LILJENQUIST & REDD
ORTHOPEDIC SURGERY

PATIENT INFORMATION

Last name:	**First:**	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status** (circle one) Single / Married / Divorced / Widow

E-mail address:	**Ethnicity and preferred language:**	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F
Mailing address:	**City:**	**State:**	**Zip code:**	
Social Security #:	**Occupation:**	**Employer:**		
Cell Phone #:	**Home Phone #:**	**Work Phone #:**		

Consent to Text/ Call: **Yes** **No**

Referred to clinic by (please check one box):			❑ Dr.	❑ Hospital	❑ Insurance Plan
❑Friend	❑ Family	❑ Yellow Pages	❑ Other Patient	❑Other	

Preferred Pharmacy:	**Family Doctor:**

INSURANCE INFORMATION

Name on Insurance Card:	**Social Security #:**	**Birth date:** / /	**Phone #:**

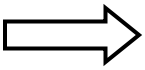
EMERGENCY CONTACT

Name of local friend or relative:	**Relationship to patient:**	**Primary phone #:**

I authorize Liljenquist & Redd Orthopedic Surgery to release any information required to process my claim as necessary in the course of examination and treatment. I hereby assign and transfer to Liljenquist & Redd Orthopedic Surgery any and all rights to receive payment of insurance benefits. This assignment covers all benefits under private insurance and/or any other health plan. I understand that this document constitutes a legally binding assignment and is not a mere authorization to collect benefits on my behalf.
I understand that I am financially responsible for all charges whether or not paid by my insurance and/or any other health plan (including Medicaid), and that Liljenquist & Redd Orthopedic Surgery will submit billings to my insurance company and/or health plan but only as a courtesy for me.

X _____ _____

Patient/Guardian Signature Date



LILJENQUIST & REDD
ORTHOPEDIC SURGERY

Billing Policy

I understand that I am responsible for all charges at the time of service. I understand that it is my responsibility to provide Liljenquist & Redd Orthopedic Surgery (LROS) with current, accurate billing information at the time of check-in and to notify the office of any changes. LROS may submit claim information n to my insurance company for processing but does so only as a courtesy for me. LROS will try and verify that the providers are in-network with your insurance company however I understand that I am ultimately responsible for knowing my plan and knowing what providers are in-network. I am responsible to pay all charges before my insurance company pays or determines the amount I owe after insurance regardless of any billing mistakes or disputes. I understand that it is my responsibility to know my specialist co pay and pay it on the day services are rendered because it is a contractual agreement with my health care plan.

I understand that if I do not have insurance I am required to pay 100% of my responsibility in advanced for services that will be rendered. This includes but is not limited to; office-visits, x-rays, procedures and surgery.

I understand that it is my responsibility to know my specialist co pay and pay it on the day services are rendered because it is a contractual agreement with my health care plan.

I understand that if I present an insufficient funds check for payment on my account, I will be charged a fee by this office and will be required to rectify my account by paying with cash, money order or credit card.

I understand that LROS will verify my insurance eligibility, deductable and coinsurance amounts prior to any elective surgery that I may have. I understand that receipt of a prior authorization is not a guarantee of payment, and I will be responsible for any bills not paid by insurance carrier. I understand that it is the policy of LROS to collect at least 50% of the estimated deducible and co-insurance amount prior to surgery, unless other arrangements are made prior to surgery. I further understand that the fee I am quoted is an estimate based on the anticipated surgery to be performed and the current information made available by my insurance carrier.

I understand that I have a financial obligation and responsibility to pay all deductable and co-insurance amounts as promptly as possible following the rendering of services. I understand that I will be provided two (2) statements for any balance due after insurance payment. I further understand that if no payment is made following receipt of the second statement that my account may be sent to a collection service for further legal action. I understand that I will be responsible for any collection, interest, or legal expenses associated with these collection actions. I understand that if sent to collections there will be 12% annual interest added to balance.

I understand that if I cannot pay my balance in full then an auto-pay payment plan will be arranged. I understand that the only way a payment plan can be made is by auto-pay with a credit or debit card securely on file.

LROS charges $20 for completion of patient forms such as; FMLA and disability paperwork. Payment is to be made before the completion and return of requested documents.

I understand that if I have Medicaid insurance and services rendered are denied, uncovered, out of network or my Medicaid is inactive at time of service I am financially responsible for all services rendered.

My signature below confirms that I have read these billing policies and understand my financial obligations as pertaining to LROS, Joseph R. Liljenquist, MD, Brigham B. Redd, MD, Chad Coon PA-C and Chase Hansen PA-C.

