Today's Date: ________________________________

How Did You Hear About Us? ____

Primary Care Physician: ____

Primary Insurance: ____

Policy Holder: _______________________________________ Policy Holder Birthdate: _________________

Patient Relationship to Policy Holder: ____

Secondary Insurance: ____

Policy Holder: _______________________________________ Policy Holder Birthdate: _________________

Patient Relationship to Policy Holder: ____

PATIENT INFORMATION

Last Name _________________________________ First ______________________ Middle ______________

Mailing Address ____

City _______________________________________ State ___________________ Zip ____________________

Home Ph ______________________ Cell Ph _____________________ Work Ph _______________________

Birthdate __________________ Age ______F______M______ Single Married Divorced Widowed

Social Security No. __________________________ or **Minor (if the patient is a minor, please complete the preferred pharmacy line and the Parental Information box below)**

Patient's Employer _____________________________________ Occupation ___________________________

Spouse's Name __________________________ Social Security No ___________________ DOB ___________

Spouse's Ph _________________ Spouse's Employer _____________________ Occupation _______________

Patient's Email ____

Preferred Pharmacy & Location ____

PARENTAL INFORMATION

Father's Name _______________________________ Social Security No ________________ DOB ___________

Mailing Address _____________________________City ________________State ______ Zip ___________
(if different than child's address)

Father's Ph _____________________________ Father's Employer ____________________________________

Mother's Name ______________________________ Social Security No ________________ DOB ___________

Mailing Address _____________________________ City ________________ State ______ Zip ___________
(if different than child's address)

Mother's Ph _____________________________ Mother's Employer ___________________________________

Parent's Email ____

PATIENT NAME: ____ **DOB:** ___________________

HEALTH HISTORY

DATE OF INJURY: ______________________________ **Was your injury work related?** ☐ Yes ☐ No

How were you injured? ____

CHIEF COMPLAINT: What is the reason for your visit? ____

Body Part: ____ ☐Left ☐Right ☐Bilateral

PAIN: Rate your current pain on a scale from 0-10 ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Check all that apply: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Pins & Needle ☐ Constant ☐ Comes & Goes

REVIEW OF SYSTEM: Check the box next to any current symptoms:

☐ Fever/Chills ☐ Nausea ☐ Headaches ☐ Blurred Vision ☐ Breathing Prob.
☐ Chest Pain ☐ Sore Throat ☐ Constipation ☐ Urination Problem ☐ Rashes

MEDICAL HISTORY: Please check any of your medical conditions:

☐ Heart Problems ☐ Osteoporosis ☐ Diabetes ☐ Thyroid Disorder
☐ Lung Problems ☐ Seizures ☐ Stomach Ulcers ☐ Rheumatoid Arthritis
☐ Kidney Problems ☐ Blood Clots ☐ Hepatitis C ☐ HIV/AIDS
☐ High Blood Pressure ☐ Other: ____

Have you ever been diagnosed with an antibiotic resistant infection (i.e. MRSA)? ☐Yes ☐No
Are you or could you be pregnant? ☐Yes ☐No

HEIGHT: ___________ **WEIGHT:** ___________ **AGE:** ___________

SURGICAL HISTORY: Previous surgeries? ☐Yes ☐No **If yes, please list:**

____

____

FAMILY HISTORY: Please list any medical conditions that run in your immediate family:

____

____

MEDICATIONS: Do you take any medications? ☐Yes ☐No **If yes, please list:**

____

____

ALLERGIES: Do you have any medication allergies? ☐Yes ☐No **If yes, please list:**

____

____

SOCIAL HISTORY: Occupation: ____

Do you drink alcohol? ☐Yes ☐No

Do you use tobacco products? ☐Yes ☐No **If yes, what kind:**_________________________

Is there anything else our staff should know to assist with your treatment?

____

X
____
Signature of Patient (or Guardian if patient is under 18) **Date**

PATIENT NAME: ____ DOB: ___________________________

FINANCIAL POLICY & CONSENT FOR TREATMENT

Thank you for choosing us as your Orthopedic Health Care Provider. The following is our Financial Policy and Consent for Treatment. Our main concern is that you receive the proper optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.

ALL PATIENTS: (or guardian) must have one form of picture identification ex: valid driver's license.

