ARIZONA MOUNTAIN ORTHOPEDICS

Ian Brimhall, D.O. • H. Ryan Hall, D.P.M. •Jeffrey Reagan, M.D. •Steven Struthers, P.A.

ATTENTION: ALL PAPERWORK MUST BE COMPLETELY FILLED OUT

Patient's Name: ____Age ________ Date of Birth _____________________
Marital status (circle one) M S W D

Mailing Address: ____City/State/Zip ____

Phone: Home _________________________ Cell __________________________ Work ____________________________

Patient Employer: ____Occupation (indicate if student)__________________________

SSN: _______________________ Spouse: _________________________Spouse's employer: ___________________________________

EMAIL ADDRESS (for appointment reminders): ____

ETHNICITY: Hispanic or Latino (circle one) yes no unknown decline Race: ____

ALLERGIES: (circle one) YES NO IF YES, PLEASE LIST ON MEDICAL HISTORY FORM ATTACHED!

Responsible Party (if patient is a minor)

Name: __________________________________ Phone: Home ___________________Cell __________________Work ________________

Address: ____Employer ____

City/State/Zip ____SSN _________________________Date of Birth___________________

Spouse ____Spouse's Employer ____

Referred by ____________________________________Family Physician ____
DESCRIBE ILLNESS OR INJURY

Date of Injury ______________________ What body part was injured? ____

Is your visit today related to a motor vehicle accident? _______ Is your visit today related to an "on the job" accident? ___________

If applicable, name of Industrial Carrier? ________________________________ Claim number _________________________________

NAME AND NUMBER OF A FRIEND OR RELATIVE NOT LIVING YOU: ____
*INSURANCE INFORMATION: PLEASE PROVIDE COPY OF INSURANCE CARD AND COPAY TO RECEPTIONIST AT TIME OF SERVICE*_____

_____ Cash pay – no insurance at time of check-in. Payment expected at time of service.

_____ Name of Primary Insurance Carrier ______________________________________ID______________________Group # ________

Copay amount: $ _________, Name of Policy Holder ____________________________ DOB ___________________SSN ___________

_____ Name of Secondary Insurance Carrier ____________________________________ ID ____________________Group # ________

Copay amount: $ _________, Name of Policy Holder ____________________________ DOB ___________________SSN ___________

AGREEMENT FOR PAYMENT AND CONSENT OT TREAMENT

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify the above information is true to the best of my knowledge. I will notify your office of any changes in my health status or to any of the above information. I authorize insurance benefits to be paid to you to the extent of any unpaid balances on my bill and in accordance with my insurance policies. I will be responsible for any differences that my benefits do not cover. I agree to cooperate fully with respect to any and all procedures or follow treatment programs and instructions recommended to me by the physician or physician's medical staff for the condition under treatment. If I refuse to accept procedures or follow treatment programs recommended or prescribed by physician or physician's medical staff, physician may regard such refusal as incompatible with the continuation of the physician-patient relationship, and in such event, physician reserves the right to cease treatment and terminate the physician-patient relationship.

Signature (patient or legal guardian): ____ Date:________________________

ARIZONA MOUNTAIN ORTHOPEDICS
Orthopedic Surgery and Sports Medicine
4830 Highway 260, Suite 103
Lakeside, Arizona 85929
Phone: 928-537-8777

DATE: ___________________

ASSIGNMENTS OF INSURANCE BENEFITS

Patient's full name: ____

Date of Birth: ______________________________________SNN: ____

Commercial Insured Patients:

For valuable consideration, I hereby authorize payment of insurance benefits to which I am entitled be made on my behalf directly to the providers at Arizona Mountain Orthopedics (AMO) for any medical services performed. I permit a copy of this authorization to be used in place of the original and authorize the release of any medical information to my insurance company that may be needed to determine these benefits payable for related services. I further direct my insurance company to forward their payments directly to the address above. This authorization will remain in effect as long as I continue to be a patient or until revoked in writing by me and delivered by certified mail to AMO.

I understand that I am financially responsible for charges not covered by this assignment.

