Nebraska Hand & Shoulder Institute, P.C.

Dolf R. Ichtertz, M.D.

Thank you for choosing NHSI as your Orthopaedics provider. Be certain you fill out the paperwork completely before you arrive to your appointment so you will receive full and proper treatment. **A Photo Id (driver's license) and a *legible* Insurance Card are required at time of visit.** If not present with you upon appointment, you will be rescheduled.

Your appointment is scheduled for:

_____ _____

DATE **TIME**

Grand Island
716 N Alpha St

Omaha
17030 Lakeside Plaza Hill, Ste #122

Lincoln
1919 S 40th St., Suite 333

Payment Policy and Policy Regarding SSN

We require that your Social Security Number be provided to our billing department before being seen by the doctor. The SSN is not needed for scheduling purposes, but we must have it recorded in the check-in paperwork or your appointment will be canceled. We apologize for any inconvenience. We will bill your insurance carrier on your behalf. All co-payments are due at the time of registration. We accept cash, check, Visa, MasterCard and Discover or you may call (800) 839-9078 to apply for Care Credit.

In Network

We are in network with Blue Cross Blue Shield, Aetna, Coventry, and various First Health plans. Due to the high variance in Coventry and First Health plans, we recommend you contact your insurance carrier to verify your benefits with our provider.

Out of Network

For out-of-network insurance, we will bill your insurance carrier on your behalf (excluding Medicare). Your benefits may differ from an in network provider. We recommend you contact your insurance carrier to clarify. Because your benefits may be less, prior to seeing the doctor **we require a $250.00 deposit for any out-of-network or self pay patients**. This payment will go toward your portion of the bill; it is NOT an additional charge. Any overpayments will be reimbursed in a timely manner.

Worker's Compensation Claims

If you choose to file a worker's compensation claim, this must be completed before you schedule an appointment with our office. Once the visit is submitted to your private insurance, we will not bill a worker's compensation carrier. If you are considering filing a worker's compensation claim, please contact us before your scheduled appointment.

Late Patients and No Call/ No Shows

Should circumstances arise that you will be **15 minutes or more** late to your appointment, please contact our office at (800) 433-9147, so if necessary we can reschedule your appointment. New patients that fail to give a 48-hour cancellation notification will be subject to a **$75.00 no show fee**. This allows us to schedule patients that are waiting to see the Doctor. Existing patients will be subject to a **$45.00 no show fee**.

Children

We request that you do not bring children under the age of 12. There is limited space in the exam rooms and children may cause interference with doctor/patient communication.

Nebraska Hand & Shoulder Institute, P.C.

716 Alpha Street • Grand Island, NE 68803 • (308) 398-4263 (HAND) • (800) 433-9147

PATIENT INFORMATION

Patient's Name _____ Prefer to be Called: _____ Account#_____

(First) (Middle) (Last) Family Dr. & Phone _____

Address _____ Allergies _____

City/St/Zip _____ Pharmacy Name _____

Birthdate _____ Age ____ SS# _____ Pharmacy Phone _____

Home Phone _____ Cell _____ Spouse's Name _____

Work Phone _____ Ext. _____ Spouse's Employer _____

Employer _____ Spouse's Work Phone _____ DOB _____

Employer's Address _____ Spouse's SS# _____

Job Title _____ Language Spoken _____

Personal Email_____

Referred By: Radio _____ Paper _____ Doctor _____ Friend/Relative _____Phonebook _____ Internet _____

Type of Insurance (circle one): Self Pay BCBS Coventry Aetna insurance _____

HAVE YOU FILED A WORKER'S COMP CLAIM FOR THIS PROBLEM/VISIT?

Injury Date _____ Claim No. _____

Ins Carrier _____ Resp. Employer _____

Claims Representative _____

Claim Rep Phone _____ Fax _____

Address _____

Nurse Case Manager _____

IN CASE OF EMERGENCY (Must list an alternate phone number to those provided above.)

Contact _____ Address _____

Phone _____ City/St/Zip _____

I authorize all payments from my Medicare, worker's compensation and/or medical insurance carrier to be paid directly to Dolf R. Ichtertz, M.D., Nebraska Hand & Shoulder Institute, P.C., for services and/or supplies rendered to me. I give my consent to Dolf R. Ichtertz, M.D., Nebraska Hand & Shoulder Institute, P.C., to release medical records to the Health Care Financing Administration, its agency, my insurance carrier or any public agency Dolf R. Ichtertz, M.D., Nebraska Hand & Shoulder Institute, P.C., deems appropriate.

The following does not apply if service is for an APPROVED worker's compensation claimant: I accept financial responsibility for charges not covered or not paid by my insurance carrier. I understand that any balance outstanding 45 days after services are rendered will begin accruing interest at 1.5% per month – 18% per annum. I understand that if I No Call/No Show I am responsible for that fee. I also understand that I may be subject to additional costs of collection and/or attorney fees in the event of default on payment.

