Patient Information

PATIENT INFORMATION

PATIENT NAME Last First M.I.	SOCIAL SECURITY NUMBER	
ADDRESS Street	DATE OF BIRTH	SEX ☐ Female ☐ Male
City State Zip / HOME PHONE NO.	CELL PHONE NO.	WORK PHONE NO.
E-MAIL	MARITAL STATUS ☐ Single ☐ Divorced ☐ Married ☐ Widowed	
RACE ☐African American ☐Asian ☐Caucasian ☐Filipino ☐Hispanic ☐Native American ☐Native Hawaiian ☐ Pacific Islander ☐Other	ETHNICITY ☐Hispanic ☐ Non-Hispanic	
2ND/SEASONAL ADDRESS Street City State Zip		
EMPLOYER	PATIENTS OCCUPATION	
EMPLOYER ADDRESS Street City State Zip		
PHARMACY NAME	PHARMACY PHONE NO.	

PERSON RESPONSIBLE FOR CHARGES

If person responsible for payment is different from patient, then complete below.

If patient is child please indicate if parents are : ☐ Married ☐ Separated ☐ Divorced

NAME	SOCIAL SECURITY NUMBER
ADDRESS Street	DATE OF BIRTH
City State Zip	HOME PHONE NO.
EMPLOYER	EMPLOYER PHONE NO.
EMPLOYER ADDRESS: Street City State Zip	

If this is a job related injury, is this the employer you were working for at the time of injury? ☐ Yes ☐ No

If due to an injury, date of loss:_____/_____/_____First symptoms: ____________

Will an attorney or Liability Carrier be involved in payment of charges? ☐ Yes ☐ No If yes, please explain: ____________

Is injury related to: ☐ Accident ☐ Auto Accident ☐ Job Related ☐ Other: ____________

If job related: Claim #____________Case Manager: ____________Phone No.: ____________

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN	NAME OF REFERRING PHYSICIAN

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY NAME	RELATIONSHIP	PHONE
ADDRESS Street	City State Zip	

INSURANCE INFORMATION

Primary Insurance		**Secondary Insurance**	
Insurance Name:	____________	Insurance Name:	____________
Policy/ID #:	____________	Policy/ID #:	____________
Group/Account #:	____________	Group/Account #:	____________
Cardholders Name:	____________	Cardholders Name:	____________
DOB:	____________	DOB:	____________
Social Security #:	____________	Social Security #:	____________
Relation to Patient:	____________	Relation to Patient:	

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while Sierra Orthopedics, PC contracts with many insurance companies, it is my responsibility to verify with my plan that Sierra Orthopedics, PC is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that Sierra Orthopedics, PC will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If however, authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize Sierra Orthopedics, PC to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines.

Patient Signature: ____________ Date: ____________

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice, which explains our legal duties and privacy practices with respect to your protected health information. We must abide by the terms set forth in this notice. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. We will post any revised notice in a prominent location in our office and, upon request, will provide to you a copy of the revised notice.

Uses and Disclosures of Your Protected Health Information:

Treatment. We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We may also disclose your protected health information to other health care providers who may be treating you or involved in your health care. For example – we may disclose your protected health information to a specialist involved in your treatment.

Payment. We may use and disclose your protected health information to obtain payment for the health care services we provide you or to determine whether we may obtain payment for services we recommend for you. We may also disclose your protected health information to another health care provider, health care clearinghouse or health plan for their payment activities. For example – we may include with a bill to a third-party payer information that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We may use and disclose your protected health information to support our business activities. For example – we may use your protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. We may disclose your protected health information for certain health care operations of another health care provider, health care clearinghouse, health plan for certain health care operations, and to an "organized health care arrangement" we participate in for its health care operations. We may also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing and transcription services). Finally, we may disclose to certain third parties a limited data set containing your protected health information for certain business activities.

Persons Involved in Your Care. We may use and disclose to a family member, a relative, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgment.

Notification. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care, of your location, general condition or death.

As Required by Law. We may use and disclose your protected health information to the extent the use or disclosure is required by law. If required by law, you will be notified of any such uses or disclosures.

Abuse or Neglect. We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. If we believe you are a victim of abuse, neglect or domestic violence, we also may disclose your protected health information to the governmental agency that is authorized to receive this information. All disclosures will be consistent with the requirements of the applicable laws.

