Dear Patient,

Thank you for choosing Upper Valley Orthopedics for your bone and joint care. We welcome new and returning patients and hope that your care in our office is both professional and friendly.

Enclosed is new/returning patient information sheets that will help in the care you receive in our office. Also, you will find a brochure of our Privacy Policy. This is required by law and we must have a signed form in our office that we provided you to. If you have any questions regarding our privacy policy, please don't hesitate to ask.

The following is some information that will help familiarize you with our practice.

Upper Valley Orthopedics
Michael J. Larson, M.D.     Kevin M. Lee, M.D.     Travis R. Torngren, M.D.     Zackery J. Cleverley, PA-C

360 East Main
Rexburg, ID 83440
(208) 356-9550 Office, (208) 356-8023 Fax
Business Hours: Monday-Thursday 8:00am-5:00pm, Friday 8:00am-1:00pm
Website: uppervalleyortho.com

**Payment Policy-** it is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered, this may only be your co-payment, deductible, and/or coinsurance, but we do ask for payment at the time of your visit. We accept all major credit cards.

**Co-payment-** this is the cost-sharing part of your bill that is a fixed amount designated by your insurance company that is your responsibility to pay at each visit.

**Deductible-** This is the amount of cost sharing that you must pay for medical services, often before your health insurance company starts to pay.

**Coinsurance-** This is the part of your bill, in addition to a copay, that you must pay. Coinsurance is usually a percentage of the total medical bill.

**For Medicaid Patients-** We MUST have a Healthy Connections Referral from your primary care physician before your appointment. If you do not have it at the time of your visit, we will have to reschedule your appointment.

If you have any questions after reading this information, we will be happy to answer them for you.

Please bring the following information to your visit:

Insurance Card(s)
Driver's License
Completed Forms
Any prior exam studies : X-Rays, MRIs, CT scans
List of current Medications

Thanks you again for choosing Upper Valley Orthopedics for your bone and joint care.

Sincerely,

Upper Valley Orthopedics
Michael J. Larson, M.D.     Kevin M. Lee, M.D.     Travis R. Torngren, M.D.     Zackery J. Cleverley, PA-C

**Name:**____________________________________________________________________________

**DOB:**____________________________________________________________________________

**Date:**____________________________________________________________________________

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## PATIENT FINANCIAL POLICY

**Upper Valley Orthopedics, PLLC**
**360 East Main** — **Tel. 208-356-9550**
**Rexburg, ID 83440** — **Fax 208-356-8023**

We are committed to providing you with the best possible care and are happy to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, and your financial responsibility. The patient or responsible party is responsible for seeing that the entire bill is paid in full within 30 days of the date of service.

WE WILL ASK TO SEE YOUR INSURANCE CARD ON YOUR FIRST VISIT AND WILL SCAN YOUR CARD INTO OUR SYSTEMS AS WE NEED TO KEEP YOUR INFORMATION CURRENT, WE MAY ASK FOR THIS INFORMATION ON A REGULAR BASIS IN ORDER TO ENSURE THAT NO CHANGE IN BENEFITS OR CARRIER HAS OCCURRED. PLEASE NOTIFY US IF YOUR INSURANCE CARRIER OR POLICY HAS CHANGED.

**CO-PAYMENTS:** Your insurance REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.

**SELF-PAY:** Self pay accounts shall exist if a patient has no insurance coverage or no evidence of insurance coverage for new patients, a payment of $200.00 is expected on the day of your appointment before being seen by the health care provider. If you are unable to pay the $200.00, please contact the billing office before your appointment. A discount off regular fees is offered for your payment made at the time of service.

**MEDICAID REFERRALS:** YOUR insurance requires a **Healthy Connections Referral** from your primary care physician it is **YOUR** responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. If you do not have a referral, you may be required to reschedule.

**ACCIDENT/WORKER COMP CASES**: For any work comp cases, you will need to provide the work comp insurance carrier, your claim number and your claim adjuster. If this information is not provided, this will be a self-pay account and we will require a payment of $200.00 at the time of service. Patients shall be financially responsible for medical services related to work comp if insurance fails to pay in full. We DO NOT treat Auto Accident cases.

**MEDICARE:** We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the co-insurance, which can be billed to a secondary insurance if you have one.

**RETURNED CHECK FEES:** Any returned check from the bank for a non-payment (Insufficient funds) shall result in the patient's account being assessed a $25.00 fee per check returned.

