Bone & Joint Specialists

PATIENT NAME: ______________________________ **Cellular#** ____________________
First Middle Last

Address: ______________________________ **Apt./Sp.#:** ____________________

City: ______________________________ **State:** __________ **Zip:** __________

Home Phone #: ( ) ________ - ________ **Work Phone #:** ( ) ________ - ________

Social Security #: ______ - ______ - ______ **Date of Birth:** __________ **Age:** ______ **Male Female**

Employer: ______________________________ **How Long?** ____________

What type of work do you do? ______________________________

Who referred you to our office? ____________________ **Address:** ____________________

******* *Complete this section only if someone other than the patient is financially responsible* *********

***Responsible Party:** ____________________ **Relationship to Patient** ____________________

***Home Address:** ______________________________

***Telephone #:** ( ) ____________________ **Birthdate:** __________

***Employer:** ____________________ ***Insured ID# or Social Security:** ____________________

EMERGENCY CONTACT: (NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU).

Contact Name: ____________________ **Relationship to Patient:** ____________________

Home Phone: ( ) ________ - ________ **Cellular #:** ( ) ________ - ________

WHAT BODY PART ARE WE SEEING YOU FOR?: ______________________________

DATE OF INJURY/ONSET: ____________________

INSURANCE INFORMATION:

Primary Insurance: ____________________ **Policy ID#:** ____________ **Group#** __________

Address: ____________________ **City/State/Zip** ____________________

Date of Birth: ______/______/______ **Insured Name:** ____________________

Secondary Insurance: ____________________ **Policy ID#:** ____________ **Group#** __________

Address: ____________________ **City/State/Zip** ____________________

Date of Birth: ______/______/______ **Insured Name:** ____________________

Worker's Comp Name & Address: ______________________________

If Worker's Comp, claim#: ____________________ **Date of Injury:** __________

Worker's Comp Adjusters Name: ____________________ **Phone#:** ____________

Fax#: ______________ **Nurse Case Manager Name:** ____________________

I hereby assign all medical benefits to which I am entitled to Bone & Joint Specialists. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release any information needed to determine these benefits or the benefits for related services.

______________________________ ____________________

Responsible Party Signature **Date**

BILLING INFORMATION

******** *ONLY COMPLETE THIS SECTION IF MOTOR VEHICLE ACCIDENT* *************

What is the name of the insurance company? ______________________________

Insurance company address: ______________________________

Claims adjusters name: ______________________ **Phone#: (   )** ______________

DO YOU HAVE AN ATTORNEY FOR YOUR INJURY? **YES** **NO**

Attorney's Name: ______________________ **Phone#: (   )** ________ - ________

Attorney's Address: ______________________________

IF THERE IS A LIEN SIGNED WITH YOUR ATTORNEY, THERE WILL BE A $250 DEPOSIT REQUIRED

******** *ONLY COMPLETE THIS SECTION IF INJURED ON THE JOB* ****************

Did the injury occur at work? **YES** **NO**

If yes, please explain the injury details: ______________________________

____

Date the injury occurred: ______________________

Did you report the injury to a supervisor? **YES** **NO** **Supervisor's Name:** ______________

Have you had any previous Worker's Compensation injuries in the past? **YES** **NO**

If yes, please explain: ______________________________

PATIENTS NAME: ______________________ **DATE:** ______________

HISTORY FORM

Name: ____ Today's Date: ______________
First Middle Last

Height ____________ Weight ____________

Area of the body you are being seen for? ________________________________

Describe injury /accident in detail: ________________________________

____

Medication	Dose	How long taking	Side effects

Allergies: ____

Are you currently or have you had problems with your:

	Circle		Describe all yes reponses
Eyes	Yes	No	______________________
Ears. Nose, Throat	Yes	No	______________________
Lungs, Breathing	Yes	No	______________________
Digestion	Yes	No	______________________
Bladder	Yes	No	______________________
Diabetes	Yes	No	______________________
Heart disease	Yes	No	______________________
High blood pressure	Yes	No	______________________
Bleeding problems	Yes	No	______________________
Balance problems	Yes	No	______________________
Numbness/tingling	Yes	No	______________________
Blackouts/ fainting	Yes	No	______________________
Psychological problems	Yes	No	______________________
Cancer	Yes	No	______________________
Arthritis	Yes	No	______________________
Polio	Yes	No	______________________
Epilepsy	Yes	No	______________________
HIV	Yes	No	______________________
Hepatitis, Tuberculosis	Yes	No	______________________
Other (please describe)	Yes	No	______________________

