Ref. by:_____

Ref. to: GB___ DK___ AAO___

ALL ACCESS ORTHO

Name: _____ FOR OFFICE USE ONLY

Birthdate: _____ XRAY:

Date: _____ CC:

Primary Care Physician: _____ INSURANCE:

1. **CHIEF COMPLAINT**

What is your chief symptom or problem:

_____

2. **HISTORY OF PRESENT ILLNESS**

a. Location of pain/problem:_____

b. What factors make pain/problem worse?_____

_____

c. When did pain/problem start (date)?_____

d. Please rate the severity or intensity of pain (circle number):

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

e. How did symptoms/condition start?

_____

_____

_____

_____

_____

_____

Name:_____ Date:_____

Acct #:_____

HEALTH HISTORY FORM - PFSH

DOB:_____ M / F Height:_____ Weight:_____ BMI:_____ R / L Handed Occupation:_____

Do you have any **ALLERGIES** or **REACTIONS** to **Latex, Iodine** or any **Medication**? ___**YES**, (please list) or ___**NO**, I have none of these allergies.

1. 3. 5.

2. 4. 6.

List all **MEDICATIONS/Herbs/Vitamins and Supplements** that you are **currently taking**:

☐ Check Box if separate list has been provided 3. 6.

1. 4. 7.

2. 5. 8.

List all **SURGERIES** that you have had **with approximate dates** of each surgery:

1. 3. 5.

2. 4. 6.

MEDICAL HISTORY

	NO	YES			NO	YES
High Blood Pressure	____	____		Asthma/Emphysema	____	____
Heart Attack/Coronary Artery Disease	____	____		Bleeding Disorder/Anemia	____	____
Irregular Heart Beat	____	____	If yes, do you have a **Pacemaker**? Yes / No	Intestinal Bleeding/Ulcer	____	____
Stroke/Paralysis	____	____		**Hypo**thyroid	____	____
Diabetes	____	____		**Hyper**thyroid	____	____
Kidney Failure/Disease	____	____	If yes, are you on **Dialysis**? Yes / No	Seizures	____	____
Rheumatologic Condition	____	____		TB	____	____
Hepatitis/Liver Disease/HIV	____	____		Reaction to Anesthesia	____	____
MRSA	____	____		Other:_____	____	____
Cancer	____	____	If yes, **Type of Cancer**/Description:_____			

FAMILY HISTORY

	NO	YES		NO	YES		NO	YES		NO	YES		NO	YES	
Stroke	___	___	Heart Attack	___	___	Diabetes	___	___	Reaction to Anesthesia	___	___	Bleeding Disorder or Anemia	___	___	Cancer ___ ___ Type:_____

SYSTEMS REVIEW - Have you **recently** had problems with any of the following?

	NO	YES	DESCRIPTION (**If Yes**, provide a description and indicate if condition is resolved)
Cold/Flu	____	____	_____
Eye/Ear	____	____	_____
Intestinal	____	____	_____
Heart	____	____	_____
Breathing	____	____	_____
Skin	____	____	_____
Nerve	____	____	_____
Urinary	____	____	_____
Bleeding	____	____	_____
Depression/Anxiety	____	____	_____

SOCIAL HISTORY

Do you **SMOKE**? ____**NEVER DID** or ____**QUIT**, I have not smoked since: _____ or ____**YES**, I smoke _____cigarettes per day
Do you use **RECREATIONAL DRUGS** (including Marijuana)? ____**NO** or ____**YES**
Do you drink **ALCOHOL?** ____**NO** or ____**YES**, number of drinks per day_____, week_____, month_____

What sport(s) do you participate in or activities do you do for **EXERCISE**? _____

High School Attended:_____ College Attended:_____

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Account No	Type	Dr. #	Date

LAST NAME		FIRST NAME	MIDDLE NAME
SEX ❑ M ❑ F	DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
PATIENT'S ADDRESS (INCLUDE CITY, STATE AND ZIP CODE			HOME PHONE
GUARANTOR'S NAME & ADDRESS, IF DIFFERENT (INCLUDE CITY, STATE AND ZIP CODE)			CELL/PAGER
EMPLOYER NAME/ADDRESS		OCCUPATION	BUSINESS PHONE
SPOUSE'S NAME		SPOUSE'S EMPLOYER	BUSINESS PHONE
EMERGENCY CONTACT NAME/ADDRESS (someone not living with you)		RELATIONSHIP	PHONE
REFERRING DOCTOR/PRIMARY CARE DOCTOR		PHONE NUMBER	E-MAIL ADDRESS

