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Patient Information (Please Print)

Name _____ DOB _____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

SSN# _____ Sex M / F Email _____ Work Phone _____

Marital Status M S O Employed / Retired / Full-time Student / Part-time Student / Other (circle one)

Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

Insurance Information

Primary Insurance Carrier _____ Claims to _____

Phone _____ Group # _____ ID # _____

Effective _____ CoPay \$ _____

Secondary Insurance Carrier _____ Claims to _____

Phone _____ Group # _____ ID # _____

Effective _____

Spouse or Insured Party Information

Spouse or Responsible Party Name _____ DOB _____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

SSN# _____ Relationship _____ Policy Holder Yes / No

Employer _____ Occupation _____

Work Address _____ Work Phone _____

Allergies

(For office use only, place sticker here.)

Appointment Information (For office use only)

Problem/Injury _____ Onset/ Date of Injury _____

Work Related Y N Prior Care/ Prior Surgeries _____

Previous Films/MRI/Scans Y N Where _____ Will Bring/Send Y N

Urgent / Next Available _____ If urgent determine patient location and time to office _____

Appointment Date _____ Time _____ Provider _____

Info in Medical Manager Y N Account # _____ Paperwork sent Y N Films requested Y N

Ins. Verified by _____ Date _____ Spoke to _____

Emergency Information

Contact _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Referred By

Physician _____ Address _____

City _____ State _____ Zip _____ Phone _____

Self Friend/Family Yellow Pages Other _____

*****Workers' Compensation Insurance*****

Insurance Carrier _____ Claims Adjuster _____

Claims Address _____ Phone Number _____

Claim Number _____ Date of Injury _____

Employer on date of injury _____ If OWCP, Diagnosis Code _____

Date of Verification _____ Verified With _____ Employee Initials _____

AUTHORIZATION: I hereby authorize Flagstaff Bone and Joint (FBJ) to furnish information requested to insurance carriers concerning my illness. I hereby irrevocably assign to FBJ all payments for medical services rendered. I understand that I am financially responsible for all charges, whether or not covered by insurance. I authorize any holder of medical information about me to release to FBJ that information needed during the course of my treatment.

Patient Signature _____ Date _____

**FLAGSTAFF BONE AND JOINT
77 WEST FOREST AVENUE, SUITE 301
FLAGSTAFF, AZ 86001**

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

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

We respect patient confidentiality and only release personal health information about you in accordance with the state and federal law. This notice describes our policies related to the use of the records of your care generated by Flagstaff Bone and Joint (FBJ).

Privacy Contact: If you have any questions about this policy or your rights contact the Privacy Coordinator at 928-773-2535

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond FBJ. This includes for:

Treatment: With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside FBJ that we are consulting with or referring you to.

Payment: Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations: We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training of staff.

Information Disclosed Without Your Consent. Under state and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies: Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care: We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law: This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect, including child abuse, elder abuse or institutional abuse.

Coroners, Funeral Directors: We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purposes of carrying out their duties.

Governmental Requirements: We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested, with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others: If a crime is committed on our premises or against our personnel we may share information with law enforcement officials to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT REQUESTS

You have the following rights under state and federal law:

Copy of record: You may request to inspect the personal health record FBJ has generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records: You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction of Record: You may ask us not to use or disclose part of the personal health information. This request must be in writing. FBJ is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Practice Manager who will consult with the staff involved in your care to determine if the request can be granted.

Contacting You: You may request that we send information to another address or by alternative means. We will honor such a request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. Due to agency policy, we are not able to provide information by e-mail.

Amending Record: If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this, contact the Practice Manager and ask for the Request to Amend Health Information Form. In certain cases, we may deny your request. If we deny your request for an amendment, you have a right to file a statement stating that you disagree with us. We will then file our response and your statement and our response to it will be added to your record.

Accounting for Disclosures: You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period, no longer than six years, and after April 14, 2003, please submit your request in writing to our Privacy Coordinator. We will notify you of the cost involved in preparing this list.

