Martin G. Sterusky, MD
Robert C. Waldrip, MD
Travis S. Jensen, DPM

OrthoArizona
Joseph M. Janzer, DO
Lawrence J. Kelly, MD

Dear Patient

Welcome to the practices of Sun Valley Orthopedic Surgeons (SVOS) and OrthoArizona, our physicians and staff are here to care for you and make your experience with us as pleasant and helpful as possible.

SVOS and OrthoArizona represent some of Phoenix's top-rated surgeons and most are board certified in their specialty. Our physicians have established their practices by providing consistent high quality patient care.

In the course of treating patients our physicians often find that some injuries and orthopedic conditions respond to non-surgical interventions such as cortisone injections, non-steroidal anti-inflammatory and physical therapy. For others, surgery is the more suitable option. Our office staff will work with you to schedule a time that is convenient for you.

SVOS and OrthoArizona have significant expertise and special interests in the treatment of spinal injuries, hand injury, trauma and sports injuries, foot and ankle. In addition, our specialists have performed thousands of procedures in total joint replacement of the hip and knee as well as ACL, meniscus and rotator cuff repair. Our expertise in treating spine injuries has also garnered the respect and confidence of our referring physicians and patients alike. Our physicians are on staff at Boswell Memorial Hospital, Del Webb Memorial Hospital, Arrowhead Community Hospital and St. Joseph's Westgate Hospital.

Should you have any questions, please do not hesitate to give us a call.

Sincerely,
The Physicians & Management of Sun Valley Orthopedic Surgeons and OrthoArizona

Martin G. Sterusky, MD
Robert C. Waldrip, MD
Travis S. Jensen, DPM

❑ New Patient ❑ Update Only

OrthoArizona
Joseph M. Janzer, DO
Lawrence J. Kelly, MD

❑ Sterusky ❑ Waldrip ❑ Jensen ❑ Janzer ❑ Kelly

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: ____________

SS #: ____________ Date of Birth ____________ Sex: ____________

Street Address: ____________

City: ____________ State: ____________ Zip Code: ____________

e-mail Address: ____________

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

City: ____________ State: ____________ Zip Code: ____________

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

Race:	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Hispanic/Latino	❑ Native Hawaiian or other Pacific Islander ❑ Prefer not to answer ❑ White
Ethnicity (Ethnic Origin):	❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Prefer not to answer	

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 ____________

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Primary Care Physician Information

Primary Care Physician Name: ______________________ Phone #: __________

Referring Physician (if different than Primary Care): ______________________ Phone #: __________

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	Secondary Insurance Information
Name: ____________________	Name: ____________________
Address ____________________ ____________________	Address ____________________ ____________________
Phone #: ____________________	Phone #: ____________________
Policy #: ____________________	Policy #: ____________________
Group #: ____________________	Group #: ____________________
Policy Holder (if different than patient):	Policy Holder (if different than patient):
Name: ____________________	Name: ____________________
Date of Birth: __________ Sex: ☐ M ☐ F	Date of Birth: __________ Sex: ☐ M ☐ F
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other __________	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/OrthoArizona 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/OrthoArizona 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) all fees, including all late fees involved should my account be placed with a collection services.*

Printed Name: ____________________ Phone #: __________

Patient or Guardian Signature: ____________________ Date: __________

Robert C. Waldrip, MD
Desert Spine Surgeons

HISTORY & PHYSICAL

Date: ______________________________

Name: ____ DOB: ____________ AGE: __________

Primary Care Physician/Family Doctor: ____

Height: ____________ Weight: ______________ (nurse only) BP _______ P _______

Chief Complaint (Check One)

- ☐ Neck Pain
- ☐ Neck Pain with Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Low Back Pain with Leg Pain

History of Present Illness

When did it start? ____

Previous Episodes: ____

Previous Treatments: ____

Past Medical History (check if you have had)

- ☐ AIDS
- ☐ Alcohol/Drug Addiction
- ☐ Anxiety

Arthritis:
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis

Bleeding Disorders:
- ☐ Deep Vein Thrombosis
- ☐ Blood Transfusion
- ☐ Anemia

Bone Problems:
- ☐ Fractures
- ☐ Scoliosis
- ☐ Osteoporosis

Bowel Problems:
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ IBS
- ☐ GERD

Breathing Problems:
- ☐ Sleep Apnea
- ☐ Chronic Bronchitis
- ☐ Emphysema

- ☐ COPD
- ☐ Asthma

Cancer:
- ☐ Breast
- ☐ Lung
- ☐ Prostate
- ☐ Skin
- ☐ Other ____________

- ☐ Depression

Diabetes
- ☐ Type I
- ☐ Type II

Eye Problems
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration

- ☐ Fibromyalgia

Heart Problems
- ☐ Angina
- ☐ Arrhythmia
- ☐ Coronary Artery Disease
- ☐ Mitral Valve Prolapse
- ☐ Congestive Heart Failure

