Sun Valley Orthopedic Surgeons

Date ___-___-___

Patient Name ____________________ **Date of Birth** ____________ **Age** ______

Referring Physician ________________ **Primary Care Physician (if different)** ____________

Cardiologist ________________ **Pulmonologist** ________________

****************DO YOU SUFFER FROM ANY OF THE FOLLOWING? (CIRCLE THE NUMBER OR NUMBERS THAT APPLY AND FOLLOW WITH A BRIEF DESCRIPTION)******************

1) CARDIOVASCULAR OR HEART DISEASE ________________
2) HIGH BLOOD PRESSURE OR HYPERTENSION ________________
3) PULMONARY PROBLEMS OR LUNG DISEASE ________________
4) BLOOD DISEASE OR DISORDERS ________________
5) DIABETES—IF YES, HOW IS IT CONTROLLED ? ________________
6) KIDNEY OR RENAL FAILURE ________________
7) NEURO OR NEUROMUSCULAR DISORDERS OR DISEASES: ________________
8) LIVER, PANCREAS, OR SPLEEN DISORDERS OR DISEASES: ________________
9) ESOPHAGEAL AND/OR GASTROINTESTINAL DISORDERS OR DISEASES: ________________
10) THYROID, PITUITARY, OR LYMPHATIC DISORDERS OR DISEASES: ________________
11) SKIN DISORDERS OR DISEASES: ________________
12) MEN ONLY—PROSTATE OR GENITAL DISORDERS OR DISEASES: ________________
13) WOMEN ONLY—GENITAL/UTERINE/GYN DISORDERS OR DISEASES: ________________
14) SENSORY DEFICITS OR DISORDERS (SIGHT, HEARING, SMELL, TASTE, TOUCH): ________________
15) CHEMICAL DEPENDENCY: ________________
16) CANCER OR ANY KIND NOT ALREADY LISTED ABOVE: ________________
17) OTHER PROBLEMS, DISORDERS, OR DISEASES NOT LISTED ABOVE: ________________

LIST ALL ALLERGIES TO EITHER FOODS, DRUGS & MEDICATIONS, CHEMICALS, ANIMALS & PLANTS ETC: ________________

LIST ALL SURGERIES YOU HAVE HAD DONE WITHIN THE LAST TEN YEARS: ________________

WHAT IS YOUR APPROXIMATE HEIGHT? ________ WEIGHT? ________

LIST ALL MEDICATIONS YOU ARE PRESENTLY USING, INCLUDE ANY NUTRITIONAL AND / OR HERBAL SUPPLEMENTS: (USE BACK OF FORM IS MORE SPACE IS NEEDED

Name of medication	What is it used for?

Name of medication	What is it used for?

Sun Valley Orthopedic Surgeons Registration Form

❑ New Patient ❑ Update Only

❑ Janzer ❑ Jensen ❑ Kelly ❑ Sterusky ❑ Tsao ❑ Waldrip

ALL INFORMATION MUST BE COMPLETED - PLEASE PRINT Today's date: ____________

Patient Information

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Patient's Last Name: ____________ First: ____________ Middle:

SS #: ____________ Date of Birth ____________ Sex: ❑ M ❑ F

Street Address: ____________

City: ____________ State: ____________ Zip Code: ____________

e-mail Address: ____________

2nd address (out-of-state)
Street Address: ____________

City: ____________ State: ____________ Zip Code: ____________

Home Phone #: ____________ Cell Phone #: ____________ Work Phone #: ____________

Race:

❑ American Indian or Alaskan Native
❑ Black or African American
❑ Asian
❑ Hispanic/Latino
❑ Non-Hispanic/Latino
❑ Native Hawaiian or other Pacific Islander
❑ White

Ethnicity (Ethnic Origin):

❑ Hispanic/Latino
❑ Non-Hispanic/Latino

Primary Language Spoken: ____________

Preferred Pharmacy Information

Pharmacy Name: ____________

Pharmacy Address/Cross Streets: ____________

Pharmacy Phone #: ____________ Pharmacy Fax #: ____________

Employment Information

Employer: ____________ Occupation: ____________

Employer Phone #: ____________

Street Address: ____________

City: ____________ State: ____________ Zip Code: ____________

Emergency Contact

Emergency Contact Name: ____________ Contact Phone # ____________

Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

Referring Physician Information

Referring Physician Name: ______________________ Phone #: ____________

Address: ____

Insurance Information

Is your condition related to an accident of any kind? ❑ Yes ❑ No ❑ Work Related ❑ Auto Accident

Date of Injury: ____________________

If this is a work injury, has medical treatment been authorized by your employer? ❑ Yes ❑ No

Primary Insurance Information

Name: ______________________

Address ______________________

____

Phone #: ______________________

Policy #: ______________________

Group #: ______________________

Policy Holder (if different than patient):

