



Thank you for the confidence you have shown in Summit Orthopaedics by allowing us to care for your orthopaedic needs. We look forward to helping you find solutions for your healthcare concern.

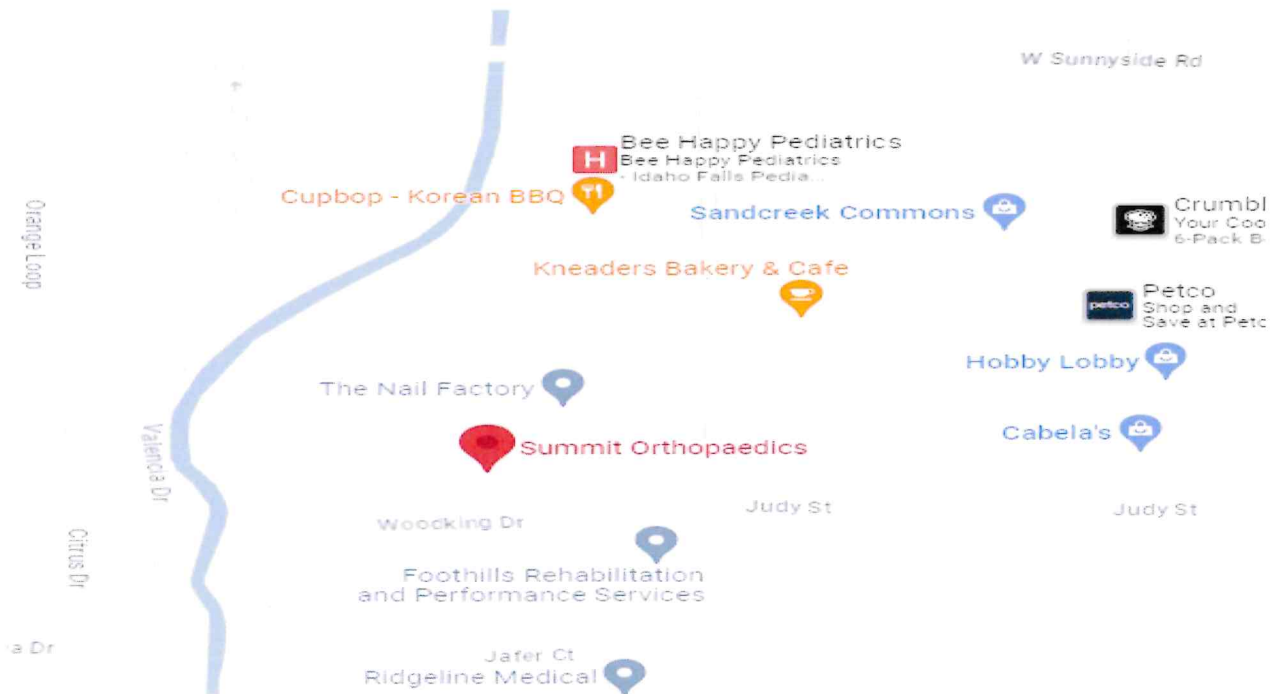
Please complete the attached forms as accurately as possible and bring them with you to your appointment. Also remember to bring your photo ID, medication list (or completed medication list, included in forms) and insurance card to your appointment.

Visit our website www.summitortho.net and find:

- Helpful information about our doctors
- Patient education materials
- Patient testimonials and information about the services we provide
- Fill out a Patient Service Survey if you want to provide feedback about your care

If you have any further questions or concerns, please don't hesitate to call our front desk at **208-227-1100**.

**See below for a map to assist you in finding our new location.





Experience You Can Trust
www.SummitOrtho.net
Main : 208.227.1100

3720 Woodking Dr,
Idaho Falls, ID 83404

PATIENT INFORMATION & DISCLOSURE FORM

Patients Last Name : First Middle Sex:
Home Address: City State Zip
Patients Social Security Number : Cell Phone Home Phone
Work Phone Age: Birthdate: Single Married Divorced Widow
Patients Employer Year with Firm Occupation
Spouse Name Social Security Number Age
Employer Occupation Work Phone

IF MINOR

Father's Name Social Security Number Age Employer
Mother's Name Social Security Number Age Employer
Occupation Work Phone
Nearest Relative Relationship Phone
Family Physician Referred by
Notify in Case of Emergency Phone Email

INSURANCE INFORMATION

Date of injury or date of onset of symptoms
Place injury occurred: Home School Work Auto Other
PRIMARY INSURANCE COMPANY NAME
Insurance Co. Address Phone
Subscriber's Name
Patient Relationship to Subscriber. Circle one (self, spouse, child) Subscriber Date of Birth
I.D. No. Group No.
SECONDARY INSURANCE COMPANY NAME
Insurance Co. Address Phone
Subscriber's Name
Patient Relationship to Subscriber. Circle one (self, spouse, child) Subscriber Date of Birth
ID No. Group No.

