

PUEBLO BONE & JOINT CLINIC
MATTHEW SIMONICH, M.D. DREW RITTER, M.D. LANCE FARNWORTH, M.D
MARK RICE, PA-C CRAIG DREW, NP-C

IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Effective April 14, 2003, revised federal regulations restrict the use and disclosure of your private health information (PHI) by our practice and other organizations. It has been, and continues to be, the policy of our practice to protect the privacy of our patient's health information and to comply with any regulations regarding the use and disclosure of patient health information. The following summarizes the new law and under what circumstances it may be disclosed.

Permitted Disclosures

Our practice is permitted to use and disclose your PHI for treatment, payment and health care operation purposes. These uses include sharing your PMI with other health care providers for confirmation of a diagnosis, using your PHI to accurately bill services we provide to you, providing your PHI to your insurance company for reimbursement, to remind you of appointments and as part of our quality improvement program.

We are also permitted to disclose your PHI in compliance with guidelines outlined by law and when required to do so by various government agencies. We may also disclose your PHI to family members, relatives or close personal friend when the information we disclose is relevant to the individual's involvement with your care or is required to assist in your health care (e.g., pick-up prescriptions or other documents, note follow-up care instructions, etc.). We will disclose your PHI when we refer you to other physicians or providers of health care. Finally, we reserve the right to change a privacy practice described in this notice as may be permitted or required by law and to make such change effective for all protected health information.

Restricted Disclosures

You have the right to request restrictions on certain uses and disclosures of your PMI and to request portions of your PHI be amended. However, our practice is not obligated to agree to requested restrictions or to amend your PHI in the manner you request. You also have the right to inspect and receive a copy of your PHI, but must pay a reasonable charge for the labor and costs associated with copying your PH. Finally, you have a right to receive an accounting of disclosures of your health information.

Authorization for Other Uses

Our practice will make other uses and disclosure of your protected health information **only** after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke authorization at any time by notifying us in writing that you wish to revoke your authorization.

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacting the Director of Business Operations, of Pueblo Bone and Joint Clinic, LLC, 3676 Parker Blvd., Suite 110, Pueblo, Co 81008, (719) 253-7102, or the Secretary of Health and Human Services. No individual will be retaliated against for filing a complaint.

Acknowledgement

I acknowledge that I have received this summary and a copy of the Notice of Privacy Practices regarding the use and disclosure of my private health information.

Patient Signature (or Legal Guardian)

Date

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Welcome to our practice

Patient Bill of Rights

As a patient you have the right to be treated fairly and honestly.
You have the right to be treated on an emergent basis when warranted.
You have the right to quality and timely treatment regardless of age, sex, religion, national origin.

As A Provider We Reserve The Right To:

Discharge you:
-For not adhering to practice policies after 30 day written notice.
-For abusive treatment of our staff.
-For routinely missing appointments and not calling to cancel.
-For activities that can be considered potentially fraudulent or abusive by your carrier or the government.

As A Patient You Are Required To:

Present for all appointments 15 minutes prior to the scheduled time for paper work and financial arrangements.
Present your insurance information/changes to policies at each visit.
Pay Co-Payment and/or deductible
Clear all prior balances before receiving additional treatment.

Your Insurance Carrier Requires You To:

Pay Co-payments
Pay deductibles/coinsurance amounts
Sign ABN

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FINANCIAL POLICY

Thank you for choosing The Pueblo Bone and Joint Clinic as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- We accept cash, check, debit or credit cards, Mastercard, Visa, and Discover.

Regarding Insurance

We participate in multiple insurance plans. For some other insurances we accept assignment benefits but in all cases we require that the guarantor, the person who is financially responsible, is *personally* liable for all balances not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies.

Past Due Accounts

Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

Co-Pays

Payment for co-pays are expected at time of service.

Returned Checks

For checks returned to us as unpaid by your bank, we will charge a \$25.00 fee.

