



## **APPOINTMENTS**

**Wi-Fi.** For your convenience, we have Wi-Fi available at our Phoenix and Scottsdale clinics.

**New Patients.** Please arrive 30 minutes prior to your appointment time to ensure your paperwork is completed. We mail your paperwork one week prior to your appointment - please complete and bring it with you to expedite your visit. Do not mail it in ahead of time. For your convenience, the forms are also available online at [www.tocamd.com](http://www.tocamd.com).

**Late for Appointments.** If you arrive 15 minutes late or more for your appointment, you may be asked to reschedule.

**X-Rays/MRI's, Etc.** If you have had any prior diagnostic testing related to your treatment, please bring your films and report with you to your appointment

**Cancellations and No Shows.** A 24 hour notice of cancellation of your appointment is appreciated. Continued missed appointments may result in dismissal from the practice.

**Minor Age Patients.** TOCA requires that a parent or legal guardian accompany all minor patients. A signed consent from a parent may be accepted with a contact number to reach the parent.

**Photo I.D.** TOCA and the Federal Trade Commission's Red Flag Rule, require new patients to present photo identification upon their first visit. A photocopy will be made and retained in your patient file. Examples of accepted identification would be a drivers license, state issued ID card, etc.

**Patient Impact.** TOCA values the opinions of our patients and looks forward to receiving feedback about your visit. After each visit, you will be e-mailed a confidential survey through an independent service called Patient Impact. We take the results of your survey and comments seriously – staff and physicians review the results monthly.

## **SCHEDULING YOUR MRI, EMG, P.T., HAND THERAPY, JOINT INJECTIONS, ETC.**

Please allow 7-10 days for us to obtain authorization to schedule these services. If you haven't heard from our office in 10 days, please call. Phone calls to our office prior to the 10 days may only delay processing your authorization. Depending on your insurance, joint injections may take up to 30 days for approval and delivery of medication.

## **PAYMENT POLICIES**

**Payments We Accept.** Cash, Checks, Debit Card, Visa, MasterCard, and Discover

Please read other side



## **PATIENT FINANCIAL RESPONSIBILITY**

**Copays.** Copays are due at the time of your visit.

**Deductible.** Surgery schedulers will collect your estimated deductible/co-insurance prior to scheduling your surgery.

**MRI, Medical Equipment, and Supplies.** We will collect your deductible/co-insurance for MRI and medical equipment and supplies (Bracing, slings, casts etc.) at the time of service.

**Self Pay.** We require a \$250.00 deposit at the time of your office visit (\$500.00 for fracture care). The cost of your treatment will be reconciled at the end of your visit. If you require surgery, finances will be discussed at that time.

**Returned Checks.** A \$25 fee will be assessed for returned checks. Once a check has been returned, you will be required to pay via cash or credit card.

**Collections.** Once an account is placed in collection status, all prior balances must be paid in full before an appointment will be scheduled. All future copays, deductibles/co-insurance will be due at the time of your visit or you will need to reschedule. Any balance assigned to a collection agency will be assessed a 30% to 40% collection fee.

## **DISABILITY FORMS, FMLA, ETC.**

**Fees.** A \$25 fee will be collected each time forms are presented to TOCA for completion.\*

**Turnaround Time.** Be prepared for a 7-10 day turnaround time for completion of forms.

\*This does not pertain to patients covered by workers comp, Medicare or AHCCCS.

## **PRESCRIPTION REFILL POLICY**

**Prescription Requests.** Requests for prescriptions are processed during regular business hours only.

**Refills.** Contact your pharmacy for all Prescription Refill Requests. The Pharmacy will contact our office directly. Allow 48 hours for our office to obtain authorization from your provider for the prescription refill(s) you have requested.

**Friday Requests.** Prescription refills requested on a Friday WILL NOT be refilled until the following Monday. Prescription requests will not be taken after business hours, over the weekend on holidays or by the on-call physician.

