SONORAN ORTHOPAEDICS

Patient Demographics

Dr. Kurtis Staples Dr. Gilbert Ortega Dr. Laura Prokuski Dr. Brian Miller

Dr. Michael Billhymer Dr. Heather Cole Dr. Lisa Truchan Dr. Paul Goodwyn

Today's Date:			Primary Care Physician:		
PATIENT INFORMATION					
Patient's last name: First:		Middle:			
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ☐ M ☐ F
Address:					
Social Security #:	Home phone #:		Cell phone #:		
Preferred Pharmacy	Employer:		Employer phone #:		
Email Address:	Married: ☐ Yes ☐ No Spouse's Name:		Race of Patient:		
How were you referred to Sonoran Orthopaedic Trauma Surgeons? ☐ Internet ☐ Referral from friend/family (Name:) ☐ Referral from another provider (Provider Name:) ☐ Emergency Department ☐ Insurance list of providers ☐ Advertisement ☐ Other:			Preferred Language of Patient ☐ English ☐ Spanish If other:		
Other family members seen here:					

In compliance with the American Recovery and Reinvestment Act of 2009 (AARA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

MEDICARE PATIENTS ONLY

Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone #:
Is this person a patient here?	☐ Yes ☐ No	Is this patient covered by insurance?	☐ Yes ☐ No
Occupation:	Employer:	Employer address:	Employer phone #:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. #.:	Birth date:	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber:					
Name of secondary insurance (if applicable):		Subscriber's name:		Group #:	Policy #:
Patient's relationship to subscriber:					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Work phone #:

SONORAN
ORTHOPAEDICS

Patient Consent for RX History

By signing this consent form you are agreeing that your provider Sonoran Orthopaedics can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not influence any actions taken prior to receiving the revocation.

Understanding all the above, I hereby provide informed consent to Sonoran Orthopaedics to enroll me in this ePrescribe Program.

I have had the chance to ask questions and all my questions have been answered to my satisfaction.

Print Name: Date of Birth: Today's Date

_____ _____ _____

Signature of patient or guardian Relationship to patient

_____ _____

PRIVACY PRACTICES AND INSTRUCTIONS FOR
DISCUSSING PERSONAL HEALTH INFORMATION

Patient Name: _____ Date of Birth _____

Phone number: _____ Today's Date: _____

Notice of Privacy Practice and Patient Rights

☐ I acknowledge receipt of the Sonoran Orthopaedics Notice of Privacy Practices and Patient Rights

Instructions for Discussing my Personal Health Information with Others

I give permission to Sonoran Orthopaedics to discuss my personal health information with the following individuals:

Name	Relationship to patient
_____	_____
_____	_____
_____	_____

I give permission to Sonoran Orthopaedics to communicate messages regarding appointments, referrals, lab results, and x-ray results as follows:

☐ You may leave a message on my answering machine

☐ You may leave a message with

_____

☐ Other (please specify)

_____

_____

_____

_____ _____

Signature of Patient Date

_____ _____

Signature of Legal Representative Relationship to Patient

HEALTH HISTORY

SONORAN ORTHOPAEDICS

NAME: DOB: AGE: DATE:

☐ RIGHT HANDED ☐ MALE

HT _____ WT_____ ☐ LEFT HANDED ☐ FEMALE

REASON FOR TODAY'S VISIT _____

PREFERRED PHARMACY NAME ADDRESS

PHONE

ALLERGIES:

ARE YOU ALLERGIC TO?			ARE YOU ALLERGIC TO ANY DRUGS? DRUG:	LIST ALL DRUG ALLERGIES INCLUDING REACTION. REACTION:
EGGS	☐ YES	☐ NO		
IODINE	☐ YES	☐ NO		
LATEX	☐ YES	☐ NO		
NUTS	☐ YES	☐ NO		
PENICILLIN	☐ YES	☐ NO		
OTHER				