PAST MEDICAL HISTORY

Surgeries/Hospitalization	Year	Complaint

Have you ever had general anesthesia? Yes No
Any problems with anesthesia? Yes No
If yes, describe____

SOCIAL HISTORY

Marital status: ( )Single ( )Married ( )Divorced ( )Separated ( )Widowed

Children: ( ) Yes ( ) No How many? __________
Do you live alone? ( ) Yes ( ) No
Exercise? ( )daily ( )weekly ( )monthly ( )rarely ( )never
What type of exercise? ____

Are you on a special diet? ( ) Yes ( ) No
History of substance abuse? ( ) Yes ( ) No What substance? ________________
Do you smoke? ( ) Yes ( ) No Packs per day? ______ for ________year(s)
When did you quit smoking? _______________ Packs per day? ______ for ________year(s)

Drink alcohol? ( ) Yes ( ) No
( ) daily ( ) 1-2 per week ( ) 1-2 per month ( ) 1-2 per year

FAMILY HISTORY

Member	**Alive**		**Age**	**Health status / cause of death**
Father	Yes	No		
Mother	Yes	No		
Sister/ Brother	Yes	No		
Sister/ Brother	Yes	No		
Sister/ Brother	Yes	No		

Note: Unchecked boxes indicate negative.

Review of Systems

Are currently or have you had any problems with:

General ☐ weight loss ☐ fever-chills ☐ fatigue ☐ weakness ☐ sweating-nightsweats
Describe: ______

Skin ☐ itching ☐ rashes ☐ hair-nail changes
Describe: ______

Head ☐ headache ☐ trauma
Describe: ______

Eyes ☐ blurring ☐ discharge ☐ vision-glasses ☐ diplopia (double vision) ☐ pain ☐ scotomata (seeing spots)
Describe: ______

Ears ☐ pain ☐ discharge ☐ vertigo ☐ deafness ☐ tinnitus (ringing of the ears)
Describe: ______

Nose ☐ sinusitis ☐ discharge ☐ obstruction ☐ epistaxis (nose bleeds) ☐ postnasal drip
Describe: ______

Mouth/Throat ☐ sores ☐ dentures ☐ hoarseness ☐ teeth-dental care ☐ gum bleeding ☐ taste
Describe: ______

Pulmonary ☐ chest pain ☐ wheezing ☐ cough ☐ coughing up blood ☐ shortness of breath ☐ coughing up sputum
Describe: ______

Breasts ☐ masses ☐ pain ☐ discharge
Describe: ______

Cardiolvascular ☐ palpitation ☐ chest pain ☐ murmurs ☐ hypertension ☐ edema (swelling in legs) ☐ claudication
Describe: ______

Gastrointestinal ☐ hematemesis ☐ pain ☐ jaundice ☐ hernia ☐ melena (blood in stool) ☐ hemorrhoids
☐ indigestion ☐ constipation ☐ dysphagia (difficulty swallowing) ☐ stool shape, color
Describe: ______

Genitourinary ☐ dysuria (painful urination) ☐ hematuria (blood in urine) ☐ incontinence (difficulty holding urine)
☐ nocturia (frequent urination at night) ☐ urgency (difficulty controlling urination) ☐ frequency (frequent urination)
Describe: ______

Sexual History ☐ syphillis ☐ gonorrhea ☐ sterility ☐ impotence ☐ testicular pain-swelling
☐ sores-discharge ☐ contraception
Describe: ______

Female-Menses ☐ spotting ☐ irregularity ☐ dysmenorrhea (painful periods)
Describe: ______

Endocrine ☐ goiter ☐ tremor ☐ heat-cold intolerance ☐ hormone therapy ☐ diabetes
Describe: ______

Allergic History ☐ allergies ☐ eczema ☐ asthma ☐ hay fever ☐ hives
Describe: ______

Blood-Lymphatic ☐ anemia ☐ transfusions ☐ bleeding tendency ☐ lymp node enlargement-pain
Describe: ______

Neurologic ☐ syncope ☐ convulsions ☐ gait-coordination ☐ paralysis-weakness ☐ speech ☐ sensation
Describe: ______