**FDA Controlled Medications.** FDA Controlled Medications cannot be called in to the pharmacy. Patients will be required to pick up a signed prescription at the office during regular business hours. Patients may be required to schedule an appointment in the office for medication management.

**PATIENT REGISTRATION**



Date: \_\_\_\_\_ Physician: \_\_\_\_\_

PID # \_\_\_\_\_ New or Update Location: \_\_\_\_\_

**PLEASE PRINT – PLEASE USE BLUE OR BLACK INK**

**PATIENT INFORMATION**

Name \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_ Male:  Female:  Single:  Married:  Age: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ By entering my email address, I give The Orthopedic Clinic Association consent to communicate with me via email.

Email of Patient or Responsible Party: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACT (Closest relative not living with you.)**

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (If patient is a minor.)**

Name \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_ Male:  Female:  Single:  Married:  Relationship to Patient: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN (PCP)**

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**REFERRING PHYSICIAN - Check if Referring Physician is PCP**

Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How did you hear about us?  Physician  Friend  Internet  Yellow Pages  Industrial  PT

Name: \_\_\_\_\_ PID \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

**PRIMARY**

Insurance: \_\_\_\_\_ Address \_\_\_\_\_

ID#: \_\_\_\_\_ Group: \_\_\_\_\_ Eff Date \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder SS# \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Male:  Female:

Relationship to Patient: \_\_\_\_\_ SPC Co-Pay \_\_\_\_\_

**SECONDARY**

Insurance: \_\_\_\_\_ Address \_\_\_\_\_

ID#: \_\_\_\_\_ Group: \_\_\_\_\_ Eff Date \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Male:  Female:

Relationship to Patient: \_\_\_\_\_ SPC Co-Pay \_\_\_\_\_

**IF INJURED ON THE JOB COMPLETE INFORMATION BELOW**

Injury Date: \_\_\_\_\_ Body Part Injured: \_\_\_\_\_ Right:  or Left:

Employer at Time of Injury: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Worker's Compensation / Industrial Insurance Claim # \_\_\_\_\_

Carrier: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

I present myself or a child for whom I accept responsibility; recognizing the need for care, consent to any and all services as ordered by my physician and agreed to by me. These services include, but are not limited to, laboratory tests, medical or surgical treatment, examination, and other services rendered under specific instructions of my physician.

\_\_\_\_\_  
PATIENT OR RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_  
DATE

# THE ORTHOPEDIC CLINIC ASSOCIATION, P.C.

# Initial Outpatient Visit and Consultation

Please provide the following medical information to the best of your ability:

