Please tell us how you were referred to our office. **THANK YOU!**

Primary Care Doctor:_____ **Referred By:**_____

PATIENT INFORMATION:

I prefer to be called: _____

Name:(Last)_____**(LEGAL First)**_____**(M.I.)**_____

Home Phone #: (_____)_____ **Cell Phone #:** (_____)_____

Email:_____ **SSN:**_____ **D.O.B:**____/_____/_____ **Sex:** _____

Race: ☐ White ☐ American Indian ☐ Asian ☐ Black/African American ☐ Other:_____ ☐ Decline

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Decline **Preferred Language:**_____

Mailing Address: _____ **City:**_____

State:_____ **Zip:** _____ **Patient status:** ☐ Single ☐ Married ☐ Other_____

Emergency Contact: Name:_____ **Phone**: _____ Relationship_____

GUARANTOR/ PARENT INFORMATION:

(person responsible for the bill, if different from above) ***AN ADULT MAY NOT NAME ANOTHER ADULT RESPONSIBLE IF THAT PERSON IS NOT PRESENT***

Name:(Last)_____ (First)_____ (M.I.)____ Relationship:_____

Phone#: (_____)_____ Email:_____

Address:_____ Zip:_____ City:_____ State:____

SSN:_____ D.O.B:_____/_____/_____ Sex: _____

EMPLOYMENT STATUS: ☐ Empl FT ☐ Empl PT ☐ Retired ☐ Not Empl ☐ Student FT ☐ Student PT
(person responsible for the bill)

Employer's Name:_____ Occupation: _____

Employer's Address:_____City:_____State:_____Zip:_____

Employer's Phone: (_____)_____ May we contact you at work? _____

WORKMAN'S COMP:

Insurance Carrier:_____ Injury Date: _____CLAIM #: _____

Employer's Name: _____ Supervisor's name:_____ Phone:_____

PRIMARY INSURANCE:

Insurance Carrier:_____ Policy Holder Name: _____ Gender:_____

Policy Holder DOB:_____/_____/_____ Policy Holder SSN: _____ Relation to Patient:_____

Policy / ID #:_____ Group #: _____

SECONDARY INSURANCE:

Insurance Carrier:_____ Policy Holder Name: _____ Gender:_____

Policy Holder DOB:_____/_____/_____ Policy Holder SSN: _____ Relation to Patient:_____

Policy / ID #:_____ Group #: _____

By signing below, I agree that all the information provided is true to the best of my knowledge. I also hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for the noncovered services. I also authorize the physician to release any information required to process this claim.

SIGNATURE:_____**DATE:**_____

RIVERS EDGE ORTHOPEDICS
SPENCER D. GREENDYKE, M.D.

3318 N. Grand Mill Lane
Coeur d' Alene, ID 83814
P 208-277-1060/ 208-277-1065 F

Notice of Privacy Practices

*Summary and Authorization

We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information to physicians or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provided for you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Unless you give us written authorization, we cannot use or disclose you health information for any reason except those described in this Notice. *** SEE PROTECTED HEALTH INFORMATION RELEASE SECTION TO GIVE AUTHORIZATION***

I have been made aware of the Privacy Practices and have been given the opportunity to review it in its entirety.

Acknowledgement of the Privacy Practices

Signature_____ Date:_____

*You may request the complete version of this Notice at any time. This is a summary of the Privacy Act along with Authorization to release medical information to friends or family members

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Please only sign if you would like to give permission for a spouse, sibling, friend or parent to be able to call -in and speak to the Medical Assistant or Doctor regarding your treatment

*****Protected Health Information Release Authorization*****

This will authorize **RiversEdge Orthopedics** to use or disclose my protected health information

to (list name):_____as described below for the following purpose:

_____Ask any question over the phone or in office regarding treatment.

_____Other (please describe) _____
_____
_____

Signature:_____ Date:_____

Rx Prescription Refill Policy Rx

Please read carefully the Prescription Refill Policy for our office.

