

**SPOKANE ORTHOPEDICS**

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name & MI \_\_\_\_\_ Nickname \_\_\_\_\_

Mailing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Contact Phone \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_ How Referred? Dr Friend Family Ads Website Yellow Pages Insurance \_\_\_\_\_

**GUARANTOR INFORMATION (person who carries insurance) Relationship: Self Spouse Parent Other \_\_\_\_\_**

Last Name \_\_\_\_\_ First Name & MI \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Other \_\_\_\_\_

1. Primary Insurance \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ Birthdate \_\_\_\_\_ Subscriber Number \_\_\_\_\_

2. Secondary Insurance \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ Birthdate \_\_\_\_\_ Subscriber Number \_\_\_\_\_

Were you injured at work? \_\_\_\_\_ Auto? \_\_\_\_\_ Home? \_\_\_\_\_ Date of Injury (Required) \_\_\_\_\_

Reason for Visit \_\_\_\_\_

Have you been treated by other Doctors for this Problem? \_\_\_\_\_ Who and When \_\_\_\_\_

Do you have or do you expect to have attorneys involved for this problem? \_\_\_\_\_

I authorize Spokane Orthopedics to bill and collect payment from my insurance carrier and release any information necessary for that purpose. I have given complete and accurate information and accept responsibility for payment if my insurance carrier denies coverage for services or products provided to me.

**SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**MEDICARE SIGNATURE RELEASE**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the provider listed, for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**PATIENTS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**PLEASE TURN TO PAGE TWO AND FILL OUT PATIENT HISTORY INFORMATION.**

320 E. Dwyer, Suite 100, Spokane, WA 99207 Phone: 509.499.3951 Fax: 509.494.0103

|   |            |              |                                       |    |     |
|---|------------|--------------|---------------------------------------|----|-----|
| <b>PATIENT NAME:</b>                                |            | <b>DATE:</b> |                                       |    |     |
| <b>REVIEW OF SYSTEMS</b>                            | <b>YES</b> | <b>NO</b>    | <b>LIST OR EXPLAIN</b>                |    |     |
| Previous Surgeries??                                |            |              |                                       |    |     |
| Pacemaker Implant??                                 |            |              |                                       |    |     |
| Other Metallic Implants??                           |            |              |                                       |    |     |
| Are you Claustrophobic?                             |            |              |                                       |    |     |
| If female, are you post-menopausal?                 |            |              |                                       |    |     |
| Ever been diagnosed with Hepatitis A, B, or C?      |            |              |                                       |    |     |
| Can anyone assist with your care at home?           |            |              |                                       |    |     |
| Do you smoke? If so, how much?                      |            |              |                                       |    |     |
| More than one alcoholic beverage each day?          |            |              |                                       |    |     |
| Have you ever been told you are diabetic?           |            |              |                                       |    |     |
| Any allergies to foods or medications?              |            |              |                                       |    |     |
| Medications you are presently taking:               |            |              |                                       |    |     |
| Have you ever had a Heart Attack?                   |            |              |                                       |    |     |
| Any family members with heart trouble?              |            |              |                                       |    |     |
| Have you ever been told you have cancer?            |            |              |                                       |    |     |
| Any family history of cancer?                       |            |              |                                       |    |     |
| Have you ever had MRSA or other infections?         |            |              |                                       |    |     |
| Have you or your family ever had Blood Clots?       |            |              |                                       |    |     |
| Have you had any problems with anesthesia?          |            |              |                                       |    |     |
| <b>Please indicate any of the following:</b>        |            |              | <b>Treating Physician</b>             |    |     |
| Chest Pain  |            |              |                                       |    |     |
| Trouble Breathing                                   |            |              |                                       |    |     |
| Stomach Problems                                    |            |              |                                       |    |     |
| Urinary Problems                                    |            |              |                                       |    |     |
| Depression  |            |              |                                       |    |     |
| <b>Any recent diagnostic test(s) performed?</b>     |            |              | <b>When and where were they done?</b> |    |     |
| Regular x-rays                                      |            |              |                                       |    |     |
| DEXA (Bone Density)                                 |            |              |                                       |    |     |
| CAT Scan  |            |              |                                       |    |     |
| MRI   |            |              |                                       |    |     |
| Ultrasound  |            |              |                                       |    |     |
| Bone Scan (Nuclear Medicine)                        |            |              |                                       |    |     |
| <b>ASSISTANT ONLY-----DO NOT WRITE IN THIS AREA</b> |            |              |                                       |    |     |
| Date:   | Ht         | Wt           | Temp                                  | BP | BMI |
| Date:   | Ht         | Wt           | Temp                                  | BP | BMI |
| Date:   | Ht         | Wt           | Temp                                  | BP | BMI |
| Date:   | Ht         | Wt           | Temp                                  | BP | BMI |
| Date:   | Ht         | Wt           | Temp                                  | BP | BMI |
| Date:   | Ht         | Wt           | Temp                                  | BP | BMI |

