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

DATE: _____

NAME: _____

EMAIL: _____

ADDRESS: _____

PHONE: _____

HOW DID YOU HEAR ABOUT US?

_____ Doctor Referral

If so what doctor referred you? _____

_____ Internet Search (Google, Bing, Yahoo, Etc.) _____

_____ Our Blog

_____ Our Integrated Orthopedics Website

_____ PRP Procedure Coupon for $100 discount for the first time

_____ Social Media (Facebook, Pinterest, YouTube, Other?) _____

_____ Our Monthly Newsletter

_____ Postcard / info I picked up at a local venue or Health Expo. Tell us Where? _____

_____ Referral from a friend or family member

_____ I am a former / returning patient

_____ Other: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME:			PATIENT DATE OF BIRTH:	
ADDRESS, CITY, STATE:				ZIP:
HOME/MESSAGE PHONE:		CELL PHONE:		
EMAIL ADDRESS:		RACE:		ETHNICITY:
PATIENT SSN:	SEX (circle one): Male Female	MARITAL STATUS (circle one): Single Married Divorced Other		
PRIMARY CARE PHYSICIAN:		REFERRING DOCTOR OR PROVIDER:		
IN CASE OF EMERGENCY NAME AND CONTACT NUMBER:				RELATIONSHIP:

INSURED/RESPONSIBLE PARTY INFORMATION
(If different from the patient please fill out completely)

RELATION TO PATIENT:

NAME		ADDRESS		
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

COVERAGE INFORMATION

WHAT IS YOUR CURRENT MEDICAL COVERAGE? (IE SELF PAY, INSURANCE, LIEN, WORKERS COMPENSATION):

1 PRIMARY MEDICAL COVERAGE:	ADDRESS (street, city, state, zip)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
2 SECONDARY/SUPPLIMENTAL MEDICAL COVERAGE:	ADDRESS (street/city/state/zip)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (PATIENT OR IF MINOR SIGNATURE OF GUARDIAN):	**DATE:**

MEDICAL RECORDS RELEASE
Authorization to release health information via fax/phone to (EXAMPLE: PERSONAL FAMILY/FRIEND, OR PROFESSIONAL):

RECORDS RECIPIANT(S)	ADDRESS(S)
1.	1.
2.	2.
3.	3.

CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE

DATES OF SERVICE	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)
FROM: TO:	❑ NEVER DATE:

Release the following information:

❑ All Records ❑ Chart Notes ❑Radiology ❑ Operative Reports ❑ History & Physicals

HIPPA AUTHERIZATION:
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:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):

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

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
- Desert Ridge Surgery Center
- Insight Pharmacy

THESE SERVICES ARE AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS:

- Paradise Valley Hospital
- 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: _____

PATIENT MEDICAL HISTORY

PLEASE PRINT AND COMPLETE

PATIENT NAME: DATE OF BIRTH:

HEIGHT: WEIGHT:

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

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

❑ NONE/No Known Allergies

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following.

	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 hospitalizations, surgeries, fractures or major illnesses 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	HIV/AIDS	Thyroid Disease
Diabetes	Hepatitis	Seizures
High Blood Pressure	Stomach Ulcer	Stroke
Heart Attack	Liver Disease	Congestive Heart Failure
Heart Disease	Heart Palpitations	Asthma
Pacemaker	Arthritis	Depression
Headaches	Heart Surgery	Osteoporosis
Kidney Stones	Chest Pain/Angina	Tuberculosis
Kidney Disease	Cancer	Peripheral Vascular Disease

Other: _____

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

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:_____

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

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

Integrated Orthopedics, PLLC Intake Form
Please fill out the following injury report as thoroughly as possible.

Name: _____ Date of Birth: _____

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

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

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

What is your pain on a scale of 1-10?
Not Painful 1 2 3 4 5 6 7 8 9 10 Severe Pain

What date did this begin? _____

Briefly describe the injury and location of the injury? _____
_____
_____
_____

Have you had previous treatment for this problem? Yes No
If yes please describe the treatment _____
_____
_____
_____

Have you had and X-ray? Yes No If Yes; Where? _____
Have you had an MRI? Yes No If Yes; Where? _____
Have you had an Injection treatment? Yes No
Have you done physical therapy for this problem? Yes No

Please describe your pain (i.e. dull, sharp, burning, aching, catching, locking, giving way, etc.)? _____
_____
_____

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

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