Printed on: 10/18/2017

Patient Information

Personal Information				
First Name	EMILY	Middle Name	-	
Last Name	EDWARDS	D.O.B	01/24/2003	
Gender	Female	Address	423 SOUTH FULLTON AVE APT3	
City	MOUNT VERNON	State	NEW YORK	
Cell Phone #	347-206-6391	Home Phone	718-881-5845	
Work	-	Zip	10553	
Email	-	Extn.	-	
Attorney	DOMINICK LAVELLE	Case Type	No-Fault	
Attorney Address	100 HERRICKS ROAD SUITE 201	Attorney Phone	800-745-4878	
Case Status	OPEN	SSN	-	

Insurance Information				
Policy Holder	-	Name	LIBERTY MUTUAL INS.	
Address	P.O. Box# 1052	City	Montgomeryville	
State	PENNSYLVANIA	Zip	18936-1052	
Phone	800 245-1700	Fax	-	
Contact Person	-	Claim File #	034381648	
Policy #	AOS228001979405			

Accident Information			
Accident Date	09/14/2016	Plate Number	-
Report Number	-	Address	-
City	-	State	-
Hospital Name	-	Hospital Address	-
Date of Admission	-	Additional Patient	-
Describe Injury	-	Patient Type	Passenger

Employer Information			
Name	-	Address	-
City	-	State	-
Zip	-	Phone	-
Date of First Treatment	-	Chart #	-

Adjuster Information			
Name	-	Phone	-
Extension	-	Fax	-
Email	-		



92-12 165th St, Jamaica, NY 11433

Phone: 201-549-9998 Ext. 1279 Fax: 646-585-4468

Email: verification@starssi.com

Surgical Booking Form

Patient Email: _____

			gcai booking		
		Pa	tient Information	on	
IAST	FIRST	N	MI □ M □ F	DOB	AGE
STREET ADDRESS				SOCIALS	ECURITY #
CITY		STATE 7	ZIP	EMERGENCY CONTA	ACT
HOME #	WORK#	CELL#		EMERGENCY #	
		Surgic	al Procedure Inform	ation	
surgeon Dr. Anjani Sinh	na		ASSISTING SURGEON		
REQUEST DATE #1 T	TME	REQUEST DATE #2	TIME	LENGTH CASE	OF
PRIMARY PROCEDURE NAME	□ LEFT □ RIGHT		CPT CODE #2	CPT CODE #3	CPT CODE #4
SURGICAL DIAGNOSIS NAME	□ LEFT □ RIGHT	ICD-9 CODE #1	CD-9 CODE #2	ICD-9 CODE #3	ICD-9 CODE #4
		Pre-Op	erative Medical Clea	агапсе	
DOES THE PATIENT REQUIRE PRE-C	OP MEDICAL CLEARA 1 NO	ANCE? I	F YES, NAME OF CLE	ARING PHYSICIAN AN	D PHONE #:
DOES THE PATIENT REQUIRE AN EI	KG? (NO	I	PATIENT HEIGHT	PATIENT	WEIGHT
			Special Requests		
EQUIPMENT Smith & Neph	new	S	SUPPLIES		
INSTRUMENTATION			OTHER		
			surance Informatio		
	YES DO	PLEASE ATTACH	CASE CLA	IM #	DATE OF INJURY
	YES □ NO	AUTHORIZATION LETT	EK		
	YES DO	ATTORNEY I	NAME		ATTORNEY PHONE #
PLEASE ATTACH SIGNED LIEN	210				
PRIMARY INSURANCE	SUBSCRIB	ER NAME	SUBSCRIE	BER SSN	SUBSCRIBER DOB
POLICY #	RELATION	SHIP TO PATIENT SELF SPOUSE	□ PARENT □ O	THER	
SECONDARY INSURANCE	SUBSCRIB	ER NAME	SUBSCRIE		SUBSCRIBER DOB
POLICY #	RELATION	SHIP TO PATIENT SELF SPOUSE	□ PARENT □ O	THER	
EMPLOYER NAME		EMPLOYER ADDRESS			ER PHONE #
EWFLOTER NAME					ER PHONE #
			Pre-Certification Aut		
INSURANCE COMPANY PHONE #		INSURANCE CO. REPRE	SENTATIVE	AUTH#	DATE OF AUTH.
		Surgeon	n's Scheduler's Infor	mation	
NAME Clara Clement		PHONE #	347-433-4855		FAX # 929-333-7950
		Treatin	ng Physical Therapy	Office	
NAME	PHONE #		DRESS		
Transportation: □ YES □ NO					