HAVE YOU BEEN TREATED AT ALL ACCESS ORTHO PRIOR TO TODAY'S VISIT? ❑ YES ❑ NO - IF NO, PLEASE ANSWER BELOW
HOW DID YOU HEAR ABOUT US? ❑ FAMILY MEMBER ❑ FRIEND ❑ PHYSICIAN ❑ YELLOW PAGES ❑ WEBSITE ❑ GOOGLE ❑ YELP ❑ EMPLOYER ❑ INSURANCE ❑ MAIL ❑ SOCIAL NETWORK

If patient is a CHILD, please complete the following:

PARENT/GUARDIAN'S NAME		RELATIONSHIP TO PT	MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
HOME PHONE	BUSINESS PHONE	CELL/PAGER	CHILD'S SCHOOL
PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR CHILD			RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

❑ PRIVATE INSURANCE ❑ WORKER'S COMPENSATION ❑ NO-FAULT ❑ TPL

PRIMARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME		SEX ❑ M ❑ F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
PHONE: FAX:	MEMBERSHIP #/POLICY #/CLAIM #		GROUP #	COVG CODE
SECONDARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME		SEX ❑ M ❑ F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
PHONE: FAX:	MEMBERSHIP #/POLICY #/CLAIM #		GROUP #	COVG CODE
TERTIARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME		SEX ❑ M ❑ F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
PHONE: FAX:	MEMBERSHIP #/POLICY #/CLAIM #		GROUP #	COVG CODE

INJURY INFORMATION

DATE OF INJURY/ONSET	CONDITIONS WE ARE TREATING YOU FOR TODAY
FOR OFFICE USE ONLY	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS
I authorize All Access Ortho, or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier. _____ (initial here)

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES – Details of your rights and how your medical information will be used and disclosed by All Access Ortho is set forth in the NOTICE OF PRIVACY PRACTICES. A copy has been given to you and is posted in the clinic. I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES. _____ (initial here)

FINANCIAL AGREEMENT: I understand that I am financially responsible for all charges whether or not paid by said insurance.
These included deductible, co-payment, cost-share, and/or non-covered benefits. I also agree to pay a late payment fee of 3% a month on any unpaid balance over 90 days old together with reasonable attorney's fees and collection expenses should the account be referred to an attorney or collection agency. I agree to pay a $20.00 processing fee in addition to any bank fees for each returned check. _____ (initial here)

I certify that the insurance information I have provided is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

Patient/Parent/Guardian Signature _____ Relationship to Patient _____ Date _____

ALL ACCESS **ORTHO**

Orthopedic care when you need it

e-PRESCRIBING

All Access Ortho LLC is in the process of implementing ePrescribing in each of our offices.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

The benefit to you:

- Less confusion over hand written prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescription filled

Patient Consent

I agree that All Access Ortho LLC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient Signature Date

ALL ACCESS **ORTHO**

PAYMENT AND INSURANCE FINANCIAL POLICY

Thank you for choosing All Access Ortho to provide you medical services. We are committed to providing you with the highest quality of affordable healthcare. We have developed this policy to help provide answers to your questions and to provide some basic information for any financial decisions that may arise during the course of your care. We ask that you read and ask any questions, then sign below to acknowledge your receipt and understanding of our policies prior to any treatment.

1. **PROOF OF INSURANCE:** All patients must complete our patient registration form as well as any other required forms prior to being seen by us. If you are insured by a plan we participate with, you must have a ***valid insurance*** card with your member ID and a ***valid State ID, driver's license, or passport***, which we can photocopy. Certain insurance carriers require us to ask you for your social security number so that we may verify your coverage. If you are unable to produce these IDs or we are unable to verify your identity or coverage, we will need to collect payment in full at the time of your visit.

2. **NO INSURANCE:** If you do not have any insurance coverage, payment will be due at the time of service.

