



integrated
orthopedics

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: _____

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:

Secondary Insurance:

Insurance Co Name: _____ Insurance Co Name: _____

Policy Holder: _____ Policy Holder: _____

Policy Holder Birth Date: _____ Policy Holder Birth Date: _____

Relationship to Patient: _____ Relationship to Patient: _____

Employer: _____ 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

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
- Sanus DME, LLC.

THESE SERVICES ARE AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS:

- Abrazo Hospital - Paradise Valley
- John C. Lincoln North Mountain
- Scottsdale Healthcare Thompson Peak
- Honor Health Piper Surgery Center
- Hanger
- Summit Medical
- American National DME
- Scottsdale Medical Equipment and Supply

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: _____

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

Any chance of Pregnancy? No Yes: how many months? _____

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:
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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? 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.)?



Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or videotape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material will be used online within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- Online – posted on the website for Integrated Orthopedics
- Conference or other educational presentations conducted by Integrated Orthopedics healthcare professionals (physician, PA, PT, etc)

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in a public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for the purposes stated in this release.

Full Name _____

Date of Birth _____

Phone _____

Email Address _____

Signature _____ Date _____

DECLINE

ACCT# (Internal use ONLY) _____

If this release is obtained from presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature _____ Date _____