<b>Patient Name: PLEASE PRINT</b>		<b>PID</b>	<b>Date</b>								
Name of Primary Physician											
Are you <input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed? Age _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F											
What problem(s) are you here for today?		When did the problem begin?									
How much <b>pain</b> do you have (circle)? 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (Worst)											
How did it occur?		Where did it occur?									
Was your injury the result of an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes please ✓ appropriate box <input type="checkbox"/> Auto <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other											
Explain:											
What makes it <b>worse</b> ?		What makes it <b>better</b> ?									
Are there <b>other symptoms</b> (✓)? <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness <input type="checkbox"/> Swelling <input type="checkbox"/> Loss of joint motion <input type="checkbox"/> Joint locking <input type="checkbox"/> Joint popping out of place <input type="checkbox"/> Pain radiating to _____											
<b>Treatments</b> you've already tried:											
If you've had the following <b>Tests</b> , please give <b>date</b> and <b>location</b> :											
X-rays		MRI									
<b>Review of Systems:</b> 1) Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:											
		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>					
GENERAL	chills	<input type="checkbox"/>	<input type="checkbox"/>	weight loss	<input type="checkbox"/>	<input type="checkbox"/>					
	fever	<input type="checkbox"/>	<input type="checkbox"/>	weight gain	<input type="checkbox"/>	<input type="checkbox"/>					
EYES	eye pain / pressure	<input type="checkbox"/>	<input type="checkbox"/>	recent vision changes	<input type="checkbox"/>	<input type="checkbox"/>					
ENT	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	snoring	<input type="checkbox"/>	<input type="checkbox"/>					
CARDIAC	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>					
	ankle swelling (not injured)	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>					
RESPIR.	productive cough	<input type="checkbox"/>	<input type="checkbox"/>	coughing blood	<input type="checkbox"/>	<input type="checkbox"/>					
	wheezing	<input type="checkbox"/>	<input type="checkbox"/>								
GI	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	heartburn/indigestion	<input type="checkbox"/>	<input type="checkbox"/>					
	stomach/abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>					
	recent change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	blood in stool	<input type="checkbox"/>	<input type="checkbox"/>					
GU	frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	painful urination	<input type="checkbox"/>	<input type="checkbox"/>					
	blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>					
MSK	generalized joint pain	<input type="checkbox"/>	<input type="checkbox"/>	generalized muscle pain	<input type="checkbox"/>	<input type="checkbox"/>					
SKIN	rash	<input type="checkbox"/>	<input type="checkbox"/>	hives	<input type="checkbox"/>	<input type="checkbox"/>					
NEURO	headache	<input type="checkbox"/>	<input type="checkbox"/>	dizziness	<input type="checkbox"/>	<input type="checkbox"/>					
	passing out	<input type="checkbox"/>	<input type="checkbox"/>	numbness, tingling	<input type="checkbox"/>	<input type="checkbox"/>					
PSYCH	depression	<input type="checkbox"/>	<input type="checkbox"/>	claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>					
HEME/LYM	night sweats	<input type="checkbox"/>	<input type="checkbox"/>	bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>					
IMMUNOLOGY	seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>								
<b>Past Medical History:</b>											
1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain											
<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>				
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Taking Pills)	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	T.B.
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant now due _____	<input type="checkbox"/>	<input type="checkbox"/>	Valley Fever
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Other Medical Problems
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots/DVT	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, C	<input type="checkbox"/>	<input type="checkbox"/>	Seizures			
<input type="checkbox"/>	<input type="checkbox"/>	Bone or Joint Infection	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infection			
<input type="checkbox"/>	<input type="checkbox"/>	Cancer of _____	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	sleep apnea			
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Stent	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Use CPAP			
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Taking Insulin)	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems			

# Initial Outpatient Visit and Consultation

<b>Patient Name:</b>		<b>PID</b>	<b>Date</b>
<b>Allergies</b> <input type="checkbox"/> None		<u>Yes</u> <u>No</u>	<b>Other Allergies</b> <u>Yes</u> <u>No</u>
1.	Reaction Type	<input type="checkbox"/> <input type="checkbox"/> Shell Fish	<input type="checkbox"/> <input type="checkbox"/> Latex
2.	Reaction Type	<input type="checkbox"/> <input type="checkbox"/> Eggs	<input type="checkbox"/> <input type="checkbox"/> Tape
3.	Reaction Type	<input type="checkbox"/> <input type="checkbox"/> Iodine	<input type="checkbox"/> <input type="checkbox"/> Contrast Dye
4.	Reaction Type	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Please list all your previous surgeries including dates		Mo/Yr	Mo/yr
a		d	
b		e	
c		f	
Please list any current medications <b>(and dose, times per day)</b> : <i>(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays / cold / sinus / allergy meds):</i>			
a	e	i	
b	f	j	
c	g	k	
d	h	l	
<b>Family History:</b>			
Please check the "Yes" or "No" box to indicate whether any close relatives in the family have any of the following illnesses. If yes, please indicate which relative(s) have the problem.			
	<u>Yes</u> <u>No</u>	<b>Please list details below:</b>	
Hypertension	<input type="checkbox"/> <input type="checkbox"/>	_____	
Heart problems murmurs	<input type="checkbox"/> <input type="checkbox"/>	_____	
Asthma	<input type="checkbox"/> <input type="checkbox"/>	_____	
Stroke	<input type="checkbox"/> <input type="checkbox"/>	_____	
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	_____	
Cancer	<input type="checkbox"/> <input type="checkbox"/>	_____	
Bleeding disorder	<input type="checkbox"/> <input type="checkbox"/>	_____	
Anesthesia problems	<input type="checkbox"/> <input type="checkbox"/>	_____	
<b>Social History:</b>			
Do you smoke? List how much	<input type="checkbox"/> <input type="checkbox"/>	Pks./Day?	How many years?
If no, did you smoke previously?	<input type="checkbox"/> <input type="checkbox"/>	Pks./Day?	How many years?
Do you drink alcohol?	<input type="checkbox"/> <input type="checkbox"/>	Drinks / Day	Week                      Month
If Female, are you pregnant?	<input type="checkbox"/> <input type="checkbox"/>	Expected delivery date: _____	
Have you used drugs?	<input type="checkbox"/> <input type="checkbox"/>	If Yes, please ✓ which one. <input type="checkbox"/> Marijuana <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Cocaine	
<b>Current work Status ( ✓ ):</b>	<input type="checkbox"/> Full Duty	<input type="checkbox"/> Light Duty	<input type="checkbox"/> Off Work <input type="checkbox"/> Retired
Job Title _____	Employer _____		
Describe your job _____			
What sports do you play? _____			
Last Tetanus Shot _____      Current Height _____      Weight _____			
<b>Patient Signature / Legal Guardian</b>		<b>Date</b>	<b>Physician Signature:</b>
			<b>Date</b>