Name: ______________________

Date of Birth: __________ Sex: ❑ M ❑ F

Relationship to Patient:
❑ Self
❑ Spouse
❑ Child
❑ Other ________________

Secondary Insurance Information

Name: ______________________

Address ______________________

____

Phone #: ______________________

Policy #: ______________________

Group #: ______________________

Policy Holder (if different than patient):

Name: ______________________

Date of Birth: Sex: ❑ M ❑ F

Relationship to Patient:
❑ Self
❑ Spouse
❑ Child
❑ Other ________________

Consent to Receive Medical Information

The person listed below has my consent to receive medical information, concerning the above patient, in person or over the phone. They will also be able to pick up any necessary prescription (other than controlled substances), x-rays and lab results.

Name: ______________________ Phone #: ______________________

Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other________________

Authorization to Bill/Pay

I hereby authorize Sun Valley Orthopedic Surgeons to release any information required in the course of my examination or treatment which could include HIV, communicable disease, or drug abuse information. I also hereby authorize payment directly to the business office of Sun Valley Orthopedic Surgeons for the surgical and/or medical benefits, if any, otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges not covered by my insurance. Further, I understand that I am responsible for all charges incurred in the collection of my account(s) and will pay all fees involved should my account be placed with a collection services.*

Printed Name: ______________________ Phone #: ____________

Patient/Guardian Signature: ______________________ Date: ____________

SUN VALLEY ORTHOPEDIC SURGEONS
AND PHYSICAL THERAPY

DESERT SPINE SURGEONS

Financial Policy

Thank you for choosing us to serve you and your family's health needs. We are committed to your care. The following is a statement of our financial policy which we require you to read and sign prior to treatment. The financial policy applies to all services provided to you by any of our providers regardless of location.

CO-PAYS AND OTHER BALANCES- UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE, ALL CO-PAYMENTS, DEDUCTIBLES AND FEES THAT ARE NOT COVERED BY YOUR INSURANCE ARE DUE AT TIME OF SERVICE. IF WE HAVE TO BILL YOU FOR YOUR CO-PAY THERE WILL BE A $10.00 FEE ADDED TO YOUR BILL. WE ACCEPT CASH, CHECK, MASTERCARD, VISA AND DISCOVER. PLEASE NOTIFY US OF ANY CHANGE IN INSURANCE, ADDRESS OR PHONE NUMBER.

SURGERY CHARGES-SHOULD YOUR TREATMENT REQUIRE SURGERY, AS PART OF THE PRE-OPERATIVE PROCESS WE WILL MAKE AN ESTIMATE OF THE FEES. THE ACTUAL CHARGES BILLED FOR YOUR SURGERY WILL REFLECT THE PROCEDURES PERFORMED AND MAY DIFFER FROM THE ESTIMATE. **PREPAYMENT OF ANY UNMET DEDUCTIBLE AND ESTIMATED CO-PAY IS DUE PRIOR TO SURGERY. IF YOU ARE A SELF PAY PATIENT, A PREPAYMENT OF ONE HALF OF ESTIMATED COST IS REQUIRED.**

INSURANCES-IT IS YOUR RESPONSIBILITY TO UNDERSTAND AND BE AWARE OF THE TERMS AND CONDITIONS OF YOUR INSURANCE PLAN. YOUR MEDICAL INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE, AS A COURTESY TO OUR PATIENTS, WILL SUBMIT A CLAIM TO YOUR INSURANCE COMPANY PROVIDED WE HAVE COMPLETE AND ACCURATE INFORMATION. TO ENSURE YOUR CLAIM IS SUBMITTED IN A TIMELY FASHION A COPY OF YOUR INSURANCE CARD(S) IS REQUIRED AT THE TIME OF SERVICE. IT IS YOUR RESPONSIBILITY TO VERIFY IF OUR PROVIDER IS PARTICIPATING IN YOUR NETWORK AND GETTING ANY REFERRALS REQUIRED FOR SERVICES RENDERED.

SELF PAY PATIENTS- PAYMENT OF A $150 FEE IS DUE AT TIME OF SERVICE, BALANCE ON ACCOUNT MAY DIFFER ONCE SERVICES ARE RENDERED, AT WHICH POINT YOU WILL BE BILLED FOR ANY REMAINING BALANCE. IF YOU ARE UNABLE TO PAY YOUR BALANCE IN FULL, YOU WILL NEED TO MAKE PRIOR ARRANGEMENTS WITH OUR PATIENT ACCOUNTS REPRESENTATIVE.

MISSED APPOINTMENTS- IT IS A REQUIREMENT THAT YOU CANCEL OR RESCHEDULE, 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT. IF YOU FAIL TO DO SO A $25 FEE WILL BE APPLIED TO YOUR ACCOUNT.

