

Bone & Joint Specialists

PATIENT NAME: _____ **Cellular#** _____
First **Middle** **Last**

Address: _____ **Apt./Sp.#:** _____
City: _____ **State:** _____ **Zip:** _____
Home Phone #: () _____ - _____ **Work Phone #:** () _____ - _____
Social Security #: _____ - _____ - _____ **Date of Birth:** _____ **Age:** _____ **Male** **Female**
Race and Ethnicity: _____ **Email:** _____
Employer: _____ **Number of years on the job?** _____
Occupation? _____ **Marital Status:** S M D W

Who referred you to our office? _____ Address: _____

Primary Care Doctor: _____ **Address:** _____

******Complete this section only if someone other than the patient is financially responsible******

*Responsible Party: _____ Relationship to Patient _____
 *Home Address: _____
 *Telephone #: () _____ Birthdate: _____
 *Employer: _____ *Insured ID# or Social Security: _____

EMERGENCY CONTACT: (NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU).

Contact Name: _____ **Relationship to Patient:** _____
Home Phone: () _____ - _____ **Cellular #:** () _____ - _____

WHAT BODY PART ARE WE SEEING YOU FOR?: _____
DATE OF INJURY/ONSET: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy ID#: _____ Group# _____
Address: _____ City/State/Zip _____
Date of Birth: / / Insured Name: _____

Secondary Insurance: _____ **Policy ID#:** _____ **Group#** _____
Address: _____ **City/State/Zip** _____
Date of Birth: / / **Insured Name:** _____

Worker's Comp Name & Address: _____
 Worker's Comp claim#: _____ Date of Injury: _____
 Work Comp Adjusters Name: _____ Tel#: _____ Fax#: _____
 Nurse Case Mgr Name: _____ Tel#: _____ Fax#: _____

I hereby assign all medical benefits to which I am entitled to Bone & Joint Specialists. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release any information needed to determine these benefits or the benefits for related services.

Responsible Party Signature

Date

Bone & Joint Specialists

How did the injury occur & where? _____

Any previous problems with this same body part in the past? ☐ Yes ☐ No

If yes, Please list: _____

Have you been seen by any other doctor for your present problem? ☐ Yes ☐ No
If yes, which doctor and when? _____

Have X-rays or any diagnostic studies been done? (ex: MRI's; CT; Bone Scan; and EMG studies)
If yes, Where, When and What body part? _____

List all prescribed medications you are currently taking and the dosage:

*****PLEASE LIST NAME OF PHARMACY SO THAT IT CAN BE ELECTRONICALLY SENT TO THE PHARMACY*****

Pharmacy Name: _____ Pharmacy Number: _____
Pharmacy Cross Streets: _____

Allergies to Medication: ☐ Yes ☐ No

If yes, please list which medication: _____

List All Previous Surgeries (lifetime): _____

List All Medical Health Problems: _____

What is your height? _____ Weight? _____

Do you currently smoke? ☐ Yes ☐ No How many packs a day? _____

If you do not currently smoke, have you ever smoked in the past? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Socially: ☐ Yes ☐ No Occasionally: ☐ Yes ☐ No

Daily: ☐ Yes ☐ No How often? _____

Any drug use currently or in the past? ☐ Yes ☐ No Please explain?: _____

PATIENT NAME: _____ DATE: _____

BONE & JOINT SPECIALISTS

DISCLOSURE:

Bone and Joint Specialists is a for-profit corporation solely owned by the physicians providing medical services to the community.

Our office does not discriminate against any person on the basis of race, gender, religion, color, national origin, disability, or age.

FINANCIAL POLICY:

PAYMENT FOR MEDICAL SERVICES RENDERED IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Our office does verify eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your eligibility status. We will do all we can to assist you with your health insurance claims however, insurance is a contract between the insurance company and the insured. Final responsibility for payment of your account rests with you. Our office will bill a secondary insurance only once as a courtesy to the patient. If the insurance does not pay, then the balance becomes the responsibility of the insured.

If you are scheduled for surgery, we require any deductible's as well as coinsurance amounts paid prior to your date of surgery. In addition to the surgeon's fee, there is a need for an assistant at the time of your surgery. The assistant's fee is in addition to the surgeon's fee.

Any prior authorizations obtained by this office on behalf of you, the patient, are not a guarantee of payment, but are based on medical necessity. Claims are subject to your policy provisions and final payment is determined only when your insurance company has received the claim. If you have any questions regarding our medical fees or questions regarding your insurance benefits, please speak with a billing specialist.

A returned check charge of \$35.00 will be charged to the account for each returned check.

DELINQUENT AND COLLECTION ACCOUNTS:

- An account becomes delinquent when the minimal monthly payment has not been received within 30 days of the statement date.
- An account that has become delinquent for 60 days, may become a collections account and may be charged a collections handling fee, court cost's and attorney's fees.
- Exemptions from the above are allowed charges under Medicare and Title XIX (Nevada Medicaid) contracts.
- There may be exceptions to all or any part of the account.
- Balances not paid by your insurance plan within 30 days, will automatically become the responsibility of the responsible party.

