



Patient Information (Please Print)

- Amber Randall, MD
- John Hall, MD

- Darius Moezzi, MD
- Torey Botti, MD
- Kevin O'Donnell, DO

Name _____ DOB _____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

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

Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

Referred By

Physician _____ Address _____

City _____ State _____ Zip _____ Phone _____

Self Friend/Family Yellow Pages Other _____

Emergency Information

Contact _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

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 _____

Insurance Information:

Do you have IHS Service Unit coverage? Yes/No _____

Did your Service Unit Refer you to us? Yes/No Unit: _____

Allergies

Primary _____

ID# _____ Group# _____

Secondary _____

ID# _____ Group# _____

(For office use only, place sticker here.)

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

Insurance Carrier _____

Claims Rep _____ Phone Number _____

Claim Number _____ Date of Injury _____

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 _____



NOTICE TO ALL FLAGSTAFF BONE AND JOINT PATIENTS

It is important that you understand the care you receive at Flagstaff Bone and Joint is not dictated by your health insurance carrier, but by what our providers recommend and by what you consent to receiving in order to provide you with the best care possible.

Orthopaedic surgery is a specialty practice and your insurance plan may have special requirements in order for you to see a specialist. **It is your responsibility** to determine if we participate with your plan, whether you need a referral before scheduling an appointment and to review what your insurance policy covers for orthopaedic services such as office visits, MRI, ultrasound, durable medical equipment, physical therapy, surgery and injectable medications. It is also your responsibility to know your benefits for copays, coinsurance and deductibles.

If you receive a service that usually requires a prior authorization such as surgery, physical therapy and MRI, we will initiate the authorization request with your insurance carrier to inquire if you have insurance benefits for that specific service. **Please understand that the authorization to proceed with that service does not guarantee that your insurance will pay 100 percent of the fees, you may be responsible for some of the fees.** Once your insurance carrier receives our claim they will process the claim according to your individual, specific policy guidelines for coinsurance, deductible and copay amounts.

I have read and fully understand the above Flagstaff Bone and Joint policy regarding my responsibility concerning my insurance policy and orthopaedic benefits.

Signature of Patient or Responsible Party: _____

Date: _____

FLAGSTAFF BONE AND JOINT FINANCIAL POLICY

Thank you for choosing Flagstaff Bone and Joint as your orthopaedic specialist. Please carefully read this document and sign below. This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our billing department will be glad to discuss these policies with you.

Orthopaedic surgery is a specialty practice and your insurance plan may require that you obtain a referral from your primary care provider before being seen. As the insured member, this is **your** responsibility. We recommend that you contact your health insurance plan to determine if we participate with your plan, whether you need a referral before scheduling an appointment and to review what your insurance policy covers for orthopaedic services such as radiology, durable medical equipment, physical therapy, surgery and injectable medications.

Flagstaff Bone and Joint participates with a variety of insurance plans. We can answer general questions about which insurance plans we participate with. Ultimately, however, it is **your** responsibility to determine whether or not we are a participating provider for your insurance plan. It is also **your** responsibility to know your provisions for copays, deductibles and coinsurance.

We will bill your insurance plan regardless of our network participation. Once our claims are processed and we receive an explanation of benefits from your insurance plan we will follow their fee schedule if we are contracted with their plan. If we are not contracted with your insurance plan we will follow the Flagstaff Bone and Joint fee schedule and bill you accordingly.

Your insurance plan may require you to supply certain information directly to them after our claim has been submitted. It is **your** responsibility to comply with their request and submit the requested information back to them in a timely fashion. If we receive notice from your insurance plan that they will not continue processing our claims until the information they requested from you is submitted, the balance will automatically become **your** responsibility until the claim is paid. Your account will then be subject to our overdue invoice process outlined in the following paragraph.

If there is a remaining balance due after your insurance plan processes and/or pays, you have 30 days to make payment on our invoice. Payment arrangements can be made for special circumstances by contacting our billing department immediately after receiving your first invoice. It is **your** responsibility to make contact with our billing department to make special arrangements. If your account becomes 30 days past due, you will receive a letter reminding you that you must satisfy this debt and pay the account within 10 days. Please be aware that if your balance remains unpaid we will then refer your account to either Tevis Reich, Attorney at Law, or the Arizona Credit Bureau. This will be an automatic assignment unless prior arrangements have been approved. Should a collection action become necessary, there will be collection fees and court costs added to your account.

