Welcome to our practice. We are committed to providing the best possible care and believe your understanding of your financial responsibilities is an important element of the treatment process.

Your health insurance policy is a contract between you and your insurance company. It is your responsibility to know the specifics of your insurance coverage and benefits, and if you have any questions to inquire before services are rendered.

NEW PATIENTS: You have been asked to fill out our patient information sheet. The accuracy of information is very important. Please print clearly. Please give us your given name and initial as they appear on your insurance card. If you go by a different name, put it in ( ) by your name. Please bring a current copy of your personal identification and insurance card with you to your appointment. Please bring your referral information.

HOSPITAL PATIENTS: You have received this letter and other forms in the mail and probably have not been to our office. Please fill out these forms and return them to the office. This process will ensure that we have the correct billing information.

PAYMENT OF SERVICES: You and your insurance company should settle your bill in full within 60 days. We accept debit cards, checks money orders, VISA, MasterCard, American Express, Care Credit and cash. It is your responsibility to be prepared to make co-payments at the time of your appointment. If you are not able to make your co-payment, you may be asked to reschedule your appointment.

INSURANCE: The insurance claim will be filed for you based on the information you provide. Please keep the billing office informed of any changes. You are responsible for payment regardless of insurance coverage.

MEDICARE: We are participating providers with Medicare. Please provide us with your secondary insurance information so that we may bill it for you. You will be responsible for any balance up to the Medicare allowable that is not paid by Medicare or the secondary insurance.

STATEMENTS: You will receive an itemized bill from Orthopaedic Associates. The statement will indicate if your insurance has been billed. Please do not ignore the bill. Orthopaedic Associates, P.A. is willing to allow you to make monthly payments, but those payments must be arranged through our billing office. Please call the billing office at (208) 375-2782 to make arrangements. The billing staff are available to answer questions.

Please sign and date below to indicate that you have read and understand your financial responsibility.

____

Signature Date

ORTHOPAEDIC ASSOCIATES, P.A.

Established 1973

Jeffrey G. Hessing, M.D.
Mark C. Clawson, M.D.
Timothy E. Doerr, M.D.
Jared P. Tadje, M.D.

Shelly Mills
Administrator

West Boise Professional Center
8854 W. Emerald, Ste. 140
Boise, Idaho 83704
(208) 378-2868
(208) 321-4790
Fax (208) 321-4836
Toll Free Numbers
1-888-321-4741
1-877-378-2868

www.orthoa.com

HOSPITAL OWNERSHIP DISCLOSURE

As a patient of Orthopaedic Associates, your physician may order tests or schedule procedures that are performed at local hospitals. These include (but are not limited to) laboratory tests, xrays, CAT scans, MRI's, injections and surgical procedures. The physicians in Orthopaedic Associates are investors at Treasure Valley Hospital, which is one of the local hospitals, that provides these services. Our physicians also practice at St. Alphonsus and St. Luke's where they do not have an ownership interest. This form is to confirm that you understand, as a patient of Orthopaedic Associates, you have the right to choose the hospital where you would like to receive your services.

Patient Signature ________________________________ Date ___________

WELCOME TO ORTHOPAEDIC ASSOCIATES

PLEASE FILL OUT EACH SECTION C0MPLETELY -- THANK YOU

PATIENT'S LEGAL NAME			DATE OF BIRTH	SEX M F	AGE MARITAL STATUS
MAILING ADDRESS			CITY	STATE / ZIP CODE	
HOME PHONE #	CELL PHONE #		WORK PHONE #	SSN#	
PATIENT'S EMPLOYER	EMPLOYER ADDRESS		CITY	STATE / ZIP CODE	

SPOUSE'S NAME (if married)	SPOUSE'S SSN#	DATE OF BIRTH
SPOUSE'S EMPLOYER	SPOUSE'S WORK PHONE #	
FATHER'S NAME (if minor)	FATHER'S SSN#	DATE OF BIRTH
FATHER'S EMPLOYER	FATHER'S WORK PHONE #	
MOTHER'S NAME (if minor)	MOTHER'S SSN#	DATE OF BIRTH
MOTHER'S EMPLOYER	MOTHER'S WORK PHONE #	
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE	E-MAIL ADDRESS	

PLEASE CIRCLE ONE: INSURANCE WORKER'S COMP AUTO OTHER SELF-PAY MEDICARE MEDICAID

WERE YOU INJURED AT WORK? YES NO	WERE YOU INJURED IN AN AUTO ACCIDENT? YES NO
DATE OF INJURY OR ONSET OF SYMPTOMS	BODY PART INVOLVED

INSURANCE COMPANY NAME (primary)			**INSURANCE COMPANY NAME** (secondary)		
ADDRESS		PHONE #	ADDRESS		PHONE #
ID#		GROUP #	ID #		GROUP #
POLICYHOLDER	BIRTH DATE	RELATIONSHIP	POLICYHOLDER	BIRTH DATE	RELATIONSHIP

EMERGENCY INFORMATION

NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU	
RELATIONSHIP	PHONE #

I authorize Orthopaedic Associates to render treatment. I authorize Orthopaedic Associates to release/obtain any medical records/x-rays from any medical care providers and my insurance carrier to facilitate processing of my claims. I authorize my insurance carrier to pay all benefits directly to Orthopaedic Associates. This authorization shall continue to be in force and effect until revoked in writing by me. By signing, I acknowledge that I am ultimately responsible for any and all charges incurred by this office.

