

ORTHOPEDECS OF N SCOTTSDALE
 10250 N 92ND STREET STE 114
 SCOTTSDALE AZ 85258 480/661-8348

Patient Name:
 Date:

NEW PATIENT MEDICAL INFORMATION FORM

Please answer the following questions as best you can. Estimate dates, ages, or answers for those not recalled accurately.
 What is your reason for seeing the doctor?

Past Medical History (Please circle)

Anxiety Alcoholism Autoimmune Disorder Asthma Cancer
 Cholesterol problems Depression Diabetes High Blood pressure Heart Attack
 Heart troubles Lung Problems Stroke

Other: _____

Past Surgeries:

Medications:

Name of medication	Dose	Frequency taken
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Allergies or Adverse effects to medication: No Yes-please list

Family History: (full blooded relatives)

	YES	NO		YES	NO
Anesthesia problems			Lung disease		
Arthritis			Migraines		
Back/Neck problems			Muscle weakness		
Cancer			Neuro. disorders		
Cardiac			Seizures		
Gastro intestinal			Psych history		
Hepatitis			Thyroid disease		
Kidney/bladder			Transfusion reaction		
Liver disorder			Smoker		

Social History:

What is (or was) your Occupation?

Marital Status: Married Divorced Never married Widowed Significant Other

Do you smoke? No Yes

Did you quit smoking in the past? No Yes

Do you drink alcoholic beverages? NO YES SOMETIMES

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NEW PATIENT INFORMATION RECORD

Date:

PLEASE RECONFIRM ALL COMPUTERIZED INFORMATION

Patient Name : _____
Address : _____
City, State, Zip : _____
Acct Nbr / PType : _____
Social Security # : _____
BirthDate / Sex : _____

Home Phone Number : _____

Work Phone Number : _____

Cell # : _____

Fax # : _____

Patient Email : _____

Number preferred for messages? Home / Cell / Work / E-mail / Other: _____

HOW WERE YOU REFERRED? Physician / Family / Friend / Yellow Pages / Other _____

PRIMARY CARE DOCTOR: _____ PHONE: _____ FAX: _____

Pharmacy: _____ Location: _____ Phone: _____

Emergency Contact : _____

Emergency Phone : _____

EMPLOYER : _____

EMPLOYER ADDRESS : _____

EMPLOYER PHONE : _____ EMAIL: _____

PRIMARY COVERAGE

Name of Primary Insured: _____ **Date Of Birth:** _____ **SS#:** _____

INSURANCE CO NAME : _____

INSURANCE ADDRESS : _____

INSURANCE PHONE : _____

POLICY NUMBER : _____

GROUP NUMBER : _____

SPOUSE INFORMATION

Name: _____ SSN: _____ DOB: _____

Employer: _____ Work Phn: _____

GUARDIAN / PARENT INFORMATION IF PATIENT IS A MINOR
Mother Father

Name : _____

SSN : _____

Address (if Different from Above) _____

Home Ph: _____

Work Ph: _____

CHECK-OUT NOTE

PLEASE PRESENT YOUR INS CARD AND A PICTURE ID AT THE FRONT DESK.

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payment for office services is due on the day of service. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made with our patient relations dept prior to SURGERIES.

RELEASE OF INFORMATION and ASSIGNMENTS OF BENEFITS DECLARATION

I hereby authorize release of any medical information necessary to process my insurance claims. Furthermore, I irrevocably ASSIGN to ORTHOPEDICS OF N SCOTTSDALE and/or its DOCTORS any and all payments from my Insurance(s) for services rendered. I understand and agree to the above conditions. This authorization can only be revoked in writing. A copy of this authorization shall be as valid as the original.