Please contact our Billing Office if you have any questions or concerns at (719) 544-4265 or (719) 543-4664

I have read the Financial Policy. I understand and agree to the Financial Policy.

Print Name

Signature

Date

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CRAIG DREW, NP

REFERRING PHYSICIAN _____ TODAYS DATE _____

Name & Phone of Family Doctor: _____

NEW PATIENT CONFIDENTIAL INFORMATION

Name of Patient: _____

Date of Birth: _____ Age: _____

Marital Status: Married___ Single___ Widowed___ Divorced___ Sex: ___

Address: _____ City: _____ State: ___ Zip: _____

Social Security No.: _____ Phone No. _____

Specific Occupation of Patient or Parent _____

Employer _____ Phone: _____

Name & Phone of Nearest Relative/Friend to Contact in Case of Emergency:

Spouse/Guardian: _____ Birthday: _____ Age: _____

Social Security Number: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Occupation: _____ Employer: _____

Work Phone: _____ Employer's Address: _____

Did You Bring X-Rays? _____ Obtained From: _____

**Is This Injury Under Litigation? ___ Attorney Name/Phone _____

INSURANCE INFORMATION

Medicare? Yes___ No___ Number _____

Medicaid? Yes___ No___ Number _____

Primary Insurance Company Name: _____

Policy/Subscriber Number _____ Name of Policy Holder _____

Group Number: _____

Secondary Insurance Company Name: _____

Policy/Subscriber Number _____ Name of Policy Holder _____

A: Is this a Workman Compensation Claim? _____ if yes, please answer the following:

Insurance Name _____ Comp Number _____

Date of Accident? _____ How did it Happen? _____

B: Is Injury the Result of an Auto Accident? _____ Date of Accident _____

Name of Insurance Company _____ Claim # _____

INSURANCE INFORMATION

I hereby Authorize Pueblo Bone & Joint Clinic to furnish information to my insurance carrier(s) concerning my examination, findings, and treatments. I understand that I am responsible for any amount not covered by Insurance. If you have HMO Insurance, a Referral is required for each problem. If you do not have a referral, Your HMO will NOT pay for your services and you are responsible for the bill.

Patient's Signature (or Parent if Patient is a Minor)

MEDICAL HISTORY
PLEASE FILL OUT COMPLETELY!

Name: _____ Date of Birth: _____ Today's Date: _____

HISTORY & PRESENT ILLNESS:

What are you seeing the Doctor for? (Please be Specific):

Date of Injury? _____

How long have you had these symptoms?

PAST MEDICAL HISTORY:

All Previous Medical Problems and Hospitalizations:

Yes___ No___ Rheumatic Fever **When** _____

Yes___ No___ Childhood Diseases **Circle** (measles, mumps, pox, ext.) **When** _____

Yes___ No___ Allergies, hives or drug reactions **When** _____

Yes___ No___ Asthma **When** _____

Yes___ No___ Diabetes **When** _____

Yes___ No___ Thyroid Problems **When** _____

Yes___ No___ Bronchitis, Emphysema **When** _____

Yes___ No___ Stroke **When** _____

Yes___ No___ Heart Attack **When** _____

Yes___ No___ High Blood Pressure **When** _____

Yes___ No___ Murmurs **When** _____

Yes___ No___ Ulcers **When** _____

Yes___ No___ Migraines **When** _____

Yes___ No___ Sexually transmitted diseases **When** _____

Yes___ No___ Cancer **When** _____

Other Problems not listed above:

PAST SURGICAL HISTORY:

Have you had any previous surgeries?

Procedures: _____ **Date:** _____ **Name of Physician:** _____

Have you had any Previous Fractures?

When _____ Type of Fracture _____

Do you use a Walker, Cane, or Brace, if so which one? _____

Read and Reviewed: _____ Date: _____

(Physician Signature)

Name: _____ Date of Birth: _____ Today's Date: _____

MEDICATION:

What Medications are you **Currently** taking?

Name:	Doses:	Times/Day:	Reason:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are You Allergic to **ANY** Medications? If so What?

