Ranawat Orthopedics HSS

- ❒ Chitranjan S. Ranawat, M.D.
- ❒ Amar S. Ranawat, M.D.
- ❒ Anil S. Ranawat, M.D.

Financial Interest Disclosure Form
Medical Staff, Allied Health Professional Staff,
Residents, and Fellows

As your treating physician(s) and as a member(s) of the Medical Staff of Hospital for Special Surgery (HSS), we would like you to know that we have several financial relationships with orthopedic device companies whose products we may use in your care at HSS. The following will provide you with information about our current financial relationships for Ranawat Orthopedics HSS:

Dr. Amar Ranawat:
Dr. Amar Ranawat is a consultant for Ceramtec, LTD, Convatec and DePuy Orthopedics, Inc. Dr. Ranawat also receives research support from Ceramtec, LTD.

Dr. Anil Ranawat:
Dr. Anil Ranawat is a consultant on the unicompartmental knee team for Stryker - MAKO Surgical Corp. Dr. Ranawat is Editor-in-Chief for which receives salary support from Springer, and receives royalties from Elsevier, Inc.

Dr. Chitranjan Ranawat:
Dr. Chitranjan Ranawat is a consultant and product designer for DePuy Orthopedics, Inc. on the Sigma® and Attune™ total knee prosthesis systems for which he receives royalty payments.

WE DO NOT RECEIVE ANY PAYMENTS FROM THESE COMPANIES FOR USE OF THEIR PRODUCTS FOR YOUR CARE AT HSS OR FOR THE CARE OF ANY OTHER PATIENTS AT HSS.

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with us, you may either contact the Hospital's Office of Corporate Compliance (212-774-2398), or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship disclosed to you, you choose to refuse a particular treatment, operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that you understand the financial interest or relationship described above. You also confirm that you have the right to ask any questions to your providing physician.

Signature_____
Patient/Parent/Guardian/Health Care Agent **Date**

Print Name_____
Patient/Parent/Guardian/Health Care Agent

_____
Relationship to Patient

PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD

For Office Use Only: If the patient does not sign this acknowledgment form, record here the good faith efforts made to obtain this acknowledgement.

_____
_____
_____

PATIENT REGISTRATION

Chitranjan Ranawat **Amar Ranawat** **Anil Ranawat**

Last Name_____First Name_____Date_____

Address_____Apt. #_____

City_____ State_____ Zip_____

Sex M F Date of Birth_____ SS# _____-_____-_____

Home Phone_____ Work_____Cell _____

Occupation_____ presently working_____ Yes _____ No

May we contact you via email regarding:
Your Appointment, Billing, Research Y_____ N_____ Email:_____

Is your current problem related to
a claim for worker's compensation or a current or potential lawsuit? Y_____ N_____

Emergency Contact

Name_____Phone_____ Relationship_____

Primary Care Physician

Name_____Phone_____Fax number_____

Address_____ City_____ State_____ Zip Code_____

Referring Physician

Name_____Phone_____ Fax number_____

Address_____ City_____ State_____ Zip Code_____

<u>Primary Insurance Information</u>

(*Please present your insurance card to the front desk staff*)

Primary Insurance Carrier_____
Policy #_____ Group #_____
Name of insured_____

<u>Secondary Insurance (Circle one)</u>

Medicare, Private Insurance, Workmen's Compensation, NO-Fault

Insurance Carrier_____

Policy # _____ Group #_____

WCB# (worker's comp) _____ Date of Accident_____

PATIENT REGISTRATION

Chitranjan Ranawat Amar Ranawat Anil Ranawat

Assignment and Release

I, the undersigned, have insurance coverage with_____and assign all medical benefits to: Ranawat Orthopaedics or Anil Ranawat. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian_____ Date _____

Referral

I realize that my particular insurance plan might require a referral for me to be seen by any of the physicians employed by Ranawat Othropaedics or Anil Ranawat. If at any time I fail to obtain a referral for a particular visit, I will be responsible for obtaining a valid referral from my primary care physician (PCP). If a valid referral is not possible, I will be solely responsible for all charges.

