**PEDIATRIC**

LILJENQUIST, OLSON & REDD
ORTHOPEDIC SURGERY

# PATIENT INFORMATION

| **Last name:** | **First:** | **Middle:** | **Preferred Name:** |
|---|---|---|---|
| | | | |

| **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

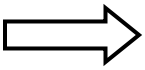
| **Name on Insurance Card:** | **Social Security #:** | **Birth date:** / / | **Phone #:** |
|---|---|---|---|
| | | | |

# 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, Chad Coon PA-C and Austin Campbell PA-C.

Signature X_____ Date _____

LILJENQUIST, OLSON & REDD
ORTHOPEDIC SURGERY

# 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
ORTHOPEDIC SURGERY

**Consent to Treat Minor Child**

Minor's Name: _____ DOB: _____

**By law, any child under the age of 18 must be accompanied by a parent or legal guardian to all patient appointments.**

If the minor arrives with someone other than a parent or legal guardian, we must have written consent from the parent of legal guardian that this person has been appointed by you to act on your behalf. For those occasions when you may not be able to be with your child, please list the individuals who may give us consent to see your child:

_____

Name Relationship to Patient

_____

Name Relationship to Patient

☐ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult. This consent may ONLY apply to **minors age 16 and older.** This consent shall be in effect for ☐ Date : _____ (only) ☐ Indefinitely, until revoked by written communicantion.

**Limitations :**

Identify any specific limitations on the kinds of medical services for which this authorization if given. (If none, state "none") _____

I (parent / legal guardian name) _____ request and authorize Liljenquist, Olson and Redd Orthopaedic Surgery and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the minor child or the minor child that is alone (16 or older) is responsible for payment of the patient portion at the time of service. I have read, understand and give my consent as stipulated above. My signature means that I have read this form and/ or have had it read to me and explained in the language that I can understand.

**Authorization &Acknowledgment:**

_____

Parent or Legal Guardian (please print) Relationship

_____

Parent or Legal Guardian Signature Date

LILJENQUIST, OLSON & REDD
ORTHOPEDIC SURGERY

**The information listed below is the information for the parent/guardian who brings the child to their initial appointment**. We CANNOT send bills to a parent or guardian who is not present with the child. We CANNOT do separate billing for different parent/guardians based off custody agreements.

## GUARANTOR INFORMATION

| | |
|---|---|
| Parent / Guardian<br><br>Responsible for bills | |
| Social Security # | |
| Date of Birth | |
| Phone # | |
| Street Address | |
| City, State, Zip Code | |

I understand that Liljenquist & Redd Orthopedic Surgery will be sending all billing correspondents to me. I understand I am responsible for making all outstanding balances are paid.

**X** Guarantor Signature: _____ Date: _____

Print Minor's Name: _____ Date of Birth: _____

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ORTHOPEDIC SURGERY

**Minor's Name**_____**DOB:** _____**Date:** _____

**What are we seeing you for today?** _____

**Please list your primary Pharmacy:** _____**Primary care physician:** _____

**Height:** _____ **Weight:** _____ **Pain level now (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 drink caffeine? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

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

_____

_____

_____

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

**Please check if you have <u>or</u> have had any of these conditions:**

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood clot
- ☐ Blood transfusion
- ☐ Cancer, specify_____
- ☐ Coronary artery disease
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Hernia
- ☐ Hypertension (high blood pressure)
- ☐ Migraines
- ☐ Orthotics
- ☐ Seizures/Epilepsy

Any other health condition:

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

**Constitutional**

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

**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

**MUSCULOSKELETAL**

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

**NEUROLOGIC**

- ☐ Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches

**ALLERGIC/IMMUNOLOGIC**

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

**Patient Name:** _____

**Date of Birth:** _____