

NEW PATIENT UPDATE

DR: _____

DATE: _____

PATIENT ACCOUNT #: _____

Patients Legal Name:

(First) _____ (Middle) _____ (Last) _____ Sex: M F

Social Sec. # _____ DOB: _____ Age: _____ Marital Status: M S W D

Address: _____ City, State and Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

School Name (if student): _____

Religious Preference: _____

Primary Physician Name and Phone: _____

EMERGENCY CONTACT

Name _____ Phone# _____ Relationship _____

RESPONSIBLE PARTY If the patient is a minor, person responsible for billing account

Name: _____ Relationship to patient: _____ Sex: M F

Address: _____ DOB: _____

City, State and Zip: _____ Social Security # _____

Phone: _____ Employer: _____

PRIMARY INSURANCE

Insurance Company: _____ Primary Insured Person: _____

Claim Address: _____ Insured Address: _____

Group #: _____ Insured Phone #: _____

Member I.D. #: _____ Social Security #: _____

Effective Date: _____ DOB: _____ Sex: M F

SECONDARY INSURANCE/ WC/ MVA

Insurance Company: _____ Primary Insured Person: _____

Claim Address: _____ Insured Address: _____

Group #: _____ Insured Phone #: _____

Member I.D. #: _____ Social Security #: _____

Effective Date: _____ DOB: _____ Sex: M F

DOI: _____

THIRD INSURANCE/ OTHER

How were you referred to us?

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Referring Physician | <input type="checkbox"/> Employer | <input type="checkbox"/> Seminar/Screening | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> Friend/Relative/Former Patient (circle one) | <input type="checkbox"/> Hospital | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Other |
| <input type="checkbox"/> HMO/PPO | <input type="checkbox"/> Case Manager | <input type="checkbox"/> Television | <input type="checkbox"/> Workers Compensation |
| | <input type="checkbox"/> School | <input type="checkbox"/> Radio | |

| | | |
|------|---------|-------|
| Name | Address | Phone |
|------|---------|-------|

PLEASE READ:

Some insurance companies will not pay your bill if you do not select one of their participating doctors. It is the patient's responsibility to determine if our doctor participates in your plan. Payment or co-payment is due at the time of service. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. In the event of legal action for collection, patient agrees to pay all costs of collection, including reasonable attorney's fees. By signature below, the parent or guardian agrees that the jurisdiction and venue for said action shall be the County of St. Louis and State of Missouri. Any balances due from patients or guardians that are outstanding for over 90 days will have an automatic monthly finance charge of 1.5% (18% annual rate).

SIGNED (Patient or Guardian) _____ DATE _____

AUTHORIZATION AND ASSIGNMENT

I authorize The Orthopedic Center to release information regarding my treatment to my insurance company, to health care providers who have referred me to The Orthopedic Center and to parties who are involved in my treatment if I have a work-related injury. I also authorize my insurance benefits to be paid directly to The Orthopedic Center. This is an authorization for medical treatment of a minor if signed by a parent or guardian. In addition to the above and in the event The Orthopedic Center is served with a Subpoena for production of records, the undersigned authorizes The Orthopedic Center to produce such records under a Business Records Affidavit without the necessity of attendance at a deposition. This above Authorization can only be withdrawn or revoked by written notification to The Orthopedic Center.

SIGNED (Patient or Guardian) _____ DATE _____



David M. Brown, M.D.
Matthew F. Gornet, M.D.
Lyndon B. Gross, M.D., Ph.D.
John O. Krause, M.D.
Paul S. Lux, M.D.

Mark D. Miller, M.D.
Michael J. Milne, M.D.
George A. Paletta, Jr., M.D.
Mitchell B. Rotman, M.D.
Brett A. Taylor, M.D.

Consent to Release Information

I, _____, authorize The Orthopedic Center of St. Louis staff to discuss my medical treatment and any billing issues with the following people: (Please list any family members, friends or legal counsel that we are allowed to discuss your treatment or billing issues with.)

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

Patient Signature: _____ Date: _____

(Parent or Guardian Signature if a minor)



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Brett A. Taylor, M.D.

Dear Friends and Patients,

Welcome. Thank you for choosing the **Orthopedic Center of St. Louis**.

The **Orthopedic Center of St. Louis** constantly strives to provide the highest quality comprehensive care for you and your family.

