ISLAND ORTHOPAEDICS

3382 WAIALAE AVE
HONOLULU, HI 96816

TEL: (808) 548-7033
FAX: (808) 548-7034

PATIENT REGISTRATION

ACCOUNT NUMBER		SOCIAL SECURITY		
LAST NAME	FIRST NAME	MI	GENDER	DATE OF BIRTH
BILLING ADDRESS	CITY	STATE	ZIP CODE	
PHYSICAL ADDRESS ONLY *IF DIFFERENT FROM ABOVE (Rx PURPOSES)*	PRIMARY PHONE	SECONDARY PHONE		
☐ SINGLE ☐ MARRIED ☐ OTHER	☐ EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ DISABLED ☐ STUDENT			
EMPLOYER	OCCUPATION			
EMERGENCY CONTACT (PHONE & RELATION)	OPTIONAL EMERGENCY CONTACT (PHONE & RELATION)			

INSURANCE INFORMATION

☐ PRIVATE ☐ MEDICARE/MEDICAID ☐ UNINSURED ☐ *WORKER'S COMPENSATION* ☐ *NO FAULT AUTO* ☐ *THIRD PARTY LIABILITY*

PRIMARY INSURANCE	SUBSCRIBER (POLICY HOLDER) NAME	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP ☐ Self ☐ Other _____
	SUBSCRIBER (POLICY HOLDER) ADDRESS & PHONE *IF DIFFERENT FROM ABOVE*		***ADJUSTER NAME***
	SUBSCRIBER ID OR MEMBER NUMBER	GROUP NAME / NUMBER	***ADJUSTER PHONE #***
	WORK COMP, AUTO, THIRD PARTY CLAIM #	***DATE OF INJURY (WC, NF, TPL)***	***ADJUSTER FAX #***
SECONDARY INSURANCE	SUBSCRIBER (POLICY HOLDER) NAME	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP ☐ Self ☐ Other _____
	SUBSCRIBER (POLICY HOLDER) ADDRESS & PHONE *IF DIFFERENT FROM ABOVE*		ADJUSTER NAME
	SUBSCRIBER ID OR MEMBER NUMBER	GROUP NAME / NUMBER	ADJUSTER PHONE #
TERTIARY INSURANCE	SUBSCRIBER (POLICY HOLDER) NAME	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP ☐ Self ☐ Other _____
	SUBSCRIBER (POLICY HOLDER) ADDRESS & PHONE *IF DIFFERENT FROM ABOVE*		ADJUSTER NAME
	SUBSCRIBER ID OR MEMBER NUMBER	GROUP NAME / NUMBER	ADJUSTER PHONE #

PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY PARENT/GUARDIAN
IF UNABLE TO ATTEND, PARENT/GUARDIAN MUST SIGN AUTHORIZATION TO TREAT MINOR PRIOR TO APPOINTMENT

GUARANTOR'S NAME & ADDRESS *(PARENT, LEGAL GUARDIAN, OR PARTY FINANCIALLY RESPONSIBLE IF PATIENT IS THE WARD OF ANOTHER)*			
RELATIONSHIP TO PATIENT	HOME PHONE	CELL PHONE	BUSINESS PHONE

FINANCIAL AGREEMENT: By signing below, I understand that I am financially responsible for all charges (including co-payment, deductible, and any other non-covered fees), whether or not paid by my insurance. I also understand that there will be a fee of $25 for any returned check. Insurance co-payments and any outstanding patient balance on my account should be paid at the time of visit. If my account is over 90 days old without payment activity, I understand that it may be turned over to a collection agency. **I am aware that canceling my appointment within 24 hours of my scheduled appointment will be considered a "no show" and that if I have more than one "no-show" appointment, I will be charged a $25 no-show fee thereafter.** If I am more than 15 minutes late to my appointment, I may be asked to reschedule my appointment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS: By signing below, I authorize Island Orthopaedics, LLC to release information including diagnosis, examination, and treatment during the course of my medical care to my referring physician, my primary care doctor, and my insurance carrier. I authorize payment for medical services provided to be made directly to my treating physician.

SIGNATURE _____ **DATE** _____

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PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. Please fill out every item. It is essential for your physician to know that you have carefully reviewed every area of this form. This information will be entered into our system and you are welcome to a copy of the report if you wish.