Signature _____ Date _____

Having signed this signifies I have received a copy of the NHSI, P.C. Privacy Policy.

Updated: _____ Updated: _____ Updated: _____

(OVER)

Reason for Visit _____

Medications (Mark all that apply) Add drug name and dosage ☐ NONE Other_____

☐ Blood Pressure _____ ☐ Anti-Depressant _____ _____

☐ Cholesterol _____ ☐ Diabetes _____ _____

☐ Blood Thinner _____ ☐Vitamins _____ _____

☐ Pain Reliever_____ ☐ Supplements_____ _____

Allergies to medications (Specify reactions. Note: Nausea is not an allergy) _____

_____

History of Surgery (Mark all that apply) ☐ No Previous Surgery Other _____

☐ Rotator Cuff ☐ Hernia Repair ☐ Arthroscopy _____

☐ Joint Replacement ☐ Neck Fusion ☐ Where:_____

☐ Hip_____ ☐ Lumbar Fusion ☐ Heart Valve Replacement _____

☐ Knee_____ ☐ Appendectomy ☐Pacemaker

☐ Shoulder_____ ☐ Carpal Tunnel Release ☐ Coronary Bypass _____

Medical History & Review of Systems (Mark all that apply) Other _____

☐ Any Known Heart Disease ☐ Gout, Arthritis, Joint Trouble _____

☐ High Blood Pressure ☐ Where?_____

☐ Chest Pain ☐ Digestive Problems _____

☐ Palpitations or Irregular Beats ☐ Ulcer in Past

☐ Swelling of Lower Legs ☐ Reflux _____

☐ Heart Arrhythmia ☐ Lung Disease

☐ Atrial Fibrillation ☐ HIV _____

☐ Heart Attack (Year_____) ☐ Hepatitis (A, B, or C?)

☐ Severe or Frequent Headaches ☐ Kidney Disease _____

☐ Stroke/TIA ☐ Difficulty Controlling Bladder

☐ Diabetes (Type I or II?) ☐ Nervous Disorders _____

☐ COPD/Asthma ☐ Tremors or Shaking

☐ Cancer _____ ☐ Stumble/Fall a lot _____

Personal Habits

Do you smoke regularly? ☐ Yes ☐ No ☐ Cigarettes ☐ Pipe ☐ Cigars How many/day? _____ How many years? _____

Do you drink alcohol regularly? ☐ Yes ☐ No Beer: ☐ 1 bottle per day ☐ 2 bottles per day ☐ Over 4 bottles per day

Other: ☐ 1 oz. per day ☐ 2 oz. per day ☐ 4 oz. per day ☐ Over 6 oz. per day

Do you have difficulty falling asleep? ☐ Yes ☐ No Is this the reason you are here? ☐ Yes ☐ No

Height _____ **Weight** _____ **lbs.**

Illness of Blood Relatives

☐Cancer ☐Diabetes ☐Heart Disease ☐Arthritis ☐Tuberculosis ☐Stroke ☐High Blood Pressure ☐Epilepsy ☐Asthma ☐Suicide

		IF LIVING		IF DECEASED	
FAMILY HISTORY	SEX	AGE	HEALTH	AGE AT DEATH	CAUSE OF DEATH
Father	XX				
Mother	XX				
(List Brothers/Sisters)	M F				
	M F				
	M F				
	M F				

Reviewed by: _____ Date: _____

Nebraska Hand & Shoulder Institute, P.C.
Dolf R. Ichtertz, M.D.

LOWER EXTREMITY QUESTIONNAIRE

Name_____ Date_____

Chief Complaint_____

_____

_____

Duration of symptoms_____

What makes it better?_____

Symptoms are worsened when walking _____ sitting _____ lying down _____

Comorbidities:	RIGHT		LEFT	
Leg cramps?	Y	N	Y	N
Diabetes?	Y	N	Y	N
Chronic low back pain?	Y	N	Y	N
Pain/abnormal sensations from buttocks to foot?	Y	N	Y	N

Do You Have Problems With:				
Difficulty walking?	Y	N	Y	N
Awakening at night due to legs/feet?	Y	N	Y	N

Numbness/burning in toes

	R	L
Great	_____	_____
2nd	_____	_____
3rd	_____	_____
4th	_____	_____
Small	_____	_____
Top of feet	_____	_____
Bottom of feet	_____	_____

How often do you have symptoms and numbness/burning:_____

Family Medical History:

How many brothers do you have?_____ How many sisters do you have?_____

How many children do you have?_____ List their ages:_____

Treatment Received to Date:

			DURATION
Medications?	Y	N	_____
Injections?	Y	N	_____

	RIGHT		LEFT		
Arch supports	Y	N	Y	N	_____
Chiropractic?	Y	N	Y	N	_____
Job or activity modification?	Y	N	Y	N	_____