SCOB, LLC 313 43rd Street · Brooklyn, NY 11232

Information and Consent for Procedure

I hereby authorize the following doctor(s): <u>Christopher S. Durant</u> and any such assistants a may be select him/her to perform the following procedure(s) on me: <u>Left Knee arthroscopy, meniscectomy</u> , shaving chondroplasty and related procedures.	ted by	
	-	
I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarant have been made to me concerning the result of the procedures.	ees	
It has been explained to me that during the course of the procedures, unforeseen conditions may be revealed necessitate additional or different procedures than those set forth in paragraph 1. I, therefore, authorize and request that the above named practitioner(s), his/her assistants, or his/her designees perform such procedurare necessary and desirable in the exercise of professional judgment. The authority granted under this para 3 shall extend to treating all conditions that are not known at the time the procedure is undertaken.	ires as	
I have been informed of the risks that are generally associated with the performance of any procedure and to administration of anesthesia, I further understand that there may be serious consequences such as headact neurological or sensory disturbances, bowel/bladder dysfunction, infection, soreness, permanent pain, delay healing, numbness, tingling, non-healing, need for future procedures or other calamitous occurrence. I under that there may be certain risks especially associated with the procedures described in paragraph 1. I have a and am satisfied that I know to the extent that I wish to know what those risks may be. I accept those risks.	yed erstand	
I consent to the photographing or videotaping of the surgery or procedure(s) to be performed, including appropriat portions of my body for medical, scientific, or educational purposes, provided that my identity is not revealed by the pictures or by descriptive text accompanying them.		
consent to the presence of observers in the operating room, such as students, medical residents, medical equipment representatives or appropriate parties approved by my surgeon.		
I authorize and consent the surgery center to perform any blood tests, including but not limited to, tests for he Hepatitis B, and Hepatitis C on any patient, during whose treatment a healthcare professional sustains a purpulation of the performance or open wound exposure to the patient's blood or other bodily fluids.	∃IV, incture,	
I consent, authorize and request the administration and management of such anesthesia as is deemed suitable the anesthesiologist assigned to my procedure. It is my understanding that the anesthesiologist will have fur charge of the administration and management of the anesthesia and any other necessary, associated procedure anesthesia.	edures	
I acknowledge that the foregoing information does not cover all of the specific information that has been proby the above named practitioner. But, the information set forth above was provided to me and I have had further opportunity to ask questions and to have received additional information.	ovided ill	
I have apprised the patient of the foregoing.		
// Time		
Patient Signature/or Authorized Representative Witness/Interpreter Signature Physician Signature	re	
The patient is unable to sign because, I therefore consent for the	patient	
Person signing on behalf of the Patient Relationship to the Patient		

INTRAOPERATIVE FINDINGS

Right / Left KNEE __ MMT (51) __ LMT (52) __ Patella, grade: 1 2 3 4 (54) ___ Trochlea, grade: 1 2 3 4 (55)_____ __ LFC, grade: 1 2 3 4 **(56)**_____ __ NFC, grade: 1 2 3 4 (57) ___LTP, grade: 1 2 3 4 (58)_____ ___ MTP, grade: 1 2 3 4 (59) _____ grade: 1 2 3 4 (60) __ Loose fragments (61) ___ Medial plica (62) ____ __ Synovitis (63) _____ __ Adhesions- anterior wall / suprapatellar pouch (64) Other: Preoperative Dx: Assistant: Anesthesia: Instrumentation/Other:

Lysis of Adhesions (65) ____ Bilateral Meniscectomy (66)