Name: _____ Date of Birth: _____

Preferred Language: _____ Ethnicity: _____ Hispanic: ◯ Yes ◯ No

Preferred Pharmacy Location (& phone number if known): _____

Name of Primary Care (Family) Physician (& phone number if known): _____

CURRENT MEDICATIONS

Are you taking ANY medication now? (prescription medication, over-the-counter medication, & dietary supplements) ◯ Yes ◯ No

NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN

MEDICATION ALLERGIES

Are you allergic to any medications? ◯ Yes ◯ No

NAME OF MEDICATION	TYPE OF ALLERGIC REACTION (RASH, SWELLING, NAUSEA, ETC.)

SURGERIES

Have you had bone, joint, or muscle surgeries prior to being treated by us? Yes No

TYPE OF SURGERY (PROCEDURE) & BODY PART (LEFT, RIGHT)	DATE OF SURGERY (PROCEDURE)

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PATIENT HEALTH HISTORY

1. Are you allergic to any of the following?

Yes	Yes
☐ Adhesive tape	☐ Metal
☐ Iodine	☐ Contrast Dye
☐ Latex	

2. Have you been diagnosed with any of the following?

Yes	Yes	Yes
☐ Bone Cancer	☐ Heart Attack	☐ Duodenal Ulcer
☐ Breast Cancer	☐ Heart Disease	☐ Hepatitis, unspecified type
☐ Colon Cancer	☐ Hypertension	☐ Hepatitis, specified type
☐ Lung Cancer	☐ Stroke	☐ Anxiety
☐ Prostate Cancer	☐ Arthritis, unspecified type	☐ Depression
☐ Other Cancer	☐ Arthritis, Osteo	☐ Diabetes
☐ Asthma	☐ Arthritis, Rheumatoid	☐ Anemia
☐ Tuberculosis		

3. Family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Diabetes before age 18	☐	☐	☐	☐	☐
Diabetes after age 18	☐	☐	☐	☐	☐
Bleeding/Clotting Problem	☐	☐	☐	☐	☐

4. Are you retired? ☐ **Yes**

5. Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

6. Do you currently use any of the following?

Tobacco Products: ☐ **None** ☐ **Cigarettes** ☐ **Smokeless Tobacco** ☐ **Cigars**

How many packs of cigarettes do you smoke in an average day: ☐ **1 pk** ☐ **1 ½ pks** ☐ **2 pks** ☐ **3 pks**

Alcoholic Beverages (A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer)

☐ **Abstainer** (< 12 drinks/yr) ☐ **Light** (< 12 drinks/mo) ☐ **Moderate** (4-14 drinks/wk) ☐ **Heavy** (>2 drinks/day)

7. Dependency or addiction to drugs now or in the past:

☐ Amphetamines	☐ Codeine	☐ Hydrocodone	☐ Oxycodone
☐ Barbiturates	☐ Diazepam	☐ Marijuana	☐ Soma
☐ Cocaine	☐ Heroin	☐ Morphine	

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REASON FOR VISIT

REQUIRED FOR INSURANCE

Onset of symptoms or DATE OF INJURY: _____

Is this a Worker's Compensation or work-related injury? ☐ Yes ☐ No

Is this a Third Party Liability or No Fault Auto related injury? ☐ Yes ☐ No

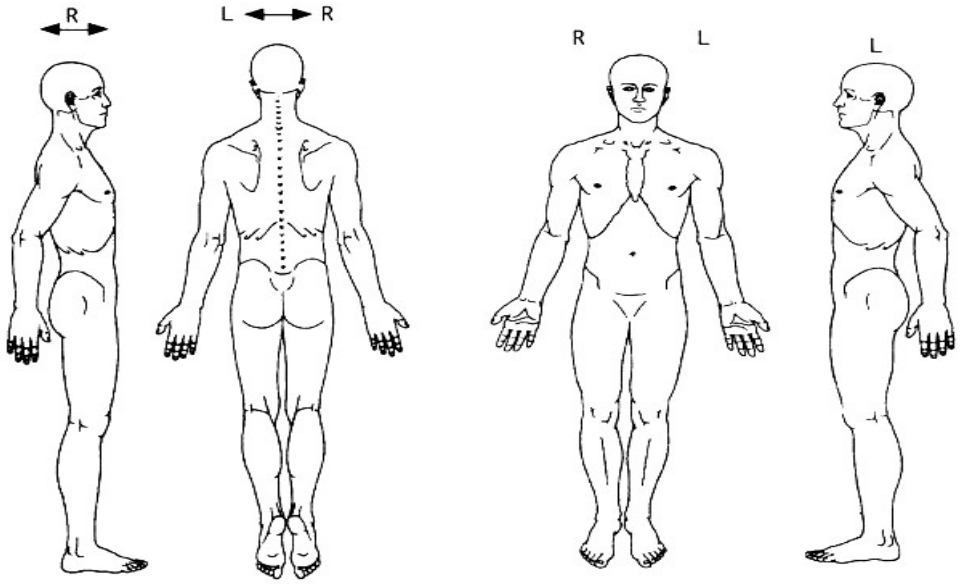
Explain how you were injured (e.g. playing SPORTS, an AUTO ACCIDENT, simply with DAILY ACTIVITIES)? Where did it happen (e.g. at home, at school, at work)?

