

I. Consent and Authorization for Release of Information

1. Release of Information. I consent to the release and use by Desert Orthopedics (referred to as "DO") of medical and other information about me to the extent permitted by law to the following:

- To a health care provider being advised or consulted in connection with my treatment or care;
- To a health plan, insurer, third party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews; and
- To a person or organization in connection with DO's health care operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.

2. Revocation. I understand that this consent shall continue until I revoke it, which I may do at anytime by giving written notice to DO.

II. Payment Authorization

1. Payment Responsibility. I agree to pay for all services furnished to me by DO, including, but not limited to, charges that are not paid in full by my insurance, government program benefits or other third-party payors, upon receipt of a statement, except as prohibited by DO's contract with my health plan or applicable law. I also agree to pay or reimburse DO for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees.

2. Payment Authorization. I authorize DO to directly bill my health plan or third-party payor for services rendered to me by or on behalf of DO, but acknowledge that DO is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a particular third-party payor. I also authorize any third-party payor through which I may have benefits to make payment directly to DO for such services. If I have a Medigap policy, I request that payment of authorized Medigap benefits be made to DO directly on my behalf by my Medigap insurer. I understand and agree that DO is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.

3. Statement to permit payment for Medicare Benefits to DO. If I am entitled to Medicare Benefits, I request payment of authorized Medicare benefits to me, or on my behalf to DO, for any services furnished to me by or in DO, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

III. Notice of Privacy Practices

1. Confidentiality. It is the policy of DO to protect the privacy and confidentiality of patients' medical information.

2. Notice of Privacy Practice. DO's Notice of Privacy Practices explains how DO may use and disclose my medical information. It also explains my rights regarding this kind of information. DO may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices at my request. DO's Notice of Privacy Practices is available at the Reception Desk.

3. Acknowledgment of Receipt. I acknowledge that I have received DO's Notice of Privacy Practices.

Signature of Patient (if applicable): _____ Date: _____

Signature of Legal Guardian (if applicable): _____ Date: _____



Name _____ Age _____ Height _____ Weight _____

Who is your primary care physician? _____ Who referred you? _____

Reason for visit? / Body part? Side: Right / Left _____

How long has this bothered you? _____

If your injury is the result of an accident, how did it happen? _____
Date of injury ____/____/____

Where did the accident happen? _____

Other details _____ Is this a worker's compensation claim? Yes / No

Have you taken ANY medications for this problem?(prescribed or OTC) _____

Have you had any other treatment for this problem?(doctor, physical therapist, etc.) _____

Have you had x-rays or testing done related to this problem? Yes / No Where/Doctor? _____

Please rate your discomfort by circling: None = 0 1 2 3 4 5 6 7 8 9 10 = Severe

Quality of the pain?(please circle) : sharp dull throbbing burning other _____

What makes your problem better? _____

What makes your problem worse? _____

MEDICATIONS

List all current medications. Include dosages & reason:

ALLERGIES to medication? _____ None

MEDICAL HISTORY

Have you ever had: (circle)

- | | | | | |
|----------------------|------------------------|-----------------|----------------------|------------------------|
| Excessive bleeding | Blood clot /DVT | Hepatitis | Rheumatoid arthritis | Alcohol addiction |
| Heart stent | Stroke | Ulcer | Osteoarthritis | Drug addiction |
| Heart attack | Fibromyalgia | Diabetes | Gout | Reaction to anesthesia |
| Irregular heart beat | Edema/Leg swelling | Kidney disease | Sleep apnea | Blood thinners/Aspirin |
| High blood pressure | Claudication/Calf pain | Thyroid problem | Muscle disease | |

Cancer: (Type) _____

None

Please list other medical problems, past and present:

SURGICAL HISTORY

Please list surgeries you have had:

_____	Date _____	Surgeon _____
_____	Date _____	Surgeon _____
_____	Date _____	Surgeon _____

No previous surgeries

REVIEW OF SYSTEMS

Do you experience: (circle)

Weight loss	Shortness of breath	Heartburn	Anxiety
Fever	Chest pain	Abdominal pain	Depression
Rash	Ankle swelling	Blood in stool	Sleep problems
Easy bruising/bleeding	Seizures	Blood in urine	<input type="checkbox"/> None
	Numbsness	Urinary incontinence	

FAMILY HISTORY

Indicate all medical conditions experienced by any parent, sibling, or child: (circle and note family member)

Heart Disease _____	Lupus _____	Rheumatoid Arthritis _____
Stroke _____	Fibromyalgia _____	Scoliosis _____
Diabetes _____	Alcoholism _____	Other _____
Cancer (type) _____		<input type="checkbox"/> None

SOCIAL HISTORY

Present grade in school _____

Patient lives with: Mother Father Both parents Foster parents Other _____

Legal guardian: Mother Father Both parents Foster parents The state

Other children living in the home: Brothers Sisters Their ages: _____

Fitness/Sports/Athletic activities: _____

BIRTH HISTORY: Full term If not, # of weeks at delivery _____ C-Section Vaginal Breech

Complications, if applicable: _____

Authorization and Consent to Medical Services and/or Treatment:

I hereby authorize the Doctor / Physician Assistant / Nurse Practitioner to provide medically necessary services, including: x-rays, fracture treatment, casting, or procedures done in the office, which are determined to be in the best interest of the patient.

SIGNATURE _____ **DATE** _____

Signature of parent or person authorized by law

relationship to patient