- ☐ High Blood Pressure
- ☐ High Cholesterol

Infections:
- ☐ Cellulitis
- ☐ MRSA
- ☐ TB

Liver Problems:
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Cirrhosis

- ☐ Migraine
- ☐ Obesity
- ☐ Pulmonary Embolism
- ☐ Seizures

Skin Problems:
- ☐ Shingles
- ☐ Other ____________

Thyroid Problems:
- ☐ Hypo/Hyperthyroid
- ☐ Other ____________

ROBERT C. WALDRIP, MD

NAME: ______________________________ DOB: ____________

DATE: ____________________

CHIEF COMPLAINT:

☐ Neck pain with NO arm pain
☐ with arm pain ☐ Rt. Arm ☐ Lt Arm

☐ Upper back pain with NO rib pain
☐ with rib pain ☐ Rt. ☐ Lt

☐ Low back pain with NO leg pain
☐ with leg pain ☐ Rt ☐ Lt

HISTORY OF PRESENT ILLNESS:

When did it start? _
☐ suddenly ☐ after:
☐ ongoing ☐ intermittent ☐ constant

Have you had other episodes ☐ Yes ☐ No
When

Have seen your PCP about this problem?
☐ Yes ☐ No When:

WHAT HAVE YOU TRIED?

☐ Bed Rest ☐ Sleeping in recliner
☐ Ice ☐ Heat ☐ Stretching

☐ Physical Therapy, Date:
☐ Chiropractor, Date
☐ Brace, Date:

Have you been to the **Emergency Room** for this problem?
☐ Yes ☐ No Where? When?

NOTES: ____
____
____
____
____

DOES YOUR PAIN INHIBIT YOUR ABILITY TO PERFORM THE FOLLOWING:

☐ Can't walk ☐ turn head ☐ Can't dress self
☐ Can't cook ☐ Cough ☐ Can't complete daily hygiene
☐ Can't sleep ☐ sneeze ☐ Can't get out of bed
☐ No appetite ☐ Can't get out of chair

WHAT MEDICATIONS HAVE YOU TRIED?

☐ Tylenol, RELIEF? ☐ Yes ☐ No

☐ ASA/Excedrin, RELIEF? ☐ Yes ☐ No

☐ NSAIDS, RELIEF? ☐ Yes ☐ No
Ibuprofen, Motrin, Advil, Aleve, Mobic, Celebrex (circle one)

☐ Creams/Oint _(name)
RELIEF? ☐ Yes ☐ No

☐ Patches RELIEF? ☐ Yes ☐ No

NOTES: ____
____
____
____
____

Unable to tolerate medications due to:

NSAIDS due to:
☐ Allergy
☐ Kidney Disease/Issues
☐ GERD
☐ Hx of Ulcers
☐ Blood Thinners
☐ Did not give adequate pain relief

TYLENOL due to:
☐ Allergy
☐ Liver Disease/Issues
☐ Did not give adequate pain relief

NARCOTICS due to:
☐ Allergy
☐ COPD
☐ Difficulty breathing due to pain
☐ Allergy
☐ Did not give adequate pain relief

Past Surgical History:

Name/Type of Surgery	Year of Surgery

Family History:

- ☐ Diabetes
- ☐ ASHD
- ☐ Colon Polyps
- ☐ Arthritis
- ☐ Hypertension
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Heart Disease
- ☐ CVA
- ☐ High Cholesterol
- ☐ Psychiatric Illness

Social History:

Occupation: ______________________________

☐ Married ☐ Single ☐ Widowed

Smoker:	☐ Yes	☐ No	Packs per day ________	How many years ________
Alcohol:	☐ Yes	☐ No	Drinks per day ________	Per week ________
Caffeine (Coffee, Iced Tea, Soda)	☐ Yes	☐ No	Drinks per day ________	

Medications:

Medication Name	Dosage	Frequency

Drug/Food Allergy: ______________________________

Review of Systems: (Check next to the ones that are positive.)