OR

Medicare Patients:

I request that payment of authorized Medicare benefits be made on my behalf to the providers at AMO for any medical services performed. I permit a copy of the is authorization to be used in place of the original and authorize any medical information about me to be released to the Health Care Financing Administration (HCFA-Medicare), or its agents, if needed to determine these benefits or the benefits payable for related services.

I understand that I am financially responsible for charges not covered by this assignment.

Please initial here ________.

HEALTH CARE AUTHORIZATION

I authorize AMO to discuss my healthcare or treatment to include, but not limited to appointments, referrals, and prescriptions with the parties listed below:

Name: ____Relation: _____________________ Phone: __________________

Name: ____Relation: _____________________ Phone: __________________

I further authorize AMO to leave a message regarding appointments, referrals and prescriptions on my answering machine/voicemail.

Signature: ____ Printed Name: ___________________________________

Patient/Parent/Guardian/Agent (circle one)

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FINANCIAL POLICY

Dr. Brimhall, Dr. Reagan, Dr. Hall, and P.A. Word recognize the importance of the successful operation of our practice. It is our hope that you will understand that our financial policy is a necessary part of assuring the financial resources required to maintain the vital health care services for our patients and the community. Our goal is to set standards that will provide our patients with the highest quality medical and surgical care.

PLEASE READ THE ITEMS THAT HAVE BEEN MARKED WITH A CHECK MARK OR AN "X." THE ITEMS CHECKED WILL INCLUDE INFORMATION DIRECTLY RELATED TO YOUR SPECIFIC ACCOUNT WITH THIS OFFICE.

___ PPOs, HMOs, Managed Care and other Contracted Plans. We are contracted with a variety of managed care and insurance plans to provide specialist services. Some of these plans require the patient to have a primary care physician (PCP). You may be required to obtain a referral or authorization from either your PCP or your insurance plan before any services can be provided to you. You are required to pay your co-pays at time of service.

___ Medicare Part B. We are participating physicians with the Medicare program. You are responsible for your yearly deductible and 20% of the allowable charges. Please advise us if Medicare is your secondary payor. Please Note: If you only have Medicare Part A, you DO NOT have coverage for physician charges.

___ Supplemental Insurance. If you have supplemental coverage, we will automatically submit your claims if you have supplied us with the insurance information. If your supplemental plan pays you, we expect you to forward those payments to us.

___ Non-Contracted Insurance. Payment is expected at the time of service and we will give you all the information you will need t bill your own insurance. All medical expenses are the patient's responsibility, regardless of insurance coverage.

___ Self-pay. (Patient's without insurance at time of services.) Patient's without insurance are considered "self-pay," and are expected to pay at the time services are rendered, UNLESS other arrangements have been made in advance with the billing office. For large surgery balances, the hospital or out-patient surgery center will make assist you in applying for AHCCCS. If you are not eligible for AHCCCS, and there are special considerations, you may apply for a Financial Agreement with our office. We also take Visa and MasterCard.

___ Workman's Compensation. If you have a work-related or industrial injury/illness, you must report this to your employer and complete a "pink" Worker's Report of Injury for the Industrial Commission of Arizona and advise us of the name and address of the work-comp insurance carrier. We are required to obtain authorization from the industrial carrier for any surgical procedures and certain diagnostic tests. Any claim denied as "non-industrial" or "closed" may be bill to your medical insurance carrier or will become your responsibility.

___ Automobile or Motor Vehicle Accidents, Legal Lien. Regardless of litigation pending on any case, accident or otherwise, you are responsible for payments of any and all series rendered to you. Payments cannot be contingent on any settlement, judgment, or verdict for which you may be paid as a result of your injuries. We do not accept liens. We expect payment at the time of service. We will not wait for automobile or third-party insurance settlements.

Financial Policy Continued:

___ IHS, CHS, AHCCCS or "potential AHCCCS." You must produce your ID card at each visit. If you are no longer eligible, or we cannot verify your eligibility, you will be responsible for payment of our charges. If you are "potential AHCCCS," it is imperative that you apply for coverage within 48 hours from the time of medical care. Failure to follow through will result in you being totally responsible for payment.