We have organized this building to include providers that complement our services so that you can get the care you need in one convenient location. This includes:

- 10 Fellowship Trained Orthopedic/Plastic & Reconstructive Surgeons with subspecialty training in specific areas.
- Digital xrays and electronic medical records in our state of the art facility
- High resolution digital MRI and MR Arthrograms on the 1st floor at **Imaging Partners of Missouri**
- **CT Partners of Chesterfield** provides state of the art CT scanning on the 1st floor
- Electrodiagnostic testing on the 3rd floor at the **Neurological & Electrodiagnostic Institute**
- **ProRehab** on the 3rd floor provides physical therapy and custom splinting, often the same day as your appointment at **The Orthopedic Center of St. Louis**
- Medical Equipment (DME) is available on-site through our office and the **Corner Pharmacy** delivers medications to each of the following surgical facilities to save you a trip to the drugstore after surgery.

If surgery is required, **Timberlake Surgery Center** is located on the 1st floor. The **St. Louis Spine and Orthopedic Surgery Center** and **Advanced Surgery Center** are located nearby and provide additional locations for outpatient surgeries, spine patients, and patients who require an overnight stay. These facilities are staffed with experienced nurses and staffs that work closely with our physicians to provide the highest quality specialized care in an efficient and personalized fashion.

Financial Disclosure

Some of the individual physicians at the Orthopedic Center of St. Louis have ownership in some of the surgical and imaging facilities listed above as permitted by both state and federal law.

You have complete freedom of choice as you select your providers and facilities.

Our physicians and staff are happy to provide you with the names of other service providers and will help coordinate your appointments with your provider of choice.

For more information, visit our website www.TOC-STL.com

We appreciate the opportunity to serve you and your family.

Signed: _____

Date: _____

Printed Name: _____

TOC: _____

**The Orthopedic Center of St. Louis
Notice of Health Information Practices**

This notice describes how your medical information may be used or disclosed and how you can access this information. Please review it carefully.

Uses and Disclosures:

We will use and disclose elements of your protected health information (PHI) in the following ways.

- Basis for planning your care and treatment
- Communication among the health professionals who may contribute to your care
- Legal document describing the care you receive
- Means that you, your insurance company or a third party payor can verify that services billed were actually provided
- Source of data for medical research
- Source of information for public health officials charged with improving the health of the nation
- Source of data for facility planning
- Source we can assess our data to improve the care we render and the outcomes we achieve
- In emergency situations or to avert serious health/safety situations
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties
- To organ, tissue and other donations organization, upon or proximate to your death, if we have no indication on hand about your donation preferences
- To use an automated telephone system to use my name, address, and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine

All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights:

- Request a restricted access to all or part of your private health information as provided by 45 CFR 164.522, if we are unable to abide by this request we will notify you
- Inspect or receive a copy of your medical record as provided by 45 CFR 164.524
- To get updates or reissue of this notice, at your request
- To request a list of disclosures of your medical records as provided by 45 CFR 164.528
- To receive correspondence of confidential information by alternate means or location as long as the request is reasonable
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken

Our duties:

We are required by law to maintain the privacy of your private health information. We must abide by the terms of this notice or any update of this notice. If this notice is updated we will notify you by mail to the address you've supplied us.

To obtain more information or report problems please contact The Orthopedic Center of St. Louis's HIPAA Compliance Officer at 314-336-2555. **Full explanation of notice is posted in our waiting room. To request your own copy, please see our receptionist.**

If you believe your privacy rights have been violated, you can file a complaint with the administrator or operations manager. If, after contacting, The Orthopedic Center of St. Louis, you are not satisfied with the response you may contact the U.S. Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Effective date of this notice is April 14, 2003.

Acknowledgement:

Signature: _____ Date: _____

Print the name of the Patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

The Orthopedic Center of St. Louis
John O. Krause, M.D.
Orthopedic Surgery; Surgery of the Foot & Ankle

NEW PATIENT INFORMATION

Name: _____ Age _____
Referring Doctor: _____ Date of Birth: ____ / ____ / ____
How did you hear about Dr. Krause? _____ Phone # _____
Primary Care Physician: _____ Address: _____ Phone # _____

Chief Complaint: _____
Date of Accident/Onset: ____ / ____ / ____ **Which side is your problem on?** Right Left
Please describe the recent events that brought on this orthopaedic problem: _____

How long has it been a problem? _____
How often do you have pain? _____
What makes it worse? _____ What makes it better? _____
Have you had prior treatment for this injury? Yes No What Treatment? When? _____

By Whom? _____

Occupation _____ Employer _____ Hours _____
Do you smoke? Yes No Cigarettes / Cigars / Other _____ Quit? ____ Yr _____
How many packs per day? _____ How many total years have you smoked? _____
Do you use chew tobacco? Yes No Do you consume alcohol? Yes No How much/often? _____
List any activities that you participate in on a regular basis outside of work (sports, gardening, weight lifting, musical instruments, etc.) _____
Are you here for a work-related injury? Yes No If yes, please complete page 3
Do you have an attorney regarding this injury? Yes No If yes, who? _____
Do you regularly attend religious services? Yes No
How important is religion/spiritual issues in your life? Very Moderately Somewhat Not important

