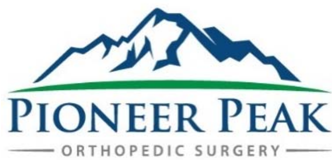


PIONEER PEAK ORTHOPEDICS
2490 S. Woodworth Loop, #200
Palmer, AK 99645
Phone: (907) 707-1671 Fax: (907) 707-1675
Email: PioneerPeak.com

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

SPOUSE'S NAME_________________________________ **EMERGENCY CONTACT/NUMBER** ____________________
PARENT'S IF PATIENT IS A MINOR ____

REFERRED BY________________________________**PERSONAL PHYSICIAN**_____________________________

INSURANCE: 1)_________________________2)_____________________________3)___________________

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 ORTHOPEDICS, LLC
NEW PATIENT INTAKE FORM

NAME________________________________**DOB**_____________**APPT DATE** ______________________

Chief Complaint: (What is the problem? 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		

_____Other____

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

____

____

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

____

Do you have any of the following problems? (Please check all that apply) _____**NONE**

____Recent weight loss or gain	____Fever/chills	____Blurred vision
____Skin rashes	____Headaches	____Hearing loss
____Sore or dry throat	____Shortness of breath	____Chronic cough
____Chest pains or tightness	____Heart palpitations	____Abdominal pains
____Nausea or vomiting	____Heartburn (reflux)	____Body aches
____Pain in multiple joints	____Difficulty with urination	____Constipation/diarrhea
____Burning with urination	____Swelling in arms or legs	____Depression

____**Are you on blood thinners?**

_____Other____

____

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):

Smoking History____Yes ____No

If yes ____Current Every Day Smoker Cigarettes per day ___________
____Former Smoker Years smoked__________

Do you use smokeless tobacco? ____Yes ____No
Are you at risk for secondhand smoke? ____Yes ____No

Alcohol Use ____None ____Socially ____Daily

If daily, how much?____

Recreational Drugs Please list ____

History of substance abuse? ____Yes ____No

If yes, do you have a contract with someone? Explain____

Drug Allergies (Please check or list others): ____**NONE**

____Penicillin ____Codeine ____Sulfa ____Kefzol ____Latex _____NSAIDS _____Aspirin

____Morphine _____Keflex ____Ancef ____Percocet ____Clindamycin ____Tramadol

____Hydrocodone ____Oxycodone ____Flexeril ____Zofran ____Norco

Type of Reactions____

Other Drug Allergies:____

____

Current Medications (**PRINT CLEARLY** and list all medications or supply us with a separate list): ____**NONE**

____

____

____

____

Please list your height and weight: **Height_______** **Weight_______**

DO NOT WRITE BELOW THIS LINE

Vital Signs Blood Pressure _________/ _________

Smoking Plan ____Advised to quit tobacco use ____Cessation materials/counseling provided

Educational Materials

____ACL Information
____MCL Information
____Cast Care Information
____Surgery Information
____Knee Scope Information
____Shoulder Scope Information
____Total Hip Information
____Total Knee Information
____Home Exercise Program
____Fracture Treatment
____Carpal Tunnel

Other____

____

____

____

____

____

Notes: (For Office Use Only):____

____

____

PAYMENT OF BENEFITS

I understand that PIONEER PEAK ORTHOPEDICS (PPO), LLC will bill my insurance as a courtesy. I have signed all claims and have provided adequate information ie, full insurance information identification numbers, insurance cards, accident questionnaire, and completed claim forms. I authorize payment of benefits by my insurance company directly to PPO, LLC. I understand that I am to pay all deductibles, insurance co-payment requirements, and supply items at the time of service. I further agree that after 60 days all balances due to PPO, LLC become my responsibility. I acknowledge I am responsible for all charges incurred. PPO, LLC will accept partial payments whether or not marked "Paid in Full" without losing our rights under this agreement. I understand that PPO, LLC *Policy of Payment* requires payment in full at the time of service if I do not have insurance coverage; unless prior arrangements are made.

Signature____Date____________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(Insured party or dependent patient, if not a minor, must sign all authorizations.) I authorize PPO, LLC to release any health information request from my insurance company with regarding to the processing of my claims. I certify that the information which I furnish on this registration form is true and correct, knowing that it is a Federal Law violation to fill out the form with facts I know are false or leaving out facts that I know are important.