INFORMATION RELEASE

I hereby authorize Summit Orthopaedics to release any information acquired in the course of my examination or treatment to the insurance carriers. I hereby authorize any physician, hospital or medical care facility to provide all information on my medical history and treatment to Summit Orthopaedics.
CONSENT TO TREAT: I consent to treatment at Summit Orthopaedics for services or supplies that have been or may be ordered by the physician. I understand that treatment may include but is not limited to: radiological examinations, injections, laboratory procedures, physical therapy, nursing care or medical and surgical treatment.
Please Read & Sign Below.
Recognized the inherent risks of transmission of contagious disease, especially during surgery, I voluntarily agree to be tested for such diseases as hepatitis, syphilis, HIV/AIDS, herpes, etc. where deemed necessary by physician. Questions should be discussed with your physician.
I AUTHORIZE SUMMIT ORTHOPAEDICS TO RECEIVE ASSIGNMENT OF INSURANCE PAYMENTS. IF THE CUSTOMARY CHARGES ARE MORE THAN THE BENEFITS ALLOWED UNDER RESPONSIBLE PARTY'S INSURANCE PLAN. I AGREE TO PAY THE DIFFERENCE. I UNDERSTAND THAT REGARDLESS OF INSURANCE COVERAGE I AM RESPONSIBLE FOR ALL CHARGES AND PAYMENTS.
I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original copy in the doctor's files and authorize the insurance company to accept the photocopy.
I release you from all legal responsibility or liability that may arise from this authorization. This authorization shall continue and be in force and effect until revoked in writing by me.

OWNERSHIP DISCLOSURE: Please note that the physicians of Summit Orthopaedics, L.L.C. have individual ownership interests in Mountain View Hospital and that they may refer you for services at Mountain View Hospital. If you would prefer to receive care or testing at another hospital or facility, please discuss this with your treating physician so that he or she may determine if that is possible.

RESPONSIBLE PARTY'S SIGNATURE

DATE



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PATIENT HEALTH HISTORY

Name: _____

Date: _____

Male / Female Age _____ Family Physician _____ Referred by _____

<p>Area of complaint _____ <input type="checkbox"/> Left <input type="checkbox"/> Right</p> <p>Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date of injury or symptom onset _____</p> <p>How and where did injury occur _____</p> <p>Prior Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>By whom? <input type="checkbox"/> ER <input type="checkbox"/> Urgent Care <input type="checkbox"/> Family Physician <input type="checkbox"/> Other</p> <p>Activities that aggravate symptoms _____</p> <p>_____</p> <p>_____</p> <p>Activities that alleviate symptoms _____</p> <p>_____</p> <p>_____</p> <p>Medications with dosages and directions Prescription, OTC, Vitamins, Supplements</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Allergies and reactions (eg. Hives, Swelling, Vomiting)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Pharmacy name & number List city if not Idaho Falls</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p style="background-color: black; color: white; padding: 2px;">Physician/Physician Assistant/Nurse/Assistant Notes</p> <p>_____</p> <p>_____</p> <p>_____</p> <p style="background-color: black; color: white; padding: 2px;">Occupation and Job description</p> <p>_____</p> <p>_____</p> <p>_____</p> <p style="background-color: black; color: white; padding: 2px;">Social History</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(ed)</p> <p>Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No How Much _____</p> <p>Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Quit date _____</p> <p>Cigarettes _____ packs/day Year started smoking _____</p> <p>Chew _____ cans/week Year started chewing _____</p> <p>Caffeine <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Height _____</p> <p>Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Weight _____</p> <p style="background-color: black; color: white; padding: 2px;">Office Use Only</p> <p>BP _____ HTN meds <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pulse _____ Resp _____</p> <p>Temp _____</p> <p>SaO2 _____ RA O2</p> <p>O2 _____ L Cont NOC</p>
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Summit Orthopaedics ("Summit") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Summit does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PATIENT HEALTH HISTORY

