



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: _____

Primary Phone: _____

OK to text message reminders? Yes No

City, State, Zip: _____

Secondary Phone: _____

OK to text message reminders? Yes No

Physical Address: _____

Email Address: _____

City, State, Zip: _____

OK to contact you via email? Yes No

Patient's Employer: _____

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 decree for a minor, please provide a copy of the documentation to the office.*

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

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



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

_____ 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



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?

Primary Medical Health Care Provider

Yes No

Initial

Other Health Care Provider Name

Yes No

Initial

Other Health Care Provider 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



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	Do you have difficulty with:	Never	Occasionally	Constant
Pain at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaching Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Popping/clicking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weather Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grinding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instability/looseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Giving way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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): _____

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

Any additional comments or information that you feel is 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 PPO and the patient agree on a payment plan, PPO may 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



*Samuel Adams, MD • 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 and 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