| Today's Date: | Gender (circle one): Male or Female | |
|---|---|---|
| Patient Name: | DOB: | SSN: |
| Mailing Address: | City, State: Zip: | |
| Out of State Address: | City, State: Zip: | |
| Home Phone Number: | Cell Phone Number: | |
| Marital Status (Circle One): Single Married Divorced Widowed Partner | | |
| Employment (Circle One): Employer_____________________ Unemployed Retired Student Self Employed | | |
| E-mail: | | |
| Pharmacy: Cross Roads or Phone Number: | | |

## Insurance Information (It is our office policy to obtain a current copy of both your insurance card(s) and a valid photo ID)

**Primary Insurance**
Primary Insurance Co:____________________________
Phone #:________________________________________
Claims Address:__________________________________
Policy/ID #:_____________________________________
Group/Claim #:___________________________________

**Policyholder's Name:**____________________________
Relation to Patient (if not self):___________________
DOB:___/___/______ Phone:__________________________
SSN:____________________________________________

**Secondary Insurance**
Secondary Insurance Co:____________________________
Phone #:________________________________________
Claims Address:__________________________________
Policy/ID #:_____________________________________
Group/Claim #:___________________________________

**Policyholder's Name:**____________________________
Relation to Patient (if not self):___________________
DOB:___/___/______ Phone:__________________________
SSN:____________________________________________

****If you have a tertiary insurance, please inform the front desk.****

## Emergency Contact Information

| Emergency Contact Name: | Relation to Patient: |
|---|---|
| Phone Number: | |

How did you hear about us? ____________________________________________________________

I hereby certify that the above information is true and correct to the best of my knowledge.

**Patient/Guardian Signature:**_______________________________________________ **Date:**____________

**The Dungy Orthopedic Center**
**Notice of Privacy Practices**

## Communication Preferences

You can request that our practice communicate with you about your health related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate all reasonable requests.

## Disclosures

You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your information to only certain individuals involved in your care or the payment for your care such as family and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law.

## Obtaining Records

You have the right to obtain and inspect a copy of your health information that may be used to make decisions about you, including medical and billing records, not including psychotherapy notes. You must submit your request in writing to The Dungy Orthopedic Center.

## Amending Records

You may ask to amend your health records if you believe the information may be incorrect or incomplete. To make an amendment, your request must be made in writing to your physician. You must provide us with a reason that supports your request and must be approved by the physician.

## Social Media Practices

Often, social media is utilized to inform patients, promote our practice, and celebrate our achievements. This includes any information published by you, the patient. This may occur across multiple media platforms and requires your authorization. You have the right to decline the use of your feedback and/or images on any of these platforms. Including, but not limited to, email and texting.

## Health Information Rights

You are entitled to a copy of this notice. You may request a copy at any time. To obtain a copy please contact the front office. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our office please contact the office manager at 480-963-2233. In addition, all complaints must be submitted in writing. You will not be penalized for filing a complaint.

Our practice will obtain written authorization for uses and disclosures that are not identified within this notice or permitted by applicable law. This notice describes how health information about you as a patient may be used and disclosed and how you are able to obtain access to this information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Signature_______________________________ Date____________________

Dungy Orthopedic Center
Permission to Release Records

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgement. If we change our notice, you may obtain a revised copy by request.

By signing this form, you acknowledge receipt of our notice regarding use and disclosure of protected health information about your treatment, payment and health care operations.

Please specify which of these phone numbers we may leave a message on:

☐ Mobile ☐ Home ☐ Work ☐ None

**Release of Information**

Please list any individual(s) you want to allow verbal and/or physical access to your health care information. This includes any other healthcare provider or facility. This release will be retained in your medical record unless it is revoked or amended in writing.

| Name: | Relationship: | Phone Number: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Emergency Contact**

Unless otherwise specified, this person has the ability to verbally and/or physically access your health care information.

| Name: | Relationship: | Phone Number: |
|---|---|---|
| | | |

Print Patient Name:______________________________ DOB: ____________

Patient/Representative Signature:______________________________ Date:____________

# Financial Policy

Thank you for choosing the Dungy Orthopedic Center for your orthopedic care. We are committed to providing you with quality care. Your understanding of our financial policy is important to our ongoing professional relationship. Please read this information carefully and sign this form prior to treatment.