HEALTH HISTORY

Height _____ Weight _____ Shoe Size _____

| | | | |
|---|--|--|--|
| Do you have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have fibromyalgia? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have rheumatoid arthritis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have lupus? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a thyroid problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have gout? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any heart problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any lung problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had a heart attack? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have stomach ulcers? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have or have you had hepatitis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have depression? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any other mental illness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any bleeding disorders? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any kidney trouble? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have cancer? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had a stroke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have anemia? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you are a woman, are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had a blood transfusion? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had a blood clot in your legs or lungs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have HIV/AIDs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Explain all yes answers and list any other medical problems: _____

PAST SURGICAL HISTORY: (List all surgeries you have had)

| <u>TYPE OF SURGERY</u> | <u>DATE (or approx. date)</u> | <u>WHERE</u> | <u>NAME OF SURGEON</u> |
|------------------------|-------------------------------|--------------|------------------------|
| _____ | ___ / ___ / ___ | _____ | _____ |
| _____ | ___ / ___ / ___ | _____ | _____ |
| _____ | ___ / ___ / ___ | _____ | _____ |
| _____ | ___ / ___ / ___ | _____ | _____ |

MEDICATIONS: (List all medications you are currently taking, including vitamins, OTC meds, herbal medications)

| <u>MEDICATION</u> | <u>STRENGTH</u> | <u>HOW OFTEN</u> |
|-------------------|-----------------|------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

ALLERGIES:

Are you allergic to Latex? Yes No

| Have you ever had an allergic reaction to a medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: | |
|---|-----------------|
| <u>MEDICATION</u> | <u>REACTION</u> |
| | |
| | |
| | |

Have you ever had a bad reaction to aspirin or a non-steroidal anti-inflammatory type medication?(i.e. Motrin, Ibuprofen)
 Yes No If yes, what was the name of the medication and what happened? _____

FAMILY MEDICAL HISTORY:

Do any of your relatives (mother, father, brothers, sisters, aunts, uncles, grandparents) have any of the following medical problems?

- | | | | |
|----------------------|--|----------------------------|--|
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatoid arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lupus/Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anesthetic Reactions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any other medical problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain all yes answers: _____

Patient Expectations

Patient Name: _____ Age: _____

Condition being treated: _____

Please check the box the most appropriately describes your current expectations for treatment.

- Definitely non-surgical
- Probably non-surgical
- Not sure
- Either surgical or non-surgical
- Probably surgical
- Definitely surgical

Please check off which factors most influence your decision to seek treatment. (Check all that apply)

- Pain the limits daily activities/work
- Pain that limits sporting activities
- Pain that limits shoewear
- I am unhappy with the appearance
- Concerns about long term damage to the bones/joint/ligaments
- Friends/family recommended I seek treatment
- Directed by workman's comp or an attorney

Review of Systems

(Circle all that apply)

General

Normal
Weight change
Fever / Chills
Fatigue / Malaise
Strength / Weakness
Overall status: _____

HEENT

Normal
Headache
Vision: blurred,
Sensitivity to light
(photophobia)
Ringing in ears (tinnitus)
Nasal discharge
Bloody nose (epistaxis)
Sore throat / Hoarseness

Cardiopulmonary

Normal
Chest pain, palpitations
Short of breath:
 exertional,
 laying down (orthopnea)
 wake up in middle of night
(PND)
Cough, sputum
Wheezing
Dizzy when standing up
(orthostasis)
Passing out (syncope)
Leg/calf pain with
exercise/walking (claudication)

Hemo-Onc

Normal
Pallor
Bruising / Bleeding

Genito-Urinary

Normal
Blood in urine (hematuria)
Flank pain
Stones / Gravel

Gastro-Intestinal

Normal
Nausea / Vomiting
Heartburn (GERD)
Regurgitation
Vomit blood (hematemesis)
Coffee ground vomit
Abdominal pain
Constipation / Diarrhea
Jaundice

Neurological

Normal
Loss of consciousness
Seizures
Numbness / Tingling

Musculoskeletal

Normal
Weakness
Swelling / Pain
Stiffness (in am)
Back pain
Joint pain

OB/GYN

Normal
Menstrual cycle:
 Normal
 No period (amenorrhea)
 Excessive
 Bleeding
 Spotting
 Menopausal
Breast: pain, masses, lesions,
 ulceration's

Endocrine

Normal
Neck mass / pain (goiter)
Lethargy / Fatigue
Breasts in males (gynecomastia)
Obesity (truncal, facial)
Flushing

Psychiatric

Normal
Personality disorder:

Depression
Anxiety
Schizophrenia
Bipolar
Suicide ideation
Homicide ideation
Drug abuse

Skin

Normal
Eczema
Psoriasis
Atopic dermatitis
Keloids
Rashes / Sores
Pain / Itching

COMPLETE THIS SECTION ONLY IF YOU ARE HERE FOR A WORK-RELATED PROBLEM

Your answers to these questions are very important. Please take the time to be as accurate and as specific as possible.

