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

Email Address:____

<u>Primary Insurance Company;</u> ______________________Employer:________________

Name of Insured Member: ____________________D.O.B.________ SS#:______________

<u>Secondary Insurance Company:</u> ______________________Employer:________________

Name of Insured Member: ____________________D.O.B.________ SS#:______________

Patient Employer____

Occupation______________________________ Business Phone________________

Responsible Party ____________________ SS#______________ D.O.B__________

Street Address____

City______________________________ State______________ Zip______________

Responsible Party Employed by______________________________________

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

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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** **<u>If yes, what type and describe reaction</u>:**

____

____

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

___________________________/_______________________ ______________________________

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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. There is a $25.00 fee for each set of forms completed.

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

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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.

____ PATIENT SIGNATURE

____________________ DATE

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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 3rd party would be responsible for. My treatment is in no way associated with any 3rd 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)

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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:

____

____

Person or entity authorized to request the information:

____

____

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 extend 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)

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Green Valley Orthopedics
Communication Consent

I give permission to be contacted in the following manner (check all that apply)

Patient Name	D.O.B.

☐ **Home Telephone**:	☐ **Written Communication**
☐ OK to leave message with information	☐ OK to mail to my home address
☐ Leave message with call-back number only	☐ OK to mail to work/office address
☐ OK to leave message with the following family members:	☐ OK to fax to this number:
☐ **Work Telephone:**	☐ **Cell Phone:**
☐ OK to leave message with information	☐ OK to leave message with information
☐ Leave message with call-back number only	☐ Leave message with call-back number only
☐ Patient information or medical records may be faxed to other Care Providers, hospitals or insurance companies if necessary.	

Patient / Responsible Party Signature	Date

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Patient Name:____ **D.O.B.**_______________________________

In accordance with the U.S. Department of Health & Human Services, Physicians are required under the Health Informed Technology for Economic and Clinical Health Act of 2009 to obtain race, ethnicity and language data for all patients in order to improve the quality of healthcare. A copy of this law is available upon request. This information is requested in efforts to make sure that everyone receives the highest quality of care. Refusing to provide the requested information will NOT affect your ability to see a doctor on receipt of and will not adversely affect the quality of care you receive at Green Valley Orthopedics. This information goes into your medical record and it is confidential. Please make the most appropriate selection below.

ETHNICITY (SELECT ONE)

______ HISPANIC: A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

______ NON-HISPANIC: Any possible options not covered in the above category.

______ UNKNOWN: A person who cannot or refuses to declare ethnicity.

RACE (SELECT ONE)

______ WHITE: A person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East.

______ BLACK/ AFRICAN AMERICAN
A person having origins in or who identifies with any of the black racial groups of Africa.

______ NATIVE AMERICAN/ALASKA NATIVE
A person having origins in or who identifies with any of the original peoples of North and South America (including Central America), and who maintains cultural identification through tribal affiliation or community recognition.

______ ASIAN/PACIFIC ISLANDER
A person having origins in or who identifies with any of the original people of the Far East, Southeast Asia, Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

______ OTHER Any possible options not covered in the above categories. Includes patients who cite more than one race.

______ UNKNOWN A person who cannot or refuses to declare race.

Is there a native language, other than English, spoken in the home? ______Yes ______No
If yes, what language?____

Patient Signature:____Date:_____________________

Parent/Guardian Signature:____ Date:_____________________