Signature

Relationship to Patient: _____

David A Thull
Board certified AAOS ABOS
Orthopedics of North Scottsdale

OFFICE POLICIES

1. We require all balances from the date of service to be paid in full before any further services are rendered regardless of whether there is insurance coverage. Future visits will also require full payment until the issue with the insurance is resolved. Payment not covered by insurance i.e. coinsurance, co-pays, deductibles, past due balances, and non-insured patient payments are collected at the time of service.
Initials _____
2. Copays are the PATIENT'S RESPONSIBILITY. A \$25.00 late fee is assessed if not paid at time of service [EVEN IF WE DO NOT ASK FOR IT BECAUSE WE DO NOT KNOW YOUR COPAY, YOU, THE PATIENT ARE RESPONSIBLE FOR KNOWING YOUR COPAY], and \$25.00 rebilling fee for each statement that must be billed for the copay. Initials _____
3. A returned check charge of \$50 will be charged for all returned checks and no further checks will be accepted.
Initials _____
4. All office appointments or scheduled surgeries require at least 24-hour prior notification of cancellation. A \$20.00 late fee is assessed if an office visit is not cancelled or rescheduled 24 hours prior to the scheduled visit. The patient may be discharged from the practice after three or more occurrences. Any no shows for a scheduled surgery will be charged \$150 and rescheduling or discharge from the practice will be at the doctor's discretion.
Initials _____
5. Please make sure that your insurance carrier is contracted with Dr. Thull. Claims are billed to the insurance carrier as a courtesy; however you are responsible for payment of all charges incurred that are not covered. All balances not paid by the insurance carrier within 90 days of the date of service will be your responsibility. We will be happy to reimburse you for any payments made by you after your insurance company has paid in full.
Initials _____
6. In the event that the insurance carrier you initially provided to our office was incorrect and another company is to be rebilled for services rendered, a \$75.00 administrative fee will be charged for reworking your account. Until this fee is paid, the account will not be reworked and the balance will be patient responsibility.
7. Balances over 30 days that are patient responsibility will be charged an 18% interest rate and a \$25.00/mth administrative fee.
Initials _____
8. By signing this form, you agree to abide by the policies of Orthopedics of North Scottsdale. The undersigned agrees to pay in full any and all accounts for themselves and their dependents no later than 90 days from the date of service. If the account is not paid in full the account will be referred to collections. We do not have the ability to finance patients' balances. In the rare case of an account being referred to collections, you will be responsible for all attorney's fees and collection expenses.
Initials _____
9. There is a charge to obtain copies of medical records or billing statements. A payment voucher will be issued upon each visit at no charge to the patient. If any additional billing statements are requested, there will be a \$10.00 administrative fee charged per voucher.
Initials _____

Signature of patient or parent/legal guardian
PATIENT name Date

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10250 N 92ND STREET STE 114
SCOTTSDALE, AZ 85258
Phone # 480/661-8348

ORTHOPEDICS OF NORTH SCOTTSDALE

State law ARS 32-1401(24)(ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. We support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that David Thull MD has a direct financial interest in the GATEWAY SURGERY CENTER. Other surgery centers that are available on a competitive basis are PIPER SURGERY CENTER and GREENBAUM SURGERY CENTER.

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file. You may receive a copy upon request.

ACKNOWLEDGEMENT; I have read this notice and I understand the disclosures that it contains.

Signature of patient

1 Dated

Orthopedics of North Scottsdale
10250 N . 92nd St. #114
Scottsdale, AZ 95258
480-661-8348

NOTICE OF PRIVACY PRACTICES

- * This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
- * At , we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- * The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by another physician we may involve in your care.
- * We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- * We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- * We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- * We may use your information to contact you. For example, we may call to confirm your appointments. If you are not at home, we may leave this information on your answering machine or with the person who answers the phone.
- * In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- * We may release some or all of your health information when required by law.
- * If this practice is sold, your information will become the property of the new owner.
- * Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- * You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- * You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- * As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- * You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- * You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- * You have the right to request an amendment to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We will include your statement in your file. If we agree to an amendment, we will not remove nor alter earlier documents, but will add new information.
- * You have the right to receive a copy of this notice.
- * If we change any of the details of this notice, we will notify you of the changes in writing.
- * You may file a complaint regarding your personal health information with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- * However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at the address above.
- * This notice is effective April 14, 2003.

Signed _____
Name of patient: ' _____

Date: _____