Paying your bill. If unusual circumstances make in impossible for you to pay for services in full or to meet out terms, we invite you to call or come in to discuss the matter with our billing office. This will avoid any misunderstandings and keep your account in good standing. Except when hardship or prior credit arrangements warrant, accounts over 90 days past due are referred to our collection agency. All collection expenses will become your responsibility. If your account goes to collections, you will be discharged from the practice. If you have any questions, please ask. We will assist you in anyway we can. We accept Visa and MasterCard. Returned checks incur a $25.00 service charge and all accounts extended past 90 days will be charged a $5.00 re-billing fee per month. We do not assess finance charges.

Appointments. A certain amount of time and preparation goes into your visit. If you are unable to keep your appointment, please give us 24-hour notice. To make or change an appointment, call 928-537-8777. For emergencies, our telephone is answered 24 hours a day, 7 days a week. Our office hours are 8:00am to 5:00pm, Monday through Fridays, except holidays. We sometimes, but rarely, close the office when there are no physicians in the office.

Prescriptions refills. As our physicians are often in surgery or at the hospitals and not available in the office, please allow a minimum of 4 business days for prescription refills whenever possible. No refills or requests for medications will be considered on weekends or holidays. We do not obtain prior authorizations for medications other than blood thinners and antibiotics.

Information. It is your responsibility to make sure that we have accurate and up-to-date information for billing your insurance. It is also important to advise us of any changes to your name, address, and phone numbers.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS POLICY. I AGREE TO THE TERMS CONTAINED HEREIN. I HAVE ALSO READ AND UNDERSTAND THE HIPPA NOTICE OF PRIVACY PRACTICES.

Please print patient's name: ____Date: ___________________

Signature: ____ Printed Name: _________________________________

Patient/Parent/Guardian/Agent (circle one)

(A photocopy of this agreement is as valid as the original.)

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INJURY DETAILS

TODAY'S DATE: ___________________

PATIENT NAME: ____

WHAT BODY PART WAS INJURED? ____

DATE OF INJURY? ____

WHERE DID IT OCCUR? ____

HOW DID OCCUR? ____

WAS THE ACCIDENT WORK RELATED? { } YES { } NO

WAS THE INJURY THE RESULT OF AN AUTOMOBILE/MOTORCYCLE ACCIDENT? { } YES { } NO

WERE ANY CITATIONS ISSUED OR ANY MISDEMEANOR OR FELONY CHARGES FILED IN CONNECTION WITH THIS ACCIDENT? { } YES { } NO

WAS THE DRINKING OF ALCOHOL OR THE USE OF PRESCRIPTION OR ILLEGAL DRUGS IN ANYWAY INVOLVED OR AT ISSUE WITH THIS ACCIDENT? { } YES { } NO

WAS ANOTHER INDIVIDUAL/PARTY RESPONSIBLE? { } YES { } NO

HAVE YOU HIRED AN ATTORNEY REGARDING ACCIDENT? { } YES { } NO

IF YES; NAME, ADDRESS, AND PHONE NUMBER FOR ATTORNEY: ____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: ____

MEDICAL HISTORY

DATE ____________________NAME____AGE___________________

HEIGHT__________________WEIGHT____________________

WHAT IS THE REASON FOR YOUR VISIT TODAY? ____

HOW/WHEN DID THE PAIN START? ____

HAVE YOU HAD ANY OF THESE DIAGNOSTIC STUDIES? XRAYS, CT SCAN, EMG, CARDIAC CATH, MRI, EKG/STRESS TEST?

IF SO, WHEN AND WHERE? ____

CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER, PRESCRIBED, AND DOSAGE: _____________________________

____

ARE YOU ALLERGIC TO ANY MEDICATIONS: { } YES { } NO IF YES, PLEASE EXPLAIN: ____________________________

____

REVIEW OF SYSTEMS: ARE YOU CURRENTLY OR HAVE YOU EVER HAD PROBLEMS WITH ANY OF THE FOLLOWING?