**FORMS/PAPERWORK:** There is $15.00 per form fee for the completion of paperwork or forms relating to disability. This fee is collected prior to completion of the paperwork, and for each time the paperwork is required. Allow five working days for completion of forms.

**SURGERY DEPOSIT:** Surgery Deposit is required before surgery. Any balance owing after surgery will need to be paid within 90 days of surgery date.

**We accept most forms of payment, including credit and debit cards, cash, and checks. You may also make credit or debit card payments over the phone.**
**If you have any questions, please call our office at 208-356-9550.**

**RESPONSIBLE PARTY**________________________________________________**DATE**____________________

**PATIENT NAME**______________________________________________________________________

UPPER VALLEY ORTHOPEDICS, PLLC & SPORTS MEDICINE

Board Certified Orthopedic Surgeons

Michael J. Larson, MD    Kevin M. Lee, MD    Travis R. Torngren, MD    Zackery J. Cleverley, PA-C

## Patient Information

| Name: | Date of Birth: | Age: |
|---|---|---|
| Address:<br>PO Box: | City, State: | Zip: |

| Work Phone: | Home Phone: | Mobile Phone: |
|---|---|---|

| Social Security Number: | ❑Male ❑Female |
|---|---|

| Emergency Contact/Relationship: | Phone: |
|---|---|

| Email: | Employer: | Referred By? |
|---|---|---|

**Responsible Party (If other than patient)**

| Name: | Relationship to patient: |
|---|---|
| Billing Address: | City, State, Zip: |

| Work Phone: | Home Phone: | Mobile Phone: |
|---|---|---|
| SSN: | Employer: | Email: |

**Insurance Information**

We are happy to bill your insurance as a courtesy to you, however; it is the patient's and/or legal guardian's responsibility to ensure payment for all medical services rendered. Please provide a copy of your insurance card(s).

| | | | |
|---|---|---|---|
| Primary | Primary Insurance Company: | | Card Provided for Scanning ❒ |
| | Insured's Name: | Birth Date: | Relation to Patient: |
| Secondary | Secondary Insurance Company: | | Card Provided for Scanning ❒ |
| | Insured's Name: | Birth Date: | Relation to Patient: |
| Tertiary | Tertiary Insurance Company: | | Card Provided for Scanning ❒ |
| | Insured's Name: | Birth Date: | Relation to Patient: |

If this visit is due to an injury, please provide exact date of injury:

Please indicate what type of Accident: ❒Auto ❒Work ❒Other

Is there an Attorney Involved? ❒Yes ❒No Name of Attorney:

**Assignment, Release, & Financial Responsibility**

By signing below, I authorize release of medical information to process claims to my insurance company and request that benefits be paid directly to Upper Valley Orthopedics, PLLC. Regulations pertaining to medical assignment of benefits apply. I understand and agree that regardless of my insurance sources, I am ultimately responsible for the balance of my account for any professional services rendered.
**Accident/Worker Comp Cases:** For any worker compensation cases, you will need to provide the work comp carrier, your claim number, and your claim adjuster. If this information is not provided, this will be a self-pay account and we will require a payment of $200.00 at the time of service. Patients shall be financially responsible for medical services related to work comp if insurance fails to pay in full, we DO NOT treat Auto Accident cases.
Surgery Deposit is required before surgery. Automatic payment arrangements can be made for any balance owing.
I agree that the facility Upper Valley Orthopedics, PLLC or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

Signed:_____________________________________________ Date:_________________________

Printed Name:______________________________________

If not signed by the patient, please indicate relationship Relationship:__________________________

I acknowledge that I have received a copy of the Upper Valley Orthopedics Notice of Privacy Practices and I authorize the Practice to use private patient information as indicated in the notice. Medicare beneficiaries: I request that payment of authorized Medicare benefits be made to either me or on my behalf for any services furnished me by Upper Valley Orthopedics, PLLC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I have read all the information on this form and certify this information to be true and correct to the best of my knowledge. This consent is valid from the date executed until revoked in writing by myself. Further, I permit a copy of this authorization to be used in place of the original.
I present for treatment and consent to my physician and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include but not limited to diagnostic procedures, x-rays, MRI's, injections, casting and splinting and other treatments and procedures considered advisable in the diagnosis and treatment of my condition. I realize the practice of medicine and surgery is not an exact science. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examination at Upper Valley Orthopedics.