Name: _____

Date: _____

Conditions	Please circle all that apply	Fill in any blanks that apply	Add any condition not listed
HIV/ AIDS	Emphysema	Migraine Headace	Heart Disease
Alcoholism	Asthma	Multiple Sclerosis	Heart Attack <small>When</small> _____
Chemical Dependency _____ <small>substance</small> _____	Cancer <small>(type)</small> _____ <small>substance</small> _____	Parkinson's Disease	Pacemaker <small>Date</small> _____
Anemia	Diabetes Type I Type II	Pneumonia in past year	Stoke <small>Date</small> _____
Anorexia	Epilepsy	Thyroid Problem	Stent <small>Date</small> _____
Arthritis <small>(type)</small> _____	Glaucoma/Cataracts	Psychiatric Care	Coronary artery disease
Gout	Liver Disease	<small>Diagnosis</small> _____	Peripheral vascular disease
Bleeding disorder	Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E	Suicide attempt <small>When</small> _____	Arrythmia
Blood thinner _____	High Blood Pressure	Other _____	Angina/Chest Pain
COPD	High Cholesterol	_____	Other _____
Lung Disease	Kidney Disease	_____	_____
Chronic Bronchitis	Dialysis <small>(type)</small> _____	_____	Cardiologist Name & # _____
Staph Infection <input type="checkbox"/> YES <input type="checkbox"/> NO	Autoimmune disorder	_____	_____
<small>When/Where</small> _____	<small>Type</small> _____	_____	_____

Circle if your blood relative(s) have any of the following	Family history: Age and cause of death <small>(if known)</small>	Personal Surgical History <small>(include all surgeries you have had and which side (left/right) if it applies)</small>
Anethetic Complications	Father _____	_____
Arthritis	Mother _____	_____
Gout	Brother _____	_____
Asthma	Brother _____	_____
Bleeding disorder	Brother _____	_____
Cancer <small>(type)</small> _____	Sister _____	_____
Diabetes	Sister _____	_____
Heart Disease	Sister _____	_____
High Blood pressure	Other _____	_____
Stroke	_____	_____
Kidney Disease	_____	_____
Lung Disease	_____	_____
Autoimmune disorder	_____	_____
Liver Disease	_____	_____
Other _____	_____	_____

Have you ever had a blood transusion YES NO Did you have any reaction YES NO _____

Have you ever had a complication to Anesthesia? YES NO What was the reaction _____

Have you ever had a blood clot? YES NO NA Where was it located? _____ Date _____

By signing below, I certify the information I have provided is correct to the best of my knowledge. I will not hold Summit Orthopaedics, Physicians or staff responsible for any errors or omissions I may have made in completing this form. I give Summit Orthopaedics and staff permission to obtain my medication history, and to provide that history to anyone involved in my care when necessary.

Today's Date _____

Signature _____



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FINANCIAL POLICY

Name _____

Date _____

Thank you for choosing Summit Orthopaedics as your health care provider. We are committed to providing you with excellent medical treatment. The following is our financial policy that we require patients to read and sign prior to treatment.

Self Pay: Payment on all accounts without insurance are due at the time of service unless you make other arrangements with a member of our billing department.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We do, however, bill most primary insurances as a service to our patients. As a courtesy to our patients, we will also bill secondary insurance one time. If you have any questions regarding which insurance companies we participate with, please see a member of our billing team. We accept most Medicare and Workers Compensation insurance.

Co-pays are required at time of service.

We will extend credit for 45 days on approved insurance company benefits if such benefits are assigned to the clinic and if the clinic has sufficient information to verify coverage and submit a proper claim. If your insurance does not pay, the patient is responsible for the balance. Summit reserves the right to place liens on any outstanding balances.

Surgery: If you require surgery, as part of the pre-operative process, we will create an estimate of the professional fees associated with the procedure. This amount is only an estimate. Actual benefits paid may differ due to your insurances definition of URC and other factors. We require a deposit equal to the amount of your deductible and co-insurance. This deposit is due by your final pre-operative appointments. Details of these arrangements can be discussed with a financial counselor.

Unpaid Accounts & Interest Charges: All unpaid accounts for which payment arrangements have not been made are subject to collection procedures. Any costs incurred in the collection of these accounts are added to the accounts. We charge interest on all balances that are over 90 days past due and reserve the right to turn those over to collections. We charge interest at a rate of 1.5% per month, 18% annually. Any checks returned for insufficient funds will be charged a 20.00 NSF fee.

Payment Options: We accept Visa, MC, Discover and AMEX as well as debit cards and checks. Payment arrangements can be made as follows:

Balances under 500.00 must be paid in full within 6 months. A regular payment must be made monthly to ensure the account remains current. Balances over 500.00 can be extended to a maximum of a 12 month period. Terms of your payment plan can be arranged with a member of our billing department.