CONSENT FOR TREATMENT: I am presenting myself for outpatient care at Allied Orthopaedics or Direct Orthopedic Care and I voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment by authorized agents, employees of Allied Orthopaedics and/or Direct Orthopedic Care and the medical staff (or their designees) as in their professional judgment may deem necessary. I acknowledge that no guarantee has been made to me as to the result of examination or treatment in this clinic.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Allied Orthopaedics and/or Direct Orthopedic Care of all insurance benefits, to which I would otherwise be entitled for these services. I understand that I will be obligated to pay for any service not paid for by my insurance including (but not limited to) services that are deemed to be medically necessary. I accept financial responsibility to Allied Orthopaedics and/or Direct Orthopedic Care for 100% of the charges. I will pay any legal fees incurred by Allied Orthopaedics and/or Direct Orthopedic Care in collecting this account.

SURGICAL DOWN PAYMENT: For all commercial insured patients a **$300.00** down payment is required prior to any surgical procedures.

SURGICAL ASSIST: The Allied Orthopaedics physicians may utilize a surgical assistant during surgery. If so, you and/or your insurance company will receive a separate bill for this service.

REFERRALS: You are responsible for providing a referral from your primary care physician as required by and consistent with the requirements of your insurance plan. If a referral is not available, you will have to come back or reschedule once it is obtained.

INSURED PATIENTS: Insurance Cards, and/or Insurance Forms must be presented prior to being seen. All Co-Pays and Deductibles are due at the time services are rendered, NO EXCEPTIONS. All insured patients are required to sign the *assignment of benefits* for payments made by the insurance company.

CASH PATIENTS: Payment for services is due at the time services are rendered. For all **uninsured** patients a new patient initial visit or an established patient new injury visit to Allied Orthopaedics and/or Direct Orthopedic Care will be a **$400.00** charge due at the time of the visit with the exception of Viscosupplementation injections which will be a **$650.00** charge due at the time of the visit, all subsequent visits will be a **$200.00** charge due at the time of the visit if following up for the same injury. For all **uninsured** patients coming in for a concussion visit the charge will be **$200.00** due at the time of the visit and all subsequent visits will be a **$100.00** charge due at the time of the visit, if following up for the same injury. Charge is due at the time of the visit, NO EXCEPTIONS. If patient is surgical please refer to surgical consent form. We accept cash, checks, Master Card, or Visa. If you are not able to make payment at the time of service, please reschedule for when you are able to do so.

WORKER'S COMPENSATION: In the event it is determined by the Worker's Compensation board that the injury is not a result of a compensable Worker's Compensation case, we will bill any private insurance. The balance is your responsibility.

DISCLOSURE: Allied Orthopaedics and Direct Orthopedic Care physicians share financial interest in Treasure Valley Hospital and Sawtooth Physical Therapy.

UNPAID BALANCES: I consent to allow Allied Orthopaedics and/or Direct Orthopedic Care to store my credit/debit card information on a third-party PCI DSS compliant server. Storage of payment information may be used to allow me to establish a payment plan as an acceptable alternative to my account being sent to collections.
FEES FOR RETURNED CHECKS: Returned checks will be subject to a $25.00 fee, for processing.
CANCELLATIONS: Please contact our office within a reasonable time to cancel your appointment, preferably 24 hours notice.
NO SHOW'S: If you do not show for a scheduled appointment you will be subject to a $25.00 fee per missed appointment.
Unpaid Balances after 60 days will be assessed a 25% APR late fee.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I HAVE READ IT, UNDERSTAND ITS CONTENTS, AND VOLUNTARILY AGREE TO ITS PROVISIONS AND HEREBY CONSENT TO ALLIED ORTHOPAEDICS AND/OR DIRECT ORTHOPEDIC CARE.

X
Signature of Patient (or Guardian if patient is under 18) **Date**

X
Signature of Witness **Date**

Patients Name: ___________________________________ **DOB:** ________________

FRACTURE CARE BILLING NOTICE ACKNOWLEDGEMENT

Center for Medicare & Medicaid Services (CMS) guidelines mandate that care for certain types of fractures (i.e. displaced fractures that require reduction) be billed differently from a typical office visit. If it is determined that your injury meets the criteria, a single, larger service charge will be billed for your initial visit. This single, larger service charge covers only your initial office visit charge and related office visit charges within 90 days thereafter (the global billing period for such fractures). Additional services including, but not limited to, X-rays, casting, splinting, and any durable medical equipment provided, are not included in the single, larger service charge billed at the time of the initial visit.

Our billing practices are consistent with the CMS guidelines. If you do not return for related office visits within the 90 day period following your initial visit, please be advised that you have paid for these office visits as part of the initial larger service charge.