**ALL MEDICATION REQUESTS**  
**REQUIRE 48 HOURS NOTICE**  
**FROM THE TIME WE RECEIVE THE**  
**REQUEST, IN ORDER TO GIVE YOUR**  
**PROVIDER TIME TO REVIEW YOUR CHART.**

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**Patient Name Printed**

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**Patient Signature/Parent/Guardian**

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**Relationship (if not patient)**

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**Date**

# PATIENT RIGHTS, PRIVACY POLICY, & AUTHORIZATION

Private Health Information is required to properly evaluate and treat each patient of Spokane Orthopedics. This information includes, but is not limited to symptoms, past history, test results, treatment plan, records from previous physicians and hospitals, registration information for insurance carriers, and any other information received pertaining to you.

This record is the physical property of the Clinic, but you have rights associated with the information contained in the record or "chart":

- You may request a review of your chart in which you will be provided an appointment time to inspect the original chart with a member of the staff. (You may not alter, remove, or add documents).
- You may request copies of any part or your entire chart by providing written documentation at least 2 weeks in advance (45 CFR 164.524). Cost associated with the duplication is in accordance with Washington State Law and paid prior to record duplication.
- Request an amendment to your records.( 45 CFR 164.528)
- Provide a written request to have your records forwarded to another physician or institution. (One time at no cost).
- Restrict who may or may not receive information from your record. (45 CFR 164.522)

Requests to make copies of your records should be submitted to the Records Clerk. All requests for amendments or restrictions must be submitted in writing to the Privacy Officer of the Clinic. Unless otherwise directed, we may use any and all information necessary to accomplish quality care for our patients and submit requirements for payment. Any restriction of information to insurance carriers may inhibit our ability for reimbursement and such restriction **MUST** be provided **BEFORE** treatment is initiated. Restrictions received after treatment has begun will only be recognized for treatment following the date of the request.

As we have always done, regardless of law, no information will be extended outside this office unnecessarily. Our directive is to provide the highest quality of patient care and make every effort to protect your privacy. If we refer you to another physician, physical therapy, home health care, or other provider, information necessary for them to evaluate and treat you properly will be provided to them. Nursing Home & transportation agents will also be coordinated to accommodate your care. Using our best judgment, we will provide information to concerned family members involved in your care, unless otherwise directed by you.

*Marketing:* We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. No PHI will be out sourced.

*Food and Drug Administration (FDA):* We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

*Workers compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

*Public health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Questions and Complaints concerning this policy should be directed to the Privacy Officer of the Clinic. If, after sufficient time, complaints have not been addressed to your satisfaction, you may file a complaint with the *Office for Civil Rights*, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F, HHH Building, Washington, D.C. 20201. *Complete office policy available for review, by request.*

HIPAA 10-16-02  
Revised 03-20-03  
Revised 12-15-09

I have received a copy of the *Patients Rights, Privacy Policy & Authorization*, and acknowledge my rights until replaced, revoked, or amended.

\_\_\_\_\_  
Patient **Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Relationship**