Phoenix Orthopaedic Consultants

Medical History

DEMOGRAPHICS

Patient's Name: _____ DOB: _____ Age: _____

Height: _____ Weight:_____ BMI: _____ Gender: _____ Email:_____

Primary Care Physician: _____ Referring Physician: _____

Allergies: Please list **any** allergies to medication, latex, food or environment (please list reaction): ☐ None

_____

Dominant Hand: ☐ Right ☐ Left Do you have an advanced directive or living will? ☐ Yes ☐ No

CHIEF COMPLAINT – CURRENT PROBLEM

What is the reason for your visit:_____

When did it start? ____☐ Days _____☐ Weeks _____☐ Months _____☐ Years

Have you had a problem like this before? ☐ Yes ☐ No

Were you seen in the ER for this problem? ☐ Yes ☐ No Which ER? _____ Date:_____

Is any litigation pending regarding this injury? ☐ Yes ☐ No

Have you received any other treatment for this condition? Where/Who? _____ When?_____

Treatment: _____

Where/Who? _____When?_____

On a scale of 1-10 (10=worst pain), the pain is a: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain is: ☐ sharp ☐ dull ☐ stabbing ☐ throbbing ☐ aching ☐ burning **Pain is:** ☐Intermittent ☐ Constant

Does the pain wake you up at night? ☐ Yes ☐ No

What makes your pain worse?_____Better?_____

Associated Symptoms: ☐ numbness /tingling ☐ Catching ☐ Loss of Bowel/Bladder ☐ Joint giving out

If an injury, did it occur: ☐ At work ☐ In an auto accident ☐ Not Applicable

Have you had 1 or more falls with an injury within the last year? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Please indicate by checking the box, if you have or had any of the following conditions:

☐ Rheumatoid arthritis	☐ Heart attack	☐ Pneumonia	☐ Diabetes
☐ Heart failure	☐ Mitral valve prolapse	☐ HIV/AIDS	☐ DVT (blood clots)
☐ Gout	☐ High cholesterol	☐ Seizures	☐ Kidney disease/stones
☐ Valley fever	☐ High blood pressure	☐ Depression/anxiety	☐ Tuberculosis
☐ Multiple Sclerosis	☐ COPD/emphysema	☐ Reaction to Anesthesia	☐ Stomach Ulcers
☐ Irritable Bowel	☐ Thyroid disease	☐ Osteoporosis	☐ Hepatitis/liver disease
☐ Polio	☐ Stroke	☐ Blood disorders	☐ Cancer_____
☐ Alzheimer's	☐ Prostate problems	☐ Asthma	☐ Sexually transmitted disease

OTHER_____

SOCIAL

Do you use tobacco products? ☐ Never ☐ Previously, but quit _____ ☐ Yes _____ type of tobacco product

Do you drink alcohol? ☐ No ☐ Yes _____number per week

Occupation: _____

Employment status: ☐ Disabled ☐ Full Time ☐ Light Duty (how long? _____) ☐ Retired ☐ Student ☐ Unemployed

☐ Unemployed due to this problem When was the last day you worked your regular job? _____

Are you currently or have you ever been on disability due to a health condition? ☐ Yes ☐ No If yes, what condition are you on disability for? _____ When did you last work? _____

MEDICATIONS

Are you currently being prescribed narcotics (like vicodin or Percocet) or any other controlled substance (like valium or Ativan) by another provider? ☐ Yes ☐ No

List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.

	Name of Medication	Dose (Include strength and number of pills/doses per day)	Prescribing Doctor
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			

FAMILY

As you review the following list, please check any of those problems which apply to your immediate family members: ☐ Diabetes

☐ High Blood Pressure ☐ Rheumatoid arthritis ☐ Inflammatory bowel disease ☐ None

☐ Heart Disease ☐ Anesthesia Problems ☐ Stroke ☐ Cancer Type:_____

Do any direct relatives have the same condition you are being seen for today? ☐ Yes ☐ No If yes who: _____

SURGERY

Please list any operations or hospitalizations you have had. Please list the year of surgery as well as the surgeon and the city where hospitalizations took place.

