PATIENT DEMOGRAPHIC FORM

PATIENT'S NAME (LAST/FIRST/MI):_____

PARENT/GUARDIAN (IF APPLICABLE):_____

DOB (MM/DD/YYYY)_____ **AGE**_____**SSN**_____

MAILING ADDRESS:

_____

Street Number/Name City Alaska Zip

BILLING ADDRESS: _____SAME AS MAILING (IF NOT PLEASE LIST BELOW)

_____

Street Number/Name City Alaska Zip

E-MAIL ADDRESS_____**CELL PHONE**_____

PARENT'S IF PATIENT IS A MINOR

HOME PHONE_____**WORK PHONE**_____

PARENT'S IF PATIENT IS A MINOR

MARITAL STATUS □ M □ S □ D □ W **SPOUSE'S NAME**_____

PARENT'S IF PATIENT IS A MINOR

REFERRED BY_____**PRIMARY CARE PHYSICIAN**_____

EMERGENCY CONTACT/NUMBER_____

SUBSCRIBER NAME_____**SUBSCRIBER DOB**_____

WORKMANS COMP RELATED? _____YES _____NO FEDERAL OR STATE STATE INJURY OCCURED?_____

IS THIS RELATED TO **AUTOMOBILE** ACCIDENT? _____YES_____NO

WORKMANS COMP OR AUTOMOBILE INSURANCE **BILLING INFORMATION**:

ADJUSTER NAME/NUMBER_____

CLAIM # _____**EMPLOYER**_____

IS **ATTORNEY** INVOLVED? _____YES_____NO (IF YES, PLEASE PROVIDE NAME)_____

_____

PAYMENT IS REQUIRED AT THE TIME OF EACH VISIT

I hereby authorize Pioneer Peak Orthopedics (PPO), LLC to furnish information to insurance carriers concerning my illness and treatments, and I hereby accept full responsibility for all fees incurred by myself and/or dependents, regardless on insurance coverage. I authorize my insurance company(s) to pay benefits directly to PPO, LLC for claims filed on my behalf.

BY SIGNING THIS, I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT.

_____

PATIENT/GUARDIAN SIGNATURE TODAY'S DATE

Please initial here _____ if you **DO NOT** want us to send a copy of our visit to your personal Physician/Provider.
(Initials)

PIONEER PEAK
ORTHOPEDIC SURGERY

NEW PATIENT INTAKE FORM

Last Name: _____ First Name: _____ M.I. ___ Height: _____ Weight: _____ DOB: _____

Chief Complaint: (What brings you in today? Example: right knee pain, left shoulder pain, arthritis, etc):

_____

History: (How and when did your problem begin?)

_____

Please indicate any treatments you have had so far: (Check all that apply)

____None ____Injections ____Physical Therapy (how long and where) _____

____Surgery (when and where) _____

____Medications (for this problem) _____

Categorize pain: (0=no pain & 10=unbearable) 0 1 2 3 4 5 6 7 8 9 10

none mild moderate moderate severe unbearable

My pain is: (Please circle all that apply) constant intermittent achy burning

deep superficial improving worsening Other:_____

Modifying factors (What makes your pain better or worse? Please check all that apply)

____Better with activity ____Worse with activity ____Better with rest ____Worse with rest

____Better with sleep ____Worse with sleep ____Better with medicines ____Nothing

____Changing positions help (describe):_____

Past Medical History (Please check all that you have been diagnosed with): ____**NEGATIVE**

____Pulmonary Embolism	____ DVT(clots)	____Fibromyalgia	____Seizures	____Stroke
____Heart Disease	____Heart Attack	____Arrhythmia	____Asthma	____COPD
____High Blood Pressure	____GERD(reflux)	____Anemia	____Thyroid Disease	____Cancer
____Excessive Bleeding	____Neuropathy	____Hearing Loss	____Colitis	____Gout
____Hepatitis	____Diabetes	____Osteoporosis	____Arthritis	____Ulcers
____Migraines	____High Cholesterol	____Sleep Apnea	____Sleep Apnea	

____Other_____

Past Surgical History (Please list any prior surgeries and approximate dates): ____**NEGATIVE**

_____Date: _____
_____Date: _____
_____Date: _____
_____Date: _____
_____Date: _____

If you have had surgery, have you had any problems with anesthesia? Please explain:_____

_____

Family History ((Does anyone in your immediate family, (mother, father, sister, brother) have a history of the following?)) Please indicate using 'M' for mother, 'F' for father, 'B' for brother, 'S' for sister on the lines provided.

____Arthritis	____Stroke	____Osteoporosis/Bone Disorders
____Coronary disease	____Heart attack/heart disease	____Lung Disease
____High blood pressure	____GERD	____Thyroid disease
____Cancer	____Diabetes	____DVT (clots)/pulmonary embolism

____Other_____

Social History: (Please check the appropriate space):
Do you drink alcohol? ____ None ____Rarely ____Less than 2 drinks/wk ____3-6 drinks/wk ____1drink/day ____More than 1 drink/day
If you quit using alcohol, how long since you quit? _____

Do you use any form of tobacco? _____ What type? _____ How much? _____ How often? _____
How long? _____ If you quit using tobacco, how long since you quit? _____

Do you use any recreational drugs? _____ What type? _____ much? _____ How often? _____
How long? _____If you quit using recreational drugs, how long since you quit? _____

Are you currently working? _____ What is your occupation? _____
Do you live alone? ____Yes ____No What are your living arrangements? _____

Drug Allergies (Please list all food and drug allergies OR CHECK HERE IF): **____NONE**
_____
_____
_____