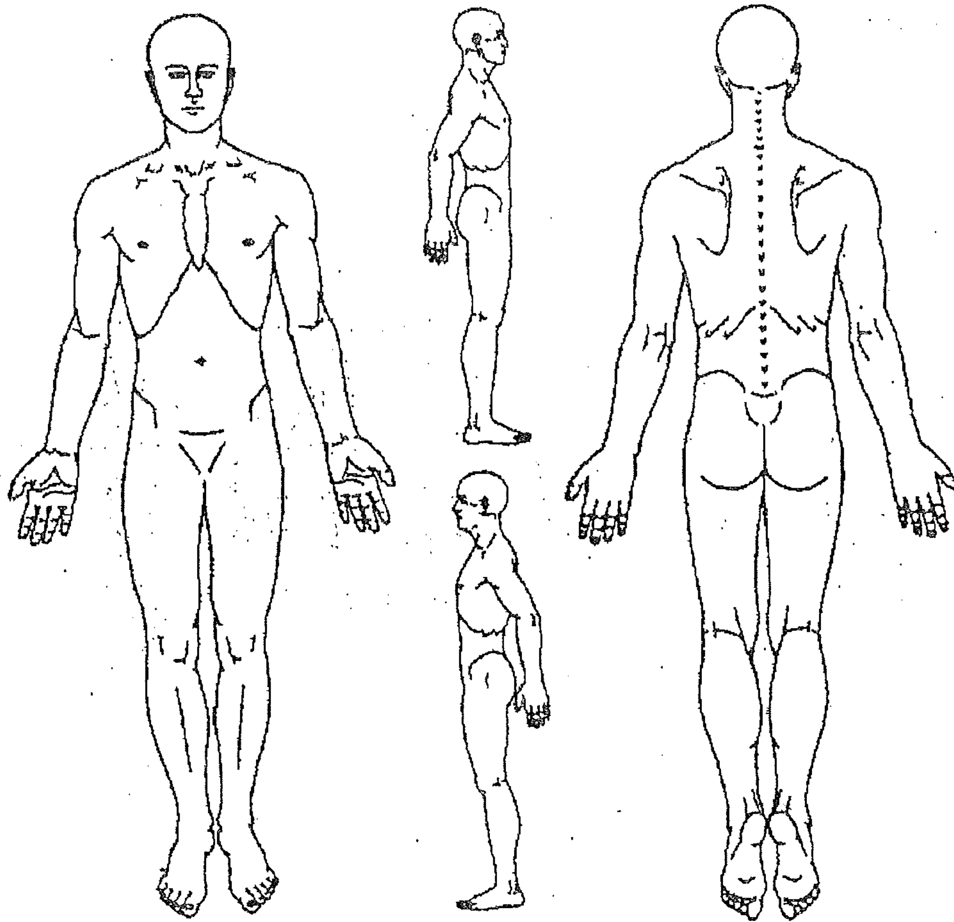
Psychologic ☐ mood ☐ sleep pattern ☐ anxiety-depression ☐ alcohol abuse ☐ drug abuse ☐ phobias ☐ memory loss
Describe: ______

Note: boxes not checked denote negative repsonse

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	∧ ∧ ∧ ∧ ∧	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	∧ ∧ ∧ ∧ ∧	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	∧ ∧ ∧ ∧ ∧	X X X X	⊗ ⊗ ⊗ ⊗



Please use the space below to describe your condition further if needed:

____

____

____

Date: ________________ Signature: ____

BONE & JOINT SPECIALISTS

DISCLOSURE:

Bone and Joint Specialists is a for-profit corporation solely owned by the physicians providing medical services to the community.

FINANCIAL POLICY:

PAYMENT FOR MEDICAL SERVICES RENDERED IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Our office does verify eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your eligibility status. We will do all we can to assist you with your health insurance claims however, insurance is a contract between the insurance company and the insured. Final responsibility for payment of your account rests with you. Our office will bill a secondary insurance only once as a courtesy to the patient. If the insurance does not pay, then the balance becomes the responsibility of the insured.

If you are scheduled for surgery, we require any deductible's as well as coinsurance amounts paid prior to your date of surgery. In addition to the surgeon's fee, there is a need for an assistant at the time of your surgery. The assistant's fee is in addition to the surgeon's fee.

