

- Schneider Smith
- Nicola Hansen
- Shevlin



Account # _____

Date _____

Reason For Treatment _____ Date of Injury, or 1st symptom _____/_____/_____
 Left Other
 Right

Patient's Legal Name: Last _____ First _____ Middle _____ Male
 Female
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell/Pager _____ D.O.B. _____ Age _____ Marital Status M S D W
S.S.# _____ Work Phone _____ Ext. _____
Patient's Employer _____ How Long? _____ Occupation _____
Spouse's Name _____ D.O.B. _____ Employer _____
Spouse's S.S.# _____ Work Phone _____ Occupation _____
Can we contact you by email: Yes No Email: _____

Patient's legal guardian _____
Father's Name (IF MINOR) _____ S.S.# _____ D.O.B. _____
City, State, Zip _____ Phone _____
Father's Home Address _____
Father's Employer _____ Occupation _____ Work Phone _____
Mother's Name (IF MINOR) _____ S.S.# _____ D.O.B. _____
City, State, Zip _____ Phone _____
Mother's Home Address _____
Mother's Employer _____ Occupation _____ Work Phone _____

Whom May We Contact In Case of Emergency? _____
Relationship _____ Phone _____

Who referred you to our Practice? Yellow pages Family/Friend E/R Physician: (Please note below)
Primary Care or Referring Physician _____ Date Last Seen _____
Have you had any of the following procedures in regard to this injury?
 X-ray MRI CT-Scan Bone Density Where _____

PRIMARY INSURANCE COMPANY NAME _____ Phone _____
Insurance Co. Address _____
Subscriber Name _____ Relationship to Subscriber
Self Spouse Child Step Parent Other Copay\$ _____
Subscriber D.O.B. _____ I.D. No. _____ Group No. _____

SECONDARY INSURANCE COMPANY NAME _____ Phone _____
Insurance Co. Address _____
Subscriber Name _____ Relationship to Subscriber
Self Spouse Child Step Parent Other
Subscriber D.O.B. _____ I.D. No. _____ Group No. _____

Motor Vehicle Accident <input type="checkbox"/> yes <input type="checkbox"/> no	Attorney Involved <input type="checkbox"/> yes <input type="checkbox"/> no	State _____	Attorney Name, Address & Phone _____				
Work-Related Injury <input type="checkbox"/> yes <input type="checkbox"/> no	Date of Injury, or 1st symptom _____/_____/_____	Have you notified your employer of your injury <input type="checkbox"/> yes <input type="checkbox"/> no	Worker's Comp Claim# _____	Employer at time of injury _____	Employer Phone # _____		

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

PLEASE READ AND SIGN THE FOLLOWING:
I directly assign all medical/surgical benefits to West Idaho Orthopedics and Sports Medicine and understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize West Idaho Orthopedics and Sports Medicine to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I, the undersigned, acknowledge receipt of a copy of West Idaho Orthopedics and Sports Medicine Notice of Privacy Practice. A copy will be available at our office.

Patient/Legal Guardian Signature _____ Date _____



PATIENT FINANCIAL POLICY

(Please read carefully)

Welcome to our practice! Thank you for choosing us as your health care provider. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions regarding this policy, please discuss them with our billing department. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care.

- Your health insurance policy is a contract between you and your insurance company. In many instances, the doctor is not involved. It is your responsibility to know the specifics of your insurance coverage and benefits.
- We have made prior arrangements with some health care plans to accept an assignment of benefits. Please call your insurance company prior to your appointment to determine if your physician is a participant in your plan. We will submit a claim to those plans for which we have a contractual agreement and will require you to pay your authorized co-payment and/co-insurance at the time of service. We will collect all co-payments and deductibles as soon as you arrive for your appointment. We accept checks, money orders, VISA, MasterCard, American Express or cash. We do not accept debit cards. It is your responsibility to be prepared to make your co-payment when you check in. If you are not able to make your co-payment, you will be asked to reschedule your appointment to a time when you are able to do so.
- If you have a health care plan that we do not have a contracting agreement with, we will prepare the claim for you on an unassigned basis. In this instance, our charges for your care and treatment for your initial visit will be due at the time of the service. We must emphasize that as Medical Care Providers, our relationship is with you, not with insurance companies, and insurance companies may calculate their reimbursement rates in a manner that may not fully cover your charges. It is important that you understand your health insurance policy and the coverage it provides.
- Please bring a current copy of your insurance card and current referral, if required by your insurance, to all of your appointments. If proof of insurance is not provided, you will be expected to make payment in full at time of service.
 - **Medicaid/Healthy Connections** patients are required to bring a current copy of their card, or if application is in progress, documentation from Medicaid that this will be a covered service.
 - **Healthy Connections** patients will also need to bring their Healthy Connections referral or make arrangements to have it sent or faxed to our office from their Primary Care Physician **prior** to their visit.
- Please advise us of any change in address, phone number, or insurance that may occur.