			DESCRIBE
AIDS/HIV POSITIVE	NO	YES	______________________
ARTHRITIS	NO	YES	______________________
BALANCE ISSUES	NO	YES	______________________
BLEEDING PROBLEMS/DISORDERS	NO	YES	______________________
BLOOD CLOTS/STENTS/BLOOD THINNERS	NO	YES	______________________
BOWEL/ BLADDER ISSUES	NO	YES	______________________
CANCER	NO	YES	______________________
DIABETES	NO	YES	______________________
DIGESTIVE ISSUES	NO	YES	______________________
EPILEPSY	NO	YES	______________________
EYES, EARS, NOSE, THROAT	NO	YES	______________________
HEART ATTACK, STROKE, PACEMAKER	NO	YES	______________________
HEPITIS	NO	YES	______________________
HIGH BLOOD PRESSURE	NO	YES	______________________
KIDNEY DISEASE	NO	YES	______________________
LUNGS/BREATHING ISSUES	NO	YES	______________________
MRSA INFECTION	NO	YES	______________________
NUMBNESS/TINGLING	NO	YES	______________________
POLIO	NO	YES	______________________
PSYCHOLOGICAL	NO	YES	______________________
TUBERCULOSIS	NO	YES	______________________

MEDICAL HISTORY CONTINUED:

PAST MEDICAL HISTORY:

ANY SURGERIES? IF YES, EXPLAIN: ____

____

PLEASE LIST ANY COMPLICATIONS YOU MAY HAVE HAD OR ANY PROBLEMS WITH ANESHESIA: ______________________

____

FAMILY HISTORY: IN YOUR IMMEDIAT FAMILY, IS THERE A HISTORY OF CANCER, HEART DISEASE, BREATING DISORDERS, HIGH BLOOD PRESSURE OR DIABETES? IF YES, PLEASE EXPLAIN: ____

____

SOCIAL HISTORY:

OCCUPATION: ____

MARITAL STATUS: _______________________________________NUMBER OF CHILDREN: _________________________

WITH WHOM DO YOU RESIDE? ____

DO YOU EXCERSISE ON A REGULAR BASIS? _________ HOW OFTEN? ____

ARE YOU ON A SPECIAL DIET? ____________ DESCRIBE: ____

DO YOU SMOKE? _____________IF SO, PACKS/DAY FOR ___________YEARS.

HAVE YOU QUIT? ____________________WHEN? ____________________

ANY HISTORY OF SUBSTANCE ABUSE? _________ IF YES, PLEASE EXPLAIN: ______________________________________

____

DO YOU DRINK ALCOHOL? _________ IF YES, HOW OFTEN? ____

REVIEWED BY ______________________________________DATE: ____

<u>Arizona Mountain Orthopedics HIPAA Notice of Privacy Practices</u>

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 describes how we 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 right to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. <u>Uses and Disclosures of Protected Health Information</u>
   Your PHI 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 physician's practice, and any other uses required by law. Regular ways of communication, including texting on password protected phones, may be utilized in cooperation of care.

2. <u>Treatment</u>
   We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your health care with a third party. For example: we would disclose your PHI, as necessary, to a home health agency that provides care to you. Or another example: your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

3. <u>Payment</u>
   Your PHI 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 PHI be disclosed to the health plan to obtain approval for the hospital admission.

4. <u>Healthcare Operations</u>
   We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, 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 your name in the waiting room when your physician ready to see you. We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Require by Law; Public Health issues are required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and organ donation research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; required Use and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Service to investigate or determine our compliance with requirements of Section 164.500.

Other permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

HIPAA Notice Continued

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law however, you may not inspect or copy the following records; psychotherapy notes, information compelled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for these purposes of treatment, payment or heath care operations. You may also request that any part of your PHI not be disclosed to family members of friends who may be involved in your care or for notification purposes as described in this Notice 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 a restriction that you may request. If physician believes it is of your best interest to permit use and disclosure of your PHI, your PHI will be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications 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 may have the right to have your physician amend your protected health information. If we deny your request for 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 we have made if any of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 privacy contact of your complaint. We will not retaliate against your for filing a complaint.

*This notice was published and becomes effective on/or before April 14, 2003***.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with request to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Signature: ____ Printed Name: __________________________________
Patient/Parent/Guardian/Agent (circle one)

Date: __________________

(You may ask for a copy of this notice at time of check-in.)