LILJENQUIST, OLSON & REDD
ORTHOPEDIC SURGERY

PATIENT INFORMATION

Last name:	**First:**	**Middle:**	**Preferred:**	**Marital status** (circle one) Single / Married / Divorced / Widow

E-mail address:	**Ethnicity and preferred language:**	**Birth date:** / /	**Legal Gender:** **Gender Identity:**
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

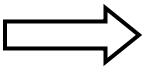
Name on Insurance Card:	**Social Security #:**	**Birth date:** / /	**Phone #:**

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 _____ Date: _____



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 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 advance 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, deductible 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 deductible 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 and a 35% collections fee.

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 autopay 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, Jonathan Olson, DO, Austin Campbell PA-C and Chase Hanson PA-C.

Signature X_____ Date _____

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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 terms and conditions of this notice. Any questions I may have been answered to my satisfaction. I understand the content of this Notice of Privacy. I have been provided with a copy of the same.

I authorize LROS to release the following healthcare information to the following individuals:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

(Please check one of the following):

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

Please list any specific restrictions: _____

☐ **My information is <u>NOT</u> to be released to anyone.**

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 providing 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: _____

LILJENQUIST, OLSON & REDD
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Name: _____ **DOB:** _____ **Date:** _____

What are we seeing you for today? _____

Date of Injury/Symptoms Start: _____ **Current height:** _____ **Current Weight:** _____

Pain level now (0-10): _____ **Primary Care Physician:** _____

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

Please list any current medications including strength _____

_____

Do you currently have bed bugs? YES NO **Have you had bed bugs in the past? YES NO**

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	☐	☐	☐	☐	☐	☐

☐ **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 drink caffeine? None Occasional Moderate Heavy

Do you use recreational drugs? _____

Please list SURGERIES you have had in your lifetime. Include the year of the surgery.

_____

_____

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
- ☐ Multiple Sclerosis
- ☐ 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
- ☐ Weight gain
- ☐ Weight loss

EYES

- ☐ Dry eyes
- ☐ Irritation
- ☐ Vision change

ENMT

- ☐ Difficulty hearing
- ☐ Ear pain
- ☐ Frequent nose bleeds
- ☐ Nose problems
- ☐ Sinus problems

MOUTH/THROAT

- ☐ Sore Throat
- ☐ Bleeding gums
- ☐ Snoring
- ☐ Dry mouth
- ☐ Oral abnormalities
- ☐ Mouth ulcer
- ☐ Teeth abnormalities
- ☐ Mouth breathing

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Arm pain on exertion
- ☐ Shortness of breath when walking
- ☐ Shortness of breath when lying down
- ☐ Palpitations
- ☐ Known heart murmur
- ☐ Light-headed on standing

RESPIRATORY

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Sleep apnea

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Change in appetite
- ☐ Black or tarry stools
- ☐ Frequent diarrhea
- ☐ Vomiting blood
- ☐ Dyspepsia (impaired digestion)
- ☐ GERD (gastro esophageal reflux disease)

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: _____