3. **INSURANCE:** We will file a claim to all carriers where we have a contractual obligation to do so. We must emphasize that as your healthcare provider, our relationship is with you, not your insurance company, and that all charges are your responsibility for the date services are rendered. If you are insured by a plan we do not participate with, payment in full will be expected for your visit at the time services are rendered. You will then be responsible for submitting your own claim to your insurance carrier for reimbursement. Understanding your insurance benefits is your responsibility. If you are unsure about your benefits or participation with your plan, please call the number on the back of your insurance card.

4. **CO-PAYMENTS AND DEDUCTIBLES:** You are responsible for any co-payments, co-insurance, deductible and/ or any non-covered services as required by your insurance company. It is our practice policy that co-payments and any deductible amounts which may apply to your care at our facility be collected by us at the time of your visit. Depending on your insurance carrier, we may not have sufficient information to determine the total amount of your co-payment(s), co-insurance, and/or deductible at the time of your visit. We may therefore bill you at a later date for your patient payments. For your convenience, we accept ***Hawaii State personal checks, cash, Visa, MasterCard and Discover Card***. A $20 administrative fee as well as any bank fees incurred will be assessed for each check or electronic transaction denied by your bank for any reason.

5. **NON-COVERED SERVICES:** Please be aware that some, and perhaps all, of the items or services you receive may not be a covered benefit under your insurance plan. Your insurance benefits are determined by the plan chosen by you and your employer and how much your employer pays for your coverage. It is your responsibility to contact your insurance company if you have any questions or concerns. It is also your responsibility to pay in full at the time of service for any non-covered items or services.

6. **MEDICARE PATIENTS AND DURABLE MEDICAL EQUIPMENT (DME):** Beginning in 2011, Medicare will no longer pay for durable medical equipment (DME) obtained at a physician's office or clinic. Therefore, if you wish to obtain DME at the time of your visit such as, but not limited to, crutches, braces, and boots, you must fill out an ABN Medicare form and pay in full at time of service for your DME supplies. If you want Medicare to pay for your DME, we will provide you with a DME prescription which you can take to your preferred DME supplier. We will provide you with a list of suppliers upon request.

7. **CLAIMS SUBMISSION**: If we are a participant with your plan, it is our policy to submit your claim to your insurance company. It is sometimes necessary for your insurance company, or our billing department, to contact you directly for information or assistance. It is your responsibility to comply with this request in a timely manner. Please understand that the balance of your account is your responsibility whether your insurance company pays your claim or not. It is in all parties' best interest to cooperate in this matter. We ask you to review all correspondence carefully and contact your insurance company or us immediately with questions or concerns. If we do not receive full payment from your insurance company within 45 days from the date of submission, the entire balance owed may become your responsibility.

8. **NONPAYMENT**: As a courtesy, we will provide you with a statement of your account. It is your responsibility to review these statements for accuracy and respond immediately to any and all requests for information and payment. If you have not received a statement from All Access Ortho within 60 days of your visit, please call us to confirm your billing information. We are required by federal law to support all services rendered with proper documentation in your medical records. We cannot alter a claim to obtain payment unless there has been a documentation error**.** If you discover an error, duplicate charge, or have any concerns about your bill, please contact our billing department (808-356-5699 Monday – Friday 8am – 4:30pm) immediately for investigation and proper corrective action. All outstanding balances are due upon receipt and become past due 30 days later. A 3% monthly service charge will be charged on accounts overdue past 90 days and may be subject to collection action pursuant to the full extent of the law. Partial payments will not be accepted. Please understand that in the event that your account is referred to collections you will be responsible for any additional costs attributable to that action including, but not limited to, agency, attorney and court costs incurred and permitted by the laws governing these actions. Also be aware that you may be refused service in the future due to non-compliance.

9. **WORKMAN'S COMP:** If you have an injury which occurred while at work, or is potentially related to work, we will submit a claim on your behalf, and seek payment for your services, from your employer's workman's compensation insurance carrier. At the time of your visit, we will require the following information: date of your injury, your employer's name, address and phone number, name of your supervisor or person to contact regarding your injury, and the name of your employer's workman's compensation carrier. If you are not able to provide us with the name of the workman's compensation carrier at your first visit with us, we ask that you obtain this information. If we do not receive this information within two weeks from the date of your first visit, we will have to refuse further service related to your injury.