	Type	Year	Surgeon	City
1)				
2)				
3)				
4)				
5)				
6)				

Have you been treated for any fractures, joint replacements, pain management or orthopedic surgery in the last 3 years? ☐ Yes ☐ No

If yes, name of the treating Physician _____ Phone Number _____

REVIEW OF SYSTEMS

Circle all symptoms you have experienced in the **RECENT** months:

General:	unexpected weight loss, weight gain, fever, chills, night sweats, fatigue
Eyes:	blurred/double vision, eye pain, vision loss, corrective lenses, sensitivity to light
ENT:	earaches, ringing in ears, nose bleeds, hearing loss/aid, trouble swallowing, hoarseness
Cardiovascular:	chest pain, palpitations, fainting, murmurs, swelling in ankles and legs
Respiratory:	shortness of breath, wheezing, coughing, painful breathing, snoring
Gastrointestinal:	heartburn, nausea, constipation, diarrhea, bloody/black stools, stomach pain
Genitourinary:	incontinence, frequent urination, urgency, painful urination, bleeding, difficult urination
Musculoskeletal:	joint pain, swelling, stiffness, muscle pain, back/neck pain, muscle weakness
Skin:	rash, itching, redness, dryness, skin changes, excessive scarring
Neurological:	numbness, headaches, dizziness, unsteady gait, tremors, seizures, loss of consciousness
Psychological:	nervousness, anxiety, depression, memory loss, panic attacks
Hematologic:	easy bleeding, HIV/AIDS, abnormal bruising, hepatitis, blood clots
Endocrine:	excessive thirst or urination, heat/cold intolerance, weight change

I hereby certify that the above information is true and correct to the best of my knowledge. I also authorize Phoenix Orthopaedic Consultants to run a Medication History check.

Patient / Representative Name (Print) _____ Signature _____

Date: ____ /____ /_____

Phoenix Orthopaedic Consultants

Registration

Patient's Last Name:_____ First Name:_____ Middle Initial: ____

Date of Birth :_____ Age:_____ Gender: ☐ Female ☐ Male

Address:_____ Home Phone:_____ Cell Phone: _____

City:_____ State:_____ Zip:_____ Email: _____

Social Security Number:_____ Preferred confidential contact: ☐ Phone ☐ Cell ☐ Email

Marital Status: ☐ S ☐ M ☐ D ☐ W Preferred language: _____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/ Pacific Islander ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

Employer:_____ Employer Phone Number: _____

Employer Address:_____ Patient's Occupation: _____

City, State, Zip: _____

Pharmacy name:_____ Phone number:_____ Cross Streets: _____

IN CASE OF EMERGENCY NOTIFY: Name:_____ Phone: _____

Address: _____

Primary Care Physician:_____ Name of Referring Physician: _____

If person responsible for payment is different from patient, then complete the following section. If patient is a child please indicate if the parents are ☐ Married ☐ Single ☐ Other

Name:_____ Social Security Number:_____

Address:_____ Date of Birth:_____

City, State, Zip:_____ Home Phone:_____ Cell Phone: _____

Employer:_____ Employer Phone:_____

Employer Address:_____

Primary Insurance:	**Secondary Insurance:**
Insurance name:_____	Insurance name:_____
Policy ID#:_____	Policy ID#: _____
Group / Account #:_____	Group / Account # : _____
Policy Holder Name:_____	Policy Holder Name: _____
DOB:_____	DOB: _____
SS#:_____	SS#: _____
Relationship to patient:_____	Relationship to patient: _____

Authorization to release information and assignment of benefits: I hereby authorize and assign payment of medical benefits to the provider of services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature will bind me as though I personally signed each claim. I also authorize the release of any medical information necessary. I understand that I am responsible for all charges. If my account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

_____ _____

Patient / Responsible Party Date

Office: (602) 298-8888
Fax: (602) 978-4129

Phoenix Orthopaedic Consultants

Deer Valley
19636 N. 27th Avenue, Ste. 401
Phoenix, AZ 85027

Arrowhead
18699 N. 67th Avenue, Ste. 120
Glendale, AZ 85308

Financial Policy: **Please read carefully**. If you would like a copy, please request from the receptionist.