For the following items, please indicate that you understand by printing your initials:

_____ In order to provide the best possible service and availability to all our patients, please call **as soon as possible** if you know you will need to reschedule your appointment.

_____ Not all health plans are the same nor do they all cover the same services and supplies. In the event that your health plan determines a service to be a "**non-covered service**", you will be responsible for the complete charge for that particular service. Payment is due upon receipt of a statement from our billing office. If you need to make arrangements for a payment plan, please contact our billing department.

_____ There will be a \$20.00 charge for insufficient fund checks issued.

I have read and understand this financial policy and agree to be bound by its terms. I also understand that such terms may be amended from time to time by West Idaho Orthopedics and Sports Medicine.

Signature of Patient/Parent/Guardian

Date

Print

Name of Patient

WEST IDAHO ORTHOPEDICS AND SPORTS MEDICINE

CONSENT FOR THE USE/DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to inform you of your rights and responsibilities with respect to your protected health information (PHI).

The Notice of Privacy Practices provides more detailed information about how West Idaho Orthopedics and Sports Medicine may use and disclose health information. I have the legal right to review the Notice of Privacy Practices before I sign this consent, and West Idaho Orthopedics encourages reading it in full. My signature below verifies that I have received or have been offered the Notice of Privacy Practices. I understand the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone, in writing, or reviewing the Privacy Notice at www.westidahoorthopedics.com. I have the right to request how my health information is used and disclosed. I also have the right to restrict how this information is disclosed, but the practice is not legally required to agree to these restrictions. West Idaho Orthopedics must receive requests for any restriction of disclosure in writing.

I hereby authorize West Idaho Orthopedics to release any information acquired in the course of my examination or treatment for the purposes of treatment, payment and healthcare operations. This information may be delivered in person, via regular mail, modem, telephone, or facsimile transmission. The information may be viewed by someone other than the intended recipient and I hereby release West Idaho Orthopedics from any liability as a result of such transmission.

I have been informed and understand West Idaho Orthopedics will create a bill for third party payers (automobile/homeowners or other business insurances) but I am responsible to pay for all charges incurred at the time of service. All third party payers must settle privately. I further understand that any unpaid balance is my financial responsibility.

I understand that I may revoke this consent in writing, but the revocation will not apply to any services provided before the revocation was signed. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse all services.

CHECK ONE:

I authorize payment of surgical and/or medical benefits directly to West Idaho Orthopedics and Sports Medicine. I understand I am financially responsible for all charges not covered and guarantee payment of this account.

-OR-

For the following reasons, I agree to be responsible for all bills incurred in the course of my examination and treatment. I understand payment will be due at time of service.

- No insurance coverage in force at this time
- I do not wish to have West Idaho Orthopedics bill my insurance company for me.

Patient Name

DOB

Signature of Patient or Responsible Party/Relation

Date

Additional authorized names to receive protected health information:



NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge that I have received or have been offered West Idaho Orthopedics and Sports Medicine's Notice of Privacy Practices. I understand that the Notice of Privacy Practices contains important information about my rights and obligations concerning my health information. I also understand that I may direct any questions or concerns about the Notice of Privacy Practices to the Privacy Contact person noted in Section 1.

Date

Signature of Patient or Personal Representative If Patient is Unable to Sign.