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The patient or responsible party is responsible for ensuring the entire bill is paid in full. On your first visit, you must provide us with current, valid, and accurate information regarding your insurance policy. Additionally, you will be required to provide a picture identification card. We will ask you for your insurance information on a regular basis in order to ensure that no changes have occurred to your insurance benefits. You are responsible with immediately informing us of any changes to your insurance benefits. Failure to do so may result in a larger financial burden to you or termination of treatment.

______ (initial)

**Insurance**

Your insurance policy is a contract between you and your insurance provider. Our relationship is with you, not the insurance company. You are responsible for knowing your co-pay, deductibles, co-insurance, and policy restrictions. You are encouraged to educate yourself as to whether you require referrals and which networks you must use under your current policy.

______ (initial)

Your insurance REQUIRES that we collect your assigned co-pay at the time of service. Please be prepared to pay it when you check-in. Your appointment will be re-scheduled if you are not able to pay your co-pay at the time of service.

______ (initial)

Our office will bill your insurance company. You are responsible to pay the patient portion of the bill within 90 days. If you have not paid your balance in full after a 90 day period, you may be sent to a collection agency. If this occurs, an additional processing fee will be added to your balance. Additionally, we reserve the right to discontinue treatment until the balance is paid in full.

______ (initial)

**Self Pay**

If you do not have insurance, we offer a discount for services rendered at the time of service. Please speak with a member of our billing department prior to your appointment to discuss the details.

______ (initial)

# Financial Policy

### Cancellation Policy

We request that you cancel scheduled appointments within 24 hours. With your timely notice, we can offer available appointments to other patients. If you do not cancel within 24 hours, you will be charged $50.00.

_____ (initial)

### Records, Form & Xray Requests

In the future, you may want a copy of your records or may require forms to be completed by a provider. The fees for these services are:

-$35.00 for records _____ (initial)

-$40.00 for forms and FMLA paperwork (7-10 business days) _____ (initial)

-$50.00 for expedited forms and FMLA paperwork (3 business days) _____ (initial)

-$10.00 for a CD copy of x-rays _____ (initial)

### Surgery

If you require or elect to have surgery, please be aware that a surgery deductible deposit will be due one week prior surgery. After consulting with your insurer, a member of our staff will contact you to discuss your surgery deductible benefits and deposit.

_____ (initial)

### Surgical Assistants

Should you require surgery, an assistant is typically required for your benefit. In most cases, the assistant will be a Physician Assistant. In some cases, insurance provider's do not provide benefits for this service. As a result, you will be charged $250.00 for this service prior to your surgery date. Should your insurer cover this experience, we will refund your money.

_____ (initial)

### Durable Medical Equipment (DME)

The doctor may recommend durable medical equipment as part of your treatment plan. In many cases, outside facilities, not associated with the Dungy Orthopedic Center, provide the equipment and you may incur a charge based on your insurance contract. These outside facilities obtain authorization for DMEs and are responsible for billing you and/or your insurance. In some circumstances, Dr. Dungy's office may provide the DME. In these cases, your billing and authorization will be generated from our office.

_____ (initial)

| ______________________ | ______________________ | __________ |
|---|---|---|
| Print Name | Signature | Date |

# Medical History

**Patient Information** **Today's Date:** ___________________

**Name:** _____________________________ **DOB:** __________ **Height:** _________ **Weight:** __________

**Primary Care Provider:** ____________________________________________________________________

**Referred By (Circle One):** Friend Relative Internet Insurance Doctor: ____________________

**Race:** __________________________________ **Ethnicity:** ______________________________________

**Current Condition**

**Reason For Visit Today (Briefly Describe Condition):** ______________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Please specify which side:** Left Right Both