SOCIAL HISTORY:

Have you ever Smoked? _____ How many Packs a day? _____ How many years? _____

Do You Drink Alcoholic Beverages? _____ How Often? _____

Have You Lost Weight Recently? _____

Have You Had Faintness, Numbness, and Convulsions? _____

Do You Use Drugs? (Marijuana, LSD, Heroin, Cocaine) _____

Do You Live Alone or with Family? _____

Do You Drive? _____

Occupational Duties: _____

FAMILY HISTORY:

(PLEASE CHECK)

- ___ Frequently Broken Bones Family Member _____
- ___ Diabetes Family Member _____
- ___ Heart Disease Family Member _____
- ___ Heart Attack Family Member _____
- ___ Asthma Family Member _____
- ___ Cancer Family Member _____
- ___ Ulcer Family Member _____
- ___ High Blood Pres Family Member _____
- ___ AIDS/HIV Family Member _____
- ___ Hepatitis Family Member _____
- ___ Kidney/Bladder Family Member _____
- ___ Kidney Stones Family Member _____
- ___ Blood Urine Family Member _____

Read and Reviewed: _____ Date: _____

(Physician Signature)

Name: _____ Date of Birth: _____ Today's Date: _____

REVIEW OF SYSTEMS:

Have you ever, or still have problems with any of the following?

HEAD/NECK **EXPLAIN**

- Yes No Headaches, dizziness _____
- Yes No Eye (glaucoma, vision changes) _____
- Yes No Ear (hearing, earaches, discharge) _____
- Yes No Nose (sinus, bleeding, obstruction) _____
- Yes No Mouth (pain, bleeding, sores) _____
- Yes No Throat (tonsillitis, hoarseness) _____

ENDOCRINE

- Yes No Heat or cold intolerance _____
- Yes No Nervousness, sluggishness _____
- Yes No Hair changes, breast nodules _____

RESPIRATORY

- Yes No Chest Pain, shortness of breathe _____
- Yes No Cough, sputum, night sweats _____

CARDIAC

- Yes No Edema, chest pain or pressure _____
- Yes No Difficulty Breathing (day or night) _____
- Yes No Blue fingers or toes _____

HEMATOLOGIC

- Yes No Tendency to bruise or bleed _____
- Yes No Anemia, lumps or bumps _____

GASTROINTESTINAL

- Yes No Heartburn, lots of gas or belching _____
- Yes No Nausea and vomiting, diarrhea _____
- Yes No Hernias, dark urine, yellow skin _____
- Yes No Hemorrhoids, stool changes _____
- Yes No Bladder or bowel changes _____

NEUROMUSCULAR

- Yes No Seizures, dizziness room spinning _____
- Yes No Tremors, nerve pain _____
- Yes No Paralysis, numbness or tingling _____
- Yes No Fatigue or insomnia _____
- Yes No Stiffness, deformity, cramps _____

GENERAL

- Yes No Skin rashes, itching, color changes _____
- Yes No Alteration in hair or nails _____
- Yes No Any other symptoms or problems _____

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Patient/Responsible Party **Date**

Read and Reviewed: _____ Date: _____
(Physician Signature)

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **DOB** _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" (PHI) under a federal health privacy law, as indicated or described below:

- All health information relating to me.
- NO information, other than that required or allowed by law.
- ONLY the following specified information. (Describe specific information including dates of service).

Please List the Individual(s) or Organization(s) to whom the Disclosure May be Made:

<u>Name</u>	<u>Relationship</u>	<u>Phone Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand in making this request that:

- If the individual(s) or organization(s) that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I may revoke this authorization at any time by notifying you in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by you before receiving my revocation.

This authorization expires one year from the date signed, as indicated below, or until revoked by me in writing.

Patient Signature: _____ Date: _____
(or Legal Guardian)

If signed by the patient's personal representative the personal representative hereby states and represents they have been appointed, or have received authorization, to act as the patient's personal representative.

Witnessed by: _____ Date: _____