Legal Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal; to the extent the disclosure is expressly authorized; or, if certain conditions have been satisfied, in response to a subpoena, discovery request or other lawful process.

Law Enforcement. If certain legal requirements are met, we may disclose your protected health information to a law enforcement official for law enforcement purposes, including legal processes; identification and location of suspects, fugitives, material witnesses or missing persons; information regarding victims of a crime; suspicion that death has occurred as a result of criminal conduct; evidence of criminal conduct occurring on our premises; and, in a medical emergency, reporting criminal conduct not on our premises.

Notice of Privacy Practices

To Avert a Serious Threat to Public Health or Safety. Consistent with applicable laws, if we believe using and disclosing your protected health information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; we may use and disclose your protected health information. We may also disclose your protected health information if it is necessary for law enforcement to identify or apprehend an individual.

Military Activity and National Security. When the appropriate conditions apply, we may use or disclose your protected health information: (1) for activities deemed necessary by appropriate military command authorities; (2) for determining your eligibility for benefits by the Department of Veterans Affairs; or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation. We may use and disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Department of Health and Human Services. As required by law, we may disclose your protected health information to the Department of Health and Human Services to determine our compliance with applicable laws.

Written Authorization. Except as stated in this notice, we will not use or disclose your protected health information without your written authorization. You may revoke this authorization at any time, in writing, except to the extent that we have used or disclosed your information in reliance on the authorization.

Food and Drug Administration. We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance.

Inmates. We may use and disclose your protected health information if you are an inmate of a correctional facility and we created or received your protected health information in the course of providing care to you.

Your Health Information Rights

Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial. If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our Privacy Officer at 18444 N. 25th Ave, Suite 320, Phoenix, AZ 85023. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. We have 30 days to respond to your request for information that we maintain at our practice sites. If the information is stored off-site, we have up to 60 days to respond, but must inform you of this delay.

Request Amendment. You have the right to request that we amend your protected health information. You must make this request in writing to our Privacy Officer. The request must state the reason for the amendment. We may deny your request if it is not in writing or does not state the reason for the amendment. We may also deny your request if the information was not created by us, unless you provide reasonable information that the person who created it is no longer available to make the amendment; is not part of the record which you are permitted to inspect and copy; the information is not part of our designated record; or is accurate and complete, in our opinion.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your protected health information for treatment, payment, or health care operations; to persons involved in your care; or for notification purposes as set forth in this notice. Although we are not required to agree to your requested restriction, if we do agree, we will comply with your request unless the information is needed for emergency treatment. Please contact our Privacy Officer as set forth in this notice to request a restriction. Accounting of Disclosures. You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or health care operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; for notification purposes; for national security or intelligence purposes; to law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of the request. Your request must be in writing and must state the time period for the requested information. Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12- months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. We may condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. You must submit your request in writing to our Privacy Officer. The request must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. You have the right to file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Complaints to our Privacy Officer must be in writing. We will not retaliate against you for filing a complaint.

For More Information. If you have questions or would like additional information, you may contact our Privacy Officer at 520 836-8988 .

Financial Policy

Thank you for choosing Sierra Orthopedics, PC® as your orthopedic specialist**. Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager and billing department will be glad to discuss these policies with you.

I understand that if I do not have my insurance card, referral, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

I understand that Sierra Orthopedics, PC 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. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and Sierra Orthopedics, PC. Our office will provide written notification to you detailing anticipated charges. If the full deductible is not applied to your claim by your insurance company, we will refund any overpayment to you when we receive overpayment.

I understand if my account is not paid in full within 90 days, a $35 collection-processing fee will be added to the outstanding balance and will be turned over to our collection agency for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash). Checks will not be accepted after two checks are processed as NSF on my account.

I understand, depending on my insurance benefits, that fractures may be processed as surgery and that casting, x-rays, or other services may incur additional charges.

Sierra Orthopedics, PC will allow 60 days from the date of filing for my insurance company to process or pay a claim. Arizona law allows insurance companies operating in the state no more than 30 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process claim for services. It is also my responsibility to notify Sierra Orthopedics, PC if there is a change in my insurance coverage, residence, or phone number. **ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.**

I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

I have read and I understand the above Financial Policy and I agree to abide by its terms.

Patient or Guarantor Name: ____________________ Relationship: ____________________________

Patient Signature: ______________________________ Date: ___________________________________