X ____

Signature of Patient (or Guardian if patient is under 18) **Date**

HIPAA PRIVACY ACT ACKNOWLEDGEMENT

ALLIED ORTHOPAEDICS and DIRECT ORTHOPEDIC CARE are concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for Allied Orthopaedics and/or Direct Orthopedic Care.

X ____

Signature of Patient (or Guardian if patient is under 18) **Date**

Patient's Name: ______________________________________ **DOB:** _________________

THIRD PARTY RESPONSIBILITY

VEHICLE ACCIDENT? **Please Circle One:**

Yes (Complete Requested Information)

No (Not Applicable)

Date of Injury: _________________________________

Vehicle Insurance Company: ____

Insurance Address/Phone No.: ____

____

Claim No.: ____

Adjuster Name: ____Phone No: ________________________

Attorney Name/Address/Phone No.: ____

____

Other Driver's Insurance Company/Claim No. (if applicable): ______________________________________

____

WORKER'S COMP? **Please Circle One:**

Yes (Complete Requested Information)

No (Not Applicable)

Date of Injury: _________________________________

Work Comp Insurance Company: ____

Claim No.: ____

Adjuster Name: ____Phone No: ________________________

Attorney Name/Address/Phone #: ____

____

X ____

Signature of Patient (or Guardian if patient is under 18) **Date**

PATIENT NAME: ____ DOB: ________________

SURGICAL PATIENT FINANCIAL POLICY AND CONSENT TO TREAT

Thank you for choosing us as your Orthopedic Health Care Provider. The following is our Financial Policy and Consent for Treatment for surgical patients. Our main concern is that you receive the proper optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.

We ask that all patients read and sign our Financial Policy and Consent for Treatment as well as complete our Financial Policy and Consent for Surgery.

SURGICAL PATIENTS:

Patients undergoing surgery will have three separate bills for their care; one from their surgeon, one from the Hospital, and one from their Anesthesiologist.

Surgeon Fee:

For all **uninsured surgical** patients a **$2500** down payment will be required **before their pre-operative appointment** with the surgeon. This down payment will be applied to the total Surgeon fee at the end of treatment. Depending on the care rendered, you may end up owing more than $2,500. We accept cash, checks, Master Card, or Visa.

For all commercial insured patients a **$300.00** down payment is required prior to any surgical procedures.

This fee will be applied to your total bill for surgery and postoperative appointments for 3 months after surgery. **The surgeon's fee does not include hospital fees & anesthesia fees.** It also does not cover your preoperative appointment, X-rays, splints, casts, braces, walking boots or other durable medical goods before or after surgery.

An estimate of your total surgeon fee can be provided upon request. This will only be an estimate, and will not reflect your final bill.

Hospital and Anesthesia Fees:

Hospital & Anesthesia fees are typically at least $10,000, but vary depending on the type of procedure you may require and the hospital that your procedure takes place. It is your responsibility to obtain estimates for the cost of your treatment at the hospital and with the anesthesiologist. We can provide you contact information for these entities, and the codes you will need to obtain said estimates.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I HAVE READ IT, UNDERSTAND ITS CONTENTS AND VOLUNTARILY AGREE TO ITS PROVISIONS AND HEREBY CONSENT TO ALLIED ORTHOPAEDICS.

X

Signature of Patient (or Guardian if patient is under 18) **Date**

X

Signature of Witness **Date**

PATIENT NAME: ____ DOB: ___________________

EMERGENCY CONTACT INFORMATION

Name: ____ Phone No: _____________________

Relationship: ____

Address: ____

City: _____________________________________ State: _______________ Zip: ______________

PROTECTED HEALTH INFORMATION RELEASE
(PATIENTS 18 YEARS AND OLDER)

□ Only release information to me personally, unless authorized below.

□ You have my authorization to speak with my Spouse/Significant Other about my medical care and test results.

Name: _______________________________________ Phone No: _____________________
Spouse/Significant Other

□ I authorize you to speak with my adult family members or other individuals about my medical care as identified below:

Name: _______________________________________ Phone No: _____________________

Relationship: __________________________________

Name: _______________________________________ Phone No: _____________________

Relationship: __________________________________

Name: _______________________________________ Phone No: _____________________

Relationship: __________________________________

□ You have my authorization to leave information on my answering machine regarding my medical care and test results.

□ Other, please describe:
____

____

X ____
Signature of Patient (or Guardian if patient is under 18) Date