

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	-		



313 43rd St, Brooklyn, NY 11232

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

Email: verification@starssi.com

Patient Email: _____

Surgical Booking Form

Patient Information					
LAST	FIRST	MI	<input type="checkbox"/> M <input type="checkbox"/> F	DOB	AGE
STREET ADDRESS			SOCIAL SECURITY #		
CITY	STATE	ZIP	EMERGENCY CONTACT		
HOME #	WORK #	CELL #	EMERGENCY #		
Surgical Procedure Information					
SURGEON Dr. Christopher Durant		ASSISTING SURGEON			
REQUEST DATE #1	TIME	REQUEST DATE #2	TIME	LENGTH OF CASE	
PRIMARY PROCEDURE NAME	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	CPT CODE #1	CPT CODE #2	CPT CODE #3	CPT CODE #4
SURGICAL DIAGNOSIS NAME	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	ICD-9 CODE #1	ICD-9 CODE #2	ICD-9 CODE #3	ICD-9 CODE #4
Pre-Operative Medical Clearance					
DOES THE PATIENT REQUIRE PRE-OP MEDICAL CLEARANCE?		IF YES, NAME OF CLEARING PHYSICIAN AND PHONE #:			
<input type="checkbox"/> YES <input type="checkbox"/> NO					
DOES THE PATIENT REQUIRE AN EKG?		PATIENT HEIGHT	PATIENT WEIGHT		
<input type="checkbox"/> YES <input type="checkbox"/> NO					
Special Requests					
EQUIPMENT Smith & Nephew		SUPPLIES			
INSTRUMENTATION		OTHER			
Insurance Information					
IS THIS WORKMAN'S COMP?	<input type="checkbox"/> YES <input type="checkbox"/> NO	PLEASE ATTACH AUTHORIZATION LETTER		CASE CLAIM #	DATE OF INJURY
IS THIS NY NO FAULT?	<input type="checkbox"/> YES <input type="checkbox"/> NO				
IS THIS PRIVATE HEALTH INS?	<input type="checkbox"/> YES <input type="checkbox"/> NO				
IS THIS A LIEN?	<input type="checkbox"/> YES <input type="checkbox"/> NO	ATTORNEY NAME		ATTORNEY PHONE #	
PLEASE ATTACH SIGNED LIEN					
PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB		
POLICY #	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				
SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB		
POLICY #	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				
EMPLOYER NAME	EMPLOYER ADDRESS		EMPLOYER PHONE #		
Insurance Pre-Certification Authorization					
INSURANCE COMPANY PHONE #	INSURANCE CO. REPRESENTATIVE	AUTH #	DATE OF AUTH.		
Surgeon's Scheduler's Information					
NAME	PHONE #		FAX #		
Treating Physical Therapy Office					
NAME	PHONE #	ADDRESS			
Transportation: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					

Information and Consent for Procedure

I hereby authorize the following doctor(s): Christopher S. Durant and any such assistants a may be selected by him/her to perform the following procedure(s) on me:

Right Knee arthroscopy, meniscectomy, shaving chondroplasty and related procedures.

I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me concerning the result of the procedures.

It has been explained to me that during the course of the procedures, unforeseen conditions may be revealed that 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 procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph 3 shall extend to treating all conditions that are not known at the time the procedure is undertaken.

I have been informed of the risks that are generally associated with the performance of any procedure and the administration of anesthesia, I further understand that there may be serious consequences such as headaches, neurological or sensory disturbances, bowel/bladder dysfunction, infection, soreness, permanent pain, delayed healing, numbness, tingling, non-healing, need for future procedures or other calamitous occurrence. I understand that there may be certain risks especially associated with the procedures described in paragraph 1. I have asked and am satisfied that I know to the extent that I wish to know what those risks may be. I accept those risks.

I consent to the photographing or videotaping of the surgery or procedure(s) to be performed, including appropriate 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.

I 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 HIV, Hepatitis B, and Hepatitis C on any patient, during whose treatment a healthcare professional sustains a puncture, mucous membrane or open wound exposure to the patient's blood or other bodily fluids.

I consent, authorize and request the administration and management of such anesthesia as is deemed suitable by the anesthesiologist assigned to my procedure. It is my understanding that the anesthesiologist will have full charge of the administration and management of the anesthesia and any other necessary, associated procedures for anesthesia.

I acknowledge that the foregoing information does not cover all of the specific information that has been provided by the above named practitioner. But, the information set forth above was provided to me and I have had full opportunity to ask questions and to have received additional information.

I have apprised the patient of the foregoing.

_____/_____/_____
Date Time

Patient Signature/or Authorized Representative

Witness/Interpreter Signature

Physician Signature

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) _____

___ Partial/Complete tear of the ACL: % _____ (53)

___ Patella, grade: 1 2 3 4 (54) _____

___ Trochlea, grade: 1 2 3 4 (55) _____

___ LFC, grade: 1 2 3 4 (56) _____

___ MFC, 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: _____

Right / Left KNEE

CPT CODES (PROCEDURES)	ICD-10 CODES (POST-OP DIAG)
___ 27570 MVA. (51)	___ M22.40 Chondromalacia 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 knee. (53)
___ 29874 with removal of loose body or foreign body. (54)	___ S83.241A Medial meniscus tear, rt knee. (54)
___ 29875 Limited synovectomy (plica resection). (55)	___ S83.242A Medial meniscus tear, left knee. (55)
___ 29876 Synovectomy (major; 2 or more compartments). (56)	___ S83.281A Lateral meniscus tear, rt knee. (56)
___ 29877 Debridement (chondroplasty). (57)	___ S83.282A Lateral meniscus tear, left knee. (57)
___ 29879 Microfracture abrasion chondroplasty. (58)	___ M12.569 Traumatic arthropathy of knee. (58)
___ 29880 PMM and PLM. (59)	___ M65.161 Synovitis, right knee. (59)
___ 29881 PMM or PLM. (60)	___ M65.162 Synovitis, left knee. (60)
___ 29882 MED or LAT meniscus repair. (61)	___ M24.10 Chondral lesion, right knee. (61)
___ 29883 MED and LAT meniscus repair. (62)	___ M24.10 Chondral lesion, left knee. (62)
___ 29888 ACL reconstruction. (63)	___ M93.261 Osteochondral lesion, right knee. (63)
___ 20610 Arthrocentesis (aspiration and/or inject) of a joint. (64)	___ M93.262 Osteochondral lesion, left 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 (Medial/Lateral condyle) (medial/lateral tibial plateau) (patella/trochlea) (58)

___ Coblation Arthroplasty (Medial/Lateral condyle) (patella/ trochlea) (59)

___ Coblation Arthroplasty (Medial/Lateral) tibial plateau (60)

___ ACL Reconstruction (61)

___ Lateral Release (62)

___ Removal of Loose Bodies (63)

___ Medial Plica Excision (64)

___ Lysis of Adhesions (65)

___ Bilateral Meniscectomy (66)