Questions or Complaints: If you have any questions or complaints you may contact our Privacy Coordinator in writing at our office for further information. We will not retaliate against you for filing a complaint.

Changes in Policy: FBJ reserves the right to change its Privacy Policy based on the needs of FBJ and changes in state and federal law.

Notice of Privacy Policy Revision Number 1
Effective Date: April 14, 2003
Vicky Wuest, Privacy Coordinator
928-214-2869

**FLAGSTAFF BONE AND JOINT
77 WEST FOREST AVENUE, SUITE 301
FLAGSTAFF, AZ 86001**

PATIENT CONSENT FORM

I understand that with new federal regulations, called the Health Information Portability and Accountability Act of 1996, I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have read the privacy policy containing a more complete description of the use and disclosures of my health information. I have been given the right to review the privacy policy prior to signing this consent.

I understand that Flagstaff Bone and Joint (FBJ) has the right to change its privacy policy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the privacy policy.

I understand that I may request in writing that FBJ restrict how my health information is used or disclosed to carry out treatment, payment, or health care operations. I also understand FBJ is not required to agree to my requested restrictions, but if FBJ does agree, then FBJ is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that FBJ has taken action relying on this consent.

Patient name: _____
(please print)

Patient Signature: _____

Signature and relationship to patient: _____
(If signing on behalf of the patient)

Date: _____

Office use only

I attempted to obtain the patient's signature in acknowledgement of this notice of privacy policy, but was unable to do so as documented below.

Date: _____ Initials: _____

Reasons: _____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your medical services. The following is a statement of our Financial Policy which we request that you read prior to any treatment.

All patients are requested to complete our "Patient Information Form" before being seen by the provider.

**FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD.**

Regarding Insurance

We do not automatically accept assignment of insurance benefits as payment in full for medical services provided. The balance of your bill is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide our office with all necessary insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some and perhaps all of the medical services you receive may be considered "reasonable and customary" under your insurance plan.

Usual and Customary

Our practice is committed to providing the best treatment possible for our patients and we charge what are in fact the usual and customary rates for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of their "usual and customary" rates.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians) are responsible for full payment of services. For unaccompanied minors, the law requires that all non-emergency treatments be denied unless all treatment charges have been pre-authorized by the parents or legal guardians. Payment is expected in full with cash, check, Visa or MasterCard being acceptable means of payment at time of service.

Collections

The overwhelming majority of our patients regularly pay their bills when due. While in the past we have accepted an occasional delay, the current economic environment compels us to introduce measures to ensure that all payments are received on time. We have implemented a collection program which reduces our operating expenses while maintaining a level of personal service that we know you desire. All accounts that become 60 days past due will be assigned to either Gerald Nabours, Attorney at Law, or the Arizona Credit Bureau. This will be an automatic assignment unless prior arrangements have been approved. Should collection action become necessary, there will be collection fees and court costs added to your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the above Financial Policy and agree to the Terms and Conditions as set forth in the above document.

Signature of Patient or Responsible Party: _____ Date: _____



Patient's Identifying Information

Please answer the following as best as you can:

Date: _____

Name: Last, First, Middle *Birth date* *Age* *Birthplace*

Primary Care Physician _____

Height: _____ ft.in. Weight: _____ lbs. Hand Dominance: R / L Have you been here in the past 3 years? _____

Reason you are being seen here: _____

Please list all known allergies: _____

Please list all current medications you are taking (mgs & dosage). Please include over the counter medication as well.

1. _____ 2. _____ 3. _____ 4. _____
 5. _____ 6. _____ 7. _____ 8. _____

◆ SOCIAL HISTORY ◆

Occupation: _____ Marital Status: _____ Number of Children: _____

Do you use tobacco now? _____ In the past? _____ Type: _____ Avg. daily amount: _____ How Long? _____

Do you drink alcoholic beverages? _____ In the past? _____ Type: _____ Weekly amount: _____ How Long? _____

Are you or could you possibly be pregnant now? _____

◆ PAST MEDICAL HISTORY ◆

List any past hospitalizations or surgeries

Month/Year	Hospital/Doctor	Diagnosis, Reason for Procedure

List any additional significant past or ongoing medical illness

Year	Illness
1.	
2.	
3.	
4.	
5.	
6.	

