Help us by letting us know how you heard about Integrated Orthopedics.

THANK YOU!

DATE: _____

NAME: _____

EMAIL: _____

PHONE: _____

HOW DID YOU HEAR ABOUT US? (*Please circle)*

- ZocDoc
- Our Blog
- Our Monthly Newsletter
- I am a former / returning patient
- Our Integrated Orthopedics Website
- Referral from a friend or family member
- PRP Procedure Information from our website
- Google _____ Bing _____ Yahoo _____ Instagram _____ Snapchat _____
- Facebook _____ Pinterest _____ YouTube ____ Other _____
- Doctor Referral -Doctor's Name _____
- Urgent Care Clinic - If so what clinic referred, you? _____
- Postcard / info I picked up at a local venue or Health Expo. Tell us Where? _____
- Other: _____

PATIENT REGISTRATION/DEMOGRAPHICS

Section A. - PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name: _____ Patient Social #: _____

Gender: [_] Male [_] Female Birth Date: _____ Age: _____ Marital Status _____

Address: _____ City, State, and Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ ***Authorization to leave voice message, please initial*** _____

Parent/Guardian: _____ Parent/Guardian Social #: _____

Relationship to Patient: _____ Parent/Guardian Birth Date: _____

Referring Physician: _____ Phone Number _____

Primary Physician: _____ Phone Number _____

Emergency Contact: _____ Relationship/Phone: _____

Employer/School/Team Name: _____

Insurance Information (*Required, even if insurance card is on file)*

Primary Insurance:

Insurance Co Name: _____

Policy Holder: _____

Policy Holder Birth Date: _____

Relationship to Patient: _____

Employer: _____

Secondary Insurance:

Insurance Co Name: _____

Policy Holder: _____

Policy Holder Birth Date: _____

Relationship to Patient: _____

Employer: _____

AUTHORIZATION TO RELEASE PATIENT INFORMATION: I hereby authorize Integrated Orthopedics to release any personal health information (PHI) required in the course of my examination or treatment to the above stated insurance company, or their affiliates.

Signed (Patient or guardian) _____ Date_____

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to Integrated Orthopedics for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

Signed (Patient or guardian) _____ Date_____

Section B. – CIRCLE OF CARE RELEASE
Authorization to release health information via fax/phone

Please list anyone that we may release information to on your behalf.

I, _____, born ____/____/_____

hereby authorize (name, address, phone number, and fax number as applicable) as part of my circle of care:

to discuss my treatment and/or release information to: Integrated Orthopedics
20940 N. Tatum Blvd, Suite B290, Phoenix Arizona 85050 Phone 602-734-1834 Fax 602-734-1835

Dates of Service from: to: Date _____ ❑ Never

Authorization Expires *(unless otherwise noted this authorization will remain in effect one year from the date signed)*

Release the following information:
❑ All Records ❑ Chart Notes ❑Radiology ❑ Operative Reports ❑ History & Physicals

☐ **DECLINED**

Signature of patient or legal representative: **Date:**

Section C. - HIPPA REVIEW/AUTHORIZATION:
Please review and sign below

I understand that:

- Once Integrated Orthopedics of Arizona discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. The medical records to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases.
- This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department (45 CFR 164.508(c)(2)(i)).