LILJENQUIST & REDD ORTHOPEDIC SURGERY

Pediatrics

ACKNOWLEDGEMENT OF DISCLOSURE OF NOTICE OF PRIVACY PRACTICES

I have read the Notice of Privacy Practices provided to me by Liljenquist & Redd Orthopedic Surgery. LROS and I have been given the opportunity to discuss the privacy practices at LROS. I understand that the practice may, at its discretion, change the term and conditions of this notice. Any questions I may have been answered to m satisfaction. I understand the content of this Notice of Privacy. I have been provided with a copy of the same.

X Signature: _____ Date: _____

Minor's Name(Print): _____ DOB: _____

I authorize Liljenquist & Redd Orthopedics Surgery to release the following healthcare information to the following individuals

(Please check on of the following):

- ☐ My complete health record
- ☐ To schedule, change, and verify my appointments
- ☐ Any billing correspondents

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

- ☐ Information is **NOT** to be released to anyone.

Please list any specific restrictions: _____

I understand that my records are protected by; The Health Insurance Portability and Accountability Act (HIPPA), and cannot be disclosed without my written consent unless it is provide a continuity of care. I also understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

X _____ Print Name: _____ Date: _____

The notice of Privacy Practices was provided to _____ , however, he/she did not acknowledge receipt for the following reason: refused, did not understand, other.

Staff Signature: _____ Date:

X Signature_____ Date_____

LILJENQUIST & REDD
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Minor's Name: _____DOB: _____ _____Date: _____

What are we seeing you for today? _____

Please list your primary Pharmacy: _____Primary care physician:_____

Current height: _____ Pain level (0-10):_____ **Date of Injury/Symptoms Start:** _____

Please list any medication, cortisone, latex or METAL **ALLERGIES** you have._____

Please list your current medications including strength._____

_____

_____

_____

Please check if any family member has had any of the following diseases.

	Mother	Father	Brother	Sister	Grandparents Mother's side	Grandparents Father's side
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐

Tobacco Use History:

☐ Never smoked/vaped

☐ Former smoker/vapor Years of tobacco use _____

☐ Current smoker/vapor How long? _____ How much a day? _____

Do you currently chew tobacco? _____

Do you drink alcoholic beverages? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Do you exercise regularly? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Do you use recreational drugs? _____

Please list any surgeries you have had in your lifetime. Include the year of the surgery as well.

_____

_____

_____

Please check if you **have or have had** any of these conditions.

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood clot
- ☐ Blood transfusion
- ☐ COPD
- ☐ Cancer, specify_____
- ☐ Coronary artery disease
- ☐ Diabetes
- ☐ Gout
- ☐ Heart attack
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Cholesterol
- ☐ Hypertension (high blood pressure)
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Orthotics
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peripheral vascular disease
- ☐ Rheumatoid arthritis
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers

Please check if you currently have any of the following symptoms:

CONSTITUTIONAL

- ☐ Fever
- ☐ Night sweats
- ☐ Abnormal Weight gain
- ☐ Abnormal Weight loss

DIET

- ☐ Diet NOT well Tolerated

Sleep

- ☐ Sleep Initiation
- ☐ Insomnia
- ☐ Periods of not breathing (sleep Apnea)

Persona/Social

- ☐ Concerns Regarding Hearing
- ☐ Concerns Regarding Vision
- ☐ Hearing Impaired
- ☐ Visually Impaired

Language

- ☐ Non-Verbal
- ☐ Speech Delay
- ☐ Receives Speech Therapy

Behavior

- ☐ Impulsive
- ☐ Anxious
- ☐ Depressed
- ☐ Aggressive
- ☐ Suicidal Thoughts

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty Breathing
- ☐ Difficulty Swallowing

GENITOURINARY

- ☐ Urinary loss of control
- ☐ Difficulty urinating

- ☐ Increased urinary frequency
- ☐ Hematuria (blood in urine)
- ☐ Incomplete emptying

MUSCULOSKELETAL

- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Joint pain
- ☐ Back pain
- ☐ Swelling in extremities

INTEGUMENTARY

- ☐ Abnormal mole
- ☐ Jaundice
- ☐ Rashes
- ☐ Laceration (cut)

NEUROLOGIC

- ☐ Loss of consciousness
- ☐ Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
- ☐ Tremor

PSYCHIATRIC

- ☐ Depression
- ☐ Sleep Disturbances
- ☐ Not safe in a relationship
- ☐ Alcohol abuse
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Suicidal thoughts

ENDOCRINE

- ☐ Fatigue
- ☐ Swollen glands

HEMATOLOGIC/LYMPHATIC

- ☐ Easy bruising
- ☐ Excessive bleeding

ALLERGIC/IMMUNOLOGIC

- ☐ Runny nose
- ☐ Sinus pressure
- ☐ Itching
- ☐ Hives
- ☐ Frequent sneezing

Patient Name: _____

Date of Birth: _____