ALEXANDER
ORTHOPAEDICS, P.A.
Specialists in Sports Medicine & Hand Surgery

100 Hospital Drive, Suite 100
PO Box 6997
Ketchum, ID 83340-6997

(208) 727-0005
FAX (208) 727-0001

A. Herbert Alexander, MD
Sports Medicine, Fractures, Arthroscopy, & Orthopaedic Surgery

Charlotte E. Alexander, MD
Hand Surgery

Patient Last Name: _____ First Name:_____ Middle Name:_____

Permanent Address: _____ City: _____ State:_____ Zip: _____

Local Mailing Address: _____ City: _____ State:_____ Zip: _____

Home Phone: (_____)_____ Local/Cell phone (_____)_____ Work Phone: (_____)_____

Date of Birth:_____ Social Security No: _____--____--_____ Sex: Male/Female

Marital Status: Married/Divorced/Legally Separated/Single/Widowed Employer:_____

Employer Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Other physicians currently treating you: _____

Family physician: _____

SPOUSE/RESPONSIBLE PARTY/GUARANTOR INFORMATION (Circle one)

Last Name: _____ First Name:_____ Middle Name:_____

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

Home Phone: (_____)_____ Work Phone: (_____)_____ Date of Birth:_____

Who is Financially Responsible for this Bill?_____ **Will you be paying by Cash____ Check____ Credit Card____ ?**

Emergency Notification: Please provide name of relative or guardian NOT living with you.

Last Name: _____ First Name:_____ Middle Name:_____

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

Home Phone: (_____)_____ Work Phone: (_____)_____ Relationship: _____

INSURANCE INFORMATION

Do you have medical insurance? Yes/No Insurance Company: _____ Policy #: _____

ID #:_____ Policyholder's Name:_____ Policyholder's Birth date: _____

Do you carry secondary insurance coverage? Yes/No Insurance Company: _____ Policy #: _____

ID #:_____ Policyholder's Name:_____ Policyholder's Birth date: _____

GENERAL MEDICAL INFORMATION

Describe your current medical problem/ reason for today's visit: _____

Onset of symptoms: _____ **Is your visit today the result of an ___accident, ___worker's compensation injury, or ___auto accident (check whichever applies). If so, what was the date of accident/injury?** _____ **Please explain how the accident/injury occurred:** _____

PERSONAL MEDICAL HISTORY

How is your health in general?_____ Have you had unexplained weight gain/loss? _____

Do you have a history of diabetes?_____ Have you had fever or chills recently?_____ **Height** _____ **Weight** _____

List Prior Surgeries	Surgery Date		Please List Current Medications:	Dosage	Reason

Medication Allergies::_____

What kind of allergic reaction?_____

ALEXANDER ORTHOPAEDICS

FAMILY HISTORY (please check any that apply):

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Hypertension	❑	❑	❑	❑	❑	❑
Heart attack	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Osteoarthritis	❑	❑	❑	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑	❑	❑	❑
Gout	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Malignant hyperthermia	❑	❑	❑	❑	❑	❑

TOBACCO, ALCOHOL NON-PRESCRIPTION DRUGS

Do you smoke or chew tobacco? Yes/No. If so, how much? _____

how long? _____ If you have stopped, when did you stop?_____ How much did you previously use?_____

Do you drink Alcohol? Yes/No If so, at what frequency and amount _____

_____

Other non-prescribed drugs: Yes/No _____

Have you ever had any of the following in the last year (check all that apply) and please comment on date, frequency?

❑ Sinus problems ❑Hay fever_____ ❑ Hypertension_____ ❑ Painful joints/injuries/fractures_____

❑ Frequent colds_____ ❑ Heart murmur _____ ❑ Skin disorders_____

❑ Difficulty hearing_____ ❑ Digestive problems _____ ❑ Headaches ❑ Memory loss_____

❑ Cataracts/ Glaucoma_____ ❑ Blood in stool_____ ❑ Dizzy spells_____

❑ Asthma_____ ❑ Hemorrhoids_____ ❑ Seizures _____

❑ Pneumonia_____ ❑ Ulcers_____ ❑ Depression_____

❑ Shortness of breath_____ ❑ Hepatitis_____ ❑ Mental disorder _____

❑ TB ❑ Lung disorders_____ ❑ Kidney disease_____ ❑ Schizophrenia _____

❑ Chest pain/pressure/ tightening _____ ❑ Frequent urinary infections_____ ❑ Cancer_____

❑ Heart attack _____ ❑ Arthritis _____ ❑ Other _____

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CONSENT TO TREATMENT

& FINANCIAL AGREEMENT

I consent to treatment by the physicians and employees of Alexander Orthopaedics including X-ray examination, laboratory procedures, anesthesia, medical or surgical treatment rendered to me, my minor dependents, or minor children over whom I have legal or temporary guardianship, under the physician's general or special instructions.

I hereby authorize Alexander Orthopaedics to furnish insured's insurance company all information that said insurance company may request concerning my medical treatment.

I hereby assign to Alexander Orthopaedics all money to which I am entitled for expense related to services performed from time to time, but not to exceed my indebtedness to Alexander Orthopaedics and authorize direct payment to Alexander Orthopaedics for those billed charges.

I understand that any money received from the above referenced insurance company over and above my indebtedness will be refunded to me when my bill is paid in full.

I understand that I am personally responsible to Alexander Orthopaedics for payment of all charges incurred by me regardless of whether they are covered by insurance. I further understand Alexander Orthopaedics may look directly to me for full payment of all charges incurred by me, even if billings have been submitted to my insurer for payment.

I am also requesting that the clinic extend credit to me for any charges I will not be paying at the time of service. In requesting credit, I hereby authorize Alexander Orthopaedics to run a credit report from any credit bureau for purposes of evaluating this and future requests for credit on my behalf.