**How would you describe your pain? (Circle all that apply):** Throbbing Dull Shooting Weak Stabbing Achy Sharp Difficult to Describe Numbness Tingling Popping Buckling Swelling Locking Grinding Giving Way Discharge Discoloration Worse at Night

**Severity of symptoms (Circle One):** Mild Moderate Severe

**Pain Scale 0-10:** ______________________

**Timing (Circle One):** Constant Intermittent Varies with Activities

**What is your dominant hand (Circle One):** Right Left

**How long ago did the problem start?** ______________________________________________________

**Were you seen in the ER? (Circle One):** Yes No If yes, which ER? ________________________

**Was there an injury? (Circle One):** Yes No If yes, explain: ____________________________
_____________________________________________________________________________________

## Medical History

Do any of the following improve or worsen your symptoms?
**Please use (✓) to select appropriate box.**

| | Improves | Worsens | Has No Affect | Does Not Apply |
|---|---|---|---|---|
| Stairs | | | | |
| Walking | | | | |
| Kneeling | | | | |
| Running | | | | |
| Standing | | | | |
| Throwing | | | | |
| Lying Down | | | | |
| Squatting | | | | |
| Elevation | | | | |
| Bracing | | | | |
| Ace Wrap | | | | |
| Ice | | | | |
| Heat | | | | |

Previous Treatments
**Please use (✓) to select appropriate box.**

| | Helped | Did Not Help | Made Worse | Have Not Tried |
|---|---|---|---|---|
| Chiropractic | | | | |
| Steroid Injection | | | | |
| Physical Therapy | | | | |
| Gel Injections | | | | |
| Anti-Inflammatories | | | | |
| Over the Counter Meds (Herbal/Homeopathic Remedies) | | | | |

## Medical History

If you have <u>ever</u> been told you have any of the following conditions, please use **(✓)** to select box to the right of the condition.

| | | | | | |
|---|---|---|---|---|---|
| Alcoholism | | Gout | | Mental Illness | |
| Anemia | | Heart Attack | | Neurological Disorder | |
| Anxiety | | Heart Rhythm Problem | | Neuropathy | |
| Asthma | | Heart Valve Problem | | Osteoarthritis | |
| Bleeding Disorder | | Hepatitis | | Polio | |
| Blood Clots | | HIV/AIDS | | Rheumatoid Arthritis | |
| Blood Transfusion | | Hypertension | | Seizures | |
| Bronchitis | | Hypothyroidism | | Stroke | |
| COPD | | Inflammatory Bowel | | Tuberculosis | |
| Currently Pregnant | | Kidney Disease | | Urinary Infections | |
| Depression | | Low Back Pain | | | |
| Diabetes | | Lung Disease | | | |

**Please give details on anything you've checked above:** ______________________________________

______________________________________________________________________________

**Cancer: What type and how long ago?** ______________________________________________

If you have **<u>NO</u>** past medical history, **<u>PLEASE (✓)</u>** here: ☐

**Surgeries** ☐ NONE

| Year | Reason |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Past Hospitalization History:**

☐ Surgery ☐ Severe Illness ☐ Pregnancy ☐ No Significant Hospitalization

**Allergies** ☐ NONE

| Name | Reaction |
|---|---|
| | |
| | |
| | |
| | |

**Medical History**

## Medication

☐ NONE

| Medication Name/ Strength (mg) | Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## Family History

Family History of: ☐ Anesthesia Problems ☐ Abnormal Blood Clots ☐ Abnormal Bleeding

Please List All Major Medical Problems for the Following Family Members:

Father: ______________________________________________________________

Mother: ______________________________________________________________

Sister: ______________________________________________________________

Brother: ______________________________________________________________

Children: ______________________________________________________________

## Social History

Employer: ________________________________ Occupation: ___________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Widowed

