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
Race and Ethnicity: _____ Email: _____
Employer: _____ How Long? _____
Occupation? _____ Marital Status: S M D W

Who referred you to our office?_____Address: _____

Primary Care Doctor: _____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: _____
Worker's Comp claim#: _____ Date of Injury: _____
Work Comp Adjusters Name:_____Tel#: _____Fax#:_____
Nurse Case Mgr Name: _____Tel#:_____Fax#:_____

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**

HISTORY FORM

Name: _____ **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

******PLEASE LIST NAME OF PHARMACY SO THAT IT CAN BE ELECTRONICALLY SENT TO THE PHARMACY******

Pharmacy Name: _____**Pharmacy Number:** _____
Pharmacy Cross Streets: _____

Allergies to Medication: ☐ **Yes** ☐ **No**
If yes, please list which medication: _____

Allergies: _____

Are you currently or have had problems with your?

	Circle		Describe all yes responses
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 children?** _____

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.
Are currently or have you had any problems with:

REVIEW OF SYSTEMS

General ☐ weight loss ☐ fever-chills ☐ fatigue ☐ weakness ☐ sweating-night sweats
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: _____

Cardiovascular: ☐ 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 ☐ dysmenorrheal (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 ☐ lymph node enlargement-pain

Describe: _____

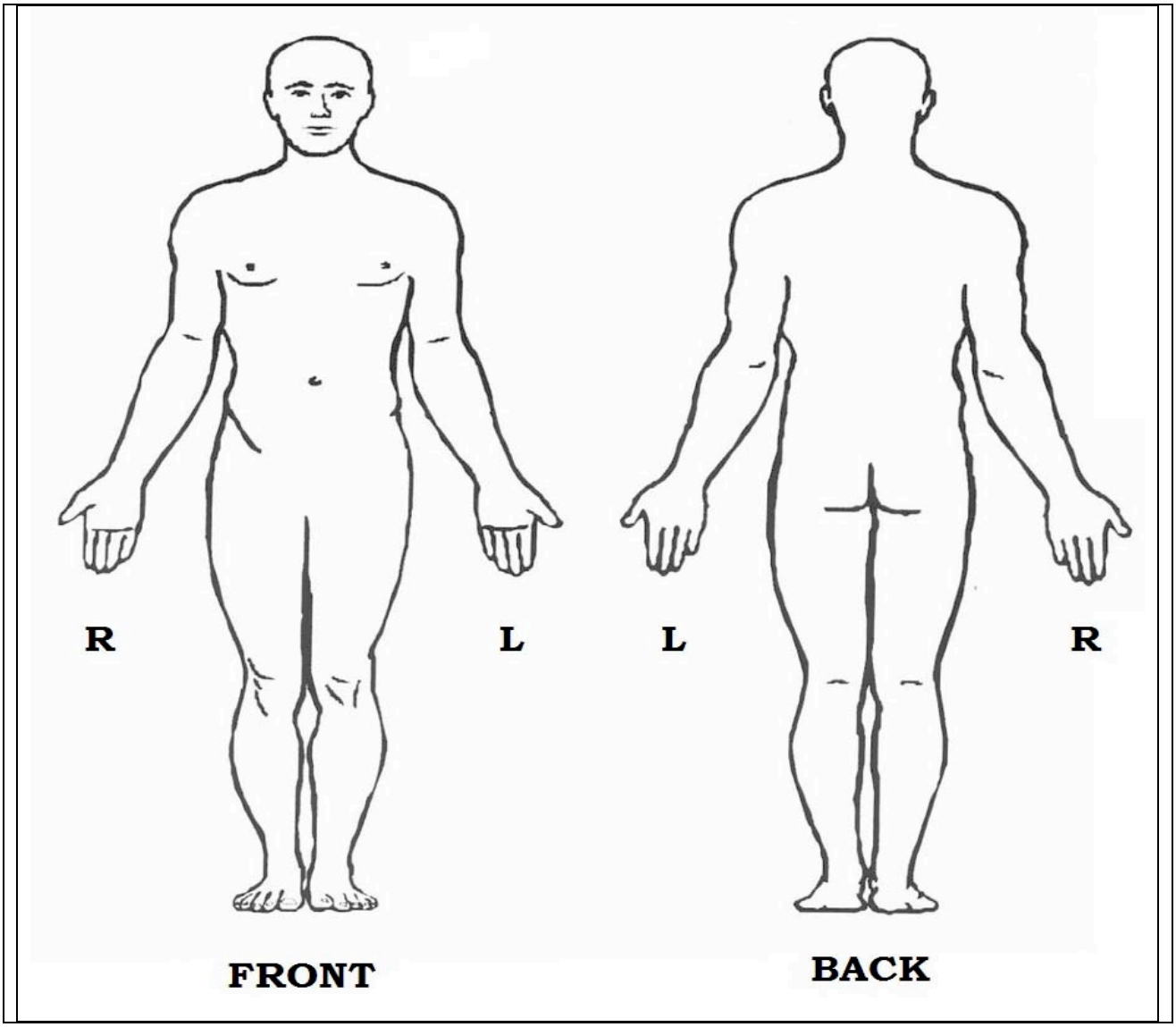
Neurologic ☐ syncope ☐ convulsions ☐ gait-coordination ☐ paralysis-weakness ☐ speech ☐ sensation

Describe: _____

Physchologic: ☐ mood ☐ sleep pattern ☐ anxiety-depression ☐ alcohol abuse ☐ drug abuse ☐ phobias ☐ memory loss

Describe: _____

Note: boxes not checked denote negative response



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

Numbness	Pins & Needles	Burning	Aching	Stabbing
----------	oooooooooo	^^^^^^	XXXXX	/////////
----------	oooooooooo	^^^^^^	XXXXX	/////////

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

_____

_____

_____

Date: _____ Name: _____

BONE & JOINT SPECIALISTS

DISCLOSURE:
Bone and Joint Specialists is a for-profit corporation solely owned by the physicians providing medical services to the community**.**
Our office does not discriminate against any person on the basis of race, gender, religion, color, national origin, disability, or age.
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 fees.
- 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.

CANCELLATION, NO SHOW AND RESCHEDULING POLICY: If you fail to provide us with a 24 hour notice of cancellation or rescheduling, or fail to keep your scheduled appointment, there will be a $50 no-show fee.

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 its billed charges. The additional money will go to the collection agency.

Signature of Responsible Party: _____ 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 of Receipt of Notice of Privacy Practices for Bone & Joint Specialists

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

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Print Name: _____

BONE & JOINT SPECIALISTS

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I Authorize: _____

_____

To release my health care information to: Bone & Joint Specialists
Name of designated individual, organization, or Provider

2680 Crimson Canyon Drive, Las Vegas, NV 89128
Address

(702 228-7355 (OFFICE) (702) 228-4499 (FAX)

Information to be Released:

- [X] All Medical Records
- [ ] All Medical Billing Records
- [ ] X-Ray and imaging reports

Dates of Treatment:

- [X] All Dates
- [ ] **Specific Dates**:

Other: _____

Purpose of disclosure: _____

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

_____ _____
Printed Name Date

_____ _____
Signature of Patient or Legal Representative Date

Authorization will expire 12 months from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.