RELEASE OF INFORMATION AUTHORIZATION /  
ASSIGNMENT OF BENEFITS FOR MEDICAL PAYMENT OF SERVICES

**Authorization for Release of Information:** I authorize The Orthopedic Clinic Association to disclose all or any part(s) of the patient's medical record to listed insurance companies and any agency conducting reviews concerning Worker's Compensation care.

**Medicare / AHCCS Patient's Certification:** I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as stated below.

**Assignment of Benefits:** I hereby authorize payment directly to The Orthopedic Clinic Association by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer.

**Insurance:** The Orthopedic Clinic Association will file your insurance as a service to you. If our office does not hear from your insurance company within 60 days, we request your help in contacting your insurance company to resolve the payment delay. The insurance plan is a contract between you and your insurance company. We must hold you responsible for any balances due.

**Payment of Services:** I understand I am financially responsible for all charges and fees related to the services rendered to me by The Orthopedic Clinic Association, I further understand that payment in full is expected upon receipt of the first statement which may include co-payments, deductibles and any services not covered by my insurance. I also understand that I am financially responsible for any charges not covered by my insurance. I hereby assign to The Orthopedic Clinic Association all benefits I am entitled to receive from any person, insurance company or entity to the extent of medical charges incurred by the patient or me and authorize payment of such benefits directly to The Orthopedic Clinic Association. In the event my account is referred to a collection agency, I will be responsible for collection costs, including interest and reasonable attorney fees.

**Health Insurance Portability and Accountability Act (HIPAA):** I acknowledge that a copy of the HIPAA Notice of Privacy Practices was made available to me. I was given the opportunity to view a copy of the Notice, which describes how health information about me may be used, disclosed, and how I can get access to this information.

**Valuables:** I (we) understand that The Orthopedic Clinic Association is not responsible for valuables and personal property brought to the facility.

I further acknowledge and grant to The Orthopedic Clinic Association a lien pursuant to A.R.S. Section 33-932, et seq. against any recovery by me or any person on my behalf made against any liability, uninsured/underinsured motorists or other form of coverage or indemnity, or against a person or entity legally responsible for the medical charges incurred to the extent such charges are not paid in full by other available insurance or by me. The Orthopedic Clinic Association and I also waive any attorney's fees or collection costs associated with the collection of medical charges pursuant to the lien hereby granted.

I CERTIFY I HAVE READ AND FULLY UNDERSTAND ALL OF THE ABOVE INFORMATION TO INCLUDE THE CONSENT FOR TREATMENT, RELEASE OF INFORMATION, INSURANCE AUTHORIZATION, AND ASSIGNMENT AND PAYMENT OF SERVICES.