- On-Call Orthopedic surgeons in Kootenai County have agreed to never prescribe controlled medications after clinic hours or on weekends and holidays.
- The patient is responsible for knowing when medication(s) will need to be refilled. (**No early refills!** Patients must follow the prescribing directions, DO NOT overuse/abuse/misuse. If a prescription is lost, stolen, misplaced, etc. no early refills will be given.)
- If you have a refill request, please contact your pharmacy and ask them to fax us the refill request.
  ★★ALL REFILL REQUESTS REQUIRE A TWO-DAY ADVANCED NOTICE FOR PROCESSING★★
- Non-controlled/non-narcotic prescriptions require a follow up appointment every 6 months.
- Controlled substances/narcotic prescriptions require a follow up appointment every 30 days.
- Post Surgical patients will receive narcotic pain medications for no longer than 30 days. Thereafter, they will need to contact their primary care physician.
- New symptoms and/or events require a clinic appointment. Provider is unable to diagnose via phone.
- Patient must pick up his/her prescription(s) in person, unless pre-authorized by staff.

Discourteous behavior toward the office staff will result in discontinuation of further narcotic prescriptions

I understand & accept the protocol listed above. Failure to comply may subject immediate termination of prescription medications.

Patient Signature: _____ Date: _____

Please Print: _____ D/O/B: _____

*Name of person picking up Rx (if not the same): _____

INTAKE FORM Date:_____

Name:_____ **DOB:**_____ **Ht:**____'____" **Wt:**_____lbs

INJURY/ ILLNESS INFORMATION

Referring Dr:_____

◆ Which of the following best describes how your medical problem began: (check only ONE)

☐ Work Related ☐ Auto Accident ☐ Accident at Home ☐ Began spontaneously ☐ Sports Injury

◆ Please tell us how your medical problem began (**DATE** & how it happened):

_____

_____

_____

◆ Which body parts are affected (indicate **Rt** OR **Lt**)? _____

◆ Please indicate treatment you have received for this injury:

☐ Physical Therapy (Where at & for how long?_____)

☐ E.R. or Urgent Care (Which location? _____) ☐ None

☐ Other: _____

◆ Rate your pain on a scale of 1-10 (10 being **extremely** severe/worst pain you've ever had)_____

◆ Characterize your symptoms: ☐ Aching ☐ Sharp ☐ Burning ☐ Stabbing ☐ Cramping

☐ Intermittent ☐ Constant ☐ Dull ☐ Throbbing ☐Other:_____

◆ Symptoms **improve** with: ☐ Rest ☐ Activity ☐ Ice ☐ Heat ☐ Medication

◆ Symptoms feel **worse** with: ☐ Rest ☐ Activity ☐ Ice ☐ Heat ☐ Other: _____

◆ Since the onset are your symptoms: ☐ Improved ☐ Worsened ☐ Unchanged

MEDICAL HISTORY (Please list **ALL** medical history/illnesses you have had or currently have)

☐Anemia	☐Diabetes	☐Liver dis./Hepatitis	☐Stomach Ulcers
☐Asthma	☐Elev. Cholesterol	☐Obesity	☐Stroke/TIA/CVA
☐Bleeding Disorder	☐Angina/Arrhythmia	☐Osteoarthritis	☐Thyroid Disease
☐Blood Transfusions	☐Fibromyalgia	☐Osteoporosis	☐Other_____
☐BPH/Prostate dis.	☐ GERD	☐Osteomyelitis	_____
☐Bronchitis	☐ Glaucoma	☐Peripheral Vascular	_____
☐Cancer	☐Gout	☐Phlebitis	_____
☐COPD	☐Hypertension	☐Rheumatoid Arthritis	_____
☐Coronary Artery dis.	☐Intestinal Disease	☐Seizures	_____
☐Depression	☐Kidney/Renal Dis.		☐None

Name: _____ Date:_____

SURGICAL HISTORY (Please list **ALL** surgeries you have had)

☐Arthroscopy Knee	☐Carpal Tunnel Release	☐Hysterectomy	☐Other: _____
☐Arthroscopy Shoulder	☐Back Surgery	☐Hernia	_____
☐Total Hip Replcmt	☐Neck Surgery	☐Bowel Surgery	_____
☐Total Knee Replcmt	☐Appendectomy	☐Tonsillectomy	_____
☐Rotator Cuff Repair	☐Gall Bladder	☐C-Section	_____