Signature of patient or legal representative: **Date:**

THIS AGREEMENT STATES THAT THE RESPONSIBLE PARTY AGREES TO TERMS STATED BELOW,

- We will bill primary and secondary insurances. You are responsible for deductible, coinsurance, copays, uncovered service, plus any supplies purchased and not covered by the insurance. If you are covered by Medicare, we will bill Medicare as your primary insurance. We will bill any secondary insurance also. You are responsible for deductible, coinsurance, copays, uncovered service, plus any supplies purchased and not covered by the insurance. You may be asked to sign an ABN (Advanced Benefit Notice) for services that are non-covered by Medicare.
- This financial agreement is based on information quoted by your insurance carrier via telephone, because your
- Insurance carrier may misquote your benefits to us, we strongly encourage all patients to verify their own benefit coverage, including co-pay amounts, remaining deductibles. THIS FINANCIAL AGREEMENT IS BASED ON BENEFITS QUOTED BY YOUR INSURANCE CARRIER AND IS EFFECTIVE THROUGH THE CALENDAR OR FISCAL YEAR, WHICH EVER CORRESPONDS TO YOUR INSURANCE POLICY.
- If reimbursement is to be received due to a personal injury, all adjustments are null and void and full balance without negotiation will be due at the time of settlement.
- All co-pays and co-insurance payments are due prior to treatment. We accept cash, check, or credit card.
- Should you be unable to keep a scheduled appointment, you must call at least 24 hours prior to your appointment. Patient's, who fail to do so, will be charged a $35 fee. These charges will be the patient's responsibility as insurance carriers will not pay for them.
- Your insurance coverage is an agreement between you (the patient) and your insurance carrier. Integrated Orthopedics will, as a courtesy, submit all eligible charges to your insurance carrier for payment. Please remember that you are ultimately financially responsible for all charges incurred during your course of treatment. A statement of charges showing patient responsible charges (those charges that are not covered by your insurance carrier) will be sent out monthly. A patient who has not patient responsible charges will not receive a statement until their course of treatment is completed. Upon completion of treatment, all patient's will receive a statement showing all pending charges, adjustments and pending insurance payments. Any charges, which are the patient's responsibility, are due immediately.
- If, after 90 days from your discharge date, we have not received payment in full from the Insurance Carrier, all outstanding charges will become the responsibility of the patient and are due immediately. We strongly encourage you to contact your insurance carrier, during this 90-day period, to check on the status of your claims. Please feel free to contact us if your insurance carrier needs additional information from us to process your claims.

I understand that I am financially responsible for all charges incurred. Should this matter be turned over to our collection attorney all costs, including reasonable collection fees (35%-50%) and any court costs incurred by Integrated Orthopedics or our attorneys, shall be the responsibility of the patient or responsible party.

_____ _____

Signature Date

_____

Print Name

Integrated Orthopedics, PLLC
20940 N. Tatum Blvd., Suite B-290, Phoenix, AZ 85050- 602-734-1834

NOTICE TO PATIENTS

State law, A.R.S. 32-1401 (25) (ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. (I/We) support this law because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that (I/We) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services that (I/We) have prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

- SurgCenter at Pima Crossing
- Insight Pharmacy
- Trusted Care
- Honor Health Piper Surgery Center

THESE SERVICES ARE AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS:

- Abrazo Hospital - Paradise Valley
- John C. Lincoln North Mountain
- Scottsdale Healthcare Thompson Peak

The law provides for the acknowledgment of your having read and understood these disclosures by dating and signing this form in the spaces provided below.

ACKNOWLEDGMENT

(I/We) have read this Notice to Patients, and (I/We) understand the disclosures that it contains.

Signature of Patient or Guardian: _____

Date: _____

Account # _____
FOR OFFICE USE ONLY

PATIENT MEDICAL HISTORY

PLEASE PRINT AND COMPLETE

PATIENT NAME: DATE OF BIRTH:

HEIGHT:
WEIGHT:

*** Preferred Pharmacy and Pharmacy phone number***:

ALLERGIES (Please list all allergies or if no known allergies please indicate)

❑ NONE/No Known Allergies

❑ FAMILY HISTORY UNKNOWN

	MOTHER	FATHER	SIBLING (Please indicate brother or sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Occupation: _____ ☐ Retired ☐ Disabled (reason _____)
☐Yes ☐No - Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐Yes ☐No - Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

SURGICAL HISTORY: Please list any surgeries you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR

MEDICAL HISTORY:
Have you EVER had any of the following? Circle or mark only those that apply.

