Desert Orthopedics
1303 NE Cushing Dr, Ste 100, Bend, OR 97701 (541) 388-2333

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

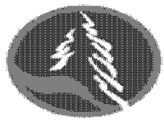
1. Confidentiality. It is the policy of DO to protect the privacy and confidentiality of patients' medical information.

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: ____________



Pediatric Spine Form

Name ______________________________ Age ________ Height ________ Weight__________

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

Please describe the problem that brings you here today: ______________________________

When and how did the problem begin? ______________________________

Did you have a specific injury? ❒ Yes ❒ No If yes, what occurred? ______________________________

Is there any litigation or a disability suit involved in your case?______________________________

Do you have a lawyer involved with this problem? ❒Yes ❒No If yes, lawyer's name: ____________________

What symptom(s) best describes your problem: ❒Pain ❒Weakness ❒Numbness ❒Swelling ❒Other__________

Do you now have any associated problems?❒Numbness ❒Tingling ❒Weakness ❒Increased pain with coughing, sneezing or straining

If you have pain, please describe the pain:
❒Sharp ❒Dull ❒Throbbing

❒Aching ❒Burning ❒Stabbing

❒Heavy ❒Electric shock

❒Other______________________________

What is the duration of the pain?
❒Constant ❒Intermittent (on and off)

❒Other______________________________

What makes your symptoms better?

____

What makes your symptoms worse?

____

TREATMENT HISTORY
Have you seen or are you being seen by a physician for this problem? ❒Y ❒ N
If yes, who?______________________________

Have you tried any of the following to help your symptoms?

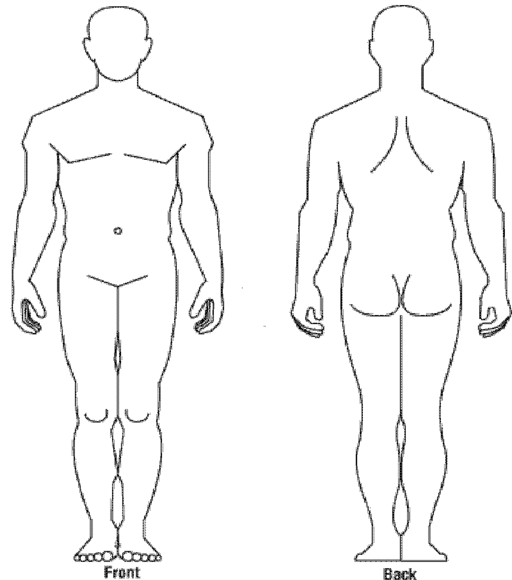
TYPE OF TREATMENT (check all that apply)		DID IT HELP?	
		YES	NO
Medications	❒		
Injections	❒		
Physical/Occupational Therapy	❒		
Acupuncture	❒		
Chiropractic Treatment/ Massage	❒		
Surgery	❒		
Implanted Neurostimulator or Pump	❒		

Circle the number corresponding to the intensity of your pain:

Back/Neck: No Pain = 0 1 2 3 4 5 6 7 8 9 10 =Worst pain

Leg/Arm: No Pain = 0 1 2 3 4 5 6 7 8 9 10 =Worst pain

Mark the areas of your body where you feel pain on the diagram:



What studies have you had for this problem?

TYPE OF STUDY (check all that apply)	
X-rays/ CT Scan	❒
MRI	❒
Bone Scan	❒
Nerve Study (EMG)	❒

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	Osteoarthritis	Alcohol addiction
Heart stent	Stroke	Ulcer	Rheumatoid arthritis	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	❒ **None**
	Numbness	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)_______________________________ ❒ **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 hearby 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**