Please circle the type of pain you are having: Burning | Stabbing | Aching | Sharp

On a scale of 1-10 (10 being the worst pain you've ever experienced) how would you rate your pain today?

Please circle: (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Please circle the location you are experiencing pain in the body below:



Print Name: _____

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

USES AND DISCLOSURES

Treatment: *We will use and disclose your protected health information (PHI) to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to all health professionals that may provide care, diagnosis or treatment to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment, to your physician. Finally, we may use and disclose protected health information for the treatment activities of another health care entity or provider.*

Payment: *Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.*

Healthcare Operations: *We may use or disclose, as needed, your PHI in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, marketing, and conducting of other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.*

Law Enforcement: *Your PHI may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting as required by law.*

Public Health Reporting: *Your PHI may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.*

Other Uses and Disclosures: *Your PHI will otherwise be used or disclosed only with your consent, authorization or opportunity to object unless required by law. If you change your mind after authorizing a use or disclosure of your PHI, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.*

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- **The right to inspect and copy your PHI.** Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.
- **The right to request a restriction on the use and disclosure of your PHI.**
- **The right to receive confidential communications concerning your medical condition and treatment.**
- **The right to amend or submit corrections to your PHI**
- **The right to receive an accounting of how and to whom your PHI has been disclosed**

We reserve the right to change the terms of this notice. These changes may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all PHI we maintain.

Complaints: You may file a complaint with us if you believe your privacy rights have been violated by us. You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective on or after September 1, 2011.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information (PHI). Signature below is only acknowledgment that you have received this notice of our privacy practices:

Print Name: _____

Signature: _____ Date: _____

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FINANCIAL POLICY AND CONSENT FOR TREATMENT

Island Orthopaedics, LLC recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following is provided to avoid any misunderstanding concerning protected health information and payment for professional services. For the protection of our patients and Island Orthopaedics, LLC, all patients are also required to present a valid form of government-issued identification upon check-in, prior to treatment.

Consent: By signing this form, I am giving my informed consent for the physicians and staff of Island Orthopaedics, LLC to treat me, including performing and/or ordering diagnostic testing or medical treatment and/or procedures, as deemed necessary in the exercise of their professional judgment. I understand I have the right to decline such testing, treatment, and/or procedures if I so choose, prior to such testing, treatment, and/or procedures being performed and/or ordered.

Payment for Service: I understand I am responsible for paying the full amount for all services on the day of service, unless my physician or Island Orthopaedics, LLC has an agreement with my insurance carrier. If I am insured, I authorize Island Orthopaedics, LLC to release all information necessary to my insurance carrier and/or its claims administrator to secure payment for services rendered. I further understand my share of the cost of the services, (e.g. co-payments, co-insurance, deductibles) may be collected upon check-out in the form of cash, check, Visa or MasterCard.

Medicare: Island Orthopaedics, LLC physicians are participating with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If I have supplemental insurance to cover the portion of the charges that Medicare does not pay, I am responsible for providing a copy of my insurance card and any forms my insurance company may require. I understand Medicare or secondary carriers may not cover some procedures and supplies, and that I am responsible for understanding which aspects of my treatment are covered before proceeding. I may be asked to sign a form (Advanced Beneficiary Notice of Noncoverage), which states that I will be responsible for these charges if deemed non-covered.

