



NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

Check one:

- By my signature below I acknowledge receipt of the Notice of Privacy Practices.**
- By my signature below I acknowledge that I have declined to accept the complete Notice of Privacy Practices and instead asked to receive only the Short Form Notice of Privacy Practices. I have been made aware that the complete Notice of Privacy Practices is available to me at any time. If I request a copy, it is available and on display in the waiting room, and is available on the Proliance Surgeons web site at address: www.proliancesurgeons.com.**

Patient or legally authorized individual signature

Date Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

We have an automatic computer system that calls and reminds patients of their appointments, do you give us permission to call you at your home phone number and remind you of your appointment?

YES NO

Can we leave a message? YES NO

Labor & Industry and/or Motor Vehicle Accident Information

DATE OF INJURY: _____

Did this result from an Auto Accident? YES NO Insurance Company _____

Claim # _____

Did this result from an accident at work? YES NO State Industrial #: _____

Which medical office did you file your claim at? _____



PATIENT H&P FORM

Name: _____ Age: _____
Last First M.I.

Date of Birth: _____ Date of last physical exam: _____ Height: _____ Weight: _____

CURRENT or CHIEF PROBLEM

Date of injury or onset: _____

Location/Body Part: _____

How it effects you? _____

When it effects you, how long does it last? _____

Swelling, bruising, etc.,? _____

PAST MEDICAL HISTORY Do you now or have you ever had: (check if "yes")

<input type="checkbox"/> Anemia	<input type="checkbox"/> Hernia	<input type="checkbox"/> Skin Disease
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tumor (benign)
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tumor (malignant)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> None of the Above
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Other-

PREVIOUS OPERATIONS Yes No, please list:

Type	Year	Reason
1.		
2.		
3.		
4.		

Have you ever had a blood transfusion? Yes No What year? _____

PRESENT MEDICATIONS Yes No, please list including aspirin, laxatives, vitamins, herbs, and other supplements:

Drug Name	Dose(mg)	Frequency(times per day)
1.		
2.		
3.		
4.		

Other significant illnesses (please list): _____

Are you pregnant? Yes No Any previous fractures? Yes No Describe: _____

Have you had a Bone Density Study? Yes No If so, date of last scan ___/___/___ Where: _____

(Doctor Answer) Recommends a DEXA Scan? Yes No

DRUG ALLERGIES Yes No, please list:

Drug Name	Reaction (rash, difficulty breathing, etc.)
1.	
2.	
3.	

What is your primary pharmacy? _____ City/State _____

SOCIAL HISTORY

Do you smoke? Yes No Past—If yes, number/day and years smoked _____ Quit when? _____

Do you drink alcohol? Yes No Type and number of drinks/week _____

Do you use drugs for reasons that are not medical? Yes No If yes, please list: _____

Do you exercise regularly? Yes No Type and amount per week: _____

Married Single Retired Living Independently Number of children: _____

FAMILY HISTORY

Do you know of any blood relative who has, have had, or died from any of the following (include age) check ALL that apply:

Cancer _____ Diabetes _____ Epilepsy _____

Heart Disease _____ High Blood Pressure _____ Psoriasis _____

Congenital Problems _____ Obesity _____ Asthma _____

Alcoholism _____ Tuberculosis _____ Thyroid Problems _____

Rheumatic Fever _____ Rheumatoid Arthritis _____ Stroke _____

None of the above have effected a blood relative

SYSTEMS REVIEW As you review the following list, please check ALL which have significantly affected you:

Head, Eyes, Ears, Throat

Gastrointestinal

<input type="checkbox"/> Headache	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Difficult seeing	<input type="checkbox"/> Constipation
<input type="checkbox"/> Difficult hearing	<input type="checkbox"/> Use laxatives frequently
<input type="checkbox"/> Hoarsness	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Difficult Swallowing	<input type="checkbox"/> Stomach pain
<input type="checkbox"/> None of the Above	<input type="checkbox"/> None of the Above

Musculoskeletal & Neurologic

Genitourinary

<input type="checkbox"/> Balance disturbance	<input type="checkbox"/> Last rectal exam
<input type="checkbox"/> Weakness(arms)	<input type="checkbox"/> Last pelvic exam
<input type="checkbox"/> Weakness(legs)	<input type="checkbox"/> Kidney infections
<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Bladder infections
<input type="checkbox"/> Joint stiffness	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Joint deformity	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Numbness(describe)	<input type="checkbox"/> Incontinence
<input type="checkbox"/> None of the Above	<input type="checkbox"/> None of the Above

Pulmonary

Cardiovascular (heart & circulatory)

<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Infections	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> None of the Above	<input type="checkbox"/> Shortness of breath at night
	<input type="checkbox"/> # of pillows you use?
	<input type="checkbox"/> Swelling of feet, ankles, legs
	<input type="checkbox"/> None of the Above

Physician/PA _____ Date _____



Patient Financial Policy for Northwest Orthopaedic & Sports Medicine

Patient's Name: _____ Date of Birth: _____

Patient Financial Classification Policies:

You are required to present a valid insurance card at every visit and as needed throughout your care.

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding patient balances and co-payments are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

Private Pay: We require \$250 deposit. We offer a 20% payment discount for patients without health insurance ("private pay") when payment is made at the time of service as follows:

Medicare: Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover through the CSM (Medicare System). If your secondary insurance does not crossover it is the patient's responsibility to either bill secondary themselves or provide at time of service information to bill their secondary insurance. We do not bill 3rd insurances. Any outstanding balances and deductibles are due prior to your appointments. Any non covered service will be due as service is rendered.

Medicaid: Our office is a Medicaid participating provider and we will bill Medicaid for you. Any outstanding balances, co-payments and deductibles are due prior to your appointments.

Worker's Compensation: If your visit is work-related we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company. If your workers compensation claim is not yet accepted and you have no "back-up" insurance we require a \$250 deposit that will be refunded after the claim has been opened.

Motor Vehicle Insurance (MVA): \$250 deposit is required on all MVA accounts. We will courtesy bill your MVA insurance if all information is provided at the time of service.

Methods of Payment:

Our office accepts the following payment methods:

Cash, Personal Check, Debit Cards, Visa, Master Card, Discover and Patient Financing options for those patients who are credit worthy.

For returned checks we assess a \$41.00 NSF charge.

If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

The patient is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments of professional fees.

24 hour cancellation notice is required, otherwise you will be Charged a \$25 no show fee.

COLLECTION CHARGE of \$10.25 will be applied to all accounts unpaid after 45 days.

Northwest Orthopaedic Associates or its agents have permission to contact me by wireless telephone for billing or payment activities. I understand and agree that I may incur charges or airtime minutes through my wireless carrier as a result of this consent.

Print Name: _____ **Signature:** _____ **Date:** _____