Durable Medical Equipment (DME) Return Policy: All returns of DME equipment must be made within 14 days and be unopened and in resalable condition with original packing material, manuals and warranty cards. Credit will not be granted for merchandise unsuitable for resale. Due to health, hygienic and safety regulations, products which relate to personal hygiene and self care are non-returnable. Products that come in contact with the body, cannot be returned- single use patient items per Public Health policy and our practice policy.

I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY

Date _____

Signature of patient or responsible party _____



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CLINICAL DOCUMENTATION CONSENT

Name _____

Date _____

To support our mission of providing high quality care, some providers in our clinic may be using a new technology that assists in the documentation process based on recorded audio of patient exams. This new technology assists providers in reducing time spent documenting visits and allows more time to be spent with the patient.

We have appropriate agreements in place to ensure the confidentiality of your information. All documentation is reviewed, edited as needed, and approved by your provider prior to finalization, to ensure accuracy and completeness.

I hereby consent to the recording of my visits while at Summit Orthopedics

Date: _____

Signature: _____



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SUMMIT ORTHOPAEDIC PRIVACY PRACTICES

Date: _____

Name of Patient: _____

If the patient is a minor: Patient Name: _____

Parent or Guardian Signature: _____

Print Parent or Guardian Name: _____

I authorize the following people to request medical information on my behalf:

Name	Relationship	Phone#
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby acknowledge that i have been presented with a copy of Summit Orthopaedics Notice of Privacy Practices

Signed: _____

Date: _____



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REVIEW OF SYSTEMS

Name : _____

Please fill out what is pertinent today (not history)

- | | |
|---|--|
| <input type="checkbox"/> Unexpected weight loss | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Joint stiffness |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Joint swelling |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Joint redness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Joint heat |
| | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Corrective lenses | <input type="checkbox"/> Skin changes |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Poor healing |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Skin redness |
| <input type="checkbox"/> Watering | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Numbness/ tingling |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Unsteady gait |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Murmurs | <input type="checkbox"/> Hallucinations |
| | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Excessive thirst or urination |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Heat/ cold intolerance |
| <input type="checkbox"/> Tightness | |
| <input type="checkbox"/> Pain in inspiration | <input type="checkbox"/> Easy bleeding & bruising |
| <input type="checkbox"/> Snoring | |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Food allergy |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Dust allergy |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Pollen allergy |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Medication allergy |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Bloody/ tarry stools | |
| <input type="checkbox"/> Urinary frequency | |
| <input type="checkbox"/> Urinary urgency | |
| <input type="checkbox"/> Difficult/ painful urination | |
| <input type="checkbox"/> Flank pain & bleeding | |



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BLUE CROSS ACCIDENTAL INJURY QUESTIONNAIRE

WE CANNOT PROCESS YOUR CLAIM UNTIL YOU COMPLETE AND RETURN THIS QUESTIONNAIRE

<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	Identification Number Group Number Patient's Name Provider of Service Dates of Service
<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Your claim appears to be related to an accidental injury. In order to process it, we must have complete answers to the questions in the following three sections </div>	

Was this condition the result of an accident? Yes <input type="checkbox"/> No <input type="checkbox"/> If NO, sign below, date this form and return it to us.	
Accident: Any occurrence of an unforeseen outside force causing bodily injury	
Provide a detailed account of how and where the injury occurred. Please use the back of this form for additional space if needed	
Date of injury	mm/dd/yy
Place of Injury	
How Injury Occured	
Was the injury or illness sustained while performing work required by your employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are you covered by Worker's Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you self employed? Yes <input type="checkbox"/> No <input type="checkbox"/>
If Worker's Compensation has been denied, please attach a copy of denial.	
Name and address of your employer	
Are you covered by insurance coverage other then Worker's Compensation for work incurred injuries Yes <input type="checkbox"/> No <input type="checkbox"/>	Name and addresses of other insurance carrier
Was another person or parties responsible for your injury? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name and address of responsible party
Please provide responsible party's insurance carrier information	
Have you received a settlement from the responsible party?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you intend to make a claim against the responsible party?	Yes <input type="checkbox"/> No <input type="checkbox"/> Possibly <input type="checkbox"/>
Have you filed or do you intend to file a claim against your own insurance coverage (e.g., automobile, homeowner's etc.)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Please provide name, address, adjuster's name & phone number:	
Have you contacted an attorney?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, please give your attorney's name and address:	
Have you purchased prescription drugs related to this accident using a prescription drug card?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Signature _____	Home Phone _____ Business Phone _____

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