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PATIENT OR RESPONSIBLE PARTY SIGNATURE

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DATE

# TOCA

## THE ORTHOPEDIC CLINIC ASSOCIATION, P. C.

PATIENT'S FULL LEGAL NAME: \_\_\_\_\_ PID \_\_\_\_\_

**IF YOU MAY WANT A COPY OF YOUR RECORDS IN THE FUTURE, PLEASE COMPLETE THIS SECTION**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE#: \_\_\_\_\_

**YOU WILL NEED TO CALL FOR YOUR RECORDS. THEY WILL NOT BE SENT AUTOMATICALLY**

**FOR THE PURPOSE OF CONTINUING CARE YOU MAY LIST UP TO TWO MORE TREATING PHYSICIANS THAT YOU WOULD LIKE FURNISHED WITH YOUR RECORDS FROM TOCA**

**DO NOT LIST PCP OR REFERRING PHYSICIAN AGAIN**

NAME: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE#: \_\_\_\_\_ FAX#: \_\_\_\_\_

NAME: \_\_\_\_\_ SPECIALITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE#: \_\_\_\_\_ FAX#: \_\_\_\_\_

FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV AND COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S SECTION 12-2801)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Parent/Legally Authorized Representative

\_\_\_\_\_  
Relationship to Patient

Reason patient was unable to sign release: \_\_\_\_\_

**PATIENTS 18 YEARS AND OLDER MUST SIGN OWN RELEASE**

**SECTION A**

Patient Height:  ft  inches      Patient Weight:  lbs      Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient's Last Name       First Name       M.I.

Surgeon's Name

**SECTION B**

**OVERALL EVALUATION**

- In general, would you say your health is:
 

Excellent	Very Good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Compared to one year ago, how would you rate your health in general now:
 

Much better now	Somewhat better now	About the same	Somewhat worse now	Much worse now
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
 

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending, Kneeling, or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking more than a mile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking several blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking one block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
 

	Yes	No
Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>
- During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
 

	Yes	No
Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>

**(Continued on other side)**

**SECTION B OVERALL EVALUATION (Continued)**

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?      Not at all      Slightly      Moderately      Quite a bit      Extremely
7. How much bodily pain have you had during the past 4 weeks?      None      Very mild      Mild      Moderate      Severe      Very severe
8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?      Not at all      A little bit      Moderately      Quite a bit      Extremely
9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, Please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of pep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a very nervous person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a happy person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc)?      All of the time      Most of the time      Some of the time      A little of the time      None of the time

11. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
I seem to get sick a little easier than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I expect my health to get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_  
Please print Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



## PATIENT PRIOR AUTHORIZATION POLICY

It is the responsibility of our insured patients to be aware of any restrictions or requirements stated in their insurance policy. These include deductibles, second opinions, policy exclusions or waived benefits, precertification, inpatient vs. outpatient benefits and restrictions regarding pre-existing conditions.

As a COURTESY, our office policy is to contact your insurance company for pre-authorization. However, a pre-authorization issued by your insurance company simply means that they agree that your office visit, medication, surgery, physical therapy or orthotics is medically necessary, though they can reverse this decision once the claim is received. This is a standard disclaimer that all insurance companies tell us when we obtain prior authorization for your medical need. What this means is that:

Prior-authorization or pre-certification does NOT guarantee payment from your insurance company. The patient is ultimately responsible.

Your insurance benefits and the payment we receive are determined by the limits that your insurance carrier sets.

It is your responsibility to be aware of your benefits and limits.

A deposit may be required, if you have not met your deductible or out of pocket expense.

Also, for those patients requiring pre-operative testing, such as blood work, EKG, chest x-ray, etc., these tests may not be approved by your insurance (such as Medicare) and therefore may not be covered by your insurance. You will be responsible if this applies to you.

By signing below, I understand that I am responsible for the charges not covered by my insurance.

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PRINT PATIENT NAME

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PATIENT/GUARANTOR SIGNATURE

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DATE