PIONEER PEAK
ORTHOPEDIC SURGERY

Welcome and Thank You for Choosing Pioneer Peak Orthopedic Surgery

Please complete this form. All information will be strictly confidential.

Patient Name: _____ **Date of Birth:** _____

Social Security Number:_____ **Marital Status:** ◯Single ◯ Partnered ◯ Married ◯ Separated ◯ Widowed

Mailing Address: _____

_____

City, State, Zip: _____

Physical Address:_____

_____

City, State, Zip: _____

Patient's Employer: _____

Primary Phone: _____

OK to text message reminders? ◯ Yes ◯ No

Secondary Phone:_____

OK to text message reminders? ◯ Yes ◯ No

Email Address: _____

OK to contact you via email? ◯ Yes ◯ No

Occupation: _____

If patient is a minor, who may authorize treatment?

Name: _____**Guardian Date of Birth:** _____

Relationship: _____**Primary Phone:**_____

Name: _____Guardian Date of Birth: _____

Relationship: _____Primary Phone: _____

**If patient does have a guardian or there is a divorce decreee for a minor, please provide a copy of the documentation to the office.*

Primary Medical Health Care Provider (First and Last Name):_____

Would you like a copy of your chart notes to be sent to them for your records: **YES**_____ **NO**_____

Person(s) to Contact in Case of an Emergency

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

☐ PPO may discuss my Medical Info with this person

☐ PPO may discuss my Billing Info with this person

☐ This person may pick up my prescriptions from PPO

☐ This person may pick up my records, forms or information

Pioneer Peak Orthopedic Surgery • 3765 E Blue Lupine Drive, Suite D; Wasilla, AK 99654 • Phone: 907-707-1671 • Fax: 907-707-1675

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Do you have medical insurance?

☐ **Yes** (Complete the Insurance Section) ☐ **No**, I intend to be Self Pay ☐ Workers Compensation

Is this related to a motor vehicle accident or any other third party liability claim? ◯ Yes ◯ No

Primary Insurance:	**Secondary Insurance:**	**Tertiary Insurance:**
I.D. #	**I.D. #**	**I.D. #**
Group Number:	**Group Number:**	**Group Number:**
Card Holder Name	**Card Holder Name**	**Card Holder Name**
Date of Birth:	**Date of Birth:**	**Date of Birth:**
Relationship to Insured:	**Relationship to Insured:**	**Relationship to Insured:**

Insurance Authorization and Assignment

PLEASE REVIEW AND INITIAL

_____ I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to Pioneer Peak Orthopedics, LLC. for services furnished to me by that facility and the affiliated physician(s).

_____ I authorize this office to release and disclose to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

_____ I have received a copy of Pioneer Peak Orthopedic LLC's Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Signature of Patient, Guardian, Person or Legal Representative *Date*

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PATIENT FIRST AND LAST NAME

Would you like a copy of your chart notes from today to be sent to them for their records? Share chart notes?

Other Health Care Providers Name ◯ Yes ◯ No Initial

Other Health Care Provider Name ◯ Yes ◯ No Initial

Do you have any forms with you today that will need to be completed? ◯ Yes ◯ No

Do you have a Nurse Case Manager to assist with your care? ◯ Yes ◯ No

Signature of Patient, Guardian, Person or Legal Representative *Date*

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Orthopedic History Questionnaire

Patient Name: _____ Date of Birth: _____ Sex: ◯ Male ◯ Female

Hand Dominance: ◯ Left ◯ Right Height: _____ Weight: _____ lbs. Is this work related? ◯ Yes ◯ No

Pain Contract: ◯ Yes ◯ No When did your symptoms begin: _____

Describe how you were injured: _____

Check all that apply:	Never	Occasionally	Constant
Pain at rest	☐	☐	☐
Pain with activities	☐	☐	☐
Loss of motion	☐	☐	☐
Night pain	☐	☐	☐
Numbness/tingling	☐	☐	☐
Popping/clicking	☐	☐	☐
Grinding	☐	☐	☐
Instability/looseness	☐	☐	☐
Morning stiffness	☐	☐	☐
Giving way	☐	☐	☐
Swelling	☐	☐	☐

Do you have difficulty with:	Never	Occasionally	Constant
Personal Care	☐	☐	☐
Work Activities	☐	☐	☐
Lifting	☐	☐	☐
Reaching Overhead	☐	☐	☐
Climbing Stairs	☐	☐	☐
Weather Changes	☐	☐	☐
Kneeling	☐	☐	☐
Sleeping	☐	☐	☐

Pain Scale: (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

(Please Circle One)

If you have additional medications, allergies, surgeries, or hospitalizations that do not fit on the provided lines, please attach your own list.