Patient's Name

Personal Representative's Name if Signing for Patient

Relationship to Patient

Additional Authorized Names Who May Inquire About Protected Health Information

_____	_____
_____	_____
_____	_____

Patient Questionnaire

Name:	Date of Visit: / /
Age:	Date of Birth: / /
Height: feet inches	Weight: pounds
Dominant Hand: right left (circle one)	

Who is your **primary physician** or family doctor?

Is this visit for a **work-related** injury or condition? yes no **Date of injury:** / /
 If yes, who is your **Employer**?

Have we treated anyone in your family? yes no If yes, who?

History of Present Illness: (What is the **reason for this visit**? Describe the onset, quality, location, duration, timing, and severity of symptoms and any treatments tried to date.)

Past Medical and Surgical History: (What other **medical problems** do you have or have you had? Describe past experience with illnesses, injuries, and treatments including any operations or surgery.)

Are you **allergic to any medications**, or do any medications make you sick? (Please list)

-
-

What **medications** do you take? (Please list each medication and dosage.)

-
-
-
-
-

Have you or any family member had **problems with surgical anesthesia**? yes no (Describe)

Have you **ever taken prednisone** or other steroid by mouth? yes no
 Have you ever had a **cortisone or other steroid injection**? yes no

Social history (circle one)

Work: Student Unemployed Homemaker Retired Employed ()

Marital status: Single Married Separated Divorced Widowed

Alcohol intake: Never Rarely Moderately Daily

Tobacco: Cigarettes (packs/day) Never smoked Quit (date: / /) Chew

Please complete the back side. →

Family History

Mother: Alive Deceased

Current health or cause of death _____

Father: Alive Deceased

Current health or cause of death _____

Siblings: # Alive _____

Health Problems _____

Deceased _____

Cause of death _____

Children: # Alive _____

Health Problems _____

Deceased _____

Cause of death _____

Check any illness that has occurred in any of you blood relative

<u>Disease</u>	<u>Who</u>	<u>Disease</u>	<u>Who</u>
_____ Tuberculosis _____	_____	_____ Bleeding disorder/blood clots _____	_____
_____ Diabetes _____	_____	_____ Kidney disease _____	_____
_____ Stroke _____	_____	_____ Depression/Anxiety _____	_____
_____ High Blood Pressure _____	_____	_____ Arthritis/Gout _____	_____
_____ Migraines _____	_____	_____ Thyroid disease _____	_____
_____ Heart disease _____	_____	_____ Cancer (type) _____	_____
_____ Liver disorder _____	_____	_____ Hepatitis _____	_____
_____ Other _____	_____		

System review: Do you or have you ever had any of these? (Check all those that apply.)

- | | |
|---|---|
| <input type="checkbox"/> recent weight change | <input type="checkbox"/> headaches |
| <input type="checkbox"/> stiff neck | <input type="checkbox"/> flu-like aches |
| <input type="checkbox"/> jaundice | <input type="checkbox"/> glaucoma |
| <input type="checkbox"/> double vision | <input type="checkbox"/> loss of vision |
| <input type="checkbox"/> nose bleed | <input type="checkbox"/> sinus infection or disorder |
| <input type="checkbox"/> asthma or wheezing | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> pneumonia or bronchitis | <input type="checkbox"/> difficulty breathing |
| <input type="checkbox"/> chest pain or angina | <input type="checkbox"/> heart murmur or arrhythmia |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> heart failure |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> cancer (list type: _____) |
| <input type="checkbox"/> thyroid disease | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> hormone therapy | <input type="checkbox"/> peptic ulcer (stomach or duodenum) |
| <input type="checkbox"/> liver disease | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> gall bladder disease | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> weakness of muscles or joints | <input type="checkbox"/> difficulty walking |
| <input type="checkbox"/> pain with walking relieved by rest | <input type="checkbox"/> psychiatric problems or care |
| <input type="checkbox"/> convulsions or seizures | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> wound healing problems | <input type="checkbox"/> skin ulceration or breakdown |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> abnormal bleeding |
| <input type="checkbox"/> anemia or blood deficiency | <input type="checkbox"/> immune deficiency |

Women Only

Date of last menstrual period: / /

Have you ever had a **bone density screening**? yes no

If yes **when?** / / **Where?**

Who filled out this form?

Patient

Other (Describe relation)

Patient Signature: _____