DATE	SIGNATURE (SIGNATURE OF PATIENT, OR PARENT/GUARDIAN IF UNDER 18)

INJURY QUESTIONNAIRE

Name: ____

Was the condition a result of an injury: Yes No

Was this related to an Auto Accident: Yes No

If yes, were you the Driver or Passenger Were you at fault of the accident? Yes No

Have you filed a claim with your auto insurance: Yes No

Was this related to an on the job injury: Yes No

If yes, name and number of your employer: ____________________________

____

Did you fill out an injury report with your employer? Yes No

What date did the injury happen: ____________________________

Where (location) did the injury happen: ____________________________

____

What activity were you doing at the time of the injury: ____________________________

____

Details of injury, please be specific: ____________________________

____

____

____

Signature: ____

Date: ________________

FINANCIAL POLICY

Thank you for choosing Orthopaedic Associates, P.A. for your orthopedic care. We are dedicated to ensuring you will receive the best care available. In return, patients are financially responsible for the services rendered.

Orthopaedic Associates, P.A. will bill your insurance carrier with the information you provide and make a good faith effort to collect for treatment services that are rendered.

However, payment is still expected within 60 days from the date of service. Orthopaedic Associates requires that co-payment, deductible, and non- covered services be paid at the time of service. Accounts not paid in full within 120 days are subject to a 1% monthly finance charge.

For our patients **without** health insurance coverage, Orthopaedic Associates, P.A. requires a payment of $175.00 at the initial visit. Unpaid balances require payment arrangements through the billing office and include monthly and subsequent visit minimum payments.

For patient **without** health insurance coverage, surgical care will require a deposit of no less than 50% of the estimated surgical fee. Payment is required at least 48 hours prior to the scheduled procedure. A payment contract stipulating monthly payments on the balance is required.

Orthopaedic Associates, P.A. accepts cash, checks and major credit cards. There will be a $30 returned check fee assessed to your account on all returned checks.

The billing office is available from 8:30 am – 4:30 pm Monday through Friday. Billing staff can be reached at (208) 375-2782.

I acknowledge that I have read and understand and will comply with Orthopaedic Associates, P.A. financial policy.

____ ____________________________

Signature **Date**

ORTHOPAEDIC ASSOCIATES NOTICE OF PRIVACY PRACTICE
(SHORT VERSION)

EFFECTIVE DATE: APRIL 14, 2003

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY:

We understand that medical information about you and your health is personal. Orthopaedic Associates is required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are required to follow the terms of the Notice that is currently in effect. A paper copy of this notice may be obtained upon request.

How Orthopaedic Associates May Use or Disclose Your Health Information:

Orthopaedic Associates protects the privacy of your health information. We must have your written authorization to use or disclose your health information. However, the law permits Orthopaedic Associates to use or disclose your health information for the following purposes without your authorization:

- **For Treatment**- Information obtained by Orthopaedic Associates will be used for medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.
- **For Payment**- We may use and disclose your health information about you so that treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or third party.
- **For Health Care Operations**- We may use and disclose health information about you in order to run the office and make sure that you and our other patients received quality care.
- **As Required by Law**- We will disclose health information about you when required to do so by federal, state or local law.
- **To avert a Serious Threat to Health or Safety**- We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Public Health Risks**- We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **For Health Oversight Activities**- We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include audits, investigations, inspections and licensure.
- **Lawsuits and Disputes**- If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court order or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.
- **For specific Government Functions**- Orthopaedic Associates may disclose health information for the following specific government functions (1) health information of military personnel, as required by military command authorities; (2) health information of inmates, to a correctional institution of law enforcement official; (3) in response to a request from law enforcement, if certain conditions are satisfied; and (4) for national security reasons.

When Orthopaedic Associates May Not Use or Disclose Your Health Information:

Except as described in this Notice, Orthopaedic Associates will not use or disclose your health information without your written authorization. If you do authorize Orthopaedic Associates to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

You Have the Following Rights With Respect to Your Health Information:

- You have the right to request restrictions on certain uses and disclosures of you health information. Orthopaedic Associates is not required to agree to a restriction that you request. If we do agree to any restriction, we will put the agreement in writing and follow it, except in emergency situations. We cannot agree to limit the uses or disclosures of information that are required by law.
- You have the right to inspect and copy your health information as long as Orthopaedic Associates maintains the health information. Your health information usually will include your medical records and billing records. To inspect or to receive a copy of your health information, you must submit a written request to 8854 W Emerald St, Ste 140, Boise, Idaho 83704. We may charge a fee for the costs of copying, and mailing, that are necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. You have a right to choose to obtain a summary instead of a copy of your health information.
- You have the right to request that Orthopaedic Associates amend your health information that is incorrect or incomplete. To request an amendment, you must submit a written request to the privacy officer, Shelly Mills, 8854 W Emerald St, Ste 140, Boise, Idaho 83704, along with the reason for the request. Orthopaedic Associates is not required to amend health information that is accurate and complete.
- You have the right to receive an accounting of disclosures of your health information we have made April 14, 2003 for purposes other than disclosures.
- (1) for Orthopaedic Associates treatment, payment or health care operations, (2) to you or based upon your authorization and (3) for certain government functions. To request an accounting, you must submit a written request to 8854 W Emerald St, Ste 140, Boise, Idaho 83704. You must specify the time period, which may not be longer than six years.
- You may request communications of your health information by alternative means or at alternative locations. For example, you may request that we contact you about your health matters only in writing or at different residence or post office box. To request confidential communication of your health information, you must submit a written request to Orthopaedic Associates. Your request must state how or when you would like to be contacted. We will accommodate all reasonable requests.

Changes to this Notice of Privacy Practices:

Orthopaedic Associates reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we have about you as well as any information we receive in the future. Any revised Notice will be posted in the front office of Orthopaedic Associates. Upon request, we will provide a revised Notice to you.

For More Information or to Report a Problem:

If you have questions or would like additional information about Orthopaedic Associates privacy practices, you may contact the Privacy Officer, Shelly Mills, 8854 W Emerald St, Ste 140, Boise, Idaho 83704 or phone 208-321-4790 or fax 208-321-4836. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer above or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Acknowledgement of Receipt of Notice

ORTHOPAEDIC ASSOCIATES

Shelly Mills, Privacy Officer, 208-321-4790

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Would you like to receive a copy of any amended Notice of Privacy Practices: Yes No (circle one)

If yes, write your e-mail or mailing address to send the amended notice to: ________________________________

Signed: __________________________________ Date: ______________ Birthdate: _______________

Print Name: ______________________________ Telephone: ____________________________________

If not signed by patient, please indicate relationship:

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or person representative of deceased patient

Name of Patient: ____

For office Use Only:

❑ Signed form received by: _____________________________________

❑ Acknowledgement refused:

Efforts to obtain:

____

____

Reasons for refusal:

____

____

Orthopaedic Associates
Medical History Sheet

Name: ________________________________ **DOB:** ____________ **Date**: _____________

PATIENT PROFILE:

Age:	Marital Status:	Occupation:	
Height:		Weight:	BMI:
Do you drink alcohol: Yes No		If so how much?	
Do you use tobacco? Yes No	Never	If so how much?	
Have you ever used tobacco?			
Have you ever used recreational drugs? Please Specify.			

What other physicians do you see? ____

____

Date of last exam:___________ Date of EKG:_________ Date of blood tests: ___________

Have you had a pneumococcal vaccination?	Yes	No	Year: _______	Handout Given
Have you had an influenza immunization?	Yes	No	Year: _______	Handout Given
Have you had urinary incontinence?	Yes	No	Year: _______	Handout Given
Have you had a colorectal screening?	Yes	No	Year: _______	Handout Given
Have you had a dexa-bone density scan?	Yes	No	Year: _______	Handout Given
Have you had a mammogram?	Yes	No	Year: _______	Handout Given
Have you had depression?	Yes	No	Year: _______	Handout Given

PAST MEDICAL HISTORY: (Check all that apply and explain)

	High Blood Pressure		Ulcers
	Heart attack		Other
	Congestive Heart Failure		Reflux
	Blood Transfusion		Strokes
	Angina		Seizures
	Heart murmur		Glaucoma
	Irregular heartbeat		Psychiatric problems
	Lung disease (specify)		Anxiety reactions
	Shortness of breath		Anemia
	Asthma		Blood clots
	Sleep apnea		Muscle disease
	Diabetes		Arthritis
	Liver disease (specify)		HIV/ AIDS
	Kidney disease (specify)		Cancer (specify)
	Thyroid disease		Other
	Hepatitis		Other

PAST SURGICAL HISTORY:

Surgery	Year	Surgery	Year

Name: ____

ALLERGIES: List allergies and the reaction you have. If no allergies, write **NONE.**

Allergy	Reaction

Which pharmacy do you use?

Name: ____________________________ Location: __________________________

MEDICATIONS: List ALL prescriptions, over the counter medications, and herbal supplements you are currently taking.

Medication	Dosage	Times per day	Reason for use

OFFICE USE:

History updated: ____________________

History updated: ____________________

History updated: ____________________

Vital Signs:

Date: __________ BP: ___________ Pulse: __________

Date: __________ BP: ___________ Pulse: __________

Date: __________ BP: ___________ Pulse: __________

Reviewed by:

Date: ______________ RN: _________________ MD: _____________________

Date: ______________ RN: _________________ MD: _____________________

Date: ______________ RN: _________________ MD: _____________________