	Right / Left KNEE		
	CPT CODES (PROCEDURES)	ICD-10 CODES (POST-OP DI	AG)
	27570 MVA. (51)	M22.40 Chondro malacia patella. (51)
	29870 Diagnostic arthroscopy; Knee. (52)	M23.40 Loose body in knee. (52)	
	29873 SAK; with lateral release. (53)	M23.90 Internal derangement of I	knee. (53)
	29874 with removal of loose body or foreign body. (54)	S83.241A Medial meniscus tear, r	t knee. (54)
	29875 Limited synovectomy (plica resection). (55)	S83.242A Medial meniscus tear, le	eft knee. (55
	29876 Synovectomy (major; 2 or more compartments). (56)	S83.281A Lateral meniscus tear, n	t knee. (56)
	29877 Debridement (chondroplasty). (57)	S83.282A Lateral meniscus tear, le	eft knee. (57
	29879 Microfracture abrasion chondroplasty. (58)	M12.569 Traumatic arthropathy o	f knee. (58)
	29880 PMM and PLM. (59)	M65.161 Synovitis, right knee. (59	3)
	29881 PMM or PLM. (60)	M65_162 Synovitis, left knee. (60)	
	29882 MED or LAT meniscus repair. (61)	M24.10 Chondral lesion, right kne	e. (61)
	29883 MED and LAT meniscus repair. (62)	M24.10 Chondral lesion, left knee	. (62)
	29888 ACL reconstruction. (63)	M93.261 Osteochondral lesion, rig	ght knee. (63
	20610 Arthrocentesis (aspiration and/or inject) of a joint. (64)	M93.262 Osteochondral lesion, le	ft knee. (64)
	29999 Coblation arthroplasty, patella. (65)		
	29884 Lysis of adhesions/suprapatellar pouch/ant. wall. (66)		
	No Medial/Lateral Meniscal tear seen (51)		
	Medial/Lateral Meniscectomy (52)		
	Medial/Lateral Meniscal Repair (53)		
	Debridement of ACL (54)		
	Major Synovectomy (55)		
	Chondroplasty (Medial/lateral) Condyle (56)	Chondroplasty (Patella/Trochlea) (67)	
	Chondroplasty (medial/lateral) tibial plateau (57)		
	Abrasion Chondroplasty (Mediai/Lateral condyle) (medial/la	ateral tibial plateau) (patella/trochlea) ((58)
	Coblation Arthroplasty (Medial/Lateral condyle) (patella/ tro	ochlea) (59)	
	Coblation Arthroplasty (Medial/Lateral) tibial plateau (60)		
	ACL Reconstruction (61)		
	Lateral Release (62)		
	Removal of Loose Bodies (63)		
_	Medial Plica Excision (64)		
	· · · · · · · · · · · · · · · · · · ·		

	Pre-Op Knee Tem WC NF Lien	Other		
Working: N Y Stopped: Returned: Refurning: Restrictions: N Y: Receiving PT: N Y: Taking med. for pain: N Y: Knee pain: 1 2 3 4 5 6 7 8 9 10/10 constant intermittent Worsens: ROM walking standing squatting Radiates: up thigh down leg There is clicking buckling numbness/tingling giving way locking Knee: within normal limits Inspection: normal. Swelling over the anterior posterior aspect suprapatellar para patella subpatellar aspect medial lateral joint line. Ecchymosis over the anterior posterior aspect suprapatellar para patella subpatellar aspect medial lateral joint line. Palpation: normal. Tenderness over the anterior posterior aspect suprapatellar para patella subpatellar aspect medial lateral joint line. Effusion anterior posterior aspect suprapatellar para patella subpatellar aspect medial lateral joint line. ROM: normal Strength: normal Limited numbness pain NORM CLAIMANT improving partial Flexion 140 degrees /5 Extension 0 degrees /5 Extension 0 degrees /5 Tests: McMurray Test Pos Neg Apley's Test Pos Neg Anterior Drawer Pos Neg Pos Neg Posterior Drawer Pos Neg Ballottement Test Pos Neg Patellofem. Crepitus Pos Neg Squat Test Dos Neg Squat Test Dos Neg Patellofem. Crepitus Pos Neg Squat Test Dos Neg	MVASeat beltDriver	Front Pa	ssengerRear Pa	ssenger
Receiving PT: _NY:	bikepedestrian			
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Valgus Stress TestPosNeg	Lachman's TestPosNeg			
Ballottement TestPosNeg				
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Eindings/from Pre-op/sheetloose bodies _Patient is currently 100% 75% 50% 25% temporarily totally / partially disa	Joint effusion	Chond	romalacia	
	Eindings/from Pre-op/sheet	(Account)		
Recommendation:	Patient is currently 100% 7	F0/ F00		13 / 13 / 13 23 33 33
		5% 50%	6 25% <u>tem</u>	porarily totally / partially disable