

## Patient Information

Welcome to Green Valley Orthopedics. We apologize for the inconvenience of paperwork but assure you that it is only on your first visit, unless any changes are made in the future. If you need any assistance please let the receptionist know.

Who referred you to our practice? \_\_\_\_\_

Patient \_\_\_\_\_  
Last Name First Name Middle initial

SS# \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell/Pager # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

**Primary Insurance Company:** \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Insured Member: \_\_\_\_\_ D.O.B. \_\_\_\_\_ SS#: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Insured Member: \_\_\_\_\_ D.O.B. \_\_\_\_\_ SS#: \_\_\_\_\_

Patient Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse or Responsible Party \_\_\_\_\_ SS# \_\_\_\_\_ D.O.B. \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Responsible Party Employed by \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Purpose of visit \_\_\_\_\_ Date of first symptom \_\_\_\_\_ X-rays Taken? \_\_\_\_\_

Is today's visit due to an accident? \_\_\_\_\_ If yes,  Work  Auto  Other: \_\_\_\_\_

If work related injury: Date of Injury \_\_\_\_\_ Claim # \_\_\_\_\_ Case Manager \_\_\_\_\_

Is there a pending litigation due to the illness / injury?  No  Yes → If yes,  
Legal information \_\_\_\_\_

In Case of Emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

I certify that the above information is true to the best of my knowledge

\_\_\_\_\_/\_\_\_\_\_  
Patient or Guardian Signature/Relationship if not self

\_\_\_\_\_  
Date

Privacy Act Statement- The information contained on this form contains confidential patient information that is legally protected by the Privacy Act of 1974, 5 U.S.C. 522, and the Health Insurance Portability and Accountability Act of 1996, P.L. 104-109 and other applicable federal and state laws.

# Medical History

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Primary Physician \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pharmacy Name & Cross Streets \_\_\_\_\_

Past & Current History (Circle all that apply to you)

Bronchitis	High Blood Pressure	Heart Problems	Asthma
Seizures	Low Blood Pressure	Kidney Trouble	Pulmonary Problems
Emphysema	Shortness of Breath	Hiatal Hernia	Chest Pain
Paralysis	Thyroid Trouble	Lupus	Leg Swelling
Diabetes	Rheumatic Fever	Ulcers	Arrhythmia
Back Pain	Tuberculosis (TB)	Stroke	Heart Murmur
Pneumonia	Bleeding Problems	Polio	Sleep Apnea
Hepatitis	Thrombophlebitis	Psychological Problems	C-PAP Machine
Psoriasis	Rheumatoid Arthritis	Pregnancy Complications	

Any Medical Problems that may complicate Anesthesia: \_\_\_\_\_

Family History: (Circle all that apply)

Hypertension	Yes	No
Heart Disease	Yes	No
Diabetes	Yes	No
Rheumatoid Arthritis	Yes	No
Lupus	Yes	No

Please list all Previous Surgeries and Dates:

\_\_\_\_\_  
\_\_\_\_\_

Any previous injuries? (please circle) Yes or No If yes, what type, any work loss?

\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications? (please circle) Yes or No If yes, what type and describe reaction:

\_\_\_\_\_  
\_\_\_\_\_

List all medications that you are currently taking, include dosage:

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, amount per day: \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, amount per day: \_\_\_\_\_

Do you have any implanted metal in your body? \_\_\_\_\_ If yes, where & Date of Procedure: \_\_\_\_\_

Do you have a Pacemaker?  Yes  No

Are you claustrophobic?  Yes  No

Are you presently taking:

Recreational drugs  Yes  No

Rx Diet Pills  Yes  No

Coumadin  Yes  No

Aspirin  Yes  No

Anti inflammatory  Yes  No

If you answered Yes to any of above please describe amount per day: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I certify that this information is correct to the best of my knowledge

\_\_\_\_\_  
\_\_\_\_\_

Patient or Guardian Signature/Relationship if not self

Date

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**GREEN VALLEY ORTHOPEDICS  
FINAL POLICY & ASSIGNMENT OF BENEFITS**

All fees for medical care are based on the usual, reasonable, and customary fee charged in this area by physicians of equal training and experience.

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

Our office verifies 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 status. We will do all we can to assist you with your insurance claims; however, insurance is a contract between you and your insurance carrier. Final responsibility for payment of your account rests with you. The exception is for those patients with injuries that are work-related and are covered by Worker's Compensation. These patients are not responsible for their bills unless their claim is denied.

Prior authorizations obtained for procedures by this office on your behalf do not guarantee payment but rather are based on medical necessity. Claims are subject to policy provisions, and your insurance carrier determines final payment. A deposit is required if you are being scheduled for surgery. If an assistant is required at the time of surgery to improve the quality of your surgical outcome, the assistant's fee is in addition to the surgeon's fee.

Having read the above, I hereby authorize payment by my insurance carrier, Medicare, or other designated payor of medical benefits to Green Valley Orthopedics for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of the assignment is considered as valid as the original

I also authorize Green Valley Orthopedics to release to my insurance carrier, Medicare or their agents any medical information about me needed to determine these benefits payable for service.

I hereby consent to and authorize medical treatment, tests, and procedures performed in the office that my physician deems advisable and necessary based on his judgment. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

**COLLECTION POLICY**

I, \_\_\_\_\_, hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.