FAMILY/ SOCIAL HISTORY

◆ Father: ☐ Living ☐ Deceased - Medical Conditions: _____

_____

◆ Mother: ☐ Living ☐ Deceased - Medical Conditions: _____

_____

◆ Siblings: ☐ All Living ☐ Some Living/Some Deceased ☐ All Deceased ☐ Unknown

- Medical Conditions: _____

◆ Marital Status: _____ ◆ Do you drink caffeinated beverages? **YES / NO**

◆ Do you drink alcohol? : ☐ Never ☐ Very Rarely ☐ Rarely ☐ Socially ☐ Daily

◆ Do you use tobacco? _____ ◆ If so, what kind & how much per day? _____

MEDICATIONS [Please list **ALL** medications you are currently taking (Rx and Over-the-counter)]

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES (Please list **ALL** allergies you have, and the reaction to each)

_____

_____

◆ By signing below, I certify the above information provided is accurate and correct to the best of my knowledge. I will notify Dr. Greendyke or his staff if there are any changes to the above.

Signature _____Date_____

PATIENT'S NAME: _____ RiversEdge Orthopedics Financial Policy

☐ I have medical insurance. It is: _____ Secondary_____

☐ I do not have medical insurance coverage and will agree to the financial terms of "Self Pay".

Insurance Guidelines:

- Your insurance may require a referral, deductible, co-payment, or pre-authorization prior to your being seen. It is the **patient's responsibility** to be aware of and meet these requirements as stated in your insurance policy.
- Your insurance contract is between you, your employer and your insurance company. Not all services, even if medically indicated, are considered covered benefits by all contracts or policies. Some insurance companies arbitrarily select certain services which they will or will not cover.
- You may expect a separate billing from an outside imaging center, hospital facility, laboratory, or pathology for work being done at your visit. *Dr. Greendyke also reads his own x-rays and bills for this service.*
- As a courtesy to you, we will bill your insurance company *if we have all of the necessary information.*
- **Your co-payment must be paid at the time of service**.
- Although we will bill your insurance, the patient is responsible for any services not covered by insurance.
- In the event that the account is not paid & we refer the account to collection, you will be responsible for all fees incurred in the collection of your bill. We will no longer be able to schedule future appointments for you.
- Third party forms will not be covered by your employer or insurance carrier, such as FMLA, Aflac, Physician's Statement's, Short or Long term Disability forms, etc. ***There will be a $25.00 fee per form***.

Self Pay Policy

- If you are a self pay patient, our policy is to collect a fee for a new patient visit up front which is $200.00.
- Patients will be given a quote of expected services before services are rendered (i.e., Injections, casts, etc.)
- 50% of the quoted fee must be collected up front before further treatment is rendered and payment arrangements agreed upon with billing agent.
- A discount will be given to patients who pay in full at time of service, to be discussed with the billing agent.
- There will be a **fee of $25.00 per third party forms** such as FMLA, Aflac, Physician's Statement's, short or long term disability forms, etc.

Workman's Compensation

- It is the responsibility of the patient to provide our office with the correct information for their work comp claim.
- We need to know the date of injury, how the injury occurred and the place of employment at time of injury, as well as the claim number, and the surety's name, address and phone number.
- If you do not have this information at the time of your appointment, please refer to *self pay policy* above.
- Please check with your human resource department with your employer for needed information of work comp carrier.
- A Work Status Report will be filled out and faxed to your work comp claim adjuster and you will not be charged for this form.
- Third party forms will not be covered by your employer or workman's compensation, such as FMLA, Aflac, Physician's Statement's, Short or Long term Disability forms, etc. ***There will be a $25.00 fee per form***.

Surgical Deposit Policy

- If you need to schedule a surgery, RiversEdge **requires a $250 deposit** to hold your surgery date.
- This will be applied toward your deductible.
- In the event that you cancel without sufficient notice, this deposit is non-refundable.

★★I **understand** that I will be responsible for any additional **third party forms**, [i.e. FMLA, Physician's Statements, long or short-term disability forms, Aflac, MetLife, etc.] the charge is **$25.00 per occurrence**, due upon completion★★

Sign_____ **Date**_____