None of the Below ❑

Infection/Infectious Disease
Blood Clots
Diabetes
High Blood Pressure
Heart Attack
Heart Disease
Pacemaker
Headaches
Kidney Stones
Kidney Disease
HIV/AIDS
Hepatitis
Stomach Ulcer
Liver Disease
Heart Palpitations
Arthritis
Heart Surgery
Chest Pain/Angina
Cancer
Thyroid Disease
Seizures
Stroke
Congestive Heart Failure
Asthma
Depression
Osteoporosis
Tuberculosis
Peripheral Vascular Disease

Other:_____

REVIEW OF SYSTEMS (circle only those that currently apply):

None of the Below ❑

GENERAL
Chills
Dizziness
Fainting
Fever
Night Sweats
Sleeping Problems
Thirst – Excessive
Weight Gain
Weight Loss

GASTROINTESTINAL
Bowel Changes
Constipation
Diarrhea
Vomiting
Nausea

NEUROLOGICAL
Coordination Problems
Learning Disabilities
Speech Problems
Convulsions
Seizures
Light-headedness
Memory Loss
Numbness / Tingling
Paralysis
Tremors

MENTAL HEALTH
Anxiety
Loss of Interest
Depression

SKIN
Dry/Sensitive Skin
Hives
Rash
Scars
Bruises Easily

GENITOURINARY
Lack of Bladder Control
Blood in Urine
Painful Urination
Frequent Urination

CARDIOVASCULAR
Chest Pains
Swelling of Ankles
Rapid Heart Beat
Irregular Heart Beat
Circulation Problems
Varicose Veins
Heart Palpitations

ENT
Bleeding Gums
Blurred Vision
Crossed Eyes
Difficulty Swallowing
Double Vision
Earaches
Ear Discharge
Hay Fever
Hoarseness
Sinus Problems
Hearing Loss
Nose-Bleeds
Persistent Cough
Persistent Runny Nose
Ringing in Ears
Recurring Sore Throat

RESPIRATORY
Coughing
Coughing up Blood
Shortness of Breath
Wheezing

Other:_____

Signature of patient or legal representative: **Date:**

Current Medications: List any medications you are currently taking, please include over the counter medications:
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

None of the Below ❑

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

- I have a pain management contract in place.
  No ❑ Yes. If yes, Dr. information: _____

Signature of patient or legal representative: **Date:**

Integrated Orthopedics, PLLC Intake Form

Please fill out the following questions as thoroughly as possible regarding your current problem.

Name: _____ Date of Birth: _____

How old are you? _____ Are you right or left handed? _____

1-What body part are you being treated for today (please choose ONLY one per office visit consultation)?

Upper Extremity:	Right Shoulder	Left Shoulder
	Right Elbow	Left Elbow
	Right Wrist/Hand	Left Wrist/Hand

Lower Extremity:	Right Hip	Left Hip	Right Knee	Left Knee
	Right Ankle	Left Ankle	Right Foot	Left Foot

Other (please note what ONE area of the body hurts if not listed above): _____

2- What is your pain on a scale of 1-10?

Not Painful 1 2 3 4 5 6 7 8 9 10 Severe Pain

3- What date did this begin?

_____

4- Briefly describe the injury and location of the injury?

_____

_____

_____

5- Have you had previous treatment for this problem? Yes No

If yes please describe the treatment_____

_____

_____

6- Have you had a X-ray? Yes No If Yes; Facility? _____

7- Have you had a MRI? Yes No If Yes; Facility? _____

8- Have you had an Injection treatment? Yes No If Yes; When? _____

9- Have you done physical therapy for this problem? Yes No If Yes; When? _____

10- Please describe your pain (i.e. dull, sharp, burning, aching)?

_____

_____

11- Please describe any mechanical symptoms (i.e. catching, locking, giving way, etc.)?

_____

_____

12- What makes your pain feel worse (i.e. specific activities, positions, motions, etc.)?

_____

_____

13- What makes your pain feel better (i.e. rest, ice, Tylenol, Ibuprofen, etc.)?

_____

_____