



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:

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

FAMILY	<p>As you review the following list, please check any of those problems which apply to your <u>immediate</u> family members: <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> None</p> <p><input type="checkbox"/> Heart Disease <input type="checkbox"/> Anesthesia Problems <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer Type: _____</p> <p>Do any direct relatives have the same condition you are being seen for today? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes who: _____</p>																																			
SURGERY	<p>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.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 35%;">Type</th> <th style="width: 10%;">Year</th> <th style="width: 30%;">Surgeon</th> <th style="width: 15%;">City</th> </tr> </thead> <tbody> <tr><td>1)</td><td>_____</td><td>____</td><td>_____</td><td>_____</td></tr> <tr><td>2)</td><td>_____</td><td>____</td><td>_____</td><td>_____</td></tr> <tr><td>3)</td><td>_____</td><td>____</td><td>_____</td><td>_____</td></tr> <tr><td>4)</td><td>_____</td><td>____</td><td>_____</td><td>_____</td></tr> <tr><td>5)</td><td>_____</td><td>____</td><td>_____</td><td>_____</td></tr> <tr><td>6)</td><td>_____</td><td>____</td><td>_____</td><td>_____</td></tr> </tbody> </table> <p>Have you been treated for any fractures, joint replacements, pain management or orthopedic surgery in the last 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, name of the treating Physician _____ Phone Number _____</p>		Type	Year	Surgeon	City	1)	_____	____	_____	_____	2)	_____	____	_____	_____	3)	_____	____	_____	_____	4)	_____	____	_____	_____	5)	_____	____	_____	_____	6)	_____	____	_____	_____
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REVIEW OF SYSTEMS	<p>Circle all symptoms you have experienced in the RECENT months:</p> <p>General: unexpected weight loss, weight gain, fever, chills, night sweats, fatigue</p> <p>Eyes: blurred/double vision, eye pain, vision loss, corrective lenses, sensitivity to light</p> <p>ENT: earaches, ringing in ears, nose bleeds, hearing loss/aid, trouble swallowing, hoarseness</p> <p>Cardiovascular: chest pain, palpitations, fainting, murmurs, swelling in ankles and legs</p> <p>Respiratory: shortness of breath, wheezing, coughing, painful breathing, snoring</p> <p>Gastrointestinal: heartburn, nausea, constipation, diarrhea, bloody/black stools, stomach pain</p> <p>Genitourinary: incontinence, frequent urination, urgency, painful urination, bleeding, difficult urination</p> <p>Musculoskeletal: joint pain, swelling, stiffness, muscle pain, back/neck pain, muscle weakness</p> <p>Skin: rash, itching, redness, dryness, skin changes, excessive scarring</p> <p>Neurological: numbness, headaches, dizziness, unsteady gait, tremors, seizures, loss of consciousness</p> <p>Psychological: nervousness, anxiety, depression, memory loss, panic attacks</p> <p>Hematologic: easy bleeding, HIV/AIDS, abnormal bruising, hepatitis, blood clots</p> <p>Endocrine: excessive thirst or urination, heat/cold intolerance, weight change</p>																																			

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: ____ / ____ / ____



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: _____

Ethnic origin: White Hispanic or Latino Black/African American Native American or American Indian Asian / Pacific Islander
 Other _____ 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

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 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 affect your good credit.**
11. **If you are scheduled for an elective surgery or in office procedure, 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.**
12. **Clinic office visits or in office procedure may be subject to a \$25 fee if canceled less than 24 hours prior to your appointment time, or you do not show up. You may be charged a \$100 cancelation fee if you cancel your surgical procedure less than 24 hours prior to the scheduled time, or you do not show up.**

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

Credit Card on File Policy

As you may be aware, the current Healthcare Market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and co-payments in amounts not known to you or us at the time of your visit. As a result, we require that all patients need to have a credit or debit card number on file with our office.

Similar to Hotels and Car Rental agencies, you are asked for a credit card number at the time you check in. The Credit Card information will be held securely until your insurance company has paid their portion and notified us of the amount of your share. We will send you a statement notifying you of receipt of your insurance's Explanation of Benefits showing processing of your claim and any portion you are legally responsible to pay. If there is a balance, your credit card will be charged for balances of \$100 or less. We will notify you of any remaining balance on your account of over \$100 before charging your credit card.

If following receipt of the claim's Explanation of Benefits we receive any unexpected information regarding your payment responsibility, we will promptly notify you to give you an opportunity to address the issue with your insurance company before we charge your credit card.

This also allows you to check out easier, faster and more efficiently as you can simply ask our staff to charge the co-pay to your "card on file". Please be assured that this payment method in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions about this payment method, do not hesitate to ask.

I authorize Phoenix Orthopaedic Consultants to charge the portion of my bill that is my financial responsibility to my credit/debit card ending in _____.

Cardholder Name

Date

Signature



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 you 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 the 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

**Medication
History**



Please Indicate if RX , OTC, Herbal Vitamin or Minerals	Name of Medication	Dosage	Frequency	How do you take this medication?
example: OTC	example: Advil	example: 200mg x 3	example: 3 times a day	example: Orally With meals

PLEASE LET US KNOW IF YOU NEED AN ADDITIONAL SHEET(s) TO LIST ALL MEDS/SUPPLEMENTS/VITAMINS/OTC DRUGS

ePrescribing is a way for doctors to send electronically an accurate, error free and understandable prescription from the office to the pharmacy. Utilizing ePrescribing provides our offices with information on which drugs are covered by your benefit plan. ePrescribing provides us with information on your current and past prescriptions to allow us to be better informed about potential medication issues.

I consent to allow Phoenix Orthopaedic Consultants to request and use my prescription medication history from pharmacy benefit registrations for documentation and treatment purposes. I further state the information provide is true and accurate.

Printed name

Signature

Today's Date