Signed:______________________________________________ Date:_________________________

Printed Name:________________________________________

If not signed by the patient, please indicate relationship Relationship:_____________________________

| Race | Preferred Language |
|---|---|
| ❒White ❒Asian ❒Black ❒Indian<br>❒Hispanic/Latino ❒Other ❒Unknown | ❒English ❒Spanish ❒Other:______________________ |

| Patient Name: | | Date: |
|---|---|---|
| Primary Care Provider: | | Tape Allergy: ❒ Yes ❒ No<br>Latex Allergy ❒ Yes ❒ No |
| Preferred Pharmacy: | | |
| Allergies | Medication | Dosage and how often |
| | | |
| | | |
| | | |
| | | |
| | | |
| Surgeries | Date | Doctor |
| | | |
| | | |
| | | |

Past Medical History: Have you ever had any of the following? Please check all pertinent boxes:

❒Cancer
❒Chest Pain/Angina
❒Atrial Fibrillation
❒Heart Problems
❒Blood Clot(DVT)
❒Heart Attack
❒Heart Murmur
❒High Blood Pressure
❒Low Blood pressure
❒Mitral Valve Prolapse
❒Pacemaker

❒Rheumatic Fever
❒Asthma
❒Bronchitis
❒COPD
❒Emphysema
❒Pneumonia
❒Pulmonary Embolus
❒Sleep Apnea
❒Diabetes
❒High Cholesterol
❒Overactive Thyroid

❒Underactive Thyroid
❒Hemorrhoids
❒Hepatitis
❒Ulcer
❒Bladder Infections
❒Kidney Infections
❒Venereal Disease
❒Anemia
❒Bleeding Disorder
❒Blood Transfusions
❒Chicken Pox

❒HIV/AIDS
❒MRSA
❒Measles
❒Tuberculosis
❒Arthritis
❒Back Trouble
❒Epilepsy/Seizure
❒Migraine Headaches
❒Stroke
❒Glaucoma
❒Pregnant

Additional Medical conditions currently being treated:___________________________________________________________

**Social History:** *Please check all that apply*

**Cigarettes/Tobacco Use:**
❒Never Smoked
❒Quit: Former Smoker
❒Smokes Daily- #packs per day_____
❒Chewing Tobacco
*Would you like info to help you quit?* ❒Yes ❒No

**Marital Status:**
❒Single
❒Married
❒Divorced
❒Widowed
❒Unknown

**Alcohol Use:**
❒None
❒Less than 1 drink per day
❒1-2 drinks per day
❒3 or more drinks per day
*Would you like info on counseling?* ❒Yes ❒No

**Other:**
❒Recreational Drug Use
❒Live Alone

Birthplace________________________ City of Residence:______________________________
Occupation________________________How Long?___________________________________
Education:__________________________________________Dominant Hand: ❒Left ❒Right
Height:__________Weight:__________

**Family Medical History** – immediate family: mother, father, brothers, sisters, grandparents:

| | Age | Conditions or Disease | If Deceased, Cause of |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings' | | | |
| | | | |
| | | | |

**Systems Review: Please check any of the following conditions you have had or now have**

General Health: ❒Good ❒Fair ❒Poor
Reaction to Anesthesia: ❒Yes ❒No ❒Malignant Hypothermia
Tendency to bleed excessively: ❒Yes ❒No

**Central Nervous and Psychiatric**

Difficulty Sleeping: ❒Yes ❒No
Troubled by Depression: ❒Yes ❒No
Troubled by Anxiety: ❒Yes ❒No
Uncorrectable vision: ❒Yes ❒No
Uncorrectable hearing: ❒Yes ❒No
Severe headaches: ❒Yes ❒No
Fainting spells: ❒Yes ❒No
Seizures or convulsions: ❒Yes ❒No

**Urinary and Gastrointestinal**

Burning with urination: ❒Yes ❒No
Frequent Urination: ❒Yes ❒No
Decreased urination force: ❒Yes ❒No
Stomach pain or burning: ❒Yes ❒No
Frequent loose stools: ❒Yes ❒No
Frequent constipation: ❒Yes ❒No

**Skin**

Frequent rashes: ❒Yes ❒No
Bruise easily: ❒Yes ❒No
History of skin cancer: ❒Yes ❒No