Current Medications (**PRINT CLEARLY** and list all medications or supply us with a separate list): **____NONE**
Oral Contraceptives Yes / No Brand_____
Drug: _____ Used for: _____ Drug: _____Used for: _____
Drug: _____ Used for: _____ Drug: _____Used for: _____
Drug: _____ Used for: _____ Drug: _____Used for: _____
Drug: _____ Used for: _____ Drug: _____Used for: _____
Drug: _____ Used for: _____

DO NOT WRITE BELOW THIS LINE

Notes: (For Office Use Only):

RELEASE OF PROTECTED HEALTH INFORMATION - FAMILY AND FRIENDS

Patient Account Number _____

Patient Name: _____

I authorize Pioneer Peak Orthopedics to release my Protected Health Information "PHI" to:

1. _____ DOB: _____ Relationship to Patient: _____
2. _____ DOB: _____ Relationship to Patient: _____
3. _____ DOB: _____ Relationship to Patient: _____

This release authorizes Pioneer Peak Orthopedics to discuss your Protected Health Information with the above listed individual(s).

Please note: A separate release form (Authorization for the Use and Disclosure of Protected Health Information) is required for Pioneer Peak Orthopedics to release your medical records to any individual(s).

By signing below, you agree that Pioneer Peak Orthopedics may release Protected Health Information to the above individual(s). This release will remain in effect for one year from the date signed below. If you wish to revoke this release you must do so in writing directed to: Pioneer Peak Orthopedics Privacy Officer. Your request will be processed within 48 hours unless otherwise specified. Please call 907-707-1671 if you have additional questions.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Printed Name of Legal Representative

Pioneer Peak Orthopedics FINANCIAL POLICY

Thank you for choosing Pioneer Peak Orthopedics.
We strive to make your appointment If you ever have a question regarding our billing policies, we will be happy to assist you.

We are In-Network providers with **Blue Cross Blue Shield, Public Employee Health Trust-PEHT, CIGNA, and Aetna**. You are responsible for deductible, co-pay and/or co-insurance amounts not collected at the time of service. Initial Here _____

As a courtesy to the patient we will check your eligibility and benefits before your appointment and bill your insurance. Co-pay and/or co-insurance are due at time of service. You will be billed for any amount not considered by your plan in addition to your deductible, co-pay and/or co-insurance amounts not collected at the time of service.
If proof of insurance/eligibility cannot be provided, payment will be due in full. Initial Here _____

We are a contracted provider with **Medicare**. You must be enrolled in **Medicare Part B** to be eligible for benefits. We will bill you for any remaining deductible, co-insurance and/or patient notified non-covered services after Medicare processes. No payment is required at the time of service. Initial Here _____

We are a contracted provider with **Medicaid/ Denali Kid Care.** You must present a current sticker for each month of eligibility. Please note our office does NOT accept CAMA or Disability Exam benefits. A referral is required if you are in the Lock-In Program, without a referral you will be considered a self-pay. Your co-pay is due at the time of service. Failure to make payment may result in delayed future appointments. Initial Here _____

We are a contracted provider with **Tricare**. Tricare Prime beneficiaries may self-refer using the Point-of-Service option if a referral has not been obtained. Tricare standard beneficiaries have a fee-for-service option with no referral requirements. Tricare for Life claims are electronically forwarded by Medicare. We will bill the **VA** for your treatments with a prior authorization. Initial Here _____

We only accept **Workers' Compensation** claims that were filed with the Alaska Department of Labor. Your claim must be open and accepted. You must provide your carriers information including claim number and date of injury. No payment is required at the time of service. Please note we do **NOT** accept Federal or Out of State Workers' Compensation. Initial Here _____

A claim must be established with your auto insurance carrier. We will only bill first party claims (your auto insurance policy) regardless of fault. Once your medical benefits are exhausted your private insurance may be billed. *YOU MUST CONTACT YOUR PRIVATE INSURANCE TO DISCLOSE YOUR LIABILITY CLAIM.* If you have no other insurance coverage, your account will be transferred to a self-pay status and payment will be due upon receipt. Initial Here _____

As a courtesy to our patients Pioneer Peak offers payment plans for qualifying balances. Payment plans are based on a maximum number of months from the date services are rendered. Once you have reached the maximum length of the payment plan you must obtain alternative financing. All payments are applied toward your oldest services first. Initial Here _____

Balances on your account must be paid in full before you will be seen again unless payment arrangement has been made. Claims over 90 days will be due in full. Delinquent accounts are subject to collections processes which may include the account being sent to an outside collection agency. Initial Here _____

- I have read, understand and agree to this Financial Policy.
- I understand that I am ultimately responsible for my balance, not my insurance carrier.
- I authorize Pioneer Peak Orthopedics to release pertinent medical information to my insurance company when requested in order to facilitate payment.
- I understand that my signature authorizes benefits to be paid directly to Pioneer Peak Orthopedics.
- I understand that should this debt become delinquent the balance may be referred to a collection agency. I will be held responsible for all fees associated with the collection of my debt.

_____	_____	_____
Printed Name of Patient	**Date of Birth**	**Account Number**
_____	_____	
Signature of Patient or Patient's Legal Representative	**Date**	

PIONEER PEAK
ORTHOPEDIC SURGERY

Acknowledgement & Receipt For
Notice of Privacy Practices

We are required by law to provide you with a copy of our Notice of Privacy Practices.

By signing below, you are acknowledging that you have been provided with a copy of our notice to keep or to view and that you have also been given an opportunity to review it.

_____	_____
Printed Name	*Appointment Date*
_____	_____
Signature	*Today's Date*
_____	_____
Employee's Name	*Review Date*