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: _____Number of years on the job? _____
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**

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 costs 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 it's billed charges. The additional money will go to the collection agency.

Signature of Responsible Party: _____ Date: _____

BONE & JOINT SPECIALISTS
Review of Systems

Patient Name: _____ Date: _____

Systemic

Recent weight loss	○ Yes	○No
Recent weight gain	○ Yes	○No
Feeling tired	○ Yes	○No
Fever (as symptom)	○ Yes	○No
Chills (as symptom)	○ Yes	○No

Pulmonary Symptoms

Cough	○ Yes	○No
Difficulty breathing	○ Yes	○No

Cardiac Symptoms

Chest pain or discomfort	○ Yes	○No
Palpitations	○ Yes	○No
Limb swelling	○ Yes	○No

ENT Symptoms

Blurry vision	○ Yes	○No
Worsening vision	○ Yes	○No
Loss of hearing	○ Yes	○No
Ringing in the ears	○ Yes	○No

GI

Upset stomach	○ Yes	○No
Constipation	○ Yes	○No
Red blood in bowel Movement	○ Yes	○No
Diarrhea	○ Yes	○No

Hematological Symptoms

Easy bruising tendency	○ Yes	○No
Easy bleeding	○ Yes	○No

Neurological Symptoms

Walk wobbly or unsteady	○ Yes	○No
Numbness	○ Yes	○No
Tingling	○ Yes	○No
Involuntary movements which come And go	○ Yes	○No

Intequmentary

A rash	○ Yes	○No
Localized loss of skin surface	○ Yes	○No

Endocrine Symptoms

Excessive thirst/fluid intake	○ Yes	○No
Urinary frequency increased	○ Yes	○No
Pain during urination	○ Yes	○No
Loss of hair from head or body	○ Yes	○No

Psychological

Emotional lability	○ Yes	○No
Anxiety	○ Yes	○No
Depression	○ Yes	○No

Musculoskeletal

Muscle weakness	○ Yes	○No
Joint stiffness, localized	○ Yes	○No
Lower back pain	○ Yes	○No
Spinning dizziness (vertigo)	○ Yes	○No

BONE & JOINT SPECIALISTS
Health History Form
Dr. Mark Rosen

Patient Name: _____ Date: _____

Family History

○Yes	○No	Stroke syndrome
○Yes	○No	Heart disease
○Yes	○No	Diabetes Mellitus
○Yes	○No	Cancer
○Yes	○No	Arthritis
○Yes	○No	High blood pressure

What is your height? _____ Weight? _____

Medical History			**Medical History**			**Medical History**
○ Yes	○No	Alzheimer's Disease	○Yes	○No	Glaucoma	
○Yes	○No	Anemia	○Yes	○No	Gout	
○Yes	○No	Angina	○Yes	○No	Hiatal Hernia	
○Yes	○No	Asthma	○Yes	○No	Hepatitis	
○Yes	○No	Atrial Fibrillation	○Yes	○No	HIV	
○Yes	○No	Benign Prostatic Hyper	○Yes	○No	High Blood Pressure	
○Yes	○No	Chronic Bronchitis	○Yes	○No	Hypertension	
○Yes	○No	Coronary Artery Disease	○Yes	○No	Insomnia	
○Yes	○No	Cancer	○Yes	○No	Prior kidney disease	
○Yes	○No	Cardiac Failure	○Yes	○No	Leukemia	
○Yes	○No	CHF (congestive heart failure				
○Yes	○No	Cholesterol Problems	○Yes	○No	Prior liver diease	
○Yes	○No	History of COPD	○Yes	○No	MI, Acute	
○Yes	○No	Depression	○Yes	○No	Multiple Sclerosis	
○Yes	○No	Dementia	○Yes	○No	Obesity	
○Yes	○No	Diabetes Mellitus	○Yes	○No	Osteoporosis	
○Yes	○No	Dialysis	○Yes	○No	Osteoarthritis	
○Yes	○No	Diverticultis Colon	○Yes	○No	Pancreatitis	
○Yes	○No	Diverticulitis-small intest	○Yes	○No	Parkinson's disease	
○Yes	○No	Emphysema	○Yes	○No	Polio	
○Yes	○No	Epilepsies	○Yes	○No	Post traumatic stress disorder	
○Yes	○No	Fracture	○Yes	○No	Pneumonia	
○Yes	○No	GERD	○Yes	○No	Esophageal Reflux	
			○Yes	○No	Rheumatoid Arthritis	
			○Yes	○No	Sinusitis	
			○Yes	○No	Sleep Apnea	
			○Yes	○No	Stroke syndrome	
			○Yes	○No	Thyroid Disorders	
			○Yes	○No	TIA (mini stroke)	
			○Yes	○No	Ulcer gastric	
			○Yes	○No	UTI	
			○Yes	○No	Valvular heart disease	
			○Yes	○No	Venous thrombosis	
			○Yes	○No	Vertigo	