**Endocrine**

Diabetes: ❒Yes ❒No
Excessive thirst: ❒Yes ❒No
Excessive urination: ❒Yes ❒No

**HEENT**

Difficulty swallowing: ❒Yes ❒No
Ear drainage: ❒Yes ❒No
Frequent earaches: ❒Yes ❒No
Wear glasses/contacts: ❒Yes ❒No
Double or blurry vision: ❒Yes ❒No

**Respiratory and Cardiovascular**

Cough: ❒Yes ❒No
Shortness of breath: ❒Yes ❒No
Chest Pain: ❒Yes ❒No
Palpitation/Fluttering heart: ❒Yes ❒No
High blood pressure ❒Yes ❒No

**Musculoskeletal**

Osteoarthritis: ❒Yes ❒No
Rheumatoid Arthritis: ❒Yes ❒No
Gout: ❒Yes ❒No
Back Problem: ❒Yes ❒No
Carpal tunnel: ❒Yes ❒No
Joint stiffness: ❒Yes ❒No
Leg cramps: ❒Yes ❒No
Muscle aches: ❒Yes ❒No
Pain in shoulder(s): ❒Yes ❒No
Painful joints: ❒Yes ❒No
Sciatica: ❒Yes ❒No
Swollen Joints: ❒Yes ❒No
Trauma to arm(s): ❒Yes ❒No
Trauma to hip(s): ❒Yes ❒No
Trauma to knee(s): ❒Yes ❒No
Trauma to ankle(s): ❒Yes ❒No
Weakness: ❒Yes ❒No

Patient's Signature:_____________________________

UPPER VALLEY ORTHOPEDICS, PLLC & SPORTS MEDICINE

| Date: | Patient Name: | Date of Birth: |
|---|---|---|

**HISTORY OF CURRENT PROBLEM**

When did the symptoms first occur or the accident happen?

If this is an accident, how did it happen?

| Have you ever had these symptoms before? | ❒Yes | ❒No |
|---|---|---|
| Is this a work related injury? | ❒Yes | ❒No |

**WHAT ARE YOU SEEING THE PROVIDER FOR TODAY?**

| **Arm:** | Right | Left | Shoulder | Elbow | Forearm | Wrist | Hand |
|---|---|---|---|---|---|---|---|
| **Leg:** | Right | Left | Hip | Knee | Calf/Shin | Ankle | Foot |

Describe the problem you are having

Have you had previous treatment for your current problem? ❒ Yes ❒ No

Have you had X-rays Taken? ❒Yes ❒No MRI? ❒Yes ❒No

| What kind of treatment? | Medication | Injection | Splint/Brace | Therapy | Nerve Test |
|---|---|---|---|---|---|

| Which provider are you seeing today? | Primary Care Physician:<br><br>Referring Physician: |
|---|---|

Do you have a pain or narcotic contract with another physician? ❒Yes ❒No If yes, who?________________________

Please circle your level of pain right now: 0 1 2 3 4 5 6 7 8 9 10

## FALL PREVENTION ASSESMENT

Have you had a fall within the past 12 months? ____Yes ____No
Do you use an assistive device such as a walker, wheelchair, or cane? ____Yes ____No
Are you experiencing any difficulties with walking or balance? ____Yes ____No
Are you taking any medications that cause you to be drowsy or dizzy? ____Yes ____No
Do you require assistance getting up from a sitting position? ____Yes ____No
Do you wear glasses or have you been diagnosed with cataracts? ____Yes ____No
Are you on any medications for blood pressure or heart rhythm? ____Yes ____No

# CIGNA HEALTHCARE MEDICARE ADMINISTRATION

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**I request that payment of authorized Medicare Benefits be made either to me or on my behalf to *Upper Valley Orthopedics* for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.**

**Signature ___________________________________ Date______________**

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***Sample Patient's Assignment Authorization***

**NAME OF BENEFICIARY, HEALTH INSURANCE CLAIM NUMBER (HICN), MEDIGAP POLICY NUMBER**

**I request that payment of authorized Medigap Benefits be made on my behalf to *UPPER VALLEY ORTHOPEDICS* for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to ______________________________________ any information needed to determine these benefits.**

**Signature _______________________________________ Date _______________**

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

### UPPER VALLEY ORTHOPEDICS, PLLC

**As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of *UPPER VALLEY ORTHOPEDICS, PLLC's* "NOTICE OF PRIVACY PRACTICES"**

**Signature ______________________________________ Date ________________**