NOTICE OR YOU MAY BE CHARGED A $50.00 NO SHOW FEE. THERE IS A $250.00 NO SHOW FEE FOR SURGERY.

*IF YOU FAIL TO SHOW UP FOR 2 SCHEDULED OFFICE APPOINTMENTS WITHOUT CANCELLING, WE WILL BE UNABLE TO CONTINUE YOUR CARE.

*ALL MEDICATION REFILLS CALLED IN AFTER 4PM ON THURSDAYS WILL BE FILLED THE FOLLOWING MONDAY. PLEASE PLAN ACCORDINGLY.

*IF YOU ARE WAITING FOR A RETURN CALL FROM A PHYSICIAN, THIS WILL BE HANDLED AS QUICKLY AS POSSIBLE. NON-EMERGENT CALLS WILL BE RETURNED AFTER OFFICE HOURS IN MOST CASES. ROUTINE CALLS SHOULD BE MADE DURING BUSINESS HOURS.

*OUR OFFICE IS OPEN MONDAY THRU FRIDAY 8AM TO 4PM. CALLS MADE AFTER HOURS OR ON WEEKENDS ARE FOR EMERGENCIES ONLY. IF YOU HAVE A CALL BLOCK ON YOUR PHONE, PLEASE TURN IT OFF SO OUR PROVIDERS ARE ABLE TO RETURN YOUR CALL.

*ALTHOUGH UNUSUAL WE APOLOGIZE FOR OUR PROLONGED WAIT TIMES, BUT WE OFTEN SEE A LARGE NUMBER OF UNSCHEDULED PATIENTS DUE TO EMERGENCIES.

PATIENT FORMS

THERE IS A **$20.00** FEE FOR FORMS TO BE FILLED OUT. THE PAPERWORK WILL NOT BE COMPLETED UNTIL THE FEE IS RECEIVED. PLEASE DO NOT ASK THE PHYSICIAN TO FILL FORMS OUT DURING OFFICE VISITS. FORMS ARE DONE ON A FIRST COME FIRST SERVED BASIS AND WE REQUIRE 7 DAYS TO PROCESS PAPERWORK.

FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST CARE AND IN RETURN EXPECT FULL AND PROMPT PAYMENT FOR OUR SERVICES. YOUR CLEAR UNDERSTANDING OF THE ABOVE POLICIES IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP.

WNY KNEE AND ORTHOPEDIC SURGERY. PC

Keith C. Stube, MD **Michael A. Parentis, MD** **Steven Karnyski, MD**
Allison Morganti, RPA-C Monica Bailey, RPA-C Harmony DePan, RPA-C

180 Park Club Lane, Suite 225, Williamsville, NY 14221 716-839-5858
3085 Southwestern Boulevard STE 203 Orchard Park, NY 14127 716-508-8252

HIPAA-Your Health Information is Protected by Federal Law

What Information is Protected?

- Information your doctors and other health care providers put in your medical record.
- Conversations your doctor has about your care or treatment with others.
- Information about you in your health insurers computer system.
- Billing information about you from your clinic/healthcare provider.
- You decide if you want to give permission before your health information may be shared.
- If you believe your health information isn't being protected, you can:
  File a complaint with your health care provider or health insurer
  File a complaint with the US Government
- You can ask your provider or health insurer questions about your rights.

Providers and health insurers are required to follow this law and must keep your information private by:

- Teaching people who work for them how your information may and may not be shared.
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure your information is protected in a way that does not interfere with your healthcare, you information can be used and shared:

- For your treatment and care coordination.
- To pay doctors and hospitals for your healthcare.
- With family, friends or others you identify who are involved with your healthcare.

For more information:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Date: Full Mth day, Year

PLEASE PRINT
Name: Pat Whole Name (First Name First) **Date of Birth**:Pat DOB **Date**: Full Mth day, Year

Age: Age Height_____ Weight_____ Acct #

Primary Care PhysicianPCP Whole Name (First Name First)
Referred by: _____

Location of Pain: _____ ☐ **Left** ☐ **Right** ☐ **Bilateral**

What causes the pain? _____

Pain Quality: ☐No Pain ☐Burning ☐Sharp ☐Sore ☐Stabbing ☐Throbbing ☐Stiffness

Pain Severity: ☐0 (none) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (severe)

Length of Current Problem: Days____ Weeks____ Months____ Years____

Pain Timing: ☐Continuous ☐Intermittent ☐Occasional ☐Worse at night ☐Worse with activity

