Bone & Joint Specialists

PATIENT NAME: ____ **Cellular#**_________________________
First Middle Last
Address: ____**Apt./Sp.#:** ___________________________
City: ____ **State:** ______________ **Zip:** ________________
Home Phone #: ( ) __________ - __________ **Work Phone #:** ( ) ___________ - ___________
Social Security #: ______ - ______ - ______**Date of Birth:** ______________ **Age:** _______ **Male Female**
Race and Ethnicity: ______________ **Email:** ____
Employer: ____ **How Long?** __________________
Occupation? ______________________________ **Marital Status: S M D W**

Who referred you to our office?__________________________**Address:** ____________________________

Primary Care Doctor: ____________________________**Address:** _________________________________

******Complete this section only if someone other than the patient is financially responsible**********

***Responsible Party:** ____________________________**Relationship to Patient**__________________________
***Home Address:** ____
***Telephone #:** ( ) _____________________**Birthdate:** ____________
Employer:** _______________________________Insured ID# or Social Security:**_______________________

EMERGENCY CONTACT: (NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU).

Contact Name: ______________________________ **Relationship to Patient:** ____________________________
Home Phone: ( ) ___________ - ___________ **Cellular #:** ( ) _____________ - _______________

WHAT BODY PART ARE WE SEEING YOU FOR?: ____
DATE OF INJURY/ONSET: ___________________________

INSURANCE INFORMATION:

Primary Insurance: ____________________________ **Policy ID#:** _________________**Group#**____________
Address: ______________________________________ **City/State/Zip** _______________________________
Date of Birth: ______/_______/_______ **Insured Name:** ____

Secondary Insurance: ___________________________**Policy ID#:**__________________**Group#**_____________
Address:_______________________________________**City/State/Zip**________________________________
Date of Birth:______/_______/________ **Insured Name:** ____

Worker's Comp Name & Address: ____
Worker's Comp claim#: ______________________________ **Date of Injury:** ______________
Work Comp Adjusters Name:___________________________**Tel#:** _________________**Fax#:**________________
Nurse Case Mgr Name: _____________________________**Tel#:**__________________**Fax#:**________________

I hereby assign all medical benefits to which I am entitled to Bone & Joint Specialists. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release any information needed to determine these benefits or the benefits for related services.

____ ____________________________
Responsible Party Signature **Date**

HISTORY FORM

Name: ____ **Date:** ____________
First Middle Last

Height ________**Weight** _________

Area of the body you are being seen for? ____

Describe injury/accident in detail: ____

Medication	Dose	How long taking	Side effects

******PLEASE LIST NAME OF PHARMACY SO THAT IT CAN BE ELECTRONICALLY SENT TO THE PHARMACY******

Pharmacy Name: ____________________________**Pharmacy Number:** ______________________________
Pharmacy Cross Streets: ____

Allergies to Medication: ☐ **Yes** ☐ **No**
If yes, please list which medication: ____

Allergies: ____

Are you currently or have had problems with your?

	Circle		Describe all yes responses
Eyes	Yes	No	________________________________
Ears, Nose, throat	Yes	No	________________________________
Lungs, breathing	Yes	No	________________________________
Digestion	Yes	No	________________________________
Bladder	Yes	No	________________________________
Diabetes	Yes	No	________________________________
Heart Disease	Yes	No	________________________________
High Blood pressure	Yes	No	________________________________
Bleeding problems	Yes	No	________________________________
Balance problems	Yes	No	________________________________
Numbness/tingling	Yes	No	________________________________
Blackouts/fainting	Yes	No	________________________________
Psychological problems	Yes	No	________________________________
Cancer	Yes	No	________________________________
Arthritis	Yes	No	________________________________
Polio	Yes	No	________________________________
Epilepsy	Yes	No	________________________________
HIV	Yes	No	________________________________
Hepatitis, Tuberculosis	Yes	No	________________________________
Other (please describe)	Yes	No	________________________________

PAST MEDICAL HISTORY

Surgeries/Hospitalization	Year	Complaint

Have you ever had general anesthesia? ☐ **Yes** ☐ **No**
Any problems with anesthesia? ☐ **Yes** ☐ **No**

If yes, describe ____

SOCIAL HISTORY

Marital status: ☐**Single** ☐**Married** ☐**Divorced** ☐**Separated** ☐**Widowed**