CANCELLATION, NO SHOW AND RESCHEDULING POLICY: If you fail to provide us with a 24 hour notice of cancellation or rescheduling, or fail to keep your scheduled appointment, there will be a \$50 no-show fee.

I understand that Bone & Joint Specialists may not be a provider on my health plan, and I will be fully responsible for any outstanding charges that my insurance plan does not cover. A photocopy of this assignment is considered as valid as the original.

In the event that my account becomes a delinquent account or a collection account, I agree to pay Bone & Joint Specialists all incurred Finance Charges, Delinquent Account Handling Fee's, Collection Account Handling Fee's and incurred Collection cost's as set forth above in section 3 of the financial policy.

If it is necessary to forward your account to our Collection Agency, a Collection Fee markup of 35 to 50% will be added to the amount owing. Interest will accrue daily at the rate of 1.5% per month or 18% per year.

The mark-up reflects Bone & Joint Specialists receiving only its billed charges. The additional money will go to the collection agency.

Signature of Responsible Party: _____

Date: _____

BONE & JOINT SPECIALISTS

Review of Systems

Have you experienced any of the following? Please put a check mark in front of any/all of the following that you have experienced. If you have experienced any of these symptoms, please be sure your family doctor is aware.

Patient Name: _____ **Date:** _____

Systemic

Recent weight loss ☐ Yes ☐ No
 Recent weight gain ☐ Yes ☐ No
 Feeling tired ☐ Yes ☐ No
 Fever (as symptom) ☐ Yes ☐ No
 Chills (as symptom) ☐ Yes ☐ No

Endocrine Symptoms

Excessive thirst/fluid intake ☐ Yes ☐ No
 Urinary frequency increased ☐ Yes ☐ No
 Pain during urination ☐ Yes ☐ No
 Loss of hair from head or body ☐ Yes ☐ No

Pulmonary Symptoms

Cough ☐ Yes ☐ No
 Difficulty breathing ☐ Yes ☐ No

Psychological

Emotional lability ☐ Yes ☐ No
 Anxiety ☐ Yes ☐ No
 Depression ☐ Yes ☐ No

Cardiac Symptoms

Chest pain or discomfort ☐ Yes ☐ No
 Palpitations ☐ Yes ☐ No
 Limb swelling ☐ Yes ☐ No

Musculoskeletal

Muscle weakness ☐ Yes ☐ No
 Joint stiffness, localized ☐ Yes ☐ No
 Lower back pain ☐ Yes ☐ No
 Spinning dizziness (vertigo) ☐ Yes ☐ No

ENT Symptoms

Blurry vision ☐ Yes ☐ No
 Worsening vision ☐ Yes ☐ No
 Loss of hearing ☐ Yes ☐ No
 Ringing in the ears ☐ Yes ☐ No

GI

Upset stomach ☐ Yes ☐ No
 Constipation ☐ Yes ☐ No
 Red blood in bowel
 Movement ☐ Yes ☐ No
 Diarrhea ☐ Yes ☐ No

Hematological Symptoms

Easy bruising tendency ☐ Yes ☐ No
 Easy bleeding ☐ Yes ☐ No

Neurological Symptoms

Walk wobbly or unsteady ☐ Yes ☐ No
 Numbness ☐ Yes ☐ No
 Tingling ☐ Yes ☐ No
 Involuntary movements which come
 And go ☐ Yes ☐ No

Integumentary

A rash ☐ Yes ☐ No
 Localized loss of skin surface ☐ Yes ☐ No

BONE & JOINT SPECIALISTS

Health History Form

Dr. Mark Hubert

Have you experienced any of the following? Please put a check mark in front of any/all of the following that you have experienced. If you have experienced any of these symptoms, please be sure your family doctor is aware.

Patient Name: _____

Date: _____

Family History

- | | | |
|---------------------------|--------------------------|--------------------------------|
| ☐ Yes | ☐ No | No past family medical history |
| ☐ Yes | ☐ No | Family history of Diabetes |
| ☐ Yes | ☐ No | Family history of cancer |
| ☐ Yes | ☐ No | Family history of Arthritis |
| ☐ Yes | ☐ No | Family history of Hypertension |