Signature of Insured/ Guardian_____ Date _____

HIPPA Privacy Notification

I, the undersigned, have been issued the HIPAA Notice of Privacy Practices. I fully understand that Ranawat Orthopaedics, PLLC is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose any health information for the purposes of treating me, obtaining payment for services referred to me and conducting health care operations.

Signature of Insured/Guardian_____ Date _____

CONFIDENTIAL MEDICAL HISTORY

Chitranjan Ranawat **Amar Ranawat** **Anil Ranawat**

Last Name_____ **First Name**_____

Age _____ **Occupation** _____

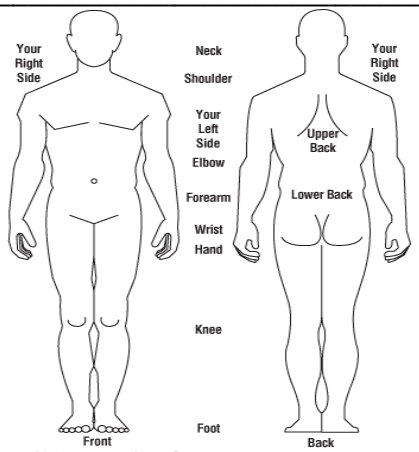
Referring Physician: _____

Chief Complaint: _____

Date of injury or onset of symptoms: _____

Describe the injury or problem: _____

_____



Where is your pain? Please Mark the Drawing
Rate your pain:
0= No Pain **10= Extreme pain**
Right now: **0 1 2 3 4 5 6 7 8 9 10**

What makes it better? _____
_____
What makes it worse? _____
_____

YOUR MEDICAL HISTORY

Have you ever been hospitalized? Yes _____ **No**_____ **(If yes, why?)**_____

_____

Have you ever had surgery? Yes_____ **No** _____ **(If yes, when?)**_____

_____

Do you think you might be pregnant at this time? Yes _____ **No** _____

Have you ever had a blood clot? Yes _____ **No** _____

Does anyone in your family have any of the following problems? Please Circle

Heart Disease	**High Blood Pressure**	**Anesthesia complications**
Cancer	**Nerve problems**	**Blood problems (anemia, abnormal bleeding)**
Stroke	**Diabetes**	**Other:** _____

Medical Profile

Name:_____

Current Medications:

Medications	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Medical History: Please **circle** appropriate response(s) and **write in answer where appropriate**

General Health: Excellent Good Fair Poor

Head: Headaches History of Injury Other (Please Describe): _____

Neck: Any Issues (Please Describe): _____

Skin: Any Issues (Please Describe): _____

Eyes: Loss of Vision Glasses Cataract Other (Please Describe): _____

Ears: Hearing Loss Other (Please Describe): _____

Nose/Throat: Bleeding Sinus Trouble Other (Please Describe): _____

Respiratory: Asthma Other (Please Describe): _____

Heart: Chest Pain Heart Disease Irregular Heartbeat High Blood Pressure Other__

Bleeding: Any Issues (Please Describe): _____

Metabolic: Diabetes Hypothyroid Other (Please Describe): _____

Stomach/Bowel: Constipation Nausea/Vomiting Bleeding Other (Please Describe): _____

Urinary: Leakage Discharge/Drainage Other (Please Describe): _____

Neurological: Headaches Seizures(epilepsy) Stroke Numbness Other: _____

Prior Diseases: Hepatitis AIDS Herpes Infection Involving Joint Other: _____

Prior Surgeries: Thyroid Surgery Heart Bypass Appendectomy Back Surgery Arthroscopy Other___

Allergies: Penicillin Food (list): Other: _____

Do you Smoke? Yes No If yes, number of packs per day? Number of years?_____

Do you Drink? Yes No If yes, number of drinks per week? Number of years?_____

Current Height: _____ **Current Weight:** _____