Current Medication(s) _____

_____

Metal Allergies: _____ Other Allergies & Reaction: _____

List ALL Previous Surgeries: *(Surgery & Year Performed)* _____

_____

Prior Hospitalizations & Reason: _____

Past Medical History:

- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Cancer _____
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney/Liver Disease
- ☐ Difficulty Breathing
- ☐ MRSA
- ☐ Thyroid Disease
- ☐ Trauma
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Other _____

Family Medical History:

- ☐ Alcoholism
- ☐ Cancer _____
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Depression
- ☐ Disability
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Migraine
- ☐ Stroke
- ☐ MRSA
- ☐ Other _____

Social History:

Tobacco? ☐ Yes ☐ No ☐ Former Smoker

Drink Alcohol? ☐ Yes ☐ No

Caffeine? ☐ Yes ☐ No

Illegal Drug Use? ☐ Yes ☐ No

Marijuana Use? ☐ Yes ☐ No

Currently Working? ☐ Yes ☐ No

Occupation: _____

If No Occupation: ☐ Disabled ☐ Retired ☐ Homemaker

Have you ever tried Physical Therapy for this condition and where? ☐ Yes ☐ No

_____

Have you ever had steroid injections for this condition and where? ☐ Yes ☐ No

_____

Have you ever had a surgical procedure for this condition? ☐ Yes ☐ No

_____

Review of Current Symptoms:

Are you currently having or have had problems with your (check boxes that apply).

Constitutional	☐ Fatique	☐ Weight Gain	☐ Weight Loss	☐ Headache	☐ Other _____
Eyes	☐ Blurred Vision	☐ Glasses/Contacts	☐ Other _____		
Ears, Nose Throat	☐ Congestion	☐ Hearing Loss	☐ Jaw Discomfort	☐ Other _____	
Lungs, Breathing	☐ Shortness of Breath	☐ Wheezing	☐ Cough	☐ Other _____	
Heart	☐ Chest Pain	☐ Irregular Heartbeat	☐ Heart Murmurs	☐ Other _____	
Gastrointestinal	☐ Nausea	☐ Vomiting	☐ Stomach Aches	☐ Constipation	☐ Diarrhea ☐ Other _____
Bladder	☐ Incontinence	☐ Urinary Tract Infection	☐ Difficulty Urinating	☐ Other _____	
Endocrine	☐ Diabetes	☐ Thyroid Problems	☐ Delays in growth	☐ Other _____	
Musculoskeletal	☐ Joint Pain	☐ Leg Pain	☐ History of Broken Bones	☐ Other _____	
Bleeding Problems	☐ Anemia	☐ Prolonged Bleeding after Cut/Injury	☐ Other _____		
Neurological	☐ Numbness/tingling	☐ Dizziness	☐ Headaches	☐ Frequent Falls	☐ Other _____
Integumentary	☐ Rashes	☐ Skin Disorders	☐ Connective Tissue Disorders	☐ Other _____	
Psychiatric	☐ Change of mood behavior	☐ Change in sleep patterns	☐ Other _____		
Immunologic/Allergic	☐ Asthma	☐ Communicable Diseases	☐ Chronic Rashes	☐ Hay Fever	☐ Other _____
Gynecologic	Pregnant? ☐ Yes ☐ No ☐ Unsure		Regular Menstrual Periods? ☐ Yes ☐ No		

Any additional comments or information that you feel in important regarding your current medical conditions:

I believe that the information provided above is accurate and complete: _____ _____

PATIENT SIGNATURE DATE

Thank you for taking the time to help us better care for you!