CURRENT MEDICATIONS: LIST ALL, INCLUDE OVER THE COUNTER MEDS, HERBS AND VITAMINS

DRUG NAME/STRENGTH	DOSE	How long	PRESCRIBING PHYSICIAN

SURGICAL HISTORY: HAVE YOU UNDERGONE ANY SURGICAL PROCEDURES? ☐ YES ☐ NO

YEAR	SURGERY	YEAR	SURGERY

ANESTHESIA: HAVE YOU EVERY HAD ANY PROBLEMS WITH ANESTHESIA? ☐ YES ☐ NO. IF YES, PLEASE EXPLAIN

_____

_____

ADVANCED DIRECTIVES (LIVING WILL AND MEDICAL POWER OF ATTORNEY

Do you have an advanced directive? ☐ YES ☐ NO

Name of surrogate decision maker _____ Phone # _____ _____

Do you have a living will ☐ YES ☐ NO

PATIENT NAME: _____

MEDICAL HISTORY: HAVE YOU EVER HAD PROBLEMS WITH: **(IF "YES", *PLEASE CHECK BOX*)**

☐ ANEMIA	☐ DEPRESSION	☐ HIGH BLOOD PRESSURE	☐ MIGRAINE HEADACHES	☐ GOUT
☐ ARTHRITIS	☐ DIABETES	☐ HIGH CHOLESTEROL	☐ MULTIPLE SCLEROSIS	☐ WOUND HEALING
☐ Osteoporosis	☐ EMPHYSEMA	☐ HIV/AIDS	☐ NEUROLOGICAL PROBLEMS	☐ STROKE
☐ BLADDER	☐ POLIO	☐ KIDNEYS	☐ OLD FRACTURE	☐ TUBERCULOSIS
☐ SICKLE CELL	☐ BLOOD CLOTS	☐ LIVER	☐ OSTEOMYELITIS	☐ THYROID DISEASE

DESCRIBE ALL YES RESPONSES: _____

IF YOU ARE OVER THE AGE OF 50 HAVE YOU RECEIVED AN INFLUENZA (FLU) SHOT WITHIN THE LAST YEAR? ☐ YES ☐ NO

DATE: _____

IF YOU ARE OVER THE AGE OF 50 HAVE YOU RECEIVED A PNEUMONIA VACINATION? ☐ YES ☐ NO

DATE: _____

REVIEW OF SYSTEMS: ARE YOU CURRENTLY HAVE ANY PROBLEMS WITH: ***(IF "YES", PLEASE CHECK BOX'S)***

GENERAL:
- ☐ Fever
- ☐ Fatigue
- ☐ Chills
- ☐ Other _____
- ☐ Check box if NO to all above

MENTAL HEALTH:
- ☐ Anxiety
- ☐ Nervousness
- ☐ Hallucinations
- ☐ Depression
- ☐ Other _____
- ☐ Check box if NO to all above

NEUROLOGIC:
- ☐ Dizziness
- ☐ Tremors
- ☐ Unsteady gait
- ☐ Numbness/Tingling
- ☐ Other _____
- ☐ Check box if NO to all above

Heart:
- ☐ Chest pain
- ☐ Murmurs
- ☐ Fainting
- ☐ Palpitations
- ☐ Other _____
- ☐ Check box if NO to all above

LUNGS:
- ☐ SOB
- ☐ Snoring
- ☐ Coughing
- ☐ Wheezing
- ☐ Tightness
- ☐ Other _____
- ☐ Check box if NO to all above

STOMACH/COLON:
- ☐ Heart burn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody/tarry stools
- ☐ Other _____
- ☐ Check box if NO to all above

SKIN:
- ☐ Redness
- ☐ Rash
- ☐ Itching
- ☐ Poor healing
- ☐ Skin Changes
- ☐ Other _____
- ☐ Check box if NO to all above