It is the policy of Phoenix Orthopaedic Consultants to have a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and also minimizing administrative costs. This financial policy has been established with these objectives in mind and to avoid a misunderstanding or disagreement concerning payment for professional services.

1. Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our business office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by the patient prior to leaving the office.

2. If a patient has insurance in which we do not participate, our office is happy to file the claim upon request; payment in full is expected at the time of service.

3. It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by the plan at the time of visit. Payments for medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.

4. Payment for professional services can be made with cash, check or credit or debit card. We also accept on line payments on our website.

5. Financial assistance is available for qualified patients. If a patient feels that he or she may qualify for assistance, the practice receptionist should be notified for referral to the appropriate individual. Patients who do not have insurance are expected to pay for professional services at the time of service unless prior arrangements have been made with us.

6. It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be re-scheduled or the patient may be financially responsible due to lack of the referral.
7. It is the patient's responsibility to provide us with current insurance information and to bring his or her insurance card to each visit.

8. Our staff is happy to help with insurance questions relating to how a claim was filed or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. The telephone number is printed on your insurance card.

9. The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of service. For unaccompanied minors, non-emergent treatment will be

denied unless charges have been pre-authorized or payment by credit or debit card, cash or check at the time of service has been verified.

10. **You will receive two monthly statements once the practice has determined your financial responsibility. If you ignore or do not pay, you will receive a third and final statement and may be sent to collections which could effect your good credit.**

11. **If you are scheduled for an elective surgery, POC will require the professional fee to be paid in advance. Arrangements can be made with our Billing Department. If not, your surgery may need to be re-scheduled.**

Our practice firmly believe that a good physician-patient relationship is based on the understanding and good communication. Questions about financial arrangements should be directed to our medical billing department. We welcome you to our practice.

If you agree with the above, please sign below.

_____ _____

Patient Signature Date

Phoenix Orthopaedic Consultants

Disclosure Form

Patient Name: _____ Date of Birth:_____

I authorize and agree that Phoenix Orthopaedic Consultants may disclose my protected health information to the following individuals unless and until I object to such disclosures, which must be provided in writing.

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

☐ Do NOT speak to any Family Members

Preferred method of contact:

☐ Phone: _____ ☐ Email: _____

- ☐ May leave a detailed message
- ☐ Do NOT leave a detailed message

Preferred language

☐ English ☐ Spanish ☐ Other: _____

_____ _____

Signature of Patient or Patients Personal Representative Date

_____

Print Name of Patient or Patients Personal Representative

HIPAA – Omnibus Notice of Privacy Practices

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

This Notice of Privacy Practices is NOT an authorization. This notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify your and that relates to your past, present, or future physical or mental condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other us required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to who you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to approve approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations may include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Uses and Disclosures that require your protected Authorization:

Other permitted and required uses and disclosures will be made **only with your consent,** authorization, or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We will not disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization at any time, in writing, except to the extent that your physician or physicians practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
The following are states of your rights with respect to your Protected Health Information

You have the right to inspect and copy your protected health information (fees may apply). Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records; Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid for in full out of pocket.

You have the right to request to receive confidential communications. You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures. You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or 6 years prior to the date of request.

You have the right to receive notice of breach. We will notify you if your unsecured protected health information has been breached.
You have the right to obtain a paper copy of this notice from us even if you have agreed to receive this notice electronically. We reserve the right to change this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

HIPAA Compliance Officer: Marcia Hall Phone: 602-298-8888 Email: mhall@phxortho.com

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of asthe notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our main phone number.

Please note that by signing below, you are acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

I UNDERSTAND AND ACKNOWLEDGE OUR NOTICE OF PRIVACY PRACTICES

_____ _____

Signature of Patient or Patients Personal Representative Date