HEENT
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Loss of Visual Field
- ☐ Ringing in the Ears
- ☐ Epistaxix (Nosebleed)
- ☐ Glasses
- ☐ Contacts
- ☐ Dentures

GI
- ☐ Weight Gain/Loss
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hematemesis
- ☐ BRBPR
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Dysphagia
- ☐ GERD
- ☐ Abdominal Pain
- ☐ Change in Appetite
- ☐ Hernias

GU
- ☐ Dysuria
- ☐ Hematuria
- ☐ Nocturia
- ☐ Frequency
- ☐ Decreased force of urination
- ☐ Retention
- ☐ Incontinence
- ☐ UTI's

PULMONARY
- ☐ Cough
- ☐ Sputum
- ☐ Hemoptysis
- ☐ Dyspnea
- ☐ Chest Pain
- ☐ Wheezing
- ☐ Asthma

NEURO
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Vertigo
- ☐ Parenthesis
- ☐ Weakness
- ☐ Tremors
- ☐ Memory Disturbance
- ☐ Tingling

RHEUM
- ☐ See HPI (office notes)

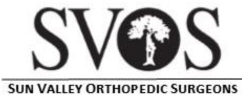
HEME
- ☐ Anemia
- ☐ Ease of bruising or bleeding
- ☐ Prior transfusions
- ☐ Lymph node enlargement
- ☐ Pain
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Orthopnea
- ☐ Shortness of Breath
- ☐ Pedal Edema
- ☐ Hypertension
- ☐ Mitral Valve Prolapse
- ☐ Phlebitis
- ☐ Deep Vein Thrombosis
- ☐ Vascular Insufficiency

DERM
- ☐ Rashes
- ☐ Puritius
- ☐ Lumps

PSYCH
- ☐ Depression
- ☐ Agitation
- ☐ Panic/Anxiety
- ☐ Manic Episodes
- ☐ Personality Changes
- ☐ Hallucinations

ENDO
- ☐ Diabetes Mellitus
- ☐ Hyper/Hypothyroid



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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 billing office.

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.

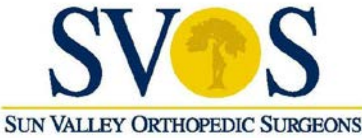
Outstanding Balances- Just as we make every effort to accommodate you when you are in need of medical care; we expect that you will make every effort to pay your bill promptly. You are ultimately responsible for your account, regardless of insurance coverage. If you are unable to pay your bill in its 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 turned to an outside collection agency a 35% late 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 Orthopedic Surgeons/OrthoArizona**. 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/OrthoArizona** for any medical or surgical services furnished. I agree to all reasonable attorney fees and late fees in the event of default of payment of my charges.

_______________________________	_______________________________	_______________
(signature of patient/responsibly party)	(printed name)	(date)



CONSENT FOR TREATMENT

Welcome to the practice of Robert C. Waldrip, M.D. Desert Spine Surgeons

During the course of your care Robert C. Waldrip, M.D. may utilize steroid injections to decrease the inflammation and pain related to your neck or back symptoms. These injections may include facet (joint) and/or trigger point (soft tissue) injections.

There are few complications with these injections. You may experience numbness or local discomfort with the injection. Certainly, if you have allergy to steroids (Depo-Medrol), or numbing medication (Marcaine or Xylocaine), please inform the staff or the doctor.

If you have any questions concerning the use of injections in your treatment, please inform the staff or the doctor.

Signature: ____ Date: _______________

Printed Name: ____

Martin G. Sterusky, MD
Robert C. Waldrip, MD
Travis S. Jensen, DPM

Joseph M. Janzer, DO
Lawrence J. Kelly, MD

HIPAA/PATIENT CONTACT CONSENT

____
Patient (Last Name) (First Name) (M.I) Date of Birth

I wish to be contacted in the following manner (please check all that apply):

☐ Home telephone: ( )__________- ____________________
☐ Work telephone: ( )__________- ____________________
☐ Cell phone: ( )__________- ____________________

May we mail a recall appointment reminder to your home? Yes_______No ______

May we mail test results to your home? Yes_______No ______

May we leave appointment, billing or medical information on your answering machine/voice mail? Yes_______No ______

I give permission to share appointment, billing or medical information with the following persons named below:

Name: ____

☐ Work telephone: ( )__________- ____________________
☐ Cell phone: ( )__________- ____________________

Name: ____

☐ Work telephone: ( )__________- ____________________
☐ Cell phone: ( )__________- ____________________

____________________________________ ____________________
Signature of Patient / Parent or Legal Guardian Date

OrthoArizona

Martin G. Sterusky, MD
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Lawrence J. Kelly, MD

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/OrthoArizona to perform a Medication Reconciliation of my medication profile with the pharmacy.

Signature ____

Date ____

Name of Patient _______________________________________

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Lawrence J. Kelly, MD

Notice of Privacy Practices
For Protected Health Information

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/OrthoArizona, 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/OrthoArizona, 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/OrthoArizona, 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/OrthoArizona, 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/OrthoArizona Notice of Privacy Practices.

Signature ____

Date ____

Name of Patient ____