MUSCLE/JOINTS:
- ☐ Joint pain
- ☐ Stiffness
- ☐ Joint swelling
- ☐ Redness
- ☐ Muscle pain
- ☐ Heat
- ☐ Joint instability
- ☐ Other _____
- ☐ Check box if NO to all above

DESCRIBE ALL YES RESPONSES: _____

PATIENT NAME: _____

FAMILY HISTORY:

	MOTHER	FATHER	SIBLINGS
Asthma	☐	☐	☐
Bleeding Disorders	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
DVT (Blood Clots)	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Kidney Disease	☐	☐	☐

	MOTHER	FATHER	SIBLINGS
Mental illness	☐	☐	☐
Osteroarthritis	☐	☐	☐
Arthirits	☐	☐	☐
Seizures	☐	☐	☐
Sickle Cell	☐	☐	☐
Stroke	☐	☐	☐
Thyroid Disease	☐	☐	☐
Other	☐	☐	☐

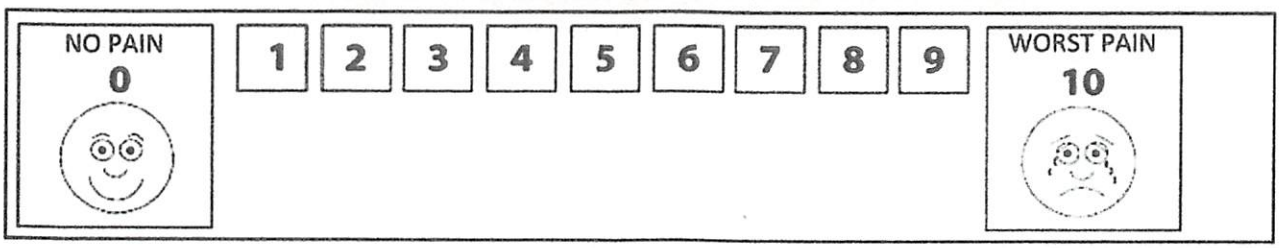
GIVE DETAILS TO "OTHER" AND ANY POSITIVE RESPONSES:

SOCIAL HISTORY:

Do you smoke tobacco?	☐ NO	☐ YES	_____ packs per day for _____ years
Did you quit smoking tobacco?	☐ NO	☐ YES	When did you quit? _____ Previous amount _____
Do you chew tobacco?	☐ NO	☐ YES	How Often? _____
Do you drink alcohol?	☐ NO	☐ YES	How much and How often? _____
Do you live alone?	☐ NO	☐ YES	Do you have children?_____ If yes, how many? _____
Do you use walking aids?	☐ NO	☐ YES	☐ Cane ☐ Walker ☐ Crutches ☐ Other
Do you have a history of substance abuse or do you use recreational drugs?	☐ NO	☐ YES	
Caffeine use?	☐ NO	☐ YES	

Do you exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily Type: _____

WHAT IS YOUR PAIN LEVEL TODAY?



Medicare Patients Only

Do you reside in a Skilled Nursing Facility? ☐ No ☐ YES

Patient Signature_____ Date: _____

If a minor, Parent or Guardian Signature_____ Date: _____

SONORAN ORTHOPAEDICS

Financial Policy

I understand that Sonoran Orthopaedics PLLC and their respective designees will use and disclose my health information for all purposes necessary for treatment, payment, and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

• **ASSIGNMENT OF INSURANCE AND APPOINTMENT OF LEGAL REPRESENTATIVE:** I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Sonoran Orthopaedics, PLLC and their affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims with the health plan
- File appeals and grievances with the health plan
- Institute and necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary.
- Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan.

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider.

• **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated during examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

• **FINANCIAL LIABILITY:** I have been provided a copy of the Sonoran Orthopaedics financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to Sonoran Orthopaedics for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:

- My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Sonoran Orthopaedics and I have not obtained such an authorization or referral or I receive services in excess of such authorization or referral, and/or
- My health plan determines that the services I receive at Sonoran Orthopaedics are not medically necessary and/or not covered by my Insurance plan, and/or
- My health plan coverage has lapsed or expired at the time I receive services at SOTS, and/or
- I have chosen not to use my health plan coverage.