WORK HISTORY:

What is your current occupation? _____

What company do you currently work for? _____

What was your occupation when you developed the problem that you are being seen for? _____

What company were you working for when you developed this problem? _____

When did you first start working for this company? _____

If you are no longer working for this company, when did you last work for this company? _____

How many hours a day do you (or did you) work? _____

How many hours a week do you (or did you) work? _____

Describe your job in detail (the job you were working when you developed your problem):

- What do you do with your hands and arms at work? _____

- How often do you do these activities? _____
- How much do you lift? _____
- How often? _____
- If you do data entry, how many hours a day? _____
- Is it continuous or intermittent? _____
- If you do something repetitive, how many times an hour do you do it? _____

Additional Comments: _____

Do you have a second job? Yes No If yes, please describe what you do and list how many hours per day and week you work there: _____

PAST WORK HISTORY:

Please list the type of work you did before you worked for the company you were working for when you developed this problem:

- Where did you work? _____
- How long did you work there? (from when to when) _____
- What did you do? _____

Additional Comments: _____

Are you currently working your regular job? Yes No If so, are you on light duty? Yes No

Additional Comments: _____

If you are on light duty, what are your work restrictions? _____

Signature: _____ Date: ____ / ____ / ____

Welcome To Our Practice

Dr. Krause and his staff, a.k.a. Team Mobility, would like to welcome you to our practice.

Mobility Matters! **Mobility** is the one thing that allows you to participate in all activities of daily life. My practice is geared toward helping each patient to meet their **mobility** goals, whether they are an elite athlete, a child playing their first soccer game, a new parent taking a walk with their baby, or an older adult walking their dog. In my orthopedic practice, I treat a variety of orthopedic conditions that affect a patient's mobility, from bunions and hammertoes to ankle fractures, to patellar tendonitis, to arthritis of the hip. Along with my staff, **Team Mobility**, my goal is to restore pain-free **mobility** to all of our patients, regardless of your level of activity

Team Mobility is a division of The Orthopedic Center of St. Louis. The Orthopedic Center of St. Louis consists of ten highly specialized physicians working in the same office. Each physician has a team dedicated to their individual practice; however, each team may not necessarily have the same policies or hours. Nevertheless, they all have the same goal which is state of the art, world class patient care delivered in a friendly, respectful, prompt setting.

Team Mobility consists of the following staff:

John O. Krause, M.D.

Diana Armstrong, APN

Melissa Franklin, MA

Meghan McCartney, MA

Emily Armstrong, MA

We strive to treat our patients with compassion and flexibility in an effort to make the process of returning you to activities as convenient as possible. Most of the feedback we get is that we are very user friendly. Dr. Krause's biggest referral source is former patients; this is something we are very proud of and hope to continue. We welcome any feedback from you either verbally or in writing (letter or email).

Office Hours:

Our office is open Monday through Friday from 8:00 am to 5:00 pm.

Dr. Krause sees patients all day on Monday, Wednesday, and on Friday.

Dr. Krause performs surgery Tuesdays and Thursdays at the following facilities:

- St. Louis Spine and Orthopedic Center (Charter Commons at Hwy 141 & Clayton)
- Timberlake Surgery Center (In our office building in Chesterfield)
- St. Louis Surgery Center (Creve Coeur at Olive and Craig Rd.)
- Barnes Jewish West County Hospital (Creve Coeur at Olive and Mason Rd.)
- Missouri Baptist Medical Center (SW Corner of I-64 and I-270)

After hours answering service is available for emergencies that number is: 314-995-0891

We have an office email that is checked daily mobilitymatters@toc-sfl.com; please feel free to utilize this option as well.