OFFICIAL USE ONLY ☐ Scanned

Reviewed by:

Height: _____ BP: _____ / _____

Weight: _____ HR: _____ Temp: _____

Patient Financial Policy

Thank you for choosing Pioneer Peak Orthopedics, LLC ("PPO") as your health care provider. We are committed to providing you with quality orthopedic care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify PPO if any patient information changes (i.e., name, address, telephone number, insurance information).

Usual and Customary. PPO is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Insurance. We are currently contracted with most insurance plans, including Medicare. Please see the separate list of insurers we are currently contracted with. Knowing your insurance benefits is your responsibility as your insurance is a contract between you and the insurance company. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co- payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. To make payments convenient, we accept cash, check, Visa, Master Card, American Express, and Discover. The charge for a returned check is $35, payable by cash. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following a returned check.

Non-covered services. Please be aware that some (or all) of the office visit or surgery services you wish or need to receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. Please be aware that you will be responsible for all services rendered.

Proof of Insurance. All patients must complete our Patient Demographic form before seeing the Provider. We must obtain a copy of your driver's license or other valid ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. As a courtesy, we will submit your insurance claims (except for third-party insurers) and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Third Party Insurance. PPO does not submit claims to motor vehicle accident (MVA) or other third-party insurers. Please notify our front desk if you are covered by a third party insurance and we will instruct you how to handle those claims.

Coverage Changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Nonpayment. PPO will send monthly statements to patients with account balances. If your insurance company does not pay your claim within 90 days of the claim being submitted, the balance will automatically be billed to you. If payment in full is not received from the insurance company and/or the patient by the end of the third month following the date of service and/or submittal of the claim to the insurance company, PPO's will attempt to reach the non-paying patient by telephone. An account that becomes 150 days past due will be turned over to a collection agency after PPO mails a collection notice to the patient's mailing address on file, unless payment is received within that 30 day period. Once PPO transfers an account to the collection agency, the non-paying patient must deal with the collection agency instead of PPO. Unless the patient documentation demonstrating a financial hardship or PPOand the patient agree on a payment plan, PPOmay discharge a non-paying patient from the practice after sending notification that the patient has 30 days to find alternative care. During that 30-day period, PPO will treat the non-paying patient on an emergency basis.

Self-Pay Accounts. Self-pay accounts are patients without insurance coverage, patients with third-party insurance and patients who wish to receive services that are not covered by their insurance plans. It is always the patient's responsibility to know if our office is participating with the patient's insurance plan. Please speak with us directly to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide our patients with the best care possible and the least amount of stress.

Minors. The parent(s) or guardian(s) is responsible for providing accurate and complete insurance information and for payment in full of deductibles, co-pays and any balances not paid by insurance.

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

By signing this form, I confirm that I have read the Financial Policy and that I understand and agree to its terms.

_____ _____

Signature of Patient or Responsibility Party *Date*

_____

Printed Name of Patient or Responsibility Party

PIONEER PEAK

ORTHOPEDIC SURGERY

Charles Haggerty, MD • Michael Montano, MD
Gregory Strohmeyer, MD • Jimmy Shaha, MD

ACKNOWLEDGEMENT & RECEIPT FOR

NOTICE OF PRIVACY PRACTICES

We are required by law to provide you with a copy of our Notice of Privacy Practices.

By signing below, you are acknowledging that you have been provided with a copy of our notices to *(keep or to view)* and that you have been given an opportunity to view it.

_____ _____

Patient or Guardian's Signature *Date*

_____

Printed Name of Patient or Responsibility Party

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Pioneer Peak Orthopedics, LLC Office Visit Recording Policy

Due to Federal and State privacy laws, audio and video recording are not permitted in our office and can be causes for termination of care. If you need to record your visit or plan for someone else to participate through your cell phone during your appointment, you must obtain permission from your physician and care team. Please let the staff or your physician know if you have concerns or questions regarding your treatment, as we can provide a copy of your chart note after the office visit.

By signing below, you acknowledge that you have been notified of our office policy an will let the staff or physician know if you have any need to record your visit or have someone else participate in your care via cell phone.

_____ _____

Patient or Guardian's Signature *Date*

_____

Printed Name of Patient or Responsibility Party