Aggravates your Pain: ☐Activity ☐Bending ☐Moving ☐Sitting

Alleviates your Pain: ☐Anti-inflammatories ☐Rest ☐Heat ☐Ice

Associated symptoms: ☐Catching ☐Giving Out ☐Popping ☐Spasms ☐Stiffness

Past Medical Problems:_____
_____

Past Surgical History

Operations Performed	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REVIEW OF SYSTEMS

Gastrointestinal (GI)
☐ Abdominal Pain
☐Diarrhea
☐Nausea
☐Vomiting
☐Reflux

Cardiovascular
☐Chest Pain
☐Fainting
☐Leg Swelling
☐Ankle Swelling
☐Exercise Intolerance

Musculosketal
☐ Muscle Cramps
☐Stiffness
☐Back Pain
☐ Joint Pain
☐ Joint Swelling

Neurologic
☐Blackouts
☐Fainting
☐Headaches
☐Tingling

Respiratory
☐Difficulty Breathing
☐Cough
☐Congestion
☐Wheezing

Blood/Lymph
☐Easy Bleeding
☐Excess Bleeding
☐ Enlarged Lymph
☐Easy Bruising

Work Related? ☐Yes ☐No Lawsuit? ☐Yes ☐No Attorney Name:_____
Occupation:_____ List prior Job if retired _____
Marital Status ☐Single ☐Married ☐ Widowed ☐ Divorced # of children_____
Do you smoke? ☐Yes ☐No Packs per day_____#years smoked_____ if quit,when_____
Do you drink alcohol ☐Yes ☐No #Drinks per day_____

WNY KNEE AND ORTHOPEDIC SURGERY, PC

Name: Pat Whole Name (First Name First) **DOB: Pat DOB**

ALLERGY/MEDICATION LIST

Pneumococcal Vaccine? ☐Yes ☐No If yes, date: _____
Influenza Vaccine? ☐Yes ☐No If yes, date: _____

If you have any **allergies** to any drugs, food, etc, please list them below:

_____
_____
_____

☐ **NO KNOWN DRUG ALLERGY**

If you are currently taking any **PRESCRIPTION medications**, please list them below:

Name	Dosage	How Often
Name	Dosage	How Often
Name	Dosage	How Often
Name	Dosage	How Often
Name	Dosage	How Often
Name	Dosage	How Often
Name	Dosage	How Often
Name	Dosage	How Often
Name	Dosage	How Often
Name	Dosage	How Often

WNY KNEE AND ORTHOPEDIC SURGERY, PC
FOOT & ANKLE • HIPS • KNEES • SHOULDERS
SPECIALIZING IN SPORTS INJURIES & MEDICINE

Date: Full Mth day, Year

KEITH C. STUBE, M.D.
ALLISON MORGANTI, RPA-C
MONICA BAILEY, RPA-C

MICHAEL A. PARENTIS, M.D.
HARMONY DEPAN, RPA-C

To: All Patients

From: Providers of WNY Knee and Orthopedic Surgery, PC

Re: Estimates on Deductibles and Procedures

Due to recent changes in government and insurance policies, the providers of WNY Knee and Orthopedic Surgery, PC are working to be proactive and give patients estimates for upcoming procedures and visits when they have deductibles and changes in co-payments.

When procedures are considered elective, we will be asking for payment up front. Our staff is working diligently to get you this information, but as you are aware, deductibles update on a daily basis. Our staff will inform you prior to your surgery of the cost related to your procedure. VISCO injections and Durable Medical Equipment are also services that we render to our patients. These services can be costly when you still need to meet your deductible and/or coinsurance. Should you decide to move forward and receive the service, our policy is to collect your portion at the time of the visit. Our goal is to give you this information prior to the service being rendered.

If you have any questions regarding your deductible or coinsurance, please call our billing department at 839-5858 option 9 and a billing representative will help you.

Date: Full Mth day, Year
PATIENT NAME: Pat Whole Name (First Name First)
PATIENT DOB: Pat DOB
PAITENT ACCT NUMBER: Acct #

PATIENT FINANCIAL STATEMENT

We are committed to providing you with the best care, and in return, expect full and prompt payment for our services. Your clear understanding of the following policies and your responsibility is important to our professional relationship:

* Copayments/Deductibles are due at the time of service.
* Our office requires a 24 hour notice when cancelling an appointment, otherwise a $50.00 fee may be charged to your account.
* We participate in most insurance plans. However, insurance is primarily a contract between you and your carrier. We must comply with the rules and regulations of your policy. Therefore, any balance due, per your carriers notification, is your responsibility. Please be aware of your covered benefits.
* We charge a $30.00 fee for any check returned by the bank.