Any prior authorizations obtained by this office on behalf of you, the patient, are not a guarantee of payment, but are based on medical necessity. Claims are subject to your policy provisions and final payment is determined only when your insurance company has received the claim. If you have any questions regarding our medical fees or questions regarding your insurance benefits, please speak with a billing specialist.

A returned check charge of $35.00 will be charged to the account for each returned check.

DELINQUENT AND COLLECTION ACCOUNTS:

- An account becomes delinquent when the minimal monthly payment has not been received within 30 days of the statement date.
- An account that has become delinquent for 60 days, may become a collections account and may be charged a collections handling fee, court cost's and attorney's fee's.
- Exemptions from the above are allowed charges under Medicare and Title XIX (Nevada Medicaid) contracts.
- There may be exceptions to all or any part of the account.
- Balances not paid by your insurance plan within 30 days, will automatically become the responsibility of the responsible party.

I understand that Bone & Joint Specialists may not be a provider on my health plan, and I will be fully responsible for any outstanding charges that my insurance plan does not cover. A photocopy of this assignment is considered as valid as the original.

In the event that my account becomes a delinquent account or a collection account, I agree to pay Bone & Joint Specialists all incurred Finance Charges, Delinquent Account Handling Fee's, Collection Account Handling Fee's and incurred Collection cost's as set forth above in section 3 of the financial policy.

If it is necessary to forward your account to our Collection Agency, a Collection Fee markup of 35 to 50% will be added to the amount owing. Interest will accrue daily at the rate of 1.5% per month or 18% per year.

The mark-up reflects Bone & Joint Specialists receiving only it's billed charges. The additional money will go to the collection agency.

Signature of Responsible Party: ______________________________ **Date:** ______________

Bone & Joint Specialsits

CONTRACT FOR CONTROLLED SUBSTANCES

Controlled substance medication (narcotics-opiods, tranquilzers, barbiturates, i.e. any drug which induces sleep or stupor) can be very useful but have high potential for misuse and abuse and are, therefore, closely controlled by government agencies. Used properly, some of them can be very effective pain medication. If used excessively, however, they can cause adverse effects, such as impaired judgment, vomiting, constipation, lethargy, organ damage, or even death. To ensure these medications are used properly, I agree to the following conditions.

1. I am RESPONSIBLE for my controlled substance medication. IF THE PRESCRIPTION OR MEDICATION IS LOST, STOLEN OR MISPLACED OR IF I USE IT UP SOONER THAN PRESCRIBED, I UNDERSTAND THAT IT WILL NOT BE REPLACED.

2. I will not request or accept narcotic medications from any other physician or individual while I am receiving such medications from my doctor at Bone & Joint Specialists (except if I am in the hospital). Besides being illegal to do so (NRS 453.391), it may endanger my health.

3. **I understand that there will be a 48 hour turnaround time (business hours) for non-narcotic medication refills; therefore, I will not wait until my medication is gone to request more medication. Controlled substances may be obtained only during a scheduled office visit. Refills will not be made at night, on holidays or on weekends.**

4. I understand that if I violate ANY of the above conditions, my controlled substance medication will be **discontinued immediately.**

I am aware of "narcotic effects", including physiological effects of tolerance (need for more medication to achieve the same pain relief) and dependence (withdrawal may occur if I stop my medications abruptly) and the effects of addiction (psychological dependence), which is less common in patients with true pain. I also understand that narcotics can adversely affect my judgment in making business decisions and in operating equipment, such as automobile. I must use special care while involved in activities requiring clear thought and concentration.

______________________________ __________________

Signature of Patient/Guardian Date

______________________________ __________________

Witness Signature Date

Bone and Joint Specialists

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact ANNA HOLLAND, OFFICE MANAGER at (702) 474-7200.

WHO WILL FOLLOW THIS NOTICE:

- Bone and Joint Specialists

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:
We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.
The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Research**
- **To Provide Information About Organ and Tissue Donation**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.
You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from ANNA HOLLAND, OFFICE MANAGER at (702) 474-7200.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact ANNA HOLLAND, OFFICE MANAGER. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION.
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of this Notice
We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date. This acknowledgement will be filed with your records.

ACKNOWLEDGEMENT

I hereby acknowledge that I have received the Notice of Privacy Practices from Bone & Joint Specialists.

Signature: ____ Date: _____________

Print Name: ____