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

I agree, whether signing as agent or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. This is a binding contract between the patient or me and the clinic. Contracts for insurance coverage are between the patient and the insurance carrier. The patient has prime responsibility to the clinic for the amount, of the bill. All amounts remaining unpaid 30 days following the date of service are subject to a **finance charge of 1½ % per month, which is an annual rate of 18%**. Minimum charge: $0.50. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

PAYMENT & INSURANCE POLICY

Financial Policy
Payment is due at the time of service. Cash, Check, Visa, MasterCard or debit cards accepted.

Insurance
As a courtesy to our patients, we will send a complimentary claim to your insurance carriers. We participate with Blue Cross, Regence BlueShield and Medicare. However, responsibility of payment is yours. **Please check with the receptionist to make sure we have the correct information for you and your insurance.**

Worker's Comp
We will need your claim number and employer information, in order to submit a claim. We do not accept out-of-state Worker's Compensation.

Auto and Third Party Insurance
Our office will be happy to submit a complimentary claim, provided you have a claim number and appropriate insurance information with you. However, payment for services is due at the time of service.

HMO's and Managed Care
A written referral from your primary physician is required prior to your appointment/visit. Should a referral not be on file prior to your arrival, you will be asked to reschedule your appointment until a referral can be obtained. It is your responsibility to obtain a referral.

Surgeries
Our business office will certify your surgery for you through your insurance company. We will also ask for a down payment prior to surgery for your coinsurance/deductible. Cash discounts are given to patients with no insurance if they can pay in full.

Disability Insurance
There will be a fee for disability paperwork. Please allow five (5) working days for completion.

CD's
We can copy your x-rays on to a CD for you for a fee of $15.00.

Pediatric Care
Children under the age of 18 will need to be accompanied by their legal guardian or an adult responsible for payment during their visit.

_____

Responsible Party Signature **Patient Signature**

_____

Patient's Agent or Representative **Relationship**

_____

Date **Alexander Orthopaedics Witness**

Alexander Orthopaedics, P.A. - Patient's Notice-Of-Privacy Policy

Keeping your medical records confidential

What you need to know about Alexander Orthopaedics, P.A. Confidentiality Policy

Alexander Orthopaedics, P.A. is committed to providing you with high quality health care and to forming a relationship with you that is built on **trust.** That means respecting your **privacy** and **confidentiality** of your medical information. We protect your privacy and confidentiality rights by creating and putting into practice policies and procedures that allow access to your personal medical information **only** for legitimate reasons.

Your medical record

As we provide your health care, we are required to maintain a complete copy of your medical history, current condition, treatment plan and all treatment given, including the results of all tests, procedures and therapies. Whether this information is stored in writing, on a computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality. Of course, the physicians and other health care professionals who are involved in your care need to access this information in order to provide appropriate treatment for you.

Your medical information is private and confidential

You, or anyone to whom you give written permission, or your legal representatives, have the right to read or get a copy of your medical information. Your medical record is the physical property of Alexander Orthopaedics, P.A.

How do we assure your privacy?

Alexander Orthopaedics, P.A. has put in place detailed policies regarding access to medical records by our staff and employees and has carefully outlined the circumstances under which your medical information may be released to parties outside Alexander Orthopaedics, P.A. These policies conform with state and federal law and are designed to safeguard your privacy. Our staff and employees are trained in the appropriate use of medical information and know that it is available to them only to continue to provide care to you or for other limited but legitimate reasons. A violation of confidentiality or the failure of an employee to protect your information from accidental or unauthorized access will not be tolerated. This may include the employee being fired from his or her job.

We ask for your permission

We do not allow others outside Alexander Orthopaedics, P.A. to access your medical information unless we have the appropriate authorization to do so. We will request your authorization to release information at your first visit or admission. In addition, some laws prevent certain types of patient information from being released without specific patient permission. Examples include, but are not limited to:

♦Confidential details of:

♦Psychotherapy (from records of my treatment by a psychiatrist, licensed psychologist or psychiatric clinical nurse specialist)

♦ Other professional services of a licensed psychologist

♦Social Work Counseling/Therapy

♦ Domestic Violence Victims' Counseling

♦ Sexual Assault Counseling

♦ HIV test results (Patient authorization required for **EACH** release request.)

♦ Records pertaining to Sexually-Transmitted Diseases

♦ Alcohol and Drug Abuse Records

Please note, however, that the law requires some information to be disclosed in certain circumstances. This includes mandatory reports of abuse of children or elderly or disabled persons.

Also, subpoenas or court orders may compel the disclosure of confidential or privileged health information in the context of a lawsuit or administrative proceeding. Medical records are sometimes used for reasons other than patient care. For example, records are periodically reviewed to evaluate the quality of care, or to be sure that Alexander Orthopaedics, P.A. follows the rules of regulatory agencies for the efficient and effective utilization of care such as Medicare, Department of Public Health, or Department of Mental Health. Your insurance company may request information that we are required to submit in order to provide and bill for your care. Anyone reviewing records must follow the same confidentiality laws and rules required of all health care providers. Patient records are valuable tools used by researchers in finding the best possible treatments for diseases and medical conditions. All researchers must follow the same rules and laws that other health care workers are required to follow to insure the privacy of patient information. Information that may identify you will not be released to anyone outside Alexander Orthopaedics, P.A. without your written approval. In all research conducted within Alexander Orthopaedics, P.A., concern for your privacy and well-being is our first priority.

If you have questions . . .

If you have questions about the privacy of your medical records, please speak with us. We will be happy to help you.

Signed this date _____

Print Your Full Name _____

Signature_____