Children: ☐**Yes** ☐**No** **How many children?** _________

Do you live alone? ☐**Yes** ☐**No**

Exercise? ☐**daily** ☐**weekly** ☐**monthly** ☐**rarely** ☐**never**
What type of exercise? ____

Are you on a special diet? ☐**Yes** ☐**No**
History of substance abuse? ☐**Yes** ☐**No What substance?** _______________________
Do you smoke? ☐**Yes** ☐**No Packs per day?** _______ **for** _______**year (s)**
When did you quit smoking? ___________________**Packs per day?** _______**for** ________**year(s)**

Drink alcohol? ☐**Yes** ☐**No**
☐**daily** ☐**1-2 per week** ☐**1-2 per month** ☐**1-2 per year**

FAMILY HISTORY

Member	Alive		Age	Health status/cause of death
Father	Yes	No		
Mother	Yes	No		
Sister/Brother	Yes	No		
Sister/Brother	Yes	No		
Sister/Brother	Yes	No		

Note: Unchecked boxes indicate negative.

REVIEW OF SYSTEMS

Are currently or have you had any problems with:

General ☐ weight loss ☐ fever-chills ☐ fatigue ☐ weakness ☐ sweating-night sweats
Describe: ____________________

Skin ☐ itching ☐ rashes ☐ hair-nail changes
Describe: ____________________

Head ☐ headache ☐ trauma
Describe: ____________________

Eyes ☐ blurring ☐ discharge ☐ vision-glasses ☐ diplopia (double vision) ☐ pain ☐ scotomata (seeing spots)
Describe: ____________________

Ears ☐ pain ☐ discharge ☐ vertigo ☐ deafness ☐ tinnitus (ringing of the ears)
Describe: ____________________

Nose ☐ sinusitis ☐ discharge ☐ obstruction ☐ epistaxis (nose bleeds) ☐ postnasal drip
Describe: ____________________

Mouth/Throat: ☐ sores ☐ dentures ☐ hoarseness ☐ teeth-dental care ☐ gum bleeding ☐ taste
Describe: ____________________

Pulmonary: ☐ chest pain ☐ wheezing ☐ cough ☐ coughing up blood ☐ shortness of breath ☐ coughing up sputum
Describe: ____________________

Breasts: ☐ masses ☐ pain ☐ discharge
Describe: ____________________

Cardiovascular: ☐ palpitation ☐ chest pain ☐ murmurs ☐ hypertension ☐ edema (swelling in legs) ☐ claudication
Describe: ____________________

Gastrointestinal: ☐ hematemesis ☐ pain ☐ jaundice ☐ hernia ☐ melena (blood in stool) ☐ hemorrhoids
☐ indigestion ☐ constipation ☐ dysphagia (difficulty swallowing) ☐ stool shape, color
Describe: ____________________

Genitourinary: ☐ dysuria (painful urination) ☐ hematuria (blood in urine) ☐ incontinence (difficulty holding urine)
☐ Nocturia (frequent urination at night) ☐ urgency (difficulty controlling urination) ☐ frequency (frequent urination)
Describe: ____________________

Sexual History: ☐ syphillis ☐ gonorrhea ☐ sterility ☐ impotence ☐ testicular pain-swelling
☐ Sores-discharge ☐ contraception
Describe: ____________________

Female-Menses: ☐ spotting ☐ irregularity ☐ dysmenorrheal (painful periods)
Describe: ____________________

Endocrine: ☐ goiter ☐ tremor ☐ heat-cold intolerance ☐ hormone therapy ☐ diabetes
Describe: ____________________

Allergic History: ☐ allergies ☐ eczema ☐ asthma ☐ hay fever ☐ hives

Describe: ____________________

Blood-Lymphatic: ☐ anemia ☐ transfusions ☐ bleeding tendency ☐ lymph node enlargement-pain

