



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)

<p>Primary Insurance Primary Insurance Co: _____ Phone #: _____ Claims Address: _____ Policy/ID #: _____ Group/Claim #: _____</p> <p>Policyholder's Name: _____ Relation to Patient (if not self): _____ DOB: ___ / ___ / ___ Phone: _____ SSN: _____</p>	<p>Secondary Insurance Secondary Insurance Co: _____ Phone #: _____ Claims Address: _____ Policy/ID #: _____ Group/Claim #: _____</p> <p>Policyholder's Name: _____ Relation to Patient (if not self): _____ DOB: ___ / ___ / ___ Phone: _____ SSN: _____</p>
<p>**If you have a tertiary insurance, please inform the front desk.**</p>	

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 regarding treatment and financial information:

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.

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 your insurance card(s) and a picture identification card at the time of each service. 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 to immediately inform us of any changes to your insurance benefits. Failure to do so may result in a larger financial burden to you or even termination of treatment.

Insurance

Your insurance policy is a contract between you and your insurance provider. Our relationship is with you, not your insurance company. Insurance policies and coverage change rapidly. **You are responsible** for knowing your co-pay, deductibles, co-insurance- and all policy restrictions, including but not limited to, required referrals and out-of-network benefits. You are encouraged to educate yourself as to whether your plan requires referrals and which networks you must use under your current policy. It is also your responsibility to confirm if our providers are in network with your plan. If you fail to do so, you may be financially responsible for a larger sum. _____ (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)

I understand that payment of co-payments, deductibles and non-covered services are to be paid at the time of service. The Dungy Orthopedic Center accepts cash, debit cards, MasterCard, Visa, and Care Credit. We accept checks by mail only for payments due after the claim has been processed. _____ (initial)

We will not bill any third party insurances or HealthShare policies. You will be responsible for any charges associated with your visit at the time of service. However, we will provide you with billing statements generated by our practice to assist you with the self-submission of your claim. _____ (initial)

Our office will bill your insurance company. You are responsible to pay the patient portion of the bill at the time of service. 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 and you will be financially responsible for all costs of collections and contingency fees. 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. Even if you are covered under an active insurance plan that we DO accept, this policy must be initialed as acknowledgement of our office policies in the event that you experience a change in coverage. _____ (initial)

Financial Policy

Contact Methods

I understand that I may be contacted by telephone regarding my outstanding balance. We will not sell your information to a third-party. I acknowledge and agree that the Dungy Orthopedic Center, its affiliates, and agents may use an automated telephone dialing system, pre-recorded or artificial voice calls, messages, and/or texting, to contact the wireless number(s) and/or residential lines that have been provided to us for appointment and payment purposes. I further agree to allow the Dungy Orthopedic Center and anyone who collects on its behalf to contact me about my account status, including past due or current charges, by telephone, using artificial or pre-recorded voice call messages, and/or texting to any wireless or residential landline I have provided or that is provided to us on behalf of an authorized representative.

(initial)

Cancellation Policy

We require 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 may be charged \$50.00.

(initial)

Records, Forms & X-ray 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:

(initial)

-\$20.00 for paper records (first 20 pages, \$0.50 for each additional page)

-\$6.50 for electronic copy of records

-\$6.50 for a CD copy of x-rays

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

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

Surgery

I understand that the Dungy Orthopedic Center will collect, prior to any surgery or procedure, deductibles and coinsurance up to an amount equal to payment in full for the planned surgical procedure. This amount will be collected as early as two weeks prior to the surgical date. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and the agreement between your insurance company and the Dungy Orthopedic Center. If the full deductible is not applied to your claim by your insurance company, we will apply any overpayment to other outstanding dates of service with a patient financial responsibility before a refund is issued. Refunds will be issued on a monthly basis after claims have been completely processed.

(initial)

Surgical Assistants

Should you require surgery, an assistant is typically required. This is a separate fee charged by the medical professional who assists Dr. Dungy with surgery. Dr. Dungy will not perform your surgery without a surgical assistant in most cases. Some insurers do not cover this cost. As a result, you may be responsible for a discounted fee of \$250.00.

(initial)

Financial Policy

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)

Worker's Compensation

Dr. Dungy sees worker's compensation cases on a case-by-case basis and only upon approval. Approval must be obtained prior to the scheduling of an appointment. If you have initiated a worker's compensation case after we have established treatment with you, it is your responsibility to inform us. If you fail to do so, you will be held responsible for any balances accrued during the course of treatment. Additionally, if you have already established care with us, Dr. Dungy must still give approval prior to scheduling an appointment.

(initial)

By signing my name below, I certify that I have read the above information. My signature also certifies my understanding of and agreement with the above policies.

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 ever 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 **NO** past medical history, **PLEASE** (✓) 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
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: _____