DURABLE MEDICAL EQUIPMENT- SOME INSURANCE POLICIES DO NOT COVER DURABLE MEDICAL EQUIPMENT AND THEREFORE IS YOUR FINANCIAL RESPONSIBILITY. PAYMENT IS DUE PRIOR TO RECEIVING DURABLE MEDICAL EQUIPMENT IF YOU ARE CASH PAY. EQUIPMENT CANNOT BE RETURNED.

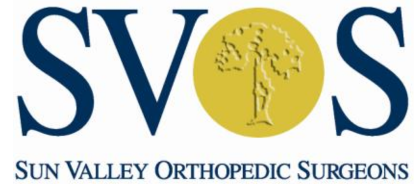
OUTSTANDING BALANCES- JUST AS WE MAKE EVERY EFFORT TO ACCOMMODATE YOU WHEN YOU ARE IN NEED OF MEDICAL CARE; WE EXPECT THAT YOU WILL MAKE EVERY EFFORT TO PAY YOUR BILL PROMPTLY. YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR ACCOUNT, REGARDLESS OF INSURANCE COVERAGE. IF YOU ARE UNABLE TO PAY YOUR BILL IN ITS ENTIRETY PLEASE CONTACT OUR BILLING DEPARTMENT TO DISCUSS YOUR OPTIONS.

DELINQUENT BALANCES- UNLESS WE APPROVE OTHER ARRANGEMENTS IN WRITING, THE BALANCE ON YOUR STATEMENT IS DUE UPON RECEIPT. IF PAYMENT IS NOT RECEIVED, WE RESERVE THE RIGHT TO REFUSE SERVICE ON DELINQUENT ACCOUNTS. IF YOUR ACCOUNT BECOMES DELINQUENT, WE WILL TAKE THE NECESSARY STEPS TO COLLECT THE DEBT. **IF YOUR ACCOUNT IS TURN TO AN OUTSIDE COLLECTION AGENCY A 35% FEE WILL BE ADDED TO THE BALANCE.**

These policies are subject to change without notice.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY **SUN VALLEY ORTHOPEDICS SURGEONS/ DESERT SPINE SURGEONS**. I UNDERSTAND THAT I AM RESPONSIBLE FOR PROMPT PAYMENT OF ANY PORTION OF THE CHARGES NOT COVERED BY INSURANCE, **INCLUDING DEDUCTIBLES AND COPAYS. I UNDERSTAND PAYMENT OF CO-PAYS IS DUE AT TIME OF SERVICE, AS WELL AS ANY PRIOR DELINQUENT BALANCE I MAY OWE.** I ALSO CONSENT THAT THE PAYMENT OF AUTHORIZED MEDICARE INSURANCE BENEFITS BE MADE ON MY BEHALF DIRECTLY TO **SUN VALLEY ORTHOPEDIC SURGEONS/ DESERT SPINE SURGEONS** FOR ANY MEDICAL OR SURGICAL SERVICES FURNISHED. I AGREE TO ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES.

______________________________	______________________________	______________
(SIGNATURE OF PATIENT/RESPONSIBLY PARTY)	(PRINTED NAME)	(DATE)



Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. to public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. to federal officials for intelligence and national security activities authorized by law.
7. to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Sun Valley Orthopedic Surgeons, Practice Administrator, 12361 W. Bola Drive, Suite 100, Surprise, AZ 85378 for further information.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Sun Valley Orthopedic Surgeons, Practice Administrator, 12361 W. Bola Drive, Suite 100, Surprise, AZ 85378 for further information. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Sun Valley Orthopedic Surgeons, Practice Administrator, 12361 W. Bola Drive, Suite 100, Surprise, AZ 85378. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

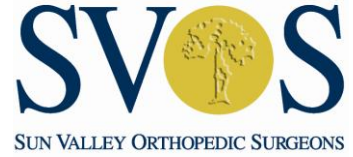
If you have any questions regarding this notice or our health information privacy policies, please contact Sun Valley Orthopedic Surgeons, Practice Administrator, 12361 W. Bola Drive, Suite 100, Surprise, AZ 85378 for further information.

I hereby acknowledge that I have been presented with a copy of Sun Valley Orthopedic Surgeons Notice of Privacy Practices.

Signature____

Date ____

Name of Patient ____



Medication Reconciliation

Medication Reconciliation allows the physician to efficiently reconcile your medication list, to quickly and accurately make the appropriate decision on each medication ordered and document all medications in your chart. Central to the reconciliation process should be a single source of up-to-date medications with all necessary order details.

I hereby authorize permission to Sun Valley Orthopedic Surgeons to perform a Medication Reconciliation of my medication profile with the pharmacy.

Signature____

Date____

Name of Patient____