Returned checks: A \$ 25.00 NSF fee will be charged for checks initially returned unpaid by your bank. If the same check is returned unpaid a second time, it may be referred to a collection service for recovery.

**OFFICE POLICIES**

Our office provides you with a standard note of disability if needed. Due to the large amount of paperwork in our office, any disability forms that you may need filled out by our personnel will require a five work-day notice for completion. Out of courtesy for our patients having surgery, we will do the first two forms at no charge; any additional forms will be charged a \$15.00 fee.

If any copies of your x-rays are needed, there will be a \$5.00 charge per sheet; this is what it costs us to produce the copies. We are merely extending our cost to the patient. **No originals are released.** We require a two-work day notice.

When an appointment slot is given to our valued patients, we are merely estimating a time for appointment arrival, due to the nature of our specialty; we might have longer wait periods than usual due to emergency add-ons. Dr. Koe gives every patient the utmost in care and spends a different amount of time with each patient depending on patient need. Please be aware that he will give you the same careful attention as soon as possible. We unfortunately cannot estimate a wait time.

I understand the above policies and agree to abide by them.

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_\_  
Date

*GREEN VALLEY ORTHOPEDICS  
CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS*

Controlled substance medications (narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and abuse and are, therefore, clearly controlled by the local, state, and federal governments. They are intended to relieve pain or to improve function and/or ability to work and not simply to feel good. Because my doctor is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. I AM RESPONSIBLE FOR MY CONTROLLED SUBSTANCE MEDICATIONS.  
If the prescription or medication is lost, misplaced, or stolen or if I use the medication up sooner than prescribed, I understand that **IT WILL NOT BE REPLACED.**
2. I WILL NOT REQUEST NOR ACCEPT controlled substance medication from another Physician or individual while I am receiving such medication from Dr. Koe. It is illegal to do so (NRS 453.391) and may endanger my health. The only exception is if it is prescribed while I am admitted to the hospital.
3. REFILLS OF CONTROLLED SUBSTANCE MEDICATIONS:
  - A. WILL BE TAKEN ONLY ON MONDAYS, TUESDAYS, WEDNESDAYS AND THURSDAYS, 8:00 A.M. TO 5:00 P.M. **YOU MUST ALLOW 2 WORKING DAYS FOR REFILLS TO BE AUTHORIZED BY YOUR DOCTOR AND CALLED IN.** REFILLS WILL NOT BE MADE AFTER HOURS, HOLIDAYS, OR WEEKENDS.
  - B. WILL NOT BE MADE IF I “RUN OUT EARLY”. I am responsible for taking my medication in the dose prescribed and for keeping track of the amount on hand.
  - C. WILL NOT BE MADE AS AN “EMERGENCY” such as Friday afternoon because I suddenly realize that I will “run out tomorrow”. I must keep track of the medication and plan ahead. I will call at least 24 hours ahead if I need assistance with a controlled substance medication prescription.
4. I understand that IF I VIOLATE ANY OF THE ABOVE CONDITIONS, my controlled substance prescriptions and/or treatment may be ended immediately. If there is a violation involved in obtaining controlled substances from another individual as described above, I may also be reported to my primary physician, local and medical facilities, and other authorities.

I understand THE MAIN TREATMENT GOAL IS TO IMPROVE MY ABILITY TO FUNCTION AND/OR WORK. In consideration of that goal, I AGREE TO HELP MYSELF BY FOLLOWING GOOD HEALTH HABITS, specifically involving exercise, weight control, and the use of tobacco or alcohol. I understand that only through following a healthy lifestyle can I hope to have the most successful outcome to my treatment.

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PATIENT SIGNATURE

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DATE

**Green Valley Orthopedics**  
**Patient Authorization**

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below. Please do not leave blank, write N/A if not applicable.

Description of the specific information to be used or disclosed:

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Person or entity authorized to request the information:

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I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address below, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

**Patient Consent**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I have read and understand the above:

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(If other than self)

**Green Valley Orthopedics**  
**STATEMENT OF NO ACCIDENT OR INJURY**

I, \_\_\_\_\_ hereby state with my signature below that I was not involved in any auto accident, slip and fall, or work-related injury that a 3<sup>rd</sup> party would be responsible for. My treatment is in no way associated with any 3<sup>rd</sup> party and no other party is responsible or liable for the cost of my treatment; therefore, please process and pay all claims immediately.

Thank you in advance.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I \_\_\_\_\_ acknowledge that I have received a copy of Green Valley Orthopedics 'Notice of Privacy Practices'. This Notice describes how Green Valley Orthopedics may use and disclose my protected health information, certain restriction on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

\_\_\_\_\_  
(Signature of Patient, or Personal Representative)      \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship to Patient)

**AUTHORIZATION TO VIEW RX HISTORY FROM EXTERNAL SOURCE**

I \_\_\_\_\_ authorize Green Valley Orthopedics to view any and all available RX History from an External Source. I am aware that Green Valley Orthopedics uses a secure connection to SureScripts to send and receive most prescriptions in the office.

\_\_\_\_\_  
(Signature of Patient, or Personal Representative)      \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship to Patient)