Insurance coverage information for accidents related to Workers Compensation, No Fault or Liability **MUST** be provided at the **INITIAL** visit for the treatment. **Changes to history and insurance coverage will NOT be accepted once treatment has begun.**

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS/COVERAGE & BENEFITS
I have reviewed & understand the above financial policy & agree with the stated terms. I also authorize direct payment of medical benefits to the WNY KNEE AND ORTHOPEDIC SURGERY, PC & the release of medical information necessary for treatment, payment & healthcare operations.

I understand that it is my responsibility to verify with my health insurance whether or not WNY KNEE AND ORTHOPEDIC SURGERY, PC is a participating provider. I hereby agree to pay the full amount of my office visit/surgery at the time of service if they are a non-participating provider. I understand that any balance that has not be satisfied at the time of service will be due immediately upon receipt of my first statement. If payment is not received or other arrangements are not made, further collection activity will commence. If we send your account to collection, an additional charge will be added to your account.

Effective 01/01/2021
Accounts not paid within 60 days of the 1st statement are subject to a $5.00 finanace charge.

*** **We are NOT a NEW YORK STATE MEDICAID provider. Therefore we do not participate with this insurance. Should you decide to come to this practice it is your responsibility to pay any copays or coinsurances.**

WE ACCEPT MASTER CARD, VISA AND DISCOVER CARD FOR PAYMENT OF ALL CHARGES.

SIGNED: DATED: Full Mth day, Year

Signed: _____ Dated: _____

MICHAEL A. PARENTIS, M.D.
Hamony DePan, RPA-C

NORTHTOWNS
180 PARK CLUB LANE, STE 225
WILLIAMSVILLE, NY 14221
(P) 716-839-5858 **(F) 716-839-5925**

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WNY KNEE AND ORTHOPEDIC SURGERY, PC LIST OF PROCEDURES

We are specialists in ALL surgeries of the knee; however we do more than knee procedures. This includes:

HIP
- Total Hip replacements
- Treatment of all Hip Fractures

SHOULDER
-Rotator Cuff Repair
-Total Shoulder Replacements
-Reverse Total Shoulder Replacement
-Bursitis/Tendonitis
-Instability Repair
-Arthroscopy

ANKLE
-Instability Correction
-Fractures
-Total Ankle Replacements
-Arthroscopy
-Any Achilles problem

FOOT
-Bunion/Bunionette
-Claw Toes
-Arthritis
-Any big toe problems
-Plantar Fasciitis
-Cysts and Ganglions
-Fractures

ELBOW
-Arthroscopy
-Tendonitis and Golfer's Elbow

HAND
-Fractures
-Carpal Tunnel Syndrome
-Cysts
-Trigger Finger

PRP INJECTIONS

PATIENT PORTAL

Our office encourages you to sign up for the Patient Portal.

The Patient portal offers secure communication for existing patients. Access your patient files, communicate with your provider, request prescription refills, change or cancel an appointment, send a message, and so much more.

Patients can enter and update their patient demographic and insurance information.

Patients can enter and update their Past Medical, Family and Social History. The practice has the ability to control the content which is uploaded.

Patients can receive lab orders, diagnostic imaging orders, and general orders via the MEDENT Patient Portal. They can also receive their lab, diagnostic imaging, and order results.

Communicate messages securely to your provider.

You are able to request appointments.

Patients can cancel appointments within a time frame determined by the practice if less than 24 hours from the scheduled appointment.

Patients can request prescription refills.

Patients can edit their pharmacy information.

Patients can add and remove medications and allergies.

Our office can generate documents and export them to your portal. This could be used for education materials, excuses and permission letters, or the Clinical Visit Summary.

Patients will have access to a summary of their chart. A patient can log in via their portal account and retrieve an electronic summary of their chart in the form of a CCD or PDF.

Patients can attach image files to messages they send the practice.

IF YOU ARE INTERESTED IN BECOMING A PORTAL PATIENT PLEASE ASK THE FRONT OFFICE FOR A SECURE SIGN IN.