Describe: ____________________

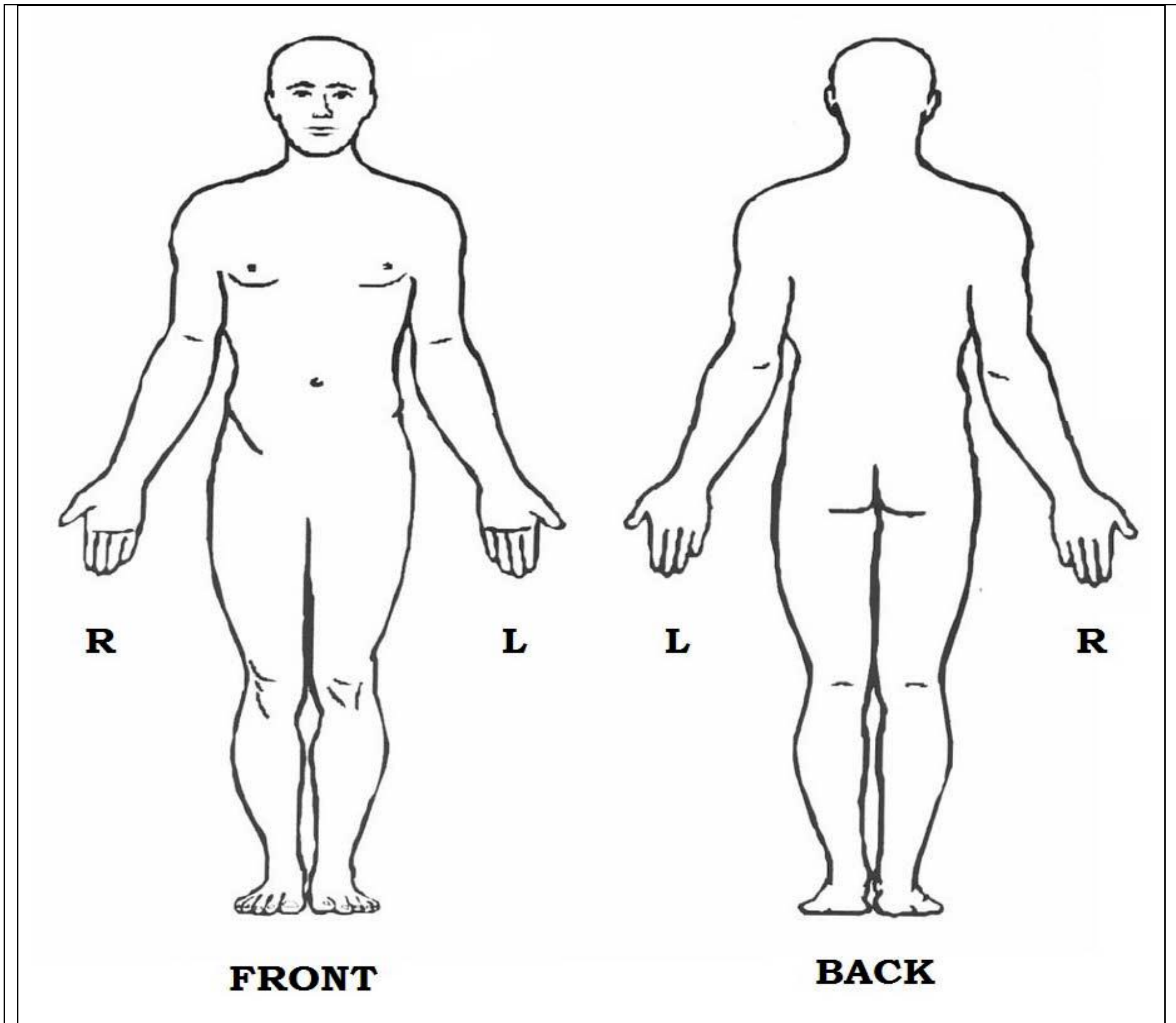
Neurologic ☐ syncope ☐ convulsions ☐ gait-coordination ☐ paralysis-weakness ☐ speech ☐ sensation

Describe: ____________________

Physchologic: ☐ mood ☐ sleep pattern ☐ anxiety-depression ☐ alcohol abuse ☐ drug abuse ☐ phobias ☐ memory loss

Describe: ____________________

Note: boxes not checked denote negative response



Please mark the area of injury or discomfort on the chart using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
--------------	ooooooooooo	^^^^^^	XXXXX	/////////
--------------	ooooooooooo	^^^^^^	XXXXX	/////////

Please use this space below to describe your condition further if needed:

____

____

____

Date: ____________________ Name: ____

BONE & JOINT SPECIALISTS

DISCLOSURE:
Bone and Joint Specialists is a for-profit corporation solely owned by the physicians providing medical services to the community**.**
Our office does not discriminate against any person on the basis of race, gender, religion, color, national origin, disability, or age.
FINANCIAL POLICY:

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

Our office does verify 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 eligibility status. We will do all we can to assist you with your health insurance claims however, insurance is a contract between the insurance company and the insured. Final responsibility for payment of your account rests with you. Our office will bill a secondary insurance only once as a courtesy to the patient. If the insurance does not pay, then the balance becomes the responsibility of the insured.

