OrthoArizona

General Patient Information

(This information is necessary for our files and will be considered confidential) Date:_____

_____ _____ _____ (____)_____
Last Name First Name Middle Phone Number

_____ _____ _____ _____
Address City State Zip Code

Sex: ☐ Male ☐ Female

_____ _____ _____
Social Security Number Date of Birth Age

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Preferred Language: ☐English ☐Spanish ☐Other:_____
Race: ☐White/Caucasian ☐Hispanic ☐African American ☐Asian ☐Native American

_____
Primary Care Physician

_____
Referred By

_____
Email

Emergency Contact

_____ _____ (____)_____
Name Relationship Phone Number

Primary Insurance Information

_____ _____ _____ _____
Insurance Company Name Policy Holder's Name Policy Holder's DOB Policy #

_____ _____Patient Relation to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other_____
Group # Social Security **if Different than Patient**

Secondary Insurance Information

_____ _____ _____ _____
Insurance Company Name Policy Holder's Name Policy Holder's DOB Policy #

_____ _____Patient Relation to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other_____
Group # Social Security **if Different than Patient**

Preferred Pharmacy Information

_____ _____
Preferred Pharmacy Name Pharmacy Address *Approximate Crossroads if address unknown

(____)_____ ☐ *If no preferred pharmacy, please check box and physician will choose pharmacy
Pharmacy Phone Number

If Patient is a Minor or Student

_____ _____ _____ _____
Responsible Party Relationship DOB Social Security Number

IT IS YOUR RESPONSIBILITY TO PROVIDE YOUR INSURANCE COMPANY WITH ANY REQUESTED INFORMATION NEEDED TO PROCESS YOUR CLAIM. IF YOUR INSURANCE PLAN REQUIRES PRE-AUTHORIZATION FROM PRIMARY CARE PHYSICIAN IT IS YOUR RESPONSIBILITY TO HAVE THE AUTHORIZATION AT THE TIME OF YOUR VISIT. WITHOUT THE REQUIRED INFORMATION OR APPROPRIATE AUTHORIZATION, TODAY'S CHARGES MAY BE YOUR RESPONSIBILITY. IN ORDER FOR ORTHOARIZONA TO CONTINUE TO OFFER SERVICES TO PATIENTS AT AFFORDABLE PRICES, IT IS OUR EXPECTATION THAT ALL PATIENTS WILL PAY THE PATIENT PORTION OF THEIR BALANCES IN FULL AT THE TIME OF SERVICE. PLEASE BE ADVISED THAT ORTHOARIZONA CONSIDERS BALANCES THAT ARE OLDER THAN 60 DAYS AS DELINQUENT. IT IS OUR POLICY TO PLACE THESE ACCOUNTS WITH AN OUTISDE COLLECTION AGENCY FOR HANDLING. ORTHOARIZONA RESERVES THE RIGHT TO CHARGE THE PATIENT AND/OR GUARANTOR A COLLECTION FEE EQUAL TO 40% OF THE OUTSTANDING BALANCE WHICH IS THE AMOUNT THAT IS CHARGED BY THE COLLECTION AGENCY FOR THEIR SERVICES. I AUTHORIZE THE DOCTOR TO PERFORM DIAGNOSTIC PROCEDURE AND TREATMENT AS MAY BE NECESSARY FOR PROPER MEDICAL CARE. I AUTHORIZE AND REQUEST ORTHOARIZONA, AND ITS DIVISIONS, TO RELEASE MY MEDICAL RECORDS TO ANY OTHER PHYSICIAN/MEDICAL FACILITIES DIRECTLY INVOLVED IN MY CARE, AND FOR THE PURPOSE OF ADMINISTERING CLAIMS. I HAVE BEEN MADE AWARE OF ORTHOARIZONA'S NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY. I HEREBY AUTHORIZE THE ASSIGNMENT OF PAYMENT OF MY MEDICAL BENEFITS TO ORTHOARIZONA AND ITS DIVISIONS. I UNDERSTAND I MAY RECEIVE SERVICES OR SUPPLIES THAT ARE NOT COVERED BY MY INSURANCE PLAN AND I AGREE TO BE DIRECTLY RESPONSIBLE FOR THESE EXPENSES. I UNDERSTAND COPAYS , DEDUCTIBLES, AND COINSURANCE ARE DUE AT THE TIME OF SERVICE. DELIQUENT ACCOUNTS THAT HAVE BEEN DETERMINED TO BE "PATIENT RESPONSIBLE" BY THE INSURANCE CARRIER MAY BE REFERRED TO A COLLECTION AGENCY FOR PAYMENT. ASSOCIATED COLLECTION AGENCY COSTS MAY ALSO BE YOUR RESPONSIBILITY. I HEREBY AUTHORIZE ORTHOARIZONA AND ITS DIVISIONS TO OBTAIN MEDICATION HISTORY FROM COMMUNITY PHARMACIES AND/OR PHARMACY BENEFIT MANAGERS FOR THE PURPOSE OF TREATMENT.