List any additional serious injuries or accidents

Year	Injury
1.	
2.	
3.	
4.	
5.	
6.	

◆ FAMILY HISTORY ◆

Please check if any of your blood relatives have had any of the following

Illness	✓	Relative	Illness	✓	Relative
Bleeding Disorders			Tuberculosis		
Problems Re: Anesthesia			Thyroid Disease		
Diabetes			Arthritis		
Heart Trouble			Mental Illness		
High Blood Pressure			Asthma		
Stroke			Sickle Cell Anemia		
Kidney Disease			Glaucoma		
Cancer			Stomach/Duodenal Ulcers		
Other:					

◆ REVIEW OF SYSTEMS ◆

Please check if you have any of the following ~ date of onset and comments

◆ GENERAL

- Loss of appetite
- More thirsty lately
- Difficulty sleeping
- Fatigue
- Drenching night sweats
- Shaking chills
- Fever
- Weight loss/gain

◆ EENT

- Sinus problems
- Sore throat
- Enlarged tonsils
- Nosebleeds
- Hearing difficulties
- Pain in ears
- Buzzing in ears
- Trouble with vision
- Dry eyes
- Dry mouth
- Dental problems
- Mouth sores or ulcers

◆ RESPIRATORY

- Wheezing
- Chronic cough
- Coughing up phlegm
- Coughing up blood

◆ CARDIOVASCULAR

- Racing heart
- Chest discomfort
- Dizzy spells/fainting
- Shortness of breath
- Short of breath at night
- More pillows to breath
- Swollen feet or ankles

◆ GASTRO INTESTINAL

- Nausea or vomiting
- Abdominal pain
- Blood from rectum
- Black or tarry stools
- Constipation or diarrhea

◆ HEMATOLOGIC/LYMPH

- Anemia
- Bruises easily
- Bleeding problems
- Blood transfusions
- Enlarged glands
- Hepatitis/HIV -AIDS

◆ MALE/FEMALE/URINARY

- Sexually transmitted disease
- Prostate trouble
- Menstrual problems
- Urinary problems

◆ MUSCULOSKELETAL

Other than what you are being seen for today

- Painful muscles or joints
- Swollen joints
- Back pain

◆ ENDOCRINE

- Diabetes
- Thyroid

◆ NEURO

- Fainting
- Seizures
- Weakness
- Paralysis
- Tremors
- Altered sensations (numbness/pain)

◆ MOOD/PSYCH

- Lack of concentration
- Lonely or depressed
- Cries often
- Memory loss
- Drug problems

◆ SKIN

- Skin rashes/sores/moles
- Itching or burning
- Bleeds easily
- Sores or ulcers

Thank you for completing this form. This will help us help you in a more comprehensive manner

Reviewed By _____

Date _____

FLAGSTAFF BONE AND JOINT
77 WEST FOREST AVENUE, SUITE 301
FLAGSTAFF, AZ 86001

CONTROLLED SUBSTANCE AND PRESCRIPTION REFILL AGREEMENT

During the course of your treatment at Flagstaff Bone and Joint (FBJ), your physician may prescribe controlled substances. The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. This agreement also outlines Flagstaff Bone and Joint's prescription refill policies. Compliance with this agreement will help to ensure that you get the safest and best possible care at our facility.