If you are scheduled for surgery, we require any deductible's as well as coinsurance amounts paid prior to your date of surgery. In addition to the surgeon's fee, there is a need for an assistant at the time of your surgery. The assistant's fee is in addition to the surgeon's fee.

Any prior authorizations obtained by this office on behalf of you, the patient, are not a guarantee of payment, but are based on medical necessity. Claims are subject to your policy provisions and final payment is determined only when your insurance company has received the claim. If you have any questions regarding our medical fees or questions regarding your insurance benefits, please speak with a billing specialist.

A returned check charge of $35.00 will be charged to the account for each returned check.

DELINQUENT AND COLLECTION ACCOUNTS:

- An account becomes delinquent when the minimal monthly payment has not been received within 30 days of the statement date.
- An account that has become delinquent for 60 days, may become a collections account and may be charged a collections handling fee, court cost's and attorney's fees.
- Exemptions from the above are allowed charges under Medicare and Title XIX (Nevada Medicaid) contracts.
- There may be exceptions to all or any part of the account.
- Balances not paid by your insurance plan within 30 days, will automatically become the responsibility of the responsible party.

CANCELLATION, NO SHOW AND RESCHEDULING POLICY: If you fail to provide us with a 24 hour notice of cancellation or rescheduling, or fail to keep your scheduled appointment, there will be a $50 no-show fee.

I understand that Bone & Joint Specialists may not be a provider on my health plan, and I will be fully responsible for any outstanding charges that my insurance plan does not cover. A photocopy of this assignment is considered as valid as the original.

In the event that my account becomes a delinquent account or a collection account, I agree to pay Bone & Joint Specialists all incurred Finance Charges, Delinquent Account Handling Fee's, Collection Account Handling Fee's and incurred Collection cost's as set forth above in section 3 of the financial policy.

If it is necessary to forward your account to our Collection Agency, a Collection Fee markup of 35 to 50% will be added to the amount owing. Interest will accrue daily at the rate of 1.5% per month or 18% per year.

The mark-up reflects Bone & Joint Specialists receiving only its billed charges. The additional money will go to the collection agency.

Signature of Responsible Party: ___________________________________ Date: _________________

Bone and Joint Specialists

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS
TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact ANNA HOLLAND, OFFICE MANAGER at (702) 474-7200.

WHO WILL FOLLOW THIS NOTICE:

- Bone and Joint Specialists

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share
health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:
We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the
care and services you receive from us. We need this record to provide you with quality
care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways
in which we may use and disclose health information about you. We also describe your
rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:
- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health
information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.
The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for
treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:
- **Research**
- **To Provide Information about Organ and Tissue Donation**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.
You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from ANNA HOLLAND, OFFICE MANAGER at (702) 474-7200.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact ANNA HOLLAND, OFFICE MANAGER. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION.
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of this Notice
We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date. This acknowledgement will be filed with your records.

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Acknowledgement of Receipt of Notice of Privacy Practices for Bone & Joint Specialists

I hereby acknowledge that I have received the Notice of Privacy Practices from Bone & Joint Specialists.

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name: ________________________________ Relationship: ______________________

Name: ________________________________ Relationship: ______________________

Name: ________________________________ Relationship: ______________________

Name: ________________________________ Relationship: ______________________

Signature: ____ Date: ______________

Print Name: ____

BONE & JOINT SPECIALISTS

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ______________________________

I Authorize: ______________________________

____

To release my health care information to: Bone & Joint Specialists ______________________________
Name of designated individual, organization, or Provider

2680 Crimson Canyon Drive, Las Vegas, NV 89128
Address

(702 228-7355 (OFFICE) (702) 228-4499 (FAX)

	Information to be Released:		**Dates of Treatment:**
X	All Medical Records	X	All Dates
	All Medical Billing Records		**Specific Dates**:
	X-Ray and imaging reports		

Other: ______________________________

Purpose of disclosure: ______________________________

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

______________________________ ______________________________
Printed Name Date

______________________________ ______________________________
Signature of Patient or Legal Representative Date

Authorization will expire 12 months from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.