Signature____Date____________

TERMS

As a courtesy, PPO, LLC will bill my primary and secondary insurance(s) if the information has been provided at the time of service. There is a $35.00 fee for all insufficient fund check returns. In the event surgery is deemed necessary, PPO, LLC will require a deposit of the estimated patient responsibility for surgical fees based on insurance coverage and deductible prior to surgery being performed. In the event there is no insurance coverage, prior arrangements must be made with the Office Manager. A surgery deposit must be received 2 (two) weeks prior to the scheduled surgery or the surgery will be cancelled. This policy does not apply to accepted Alaska Workers' Compensation claims, Medicare, Medicaid, and Denali Kid Care patients. Surgery fees includes 90 days of normal follow-up days but excludes, injections, x- rays, and supplies. Deductibles and insurance co-payments are due at the time of service. PPO's Office Manager and/or the Billing Specialist will gladly assist you with the financial arrangements or review your insurance coverage. Workers' Compensation claims must be verified with the Workers' Compensation carrier. PPO, LLC does not accept out of state workers' compensation claims or Office of Worker's Compensation Programs claims. Claims not verified are the financial responsibility of the patient and are payable at the time of service. Refunds will be available when the insurance carrier has settled all outstanding dates of service on your account. Automobile accident claims must be preauthorized and a copy of the Personal Injury Policy (PIP) Ledger must be received to verify funds are available; unless there is no other coverage available. Without the automobile PIP ledger, PPO, LLC will require a 50% deposit of the estimated surgery cost at least 2 (two) weeks in advance. If the required document is not received, the surgery will be cancelled. PPO, LLC does not accept third party liability claims under any circumstances. Any treatment or supplies provided prior to this authorization is the responsibility of the patient at the time of service. If your account is turned to collection agency, an additional 25% fee will be added to your account for the collection agency. My signature below is my understanding and agreement to the above financial policies of PPO, LLC. This authorization is valid for the duration of my care or maximum period of 24 months from today's date.

Signature____Date____________

(PRINT) PATIENT NAME______________________

NOTICE OF PRIVACY PRACTICES

Effective 12/01/2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability & Accountability Act (HIPAA). It describes how we may use or disclose your protected health information (PHI), with whom that information may be shared, and the safeguards we have in place to protect it. This Notice also describes your rights to access and amend your PHI. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE You will be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your PHI and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your PHI in accordance with law.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION "Protected health information (PHI)" is individually identifiable health information and includes demographic information (for example, age, address, etc.), and relates to your past, present or future physical or mental health or condition and related health care services. Our Practice is required by law to do the following: (1) keep your PHI private, (2) Present to you this Notice of our legal duties and privacy practices related to the use and disclosure of your PHI, (3) follow the terms of the Notice currently in effect, and (4) post and make available to you any revised Notice. We reserve the right to revise this Notice and to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. The Notice's effective date is at the top of this page and at the bottom of the last page.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION Following are examples of permitted uses and disclosures of your PHI. The examples below are not exhaustive.

Required Uses and Disclosures By law, we must disclose your health information to you unless it has been determined by a health care professional that it would be harmful to you. Even in such cases, we may disclose a summary of your health information to certain of your authorized representatives specified by you or by law. We must also disclose health information to the Secretary of the U.S. Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws on the protection of your health information.

Treatment We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we may disclose your PHI from time-to-time to another physician or health care provider (for example, a specialist, pharmacist, or laboratory) who, at the request of your physician, becomes involved in your care. In emergencies, we will use and disclose your PHI to provide the treatment you require.

Payment Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities we may need to undertake before your health care insurer approves or pays for the health care services recommended for you, such as determining eligibility or coverage for benefits. For example, obtaining approval for a surgical procedure might require that your relevant PHI be disclosed to obtain approval to perform the procedure at a particular facility. We will continue to request your authorization to share your PHI with your health insurer or third-party payer.

Health Care Operations We may use or disclose, as needed, your PHI to support our daily activities related to providing health care. These activities include billing, collection, quality assessment, licensing, and staff performance reviews. For example, we may disclose your PHI to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may call you, by name, in the waiting room when your physician is ready to see you. We may use or disclose your PHI as necessary to contact you at your home telephone number to remind you of your next appointment and/or mail a postcard appointment reminder to your home address. We will share your PHI with other persons or entities that perform various activities (for example, a transcription service) for our Practice. These business associates of our Practice are also required by law to protect your health information. We may use or disclose your, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about our Practice and our services.

Required by Law We may use or disclose your PHI if law or regulations requires the use or disclosure.