BONE & JOINT SPECIALISTS
Health History Form Continued
Dr. Mark Rosen

Patient Name: _____ Date: _____

Past Surgical History

○Yes	○No	Prior surgical/Procedural history
○Yes	○No	Previous pregnancies including Cesarean section(s) _____
○Yes	○No	Hx of eye surgery for cataracts
○Yes	○No	Hernia Repair
○Yes	○No	Hysterectomy
○Yes	○No	Cardiac Pacemaker
○Yes	○No	Surg of Pharnx, Adenoids, and Tonsils
○Yes	○No	Cholecystectomy/Gallbladder
○Yes	○No	TURP
○Yes	○No	Appendectomy
○Yes	○No	Arthroscopy
○Yes	○No	Thyroidectomy
○Yes	○No	Mastectomy
○Yes	○No	Cosmetic Surgery
○Yes	○No	Reaction to anesthetics

How did the injury occur & where? _____

Any previous problems with this same body part in the past? ☐ Yes ☐ No
If yes, Please list: _____

_____

Have you been seen by any other doctor for your present problem? ☐ Yes ☐ No
If yes, which doctor and when? _____

Have X-rays or any diagnostic studies been done? (ex: MRI's;CT;Bone Scan; and EMG studies)
If yes, Where, When and What body part? _____

Do you currently smoke? ☐ Yes ☐ No How many packs a day? _____
If you do not currently smoke, have you ever smoked in the past? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Socially: ☐Yes ☐No Occasionally: ☐ Yes ☐No
Daily: ☐ Yes ☐ No How often? _____

History of drug use currently or in the past? ☐Yes ☐No Please explain?: _____

_____

BONE & JOINT SPECIALISTS
MEDICATION & SURGICAL RECORD
Please complete the following information for review by your provider

Today's Date: _____

Name: _____Birth Date: _____/_____/_____ Age: _____

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

Pharmacy Name: _____Pharmacy Number: _____

Pharmacy Adress: _____

Allergies to Medications: ☐ None ☐ Yes, List:

Name of Medication allergic to:	Allergic Reaction to medication:	Name of Medication allergic to:	Allergic Reaction to medication:

MEDICATION LIST:

DATE	MEDICATIONS	DOSAGE	DATE	MEDICATIONS	DOSAGE

Metal Allergy: ☐ Yes ☐ No Reaction: _____

SURGICAL HISTORY

Previous Surgeries: ☐ None

PREVIOUS SURGERY?	DATE/YEAR	PREVIOUS SURGERY?	DATE/YEAR

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.

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: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A notice or demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206 – 38.248, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9 U.S.C. §§ 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of NRS 38.238.

Article 4: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Nevada and federal law.

Article 6: **Condition of Treatment:** I understand that signing this arbitration agreement is not a condition of **my** receiving medical treatment.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ ***INITIAL HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUMENT TITLED "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT."***

By:_____
Physician or Duly Authorized Representative Signature (Date)

By:_____
Patient's Signature (Date)

By:_____
Print or Stamp Name of Physician, Medical Group or Association Name

By:_____
Print Patient's Name

By:_____
Signature of Translator (Date)

By:_____
Patient's Representative's Signature (Date)

Print Name of Translator

Print Name and Relationship to Patient

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

2020 Palomino Lane, Suite 110, Las Vegas, NV 89106
Address

(702 474-7200 (OFFICE) (702) 474-0009 (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.