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You must inform your employer of your injury prior to being seen by us. If you are unable to inform your employer before you are seen, you will need to make sure you do so after you have been treated. If you have not filed an injury report with your employer (WC- 1) or informed your employer of your visit to All Access Ortho, you will be responsible for the claim and we may refuse further service related to your injury. If you request that we submit a claim to your medical insurance carrier and your injury is determined to be work related, we cannot guarantee that your medical insurance carrier will pay for your visit. We will not be able to change our documentation once you have reported to All Access Ortho staff that your visit was due to an injury that occurred at work or was related to work. If your claim is denied for any reason or if your employer fails to timely file your claim, you will be held responsible for the full payment for the services rendered. If you have been treated by another physician for your injury, other than an emergency room visit, before coming to All Access Ortho, we will not be able to assume care for your injury. If your claim is rejected due to errors in the information you provided, you will be responsible for all charges.

10. **NO-FAULT LAW**: If you were injured as a result of an automotive accident ***which occurred in Hawaii,*** we will seek payment for your services from the no-fault insurance carrier of the owner of the vehicle you were riding in, regardless of who was at fault for the accident. If you are the vehicle owner, you are required to give us a copy of your ***no-fault insurance card*** and your ***insurance claim number***. If you were not the owner of the vehicle, you are required to give us a ***police report number as well as a copy of the police report within four weeks*** of the accident so we will know the name of the insurance carrier to seek payment from for your services. We will only bill your **medical** insurance carrier if the accident occurred in Hawaii, and you have a denial letter from the no-fault insurance carrier stating you have exhausted your no-fault allowances or stating you are not eligible for payments under no-fault law. When billing your **medical** insurance carrier, we are required by law to report on our claim submission that your injury was the result of an automotive accident. If your automotive related injury occurred more than a year before your visit, we may require proof that your no-fault coverage has not been exhausted before we submit your claim to your **medical** insurance carrier. If your claim is rejected due to errors in the information you provided, you will be responsible for all charges.
11. **THIRD PARTY LIABILITY**: Injuries that did not occur at work or did not involve a motor vehicle, and were caused by a third party who you think should be responsible, will be considered third party injuries. Some examples of third party injuries are injuries that occur at stores, restaurants, or on sidewalks, and a third party may or may not be responsible, and/or liable. ***All Access Ortho will not seek payment from the third party on your behalf***. The cost of a visit due to an injury from a third party will be due in full at time of service. We will give you an itemized statement to submit to the party you think is responsible for your injury for reimbursement.

ACKNOWLEDGEMENT AND CONSENTS

Titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical, or other information, about me to release to the Social Security Administration, other intermediaries, or carriers of the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the facility for its charges and for any charges of physicians or other providers for whom the facility is authorized to bill in connection with its service.

MEDICARE/MEDICAID/TRICARE PATIENT S CERTIFICATION: I certify that the information given by me in applying for payment under

PATIENT FINANCIAL RESPONSIBLITIES: I acknowledge full financial responsibility for services rendered by All Access Ortho LLC. I understand that I am responsible for prompt payment of any charges, including co-pays, deductibles, and co-insurance amounts. I understand that the payment of co-pays, deductibles and co-insurances are expected at the time of service, as well as any outstanding balance that I may owe All Access Ortho. I also consent that payment of authorized Medicare and any other insurance benefits may be made on my behalf directly to All Access Ortho for any medical or surgical services rendered. I agree to be financially responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in the above Payment and Insurance Financial Policy.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS: I hereby give my consent to All Access Ortho to use or disclose, for the purposes of carrying out treatment, payment, or healthcare operations, all protected health information contained in the patient record.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: I hereby acknowledge receipt of All Access Ortho's Notice of Privacy Practices. This notice provides detailed information about how the practice may use and disclose my confidential health information. I understand that All Access Ortho has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided or made available on our website, www.allaccessortho.com

Thank you for taking the time to review our financial policy. If you have any questions or concerns, please let us know.

A copy of our financial policy can be found on our website, www.allaccessortho.com

If you prefer a copy of the Financial Policy you signed, please notify the receptionist.

I have read, understand and agree to abide by the guidelines outlined in this policy.

_____ _____

Signature Date

_____ _____

Print Name Relationship to Patient

Revised: 11/14/2013