Appointments: Appointments can be made or changed through our main, in-house, telephone line, 314-336-2555. We would appreciate a telephone call or email if you are going to be running late or if you have to cancel appointments. In rare circumstances, we have had patients no-show repetitively for appointments that we had to stop making appointments for them and refer them to another practice. Dr. Krause does his best to stay on time for patient appointments. However, it is an orthopedic practice that sees emergency patients and may have unforeseen delays. We will try to keep you updated on whether Dr. Krause is running on time on any given day. You are welcome to reschedule an appointment if Dr. Krause is running late and you cannot wait due to other responsibilities. Dr. Krause always encourages his patients to bring reading materials/work to do while waiting. You will have computer access to the internet while waiting in each exam room.

X-rays/Imaging: Dr. Krause requires x-rays to be obtained on most of his new patients. If you are bringing x-rays from an outside facility, please have them put on a disc and also include the written report. You may be required to have some new x-rays taken by Dr. Krause. If an MRI is required to diagnose your condition, our office normally schedules these at Imaging Partners of Missouri, which is located on the main level of our building. Not only do they have high resolution MRI scanner, but this allows x-ray images to be delivered to him electronically and the radiologist calls him with verbal, same day results. We do our best to schedule your appointments so that you can get your MRI then come up to our office immediately afterwards to review the results with Dr. Krause. As always, you have freedom of choice as you select your provider, as long as you use a closed scanner with high resolution.

Narcotic Policy: Dr. Krause has a very strict policy regarding narcotics. It is his policy that patients will receive prescription narcotics only when they are in the immediate post-operative period or have an acute traumatic injury. Depending on the nature of your surgery or injury, you should only require narcotics for a limited period of time. Every effort will be made to switch you over to a non-narcotic pain medication as soon as your pain level permits. If you require long term narcotic use or narcotic use for chronic, non-traumatic conditions, you will be referred to your primary care provider or a pain management physician.

If you are prescribed a narcotic pain medication you must:

1. Only use one pharmacy for these prescriptions. If you feel you have good reason and must change pharmacies, you must notify us in advance.
2. Only receive your narcotic pain medicine from one physician.
3. It is your responsibility to call your pharmacy for refill requests in a timely manner. Dr. Krause is not in the office every day. Therefore, if you require a refill on your prescriptions by a certain day, please make sure your pharmacy faxes a request before noon. Refill requests will not be addressed on weekends or after hours. We regret that we cannot make exceptions to this.
4. We ask you to inform us of your present medications. Please tell us of any new medications that you have received from other physicians at each appointment.

YOU MUST USE YOUR MEDICINE AS DIRECTED. EARLY REFILLS WILL NOT BE HONORED FOR ANY REASON. DO NOT LOSE YOUR PRESCRIPTION(S). DO NOT LET OTHERS USE MEDICATIONS FOR ANY REASON.

Any violation of the above may be addressed by referring you to a pain medicine specialist or discontinuing your narcotic medicine.

Medical Records/Disability Forms: If you need your patient information for any reason this is available by contacting our main office at 314-336-2555 and asking for the medical records department. This department is also responsible for filling out all disability and FMLA paperwork.

Billing Issues: We are happy to bill your medical insurance for you. Please understand that our billing service is offered as a courtesy to you. It does not obligate us to wait indefinitely for payment by your carrier. Co-payments are required to be paid before every visit and we reserve the right to reschedule your appointment if you are not prepared to pay your co-pay. Before elective surgery, we will check with your insurance company to determine if authorization is required. It is your responsibility to also contact your insurance company to determine your coverage, check any pre-existing condition clauses, eligibility, and your financial responsibility. You may be required to pay a portion of your financial responsibility prior to your elective surgery. Dr. Krause reserves the right to cancel surgery if your financial obligation has not been met. If you have any billing questions please contact our main office 314-336-2555 and ask to speak to the billing department.

Litigated/Work Comp Issues: Our office cannot legally bill your private insurance if there is pending litigation or if there is a workman's compensation claim. It is the responsibility of the patient/guarantor to disclose potential/impending litigation or potential workman's compensation filing. Failure to do so constitutes insurance fraud with associated legal consequences. Please ask Dr. Krause or the staff if you have specific questions.

Workers Compensation Patients: Dr. Krause is very experienced in workman's compensation injuries and laws pertaining to work comp. He will help you to get you back to your activities and to work as quickly as possible. After your examination, Dr Krause will advise you of your work restrictions due to your injury or condition. Our office is aware that the work you are capable of doing may not necessarily be an option at your place of employment. Nevertheless we still must list the restrictions on your work status statement and your employer will advise as to whether or not they can accommodate you. Please keep in mind that worker's comp patients are not allowed to change or reschedule their own appointments without authorization from the case manager/adjuster. Therefore, all changes must go through their workers' compensation case manager/adjuster.

We thank you for the trust you have placed in us. We hope you find our practice to be friendly and professional and that it meets your expectations for your given orthopedic condition.