General

1. You are expected to inform our office of any new medications or medical conditions, and of any adverse reactions you experience from any of the medications that you take.
2. You will not attempt to get controlled substances from any other health care provider without telling them that you are taking medications prescribed by FBJ providers. In addition, you will keep FBJ informed of all medications you may receive from other physicians. This includes the emergency department at hospitals if you are treated.
3. You agree to not give or sell your medications to any other person, or otherwise permit others to have access to your medications. You agree to keep these medications in a secure place.
4. You will not alter your medications in any way (for example crushing or chewing tablets). Furthermore, you understand that changing the date, quantity, or strength of medications or altering a prescription in any way, shape, or form is against the law.
5. It should be understood that any medical treatment is initially a trial, in that a continued prescription is contingent on evidence of benefit. In addition, you understand that once orthopaedic care is completed, refills of medications may be transferred to your primary care physician. If you do not have a primary care physician at that time, you will have from 1-3 months to find a physician who will take over your care and prescribe your medications.

Refills

1. Your physician is Dr. _____ . Your doctor is available for refills during the hours of 8:00am to 5:00pm on: _____ .
2. **Prescriptions will not be phoned in after hours, on weekends or holidays. No exceptions.**
3. **Please call in for refill requests at least 3 days prior to your last dose of medication.** Do not wait until the day your medication runs out.
4. Some prescriptions cannot be refilled by phone or mail. In these situations, you must pick up your prescription from our office during normal business hours: Monday – Friday, 8:00am to 5:00pm.
5. Refills will not be made if you “run out early.” You agree to use your medications at a rate no greater than the prescribed rate unless it is discussed directly with your FBJ physician.
6. Refills are contingent upon keeping scheduled appointments and following the FBJ prescription policy. You agree to fully comply with all aspects of your treatment program, including behavioral, medicinal, and physical therapy. Failure to do so may lead to discontinuation of your medication.
7. Please use only one pharmacy for refills of your medications, whenever possible. Should the need arise to change pharmacies, our office must be informed. Using the same pharmacy helps assure that the pharmacy will stock your medications for refills and that the pharmacy will know that you have a legitimate need for the medications. The pharmacy that you have selected is: _____ Phone: _____ .

If at any time you are concerned about your medications or side effects of your medications please call your physician. I understand that if I violate these policies, my controlled substance prescriptions with FBJ may be terminated. I have read the above Controlled Substance and Prescription Refill Agreement and agree to the Terms and Conditions as set forth in the above document.

Signature of Patient or Responsible Party: _____ Date: _____



PHYSICIANS & SURGEONS BUILDING

Flagstaff Bone and Joint
 77 West Forest Avenue, Suite 301
 Flagstaff, AZ 86001

Driving Directions from East of Flagstaff Communities:

I-40 west to exit 198 (Butler Ave).
 After off-ramp, right onto Butler heading west.
 Straight through 1st traffic light onto Enterprise Rd.
 Next traffic light turn left onto Route 66 (heading west).
 Next traffic light turn right onto Switzer Canyon Dr.
 Continue on Switzer Canyon to top of hill.
 Second traffic light is Beaver St. Turn right onto Beaver St. and continue up hill to main hospital complex.
 Second entrance on right is the parking lot for Physicians & Surgeons Building. Park and enter through entrance that faces north toward the Peaks. Take elevator to the third floor and Suite 301 is the first office facing the elevators.

Driving Directions from South of Flagstaff Communities:

I-17 heading north to Flagstaff.
 I-17 turns into South Milton Rd.
 Heading north on Milton continue until you pass under railroad overpass.
 Get into left turn lane at the light. Turn left onto Humphreys St.
 Third traffic light is Columbus Ave. Turn right onto Columbus Ave.
 Next traffic light is Beaver St. Turn left onto Beaver St. and continue up the hill past the main hospital complex.
 Second entrance on the right is the parking lot for Physicians & Surgeons Building. Park and enter through the entrance that faces north toward the Peaks. Take the elevator to the third floor and Suite 301 is the first office facing the elevators.

Driving Directions from West of Flagstaff:

I-40 heading east towards Flagstaff.
 Take I-17 exit north towards Flagstaff.
 Directions at this point are the same as above for communities south of Flagstaff.