PROLIANCE ORTHOPAEDICS & SPORTS MEDICINE

BELLEVUE • ISSAQUAH • REDMOND

A Service of PROLIANCE SURGEONS®

PATIENT INFORMATION

Name _____ Social Security # _____
Last First Middle

Ethnicity: ❑ Declined ❑ Hispanic ❑ Non-Hispanic ❑ Unknown

Race: ❑ African American ❑ American Indian, Alaska Native ❑ Asian ❑ Caucasian ❑ Declined ❑ Native Hawaiian, Pacific Islander ❑ Other

Preferred Language: ❑ English ❑ Spanish ❑ Other:_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner ❑ Widowed

Birthdate_____ Age _____ ❑ Male ❑ Female

Home Address _____ _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email address _____ Employer _____ Occupation_____

Employer Address _____ Work Phone _____

Spouse/Parent Name _____ Work Phone _____

Spouse/Parent Employer _____

PRIMARY CARE PHYSICIAN: _____ **REFERRED BY:** _____

Reason for this visit: Illness ❑ Injury ❑ Job related injury ❑ Auto accident ❑ Other _____

Date of injury or onset of problem_____ Part of body injured _____ ❑ Right ❑ Left

How did this happen? _____

If you were hospitalized for this: Where _____ When_____

Worker's Comp / Auto Insurance Carrier _____ Claim #_____

Address_____Claim Mgr Name & Number_____Date of Injury/Accident_____

Primary Insurance _____ ID# _____ Group # _____

Subscribers Name _____ Subscriber's Date of Birth _____ Relationship to subscriber ❑ self ❑ spouse ❑ child

Claims Billing Address _____ Phone _____

Secondary Insurance _____ ID#_____ Group #_____

Subscribers Name _____ Subscriber's Date of Birth _____ Relationship to subscriber ❑ self ❑ spouse ❑ child

Claims Billing Address _____ Phone _____

In case of EMERGENCY: Relative to contact (not living with patient) _____

Relationship _____ Phone _____

If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party _____ Address _____

Relationship to patient _____ Social Security # _____ Birthdate _____

I acknowledge that I am financially responsible for all charges. I hereby authorize my insurance benefits to be paid directly to my physician. I also authorize the doctor and/or insurance company to release any information required for this claim.

Note: If the patient is under 18 years of age, the accompanying parent is responsible for all bills.

Signature _____ Date _____

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Health History

This history form provides us with information to help us meet your healthcare needs. Please complete this form answering each question. ***This is a confidential part of your medical record and will be kept in this office.***

Patient Name: _____ **Birthdate**_____ **Date** _____

What condition/body part(s) are you being seen for today? _____

_____

Onset date: _____ Previous treatment for this condition? ☐ Yes ☐ No

Treatment given: _____ Date treated: _____

_____

Where treated: _____

Check all treatment(s) received for this condition:

- ☐ Anti-inflammatories
- ☐ Pain medication
- ☐ Muscle relaxant
- ☐ Injection
- ☐ Surgery & Date
- ☐ X-rays
- ☐ MRI
- ☐ CT scan
- ☐ Bone scan
- ☐ EMG
- ☐ Hospitalization
- ☐ Casting/splint
- ☐ Physical therapy
- ☐ Fracture to put back in place

Allergies

☐ None Height _____ Weight _____

List all known allergies:

_____

_____

_____

Current Medications

☐ None ☐ See attached list

List all known medications and dosage:

_____

_____

_____

_____

_____

_____

Past Medical History

Have you ever had:	No	Yes	Year
Anemia			
Angina			
Arthritis			
Asthma			
Bad teeth			
Bladder infection			
Bladder problems			
Blood clots			
Cancer			
Depression			
Diabetes			
Emphysema			
Epilepsy			

Have you ever had:	No	Yes	Year
Glaucoma			
Gout			
Heart attack			
Heart arrhythmia			
Hepatitis			
High blood pressure			
Kidney disease			
Liver disease			
Psychiatric treatment			
Stomach ulcers			
Stroke			
Thyroid disorders			
Tuberculosis			

Continued on Reverse

Social History

Please answer each of the following:

Occupation: _____ How many years? _____

	No	Yes	How Much
Caffeine:			
Drugs:			

	No	Yes	How Much
Tobacco:			
Alcohol:			

Family History

Is there a family history of arthritis, heart disease, stroke or cancer or any other systemic condition?