Patient Medical History

- | | | | | | |
|---------------------------|--------------------------|--------------------------------|---------------------------|--------------------------|------------------------------|
| ☐ Yes | ☐ No | Alzheimer's Disease | ☐ Yes | ☐ No | Hepatitis |
| ☐ Yes | ☐ No | Anemia | ☐ Yes | ☐ No | HIV |
| ☐ Yes | ☐ No | Angina | ☐ Yes | ☐ No | Previous High Blood Pressure |
| ☐ Yes | ☐ No | Asthma | ☐ Yes | ☐ No | Hypertension |
| ☐ Yes | ☐ No | Atrial Fibrillation | ☐ Yes | ☐ No | PTSD |
| ☐ Yes | ☐ No | Bipolar disorder | ☐ Yes | ☐ No | COPD |
| ☐ Yes | ☐ No | Chronic Bronchitis | ☐ Yes | ☐ No | Lupus |
| ☐ Yes | ☐ No | Coronary Artery Disease | ☐ Yes | ☐ No | Insomnia |
| ☐ Yes | ☐ No | Cancer | ☐ Yes | ☐ No | Prior kidney disease |
| ☐ Yes | ☐ No | Cardiac Failure | ☐ Yes | ☐ No | Leukemia |
| ☐ Yes | ☐ No | Cellulitis | ☐ Yes | ☐ No | Prior liver disease |
| ☐ Yes | ☐ No | CHF (congestive heart failure) | ☐ Yes | ☐ No | MI, Acute |
| ☐ Yes | ☐ No | Cholesterol Problems | ☐ Yes | ☐ No | Migraine |
| ☐ Yes | ☐ No | Chron's | ☐ Yes | ☐ No | MS |
| ☐ Yes | ☐ No | Depression | ☐ Yes | ☐ No | Obesity |
| ☐ Yes | ☐ No | Dementia | ☐ Yes | ☐ No | Osteopenia |
| ☐ Yes | ☐ No | Dialysis | ☐ Yes | ☐ No | Osteoporosis |
| ☐ Yes | ☐ No | Diverticulitis-colon | ☐ Yes | ☐ No | Osteoarthritis |
| ☐ Yes | ☐ No | Diverticulitis-small intestine | ☐ Yes | ☐ No | Pancreatitis |
| ☐ Yes | ☐ No | Diverticulitis Colon | ☐ Yes | ☐ No | Parkinson Disease |
| ☐ Yes | ☐ No | Diverticulitis-small intest | ☐ Yes | ☐ No | Polio |
| ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No | Rheumatoid Arthritis |
| ☐ Yes | ☐ No | Emphysema | ☐ Yes | ☐ No | Sleep apnea |
| ☐ Yes | ☐ No | Epilepsies | ☐ Yes | ☐ No | Stroke Syndrome |
| ☐ Yes | ☐ No | Fracture | ☐ Yes | ☐ No | Thyroid disorder |
| ☐ Yes | ☐ No | GERD | ☐ Yes | ☐ No | TIA (mini stroke) |
| ☐ Yes | ☐ No | Glaucoma | | | |
| ☐ Yes | ☐ No | Gout | | | |
| ☐ Yes | ☐ No | Hiatal Hernia | | | |

BONE & JOINT SPECIALISTS
Health History Form Continued
Dr. Mark Hubert

Patient Name: _____ **Date:** _____

Past Surgical History

- | | | |
|---------------------------|--------------------------|---|
| ☐ Yes | ☐ No | Prior surgical/Procedural history |
| ☐ Yes | ☐ No | Previous pregnancies including
Cesarean section(s) _____ |
| ☐ Yes | ☐ No | Hx of eye surgery for cataracts |
| ☐ Yes | ☐ No | Hernia Repair |
| ☐ Yes | ☐ No | Hysterectomy |
| ☐ Yes | ☐ No | Cardiac Pacemaker |
| ☐ Yes | ☐ No | Surg of Pharynx, Adenoids, and Tonsils |
| ☐ Yes | ☐ No | Cholecystectomy/Gallbladder |
| ☐ Yes | ☐ No | TURP |
| ☐ Yes | ☐ No | Appendectomy |
| ☐ Yes | ☐ No | Arthroscopy |
| ☐ Yes | ☐ No | Thyroidectomy |
| ☐ Yes | ☐ No | Mastectomy |
| ☐ Yes | ☐ No | Cosmetic Surgery |
| ☐ Yes | ☐ No | Reaction to anesthetics |

Other: _____

Bone and Joint Specialists

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact ANNA HOLLAND, OFFICE MANAGER at (702) 474-7200.

WHO WILL FOLLOW THIS NOTICE:

- Bone and Joint Specialists

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Research**
- **To Provide Information about Organ and Tissue Donation**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from ANNA HOLLAND, OFFICE MANAGER at (702) 474-7200.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact ANNA HOLLAND, OFFICE MANAGER. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION.

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date. This acknowledgement will be filed with your records.

Acknowledgement of Receipt of Notice of Privacy Practices for Bone & Joint Specialists

I hereby acknowledge that I have received the Notice of Privacy Practices from Bone & Joint Specialists.

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Print Name: _____

BONE & JOINT SPECIALISTS

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I Authorize:

To release my health care information to: Bone & Joint Specialists

Name of designated individual, organization, or Provider

2020 Palomino Lane, Suite 110, Las Vegas, NV 89106

Address

(702) 474-7200 (OFFICE) (702) 474-0009 (FAX)

Information to be Released:

☒	All Medical Records
☐	All Medical Billing Records
☐	X-Ray and imaging reports

Dates of Treatment:

☒	All Dates
☐	Specific Dates:

Other: _____

Purpose of disclosure: _____

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

Printed Name

Date

Signature of Patient or Legal Representative

Date

Authorization will expire 12 months from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.