SONORAN ORTHOPAEDICS

Financial Policy

• **POLICY FOR THE COLLECTION OF PATIENT DEDUCTIBLES, COINSURANCE AND OTHER PATIENT BALANCES:** The Practice will ***never*** waive any coinsurance, deductible or other patient responsibility except for reasons of financial hardship as set forth in the attached Charity Care Policy. The Practice will ***never*** waive a balanced bill, that is, the different between charge and payment for out of network patients of the Practice (hereinafter, "Balance Bill"), except for reasons of financial hardship as set forth in the attached Charity Care Policy. The Practice shall immediately bill patients for any coinsurance, deductible or other patient responsibility upon receipt of an EOB or other correspondence from the payer that such coinsurance, deductible or other patient responsibility is payable by the patient. The Practice shall bill patients for a Balanced Bill after but not before the first level appeal for increased reimbursement is filed by the Practice. In some cases, the Practice shall bill patients for a Balanced Bill after a first level appeal is filed by the Practice. Patients of the Practice shall sign for receipt of the Practice's Charity Care Plan, an Assignment of Benefits at the time services is first rendered by the Practice. The Practice understands that both State and Federal law require that the patient be provided a Balanced Bill Statement. The Practice will ensure that patients understand that they are responsible for deductibles, coinsurance, the
balanced bill and any other patient responsibility designated by the payer's EOB. Patients must return claim checks sent to patients within 10 days of receipt to avoid collections.

• **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Sonoran Orthopaedics. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

ASSISTANT AT SURGERY: I understand I may receive certain ancillary medical services from Sonoran Orthopaedics. I understand that physician assistants may not provide services in my presence but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third-party payer.

LIENS: I fully understand that I am directly responsible to said doctors for all medical bills submitted by Sonoran Orthopaedics for service rendered me and that this agreement is made solely for said doctors' additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fees. Further, I hereby authorize and direct my attorney to pay directly to Sonoran Orthopaedics such sums as may be due and owing for medical service rendered me and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Sonoran Orthopaedics.

FRACTURE/SURGICAL CARE: Fracture/Surgical Care is billed out as a "packaged" service which includes the following: Evaluation, the first cast, splint, boot application, and/or surgery and 90 days of postoperative follow-up care from the date of the fracture. ***There are some service that we bill separately*** which include: any casting supplies, replacement cast applications, evaluations for any ***additional*** problems or injuries and treatment of complications. Your insurance carrier requires that we report our services using the coding system known as the *Current Procedural Terminology* (CPT). The codes for fracture care can be found in the *Surgery* section of the CPT book. This is not to imply that you will have or had surgery or that you will be or were taken to the operating room. This is how the CPT book was set up by the *American Medical Association* (AMA) for user-friendly purposes by both the insurance companies and physicians. ***Please note, your insurance company may cover these services for fracture/surgical care differently than office visits. Therefore, your services may be paid as a surgical procedure, with deductible and co-insurance guidelines applied.***

SONORAN ORTHOPAEDICS

Financial Policy

SURGICAL CARE IN AN OUTSIDE FACILITY (hospital or SurgCenter): If you have surgery in an outside facility you will receive a bill from us representing the surgeons' fee. In addition, you likely will receive a separate bill for services rendered by the hospital or surgcenter, anesthesiology and possibly radiology and pathology. Please be sure that you understand your insurance coverage and benefits prior to undergoing surgery.

If you have any questions or concerns, please contact our **Billing Department at 1-866-325-7076**

• **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that I may incur a cancelation fee if I do not provide the required notice of cancelation, or if I do not keep my appointment and have not canceled.

I have been provided SOTS Patient Financial Polices. I understand the information listed above which has been fully explained to me.

