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 messages; 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.
- <u>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.</u>
- 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.
- <u>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.</u> 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
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
- 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: ____

Integrated Orthopedics

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 (please check if applicable)	FATHER (please check if applicable)	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	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):

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 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____________________