If you do not have insurance, please see our billing department to arrange a cash payment at time of service. For your convenience, we accept cash, check, Master Card, Discover and Visa.

Flagstaff Bone and Joint will charge a \$35 service fee added to your account for any checks returned for any reason. You will be responsible for payment of this fee and the amount of the returned check. Non Sufficient Fund checks must be redeemed with certified funds (cashier's checks, money order or cash).

I have read and fully understand the Financial Policy set forth by Flagstaff Bone and Joint and I agree to the Terms of this Financial Policy.

Signature of Patient or Responsible Party: _____ **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: _____



Patient's Identifying Information

Please answer the following as best as you can:

Date: _____

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

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

<p>◆ GENERAL</p> <input type="checkbox"/> Loss of appetite <input type="checkbox"/> More thirsty lately <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Fatigue <input type="checkbox"/> Drenching night sweats <input type="checkbox"/> Shaking chills <input type="checkbox"/> Fever <input type="checkbox"/> Weight loss/gain	<p>◆ CARDIOVASCULAR</p> <input type="checkbox"/> Racing heart <input type="checkbox"/> Chest discomfort <input type="checkbox"/> Dizzy spells/fainting <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Short of breath at night <input type="checkbox"/> More pillows to breath <input type="checkbox"/> Swollen feet or ankles	<p>◆ MUSCULOSKELETAL <i>Other than what you are being seen for today</i></p> <input type="checkbox"/> Painful muscles or joints <input type="checkbox"/> Swollen joints <input type="checkbox"/> Back pain
<p>◆ EENT</p> <input type="checkbox"/> Sinus problems <input type="checkbox"/> Sore throat <input type="checkbox"/> Enlarged tonsils <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Hearing difficulties <input type="checkbox"/> Pain in ears <input type="checkbox"/> Buzzing in ears <input type="checkbox"/> Trouble with vision <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry mouth <input type="checkbox"/> Dental problems <input type="checkbox"/> Mouth sores or ulcers	<p>◆ GASTRO INTESTINAL</p> <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Blood from rectum <input type="checkbox"/> Black or tarry stools <input type="checkbox"/> Constipation or diarrhea	<p>◆ ENDOCRINE</p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid
<p>◆ RESPIRATORY</p> <input type="checkbox"/> Wheezing <input type="checkbox"/> Chronic cough <input type="checkbox"/> Coughing up phlegm <input type="checkbox"/> Coughing up blood	<p>◆ HEMATOLOGIC/LYMPH</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Bruises easily <input type="checkbox"/> Bleeding problems <input type="checkbox"/> Blood transfusions <input type="checkbox"/> Enlarged glands <input type="checkbox"/> Hepatitis/HIV -AIDS	<p>◆ NEURO</p> <input type="checkbox"/> Fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremors <input type="checkbox"/> Altered sensations (numbness/pain)
	<p>◆ MALE/FEMALE/URINARY</p> <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Prostate trouble <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Urinary problems	<p>◆ MOOD/PSYCH</p> <input type="checkbox"/> Lack of concentration <input type="checkbox"/> Lonely or depressed <input type="checkbox"/> Cries often <input type="checkbox"/> Memory loss <input type="checkbox"/> Drug problems
		<p>◆ SKIN</p> <input type="checkbox"/> Skin rashes/sores/moles <input type="checkbox"/> Itching or burning <input type="checkbox"/> Bleeds easily <input type="checkbox"/> Sores or ulcers

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

Reviewed By _____

Date _____

**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 at Flagstaff Bone and Joint is _____ Dr. _____ is not a Pain Management Physician, he/she is a Doctor of Osteopathic Medicine and will not prescribe pain medication unless you have had a surgical procedure by one of Flagstaff Bone and Joint's Orthopaedic Surgeons. Flagstaff Bone and Joint's Orthopaedic Surgeons will only provide pain medication during your post surgical global period. If you need a prescription refill during your post operative period, Dr. _____ is available for refills during the hours of 8:00am and 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.