☐No ☐Unknown ☐Yes (explain below)

Condition and relative: _____

Previous Surgeries

☐None List procedure and date performed:

_____

_____

_____

_____

_____

_____

Review of Systems

Check all conditions and symptoms that you currently have:

1	*General*	___ Fever	___ Chills	___ Weight loss	____ Weight gain
2	*Eyes*	___ Blurred vision	___ Double vision	___ Poor vision	___ Glasses
3	*Ears/nose/throat*	___ Ringing in ears	___ Sinus congestion	___ Hearing loss	____ Sore throat
4	*Heart*	___ Chest Pain	___ Irregular heart beat	___ Palpitations	___ Other
5	*Lungs*	___ Cough	___ Shortness of breath	___ Difficulty breathing	___ Other
6	*Intestinal*	___ Upset Stomach	___ Bloody stools	___ Constipation	___ Diarrhea
7	*Urinary*	___ Burning	___ Frequent urination	___ Incontinence	___ Other
8	*Musculoskeletal*	___ Joint pain	___ Muscle weakness	___ Joint stiffness	___ Other
9	*Skin*	___ Rashes	___ Sores	___ Masses	___ Scars
10	*Neurological*	___ Tremors	___ Numbness	___ Poor balance	___ Dizziness
11	*Psychiatric*	___ Depression	___ Mood swings	___ Anxiety	___ Other
12	*Endocrine*	___ Hair loss	___ Excessive thirst	___ Fatigue	____ Other
13	*Blood/Lymphatic*	___ Leg swelling	___ Bleeding tendency	___ Bruise easily	___ Other
14	*OB/GYN*	___ Pregnant	___ Birth control pills	___ Hormone therapy	___ Menopausal

Provider Comments _____

_____

_____ ❒ All other systems negative

Patient Signature: PLEASE SIGN HERE Provider Signature: _____

Date: _____ Date: _____

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Authorization to Leave Personal Health Information By Alternate Means

Patient Name: _____ **Date of Birth:** _____

Patient Mailing Address: _____

(Please check all that apply)

☐ May leave detailed message on voicemail at home # : _____

☐ May leave detailed message on voicemail at work # : _____

☐ May leave information with spouse (name) : _____

☐ May leave information with other family member: _____

☐ May leave detailed message on cellular phone # : _____

☐ May leave detailed message at a different location # : _____

☐ May send detailed message by email to: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

_____ _____

Patient or legally authorized individual signature Date

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NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, personal representative)

This area for staff notes (if any):

This form will be retained in your medical record.

Last updated: August 17, 2006

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Proliance Orthopaedics and Sports Medicine Financial Policy

Proliance Orthopaedics and Sports Medicine, a division of Proliance Surgeons is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing Proliance Orthopaedics and Sports Medicine.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
- Knowing your insurance benefits and limitations
- Paying your co-payment at the time of service
- Paying any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with Proliance Surgeons at all times
- Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our business office @ 425-507-0733 and make payment arrangements.

Co-Pays/Deductibles/Co-Insurance – Please be prepared to pay for your portion of the charges on the date of service.

Surgery – If surgery is indicated, a pre-payment of both physician and facility fees is required for all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.

Non-Participating Insurance – If we do not participate in the insurance you have you will be required to pay a deposit of $250.00, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

Uninsured Patients

Office Visits – A $250.00 for new patient visits and $150.00 for follow up visits, deposit is required prior to the appointment. If visits and services are paid in full at the time of service, we offer a 20% discount (see exclusions below). Office visits may include x-rays, casting and materials at an additional charge. Charges are not finalized until chart notes are complete.

Surgery – For uninsured patients having surgery, we offer a 20% discount when charges are paid before or on the day of service (see exclusions below).

Exclusions – The discounts referenced above do not apply in cases of motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

Motor Vehicle Accidents (MVA) Insured and Third Party Patients

A deposit as outlined above will be required. We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill your MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

Workers' Compensation

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a $250.00 deposit that will be refunded after the claim has been opened.

Other Charges

No Show – Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments.

Please provide us with at least 48 hours advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged for the interpreter.

Forms – There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

Payment

Payment Options – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third party checks). We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts – We charge a $10.25 monthly account management fee on balances over 45 days old. We may assign an account to collections if balances are unpaid after 60 days. Patients assigned to collections may be denied additional service.

Alternative Payment Arrangements – If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Bankruptcy/Prior Bad Debt – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Proliance Orthopaedic and Sports Medicine or other Proliance Surgeons care centers may be required to pay for their portion of new charges *and/or deposit* at the time of service.

These policies are subject to change without notice. Please check our website at www.pro-osm.com for any changes.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Co-Responsible Party Date

_____ _____

Patient Name (Please Print) Date