Insurance Claims: As a courtesy, Island Orthopaedics, LLC will file insurance claims with my insurance carrier. My insurance company, in lieu of reimbursing me directly, will pay Island Orthopaedics, LLC any benefits for services rendered. I understand my insurance policy is a contract between myself and my insurance carrier only, and that my medical insurance carrier may pay less than the actual bill for services. I may, therefore, be responsible for payment of all services rendered. I understand I am responsible for providing complete insurance information for accurate filing of claims and that Island Orthopaedics, LLC may request my current insurance card at each visit. Reduction or rejection of my claim by my insurance company does not relieve the financial obligation I have incurred. It is my responsibility to know and understand my medical insurance coverage. Not all services are a covered benefit in all contracts. Additionally, some services provided will be billed separately from the office visit and may require a separate co-pay or be applied to my co-insurance/deductible. (Please call your insurance company to verify your benefits.) I will be responsible for all fees not paid by my insurance company.

Referrals and Authorizations: Before seeing a specialist, some insurance companies (particularly HMOs, Ohana, and TRICARE) require that I obtain an authorization or referral from my primary care physician prior to any visit. It is my responsibility to know if this is required by my insurance and, if so, to obtain the referral. If this is not done by the day of my appointment, I may be asked to reschedule my appointment or pay the full amount for all services on the day of service. It is my responsibility to keep track of my referral expiration dates and number of visits allowed. If my insurance company rejects a claim because a valid authorization or referral was not in place, the full cost of the visit and treatment/services rendered will be my responsibility.

Worker's Compensation, No Fault Auto, Third Party Liability claims: I understand Island Orthopaedics, LLC requires my workers compensation/no fault auto/third party liability carrier's name, address, and claim number prior to my visit. If that information is not provided, I may be responsible for paying the full amount for all services on the day of service. Additionally, if my claim is denied, I am responsible for all charges incurred.

Self-Pay Patients: If I have no medical coverage, I agree that I am responsible for all financial charges for medical treatment and services incurred while under the care of Island Orthopaedics, LLC, and payment in full is due at the time treatment and services are rendered. I understand I have the right to decline treatment and services before they are rendered, and inquire about risk and benefits of alternative treatment.

Quest Pending Patients: Island Orthopaedics, LLC may collect a $50 deposit for each visit while my application for Medicaid benefits is being processed. I understand that if I am denied Medicaid benefits, each $50 deposit will be applied to the cost of services rendered. I will be responsible for all charges incurred, not paid for by my deposit.

Minor Patients: Responsibility for payment for treatment of minor children rests with the parent/legal guardian who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved. Any unaccompanied minor may be rescheduled if consent for treatment and accommodations are not arranged with Island Orthopaedics, LLC prior to the appointment.

Scheduling Fees: If I am unable to keep my scheduled appointment, I agree to call Island Orthopaedics, LLC at least 24 hours in advance. Island Orthopaedics, LLC may reserve the right to charge $25.00 for any appointment which is not cancelled with 24 hours notice.

Unpaid Account Balances: In the event that I fail to make payments for services rendered, my account may be turned over to a collection agency. I will be responsible to pay the collection agency's fees that may be incurred in the collection of any outstanding balance.

Benefit Assignment: I hereby authorize the assignment of benefits (payments) directly to Island Orthopaedics, LLC for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance company. I understand that co-payments, deductibles, co-insurance, and non-covered services are due in full at the time of service.

Agreement: I have read, understood, and agree to the terms and policies of Island Orthopaedics, LLC as stated above. I am of sound mind and have been given the opportunity to ask questions and clarify any part of which was unclear to me prior to signing this document.

Print Name: _____

Signature: _____ Date: _____

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CLOSED TREATMENT OF FRACTURES

Patients presenting to our office with fractures may have their fracture "closed treated." This means the fracture site is not surgically opened but instead may be casted, manipulated, or managed without manipulation for a 90 day period. For 90 days following closed treatment, all office visits are included to enable your physician to manage the healing of your fracture as he deems medically necessary. It does not include x-rays, injections, additional cast applications, casting supplies, post-operative shoes, immobilization boots, examinations unrelated to the fracture site, and any additional procedures. Fractures incur this charge because you are paying for our orthopedist's expert opinion on how to best treat your fracture. Our physicians have undergone additional training in fracture care and that is why you are here seeking their advice.

Please be aware you will see two charges on your bill on your first visit with a new fracture– one charge for your office visit and a second for fracture management. Even though patients who receive closed treatment do not have open surgery, they may see "treatment of fracture" or "surgery" on their bill. This is because the type of codes we use bill to insurance are categorized by insurances as surgery codes.

If you have any additional questions about your bill, please do not hesitate to call our office at (808) 548-7033.