Patient/Guardian Signature:_____ **Date:**_____

Patient Communication and Consent

Patient Name: _____Date of Birth: _____

There are occasions when OrthoArizona may have to call to discuss Confidential Protected Health Information. Please let us know how you would like us to get this information to you:

____ Ok to call my home/cell phone and leave a message on the answering machine

____ Ok to call my home but DO NOT leave a message

____ Do Not call my home phone but call this number ( )_____

____ Do Not leave messages with family member

Who may receive information regarding your Protected Health Information?
Check all that apply.

____ Spouse Name and date of birth: _____

____ Children Names and birthdates: _____

____ Parents Names and birthdates: _____

____ Significant Other/Friend Name and birthdates: _____

_____

_____

I have received a copy of the Notice of Privacy Practices from this provider and authorize the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to OrthoArizona.

Signature: _____ Date: _____

OrthoArizona

NOTICE TO PATIENTS

We are notifying you that we may recommend that you receive medical or diagnostic services from Arizona Spine and Joint Hospital, a federally recognized "physician owned" specialty hospital, Trusted Care Surgery Center, a "physician owned" surgery center, Center at Val Vista Skilled Nursing Facility, Center at Arrowhead Skilled Nursing Facility and Modern Vascular. In compliance with A.R.S. 32-1401(27)(ff) we are advising you we have a direct financial interest in the above treatment agencies.

You should be aware that alternative health care facilities may be available to you. The list below is some of the alternative facilities, however based on your insurance there may be other options.

- Simon Med Imaging
- Banner Gateway
- Banner Baywood
- Banner Desert
- Mercy Gilbert Hospital
- Chandler Regional Hospital
- Oasis
- Phoenix Children's
- Sante of Mesa
- EVDI

Please sign below to acknowledge your receipt and understanding of this disclosure and that you have had an opportunity to ask and receive answers to any questions you may have about this disclosure.

ACKNOWLEDGMENT: I HAVE READ THIS "NOTICE TO PATIENTS" FORM AND UNDERSTAND THE DISCLOSURE THAT IT CONTAINS.

Date:_____

Printed Patient Name:_____

Signature of Patient or Guardian:_____

OrthoArizona

Patient Intake Form

Patient Name: _____ Date of Birth: _____ Date:_____

Reason for Visit: _____ Body Part: (Left or right): _____

Date of Injury or Problem: _____ How did the injury occur? _____

Rate pain intensity from 1-10 (1 being the least amount of pain to 10 being the highest: _____

Referred to office by: _____ Primary Care Physician: _____

Have you been treated for this injury by any other provider? Yes No

If yes, what provider? _____

Were X Rays taken? Yes No Date Taken: _____

Hospital/Imaging Center: _____

Medications and Allergies

Do you **CURRENTLY** take any medication, supplements, or herbal vitamins?

- ☐ No – I do not take medications.
- ☐ Yes – I take the following medication(s). Please list medication and dose below:

MEDICATION (circle if taking for current problem)	DOSE

Did you have any allergies to medication or any other allergies you may have (Examples: food, latex, iodine, etc.)?

- ☐ No – I do not have any allergies
- ☐ Yes – I do have allergies. Please list them below.

Allergy	Reaction

This page is for your records.

You do not need to submit this page with your registration paperwork.

MEZONA ORTHOPAEDIC
A DIVISION OF OSNA
NOTICE OF PRIVACY PRACTICES

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 po0rtability 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. Lawsuits and/or similar proceedings in response to a court or administrative order.
2. If required doing so by a law enforcement official.
3. 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.
4. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
5. To federal officials for intelligence and national security activities authorized by law.
6. For workers Compensation and similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

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 at work. We will accommodate reasonable requests.

You can request a restriction in our use or disclosure of you health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure or 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.

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: (Mezona Orthopaedic Medical Records 2940 E Banner Gateway Dr. # 200 Gilbert AZ 85234).

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 Privacy Officer, 2940 E Banner Gateway Dr. # 200 Gilbert AZ 85234. You must provide us with a reason that supports your request for amendment.

Right to a copy of this notice: You are entitled to receive a copy of this Notice of Privacy Practices. We reserve the right to change the terms of this notice at any time, provided such changes are permitted by applicable law. Before we make any significant changes, we will change this notice and make the new notice available upon request.

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 Mezona Orthopaedic, Privacy Officer 480-964-2908. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

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 questions regarding this notice or our health information privacy policies please contact: Privacy Officer at 480-964-2908, or in writing at Mezona Orthopaedic 2940 E. Banner Gateway Dr. # 200 Gilbert AZ. 85234