Public Health We may disclose your PHI, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, track products, enable product recalls, make repairs or replacements, or conduct post-marketing review.
Legal Proceedings We may disclose your PHI during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
Law Enforcement We may disclose your PHI for law enforcement purposes, including information requests for identification and location; and circumstances pertaining to victims of a crime.
Coroner, Funeral Directors, and Organ Donations We may disclose your PHI to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose protected health information to funeral directors as authorized by law. PHI may be used and disclosed for cadaver organ, eye or tissue donations.
Research We may disclose your PHI to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
Threat to Health or Safety Under applicable Federal and State laws, we may disclose your PHI to law enforcement or another health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
Military Activity and National Security When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty, or to a foreign military authority if you are a member of that foreign military service. We may also disclose your PHI, under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.
Worker's Compensation We may disclose your PHI to comply with workers' compensation laws and similar government programs.
Inmates We may use or disclose your PHI, under certain circumstances, if you are an inmate of a correctional facility.
Parental Access State laws concerning minors permit or require certain disclosure of PHI to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State and will make disclosures following such laws.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your PHI. The following are examples in which your agreement or objection is required.
Individuals Involved in Your Health Care Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your PHI that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION You may exercise the following rights by submitting a written request to our Privacy Officer (our Privacy Officer is our Office Manager). Our Privacy Officer can guide you in pursuing these options. Please be aware that our Practice may deny your request; however, in most cases you may seek a review of the denial.
Right to Inspect and Copy You may inspect and/or obtain a copy of your PHI that is contained in a "designated record set" for as long as we maintain the PHI. A designated record set contains medical and billing records and any other records that our Practice uses for making decisions about you. This right does not include inspection and copying of the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and PHI that is subject to a law that prohibits access to PHI. You will be charged a fee for a copy of your record and we will advise you of the exact fee at the time you make your request. We may offer to provide a summary of your information and, if you agree to receive a summary, we will advise you of the fee at the time of your request.
Right to Request Restrictions You may request, in writing to our Privacy Officer, for us not to use or disclose any part of your P H I for treatment, payment or health care operations. In your request, you must tell us: (1) what information you want restricted, (2) whether you want to restrict our use or disclosure, or both, (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. If we believe that the restriction is not in the best interest of either party, or that we cannot reasonably accommodate the request, we are not required to agree to your request. If the restriction is mutually agreed upon, we will not use or disclose your PHI in violation of that restriction, unless it is needed to provide emergency treatment. You may ask us not to disclose certain information to your health plan. We must agree with that request only if the disclosure is not for the purpose of carrying out treatment and pertains solely to a health care item or service for which we have been paid out of pocket in full. You may revoke a previously agreed upon restriction, at any time, in writing.
Right to Request Alternative Confidential Communications You may request that we communicate with you using

alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Request Amendment If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your PHI as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to Accounting of Disclosure You may request that we provide you with an accounting of the disclosures we have made of your PHI. This right applies to disclosures made for purposes other than treatment, payment or health care operations as described in this Notice and excludes disclosures made directly to you, to others pursuant to an authorization from you, to family members or friends involved in your care, or for notification purposes. The accounting will only include disclosures made no more than 6 years prior to the date of your request. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this Notice.

Rights Related to an Electronic Health Record If we maintain an electronic health record containing your PHI, you have the right to obtain a copy of that information in an electronic format and you may choose to have us transmit such copy directly to a person or entity you designate, provided that your choice is clear, conspicuous, and specific. You may request that we provide you with an accounting of the disclosures we have made of your PHI (including disclosures related to treatment, payment and health care operations) contained in an electronic health record for no more than 3 years prior to the date of your request (and depending on when we acquired an electronic health record).

Other Rights You have the right to opt out of fundraising contacts. PIONEER PEAK ORTHOPEDICS, LLC will not "sell" PHI without the individual's authorization. You will be notified after a breach of unsecured PHI.

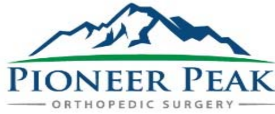
Right to Obtain a Copy of this Notice You may obtain a paper copy of this Notice from us by requesting one or view and down load it electronically at our Practice's website at www.pioneerpeak.com.

Special Protections This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV related information, mental health information, and substance abuse information. These laws have not been superseded and have been taken into consideration in developing our policies and this Notice.

Complaints If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION Our Privacy Officer can be contacted at 907-707-1671. You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices. You may also e-mail questions to our Privacy Officer at pioneerpeakortho@gmail.com.

Revised 12/01/2015



ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

We are legally required to give you a copy of the *Notice of Privacy Practices* and to get a signed statement that you received it. By signing this form, you are saying that you have received PIONEER PEAK ORTHOPEDICS, LLC's Notice of Privacy Practices.

Pioneer Peak Orthopedics, LLC Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully.

The undersigned hereby acknowledges receipt of *Notice of Privacy Practices* for Pioneer Peak Orthopedics, LLC and each of its components.

____
Patient's Printed Name(Last, First MI)

________________________________ ______________________________
Patient Signature Date

________________________________ ______________________________
Parent/Guardian Signature (if applicable) Relationship to Patient (if applicable)

If the patient did not sign an acknowledgement of receipt of the Notice of Privacy Practices, complete the following:
List efforts taken to get patient's acknowledgement and reasons acknowledgement was not signed:
____
____
____
____

____
Staff Member's Printed Name

____
Staff Member's Signature Date