_____ Date _____

Patient Signature

_____ Date _____

Guarantor Signature

SONORAN ORTHOPAEDICS

GLOBAL SERVICES ACKNOWLEDGMENT

What Services are NOT Included in the Global Period?

Global services are the first 90 days following a major surgery. During this time, you will not be assessed a copay for your clinic visit.

The following services are not included in the global period. These services may be billed and paid for separately:

- Initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries. This is billed separately.
- Services of other physicians related to the surgery (e.g., surgical assistants, anesthesia.
- Visits ***unrelated*** to the diagnosis for which the surgical procedure is performed. ***Example: Patient has surgery on left knee and comes into the clinic for a post op visit and complains of right elbow pain. This visit is no longer considered in the global and is subject to co-pays and deductibles.***
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiological procedures
- Additional surgical procedures that occur during the post-operative period.
- Treatment for post-operative complications requiring a return trip to the Operating Room (OR).
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Evaluation/ Management (office visit) services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.

Note: A new post-operative period begins with the subsequent procedure. This includes procedures done in two or more parts performed on separate dates.

By signing my name below, I certify that I have read the above information. Any questions concerning this information have been answered to my satisfaction.

_____ _____

Patient (or Guardian) Signature/Date of birth Date

SONORAN ORTHOPAEDICS

Non Contracted Statements

ATTENTION

WE MAY *NOT* BE CONTRACTED WITH YOUR INSURANCE.

If you do not meet the **EMERGENCY ROOM REFERRAL** or **90 DAY GLOBAL PERIOD** descriptions below:

NEW PATIENTS will be required to pay a **$300.00** deposit for your visit.

ESTABLISHED PATIENTS will be required to pay a **$150.00** deposit for your visit.

EMERGENCY ROOM REFERRAL: If you have been referred to our office from the emergency room, generally your insurance will authorize your initial visit with us, ***but no subsequent visits.*** It is important that you check with your insurance company regarding your benefits. Some insurance companies offer out-of-network benefits. If so, your insurance will pay at the reduced benefit and ***you will be responsible for the remaining balance***.

90 DAY GLOBAL PERIOD: If you were seen and treated in the emergency room by one of our surgeons and the treatment/procedure you received has a 90 Day Global Period all visits within the 90 Day Global Period are included in the surgical package. After the 90 days you will be required to pay a deposit for your visit. If you do not have out-of-network benefits or you choose to not utilize your out-of-network benefits, our office staff will assist you in finding a contracted provider.

TREATMENT AGREEMENTS:

1. Your treatment is our top priority. If we dedicate our time to your care, it is our expectation that you are compliant in your follow-up visits until completion.
2. We schedule appointments for our convenience AND yours. When you are late for your appointment, it affects all other patients scheduled for that day. Therefore, for those who are more than 10 minutes late, we will do our best to fit you into the schedule as quickly as possible without delaying others. Please call 24 hours in advance for cancellations. We politely remind you that we are a trauma service and emergencies do arise.
3. We feel we offer you the best professional care, skill, judgment in planning and delivery of treatment for your orthopedic injuries. Your payment is reimbursement for our services. **By signing below, you are agreeing to fulfill your financial commitment to our office promptly and completely, and you further agree to pay for all collection costs, attorney fees, and other costs that may be incurred to enforce collection of any amounts outstanding.**

4. **Should you receive a check from your insurance company, DO NOT SPEND IT!** Insurance companies commonly send your surgeons compensation to the patient since we are non-contracted with them. If you receive a check from the insurance company for our services, please contact our office. ***If your insurance company notifies us that your surgeon's payment was sent to you, you will be expected to pay your balance in full immediately.***

Please remember that insurance is considered a method for reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Any unpaid debt to our office is your responsibility.

I, _____ have read the above and understand my responsibility in knowing my benefits and what will be my financial responsibility.

_____ _____

Signature Date