Caffeine Use: ☐ Tea Intake ☐ Coffee Intake ☐ Soda Intake ☐ Energy Drinks

Alcohol Use: ☐ Rarely ☐ Daily ☐ Socially ☐ Never ☐ Recovering Alcoholic

How many drinks per day?: ______________________________

Recreational Drugs: ☐ Never ☐ Currently ☐ In the Past ☐ None

If yes, what drug(s)?:___________________________________

Smoking: ☐ Never ☐ Former ☐ Currently: How many per day? _____ Years? ____

**Medical History**

Are you currently experiencing any of the following? **Please use (✓) to select appropriate box(es).**

| | | | | | |
|---|---|---|---|---|---|
| Fevers | | Vision Changes | | Nausea/ Vomiting | |
| Fatigue | | Glasses/Contacts | | Painful/Frequent Urination | |
| Weight Gain | | Dry Eyes | | Cold Intolerance | |
| Weight Loss | | Nose Bleeding | | Hair Loss | |
| Excess Stress | | Cough | | Excess Hair | |
| Blistering | | Shortness of Breath | | Excess Sweating | |
| New/Changing Growths | | Wheezing | | Irregular Periods | |
| Thinning Hair | | Chest Pain | | Joint Pain/Arthritis | |
| Nail Changes | | Congestive Heart Failure | | Muscle Weakness | |
| Keloids | | Leg Swelling | | Anemia | |
| Cold Sores | | Fast/Irregular Heart Beat | | Blood Clots | |
| Dry Skin | | Poor Circulation | | Enlarged Lymph Nodes | |
| Dry Lips | | Abdominal Pain | | Frequent Infections | |
| Sun Sensitivity | | Constipation | | Environmental Allergies | |
| Pigment Change | | Diarrhea | | | |
| Rash | | Change in Appetite | | | |

## Social History

Have you experienced or had any of the following previously? **Circle yes or no:**

Blood Clot in your legs or lungs? Yes No
Problems with excessive bleeding? Yes No
Latex allergy? Yes No
Problems with anesthesia? Yes No
MRSA infection? Yes No
Sleep apnea? Yes No
Adhesive allergies/skin irritation? Yes No
Excessive swelling after surgery? Yes No
Previous wound healing issues? Yes No
C-Spine surgery? Yes No
Metal allergies? Yes No

# Discrimination is Against the Law

The Dungy Orthopedic Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Dungy Orthopedic Center provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters;
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

The Dungy Orthopedic Center provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the practice manager.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- Practice Manager: Adrienne McLendon
- Mailing Address: 2121 W. Chandler Blvd. Ste. 110<br>Chandler, AZ 85224
- Telephone number: (480) 963-2233
- Fax: (480) 963-2277
- Email:

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Signature: ____________________________________________ Date: _______________

| ATTENTION: If you speak English, language assistance services are available to you, free of charge. Call 1-855-803-9035. | ATENCIÓN: Si habla español, los servicios de asistencia lingüística están a su disposición gratuitamente. Llame al 1-855-803-9035. |
|---|---|
| DINE: Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-803-9035. | 注意：如果你說中文，免費提供語言協助服務。 致電 1-855-803-9035。 |
| Chú ý: Nếu bạn nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn, miễn phí. Gọi 1-855-803-9035. | تكلفة اي دون من بلغتك الضرورية.<br>1-855-803- ب اتصل مترجم مع للتحدث<br>9035. |
| PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-803-9035. | 주의 : 한국어를 말할 때 무료로 언어 지원 서비스를 이용할 수 있습니다. 1-855-803-9035로 전화하십시오. |
| ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-803-9035. | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-803-9035. |
| ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-803-9035. | 注意：日本語を話す場合は、無料で言語サポートサービスをご利用いただけます. 1-855-803-9035までお電話ください。 |
| توجه: اگر شما صحبت می کنند ژاپنی، هستند، شما دسترس در زبان کمک خدمات 1-855-803-9035. پاسخ. باشد می رایگان | [illegible] 1-855-803-9035 [illegible] |
| Ukoliko Vi ili neko kome Vi pomažete ima pitanje o, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-855-803-9035. | ความสนใจ: ถ้าคุณพูดภาษาอังกฤษ, ภาษาบริการให้ความช่วยเหลือที่มีให้คุณเสียค่าใช้จ่าย โทร 1-855-803-9035 |