MILLER ORTHOPEDIC SPECIALISTS

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Patient Name _____ Marital Status: M S D W (Circle One)
Last First MI Maiden

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: M F

Address: _____
Street City State Zip

E-mail Address: _____ Race:_____ Ethnicity:_____ Preferred Language:_____

Phone Home: (_____)_____#____ Work: (_____)_____#____ Cell: (_____)_____#____

NOTE: Please designate the phone number that is best to reach you for reminder/reschedule/call back (ex: #1-best number, #2-next best number etc.)

IF WE ARE UNABLE TO REACH YOU, WHO MAY WE RELEASE MEDICAL AND/OR BILLING INFORMATION TO? (Emergency Notification and Contacts)

(Exception: X-Ray, Path and/or Lab results will be given only to the patient or "designee". Results will not be left on an answering machine.)

_____
Name Relationship Phone #

_____
Name Relationship Phone #

Referring Doctor: _____ Family Doctor: _____
Name City State Name City State

Reason for exam:_____

How did incident occur? _____

Body Part: _____ ❑ Left ❑ Right ❑ Both

Date of Injury? _____ ❑ Gradual Onset

Have you been treated for the injury prior to your appointment today? ❑ Yes ❑ No

If yes, date you were first treated? _____ Where? _____ Who treated you? _____

Were **X-Rays** **Bone Scan** **CT Scan** **MRI** **EMG/NCV** taken? *(Circle all that apply)*

Location these were taken: _____

Employment Information

Company Name:_____

Address: _____
City State Zip

Occupation: _____

If this is an injury, is the injury related to an on the job accident? ❑ Yes ❑ No

If Yes:

a) Have you reported the accident to your employer? ❑ Yes ❑ No
b) Were you referred by a Work Comp Doctor? ❑ Yes ❑ No

If No:

a) Was this injury a result of a car accident? ❑ Yes ❑ No
b) Did the injury occur on another person's property? ❑ Yes ❑ No

Do you have an attorney representing you in a claim regarding the above injury?

*Attorney:*_____
Name Address City State Zip

INSURANCE INFORMATION (copy of insurance card is needed)

Insurance Name: _____ Policy Holder: _____ _____-_____-_____
Primary Name Date of Birth SS# of Policy Holder

Insurance Name: _____ Policy Holder: _____ _____-_____-_____
Secondary Name Date of Birth SS# of Policy Holder

If patient is a minor, please print name of parent or guardian responsible for bill: (*must be present)*

Guardian Name:_____

Address: _____
Street City State Zip

Date of Birth_____ Soc Sec # _____-_____-_____
MM/DD/YY

Revised 07_2021

Patient Name: _____ Age: _____ Date:_____

Please list ***ALL MEDICATIONS*** Prescription/Non-Prescription, including Herb/Dietary Supplements that you are presently taking: (f you should need more space, please turn page over.)

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

Please list ***ALL ALLERGIES*** drug, food or other; including ***LATEX*** if applicable:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list ***ALL PAST SURGERIES AND DATES:***

_____ _____

_____ _____

_____ _____

My pharmacy preference is: _____

Name Addresss City State

Have you had, or do you presently suffer from:

Yes/No			***Yes/No***		
❑	❑	Cancer	❑	❑	HIV
❑	❑	Seizures/Stroke	❑	❑	Chemical Dependency/Alcoholism
❑	❑	Liver/Hepatitis/Jaundice	❑	❑	Reaction to General / Local Anesthesia
❑	❑	Heart Failure/Heart Attack	❑	❑	Have you ever had cortisone?
❑	❑	Diabetes	❑	❑	Do you smoke? How much? _____
❑	❑	Emphysema/Chronic BronchitisAsthma	❑	❑	Are you pregnant?
❑	❑	Thyroid Disorder	❑	❑	Have you gone through menopause?
❑	❑	Blood Clots/Phlebitis	❑	❑	Have you had a bone density test in the last 2 years?
❑	❑	Urinary Tract/Kidney/Bladder Infection	❑	❑	Have you ever taken Coumadin?
❑	❑	Sleep Apnea			

List any other medical problems not mentioned above: _____

_____

Significant family/health history: _____

_____

I hereby verify the above information is accurate and complete to the best of my knowledge:

Signature: _____ Date:_____

Reviewed by: _____ Date:_____

_____ Date:_____

REFERRAL SOURCE: How did you hear about Miller Orthopedic Specialists: (Please Check ONE)

❑ TV ❑ Radio ❑ Search (Google/Bing) ❑ Facebook ❑ Newspaper ❑ Yellow Pages ❑ My Physician ❑ Family
❑ Friend ❑ Sports Poster ❑ MOS Website ❑ Presentation ❑ Previous Patient ❑ Urgent Care _____
❑ ER Mercy ❑ ER Jennie Ed ❑ ER Other _____ ❑ Work Comp _____ ❑ Coach _____
❑ MOS Employee _____ ❑ Physical Therapist _____ ❑ Athletic Trainer _____
❑ Other (Please list source): _____

Review of Systems

Patient Name _____ **Date** _____

Please mark ALL

General (Constitutional)

Yes	No	
☐	☐	Weight Loss
☐	☐	Weight Gain
☐	☐	Fever
☐	☐	Trouble Sleeping
☐	☐	Difficulty with daily activity (if yes, please explain)

_____

_____

Eyes/Ears/Nose/Throat (HEENT)

Yes	No	
☐	☐	Headaches
☐	☐	Ringing in Ears
☐	☐	Vertigo/Dizziness

Respiratory

Yes	No	
☐	☐	Cough
☐	☐	Shortness of Breath

Cardiovascular

Yes	No	
☐	☐	Edema (swelling of ankles)
☐	☐	Chest Pain
☐	☐	Dyspnea on Exertion(shortness of breath)

Intestinal (Gastrointestinal)

Yes	No	
☐	☐	Heartburn
☐	☐	Upset stomach due to medication
☐	☐	Change in bowel/bladder habits

Urinary (Genitourinary)

Yes	No	
☐	☐	Frequent Urination
☐	☐	Burning

Neurological

Yes	No	
☐	☐	Numbness
☐	☐	Tingling

Psychological (Psychiatric)

Yes	No	
☐	☐	Depression
☐	☐	Nervousness

Skin (Integumentary)

Yes	No	
☐	☐	Rashes
☐	☐	Open Sore

Musculoskeletal

Yes	No	
☐	☐	Stiffness
☐	☐	Joint Swelling
☐	☐	Muscle Weakness
☐	☐	Back Pain

Lymph/Hematology (Hematologic)

Yes	No	
☐	☐	Bleeding Tendency
☐	☐	Anemia
☐	☐	Bruise Easily

Reviewed By_____ Date_____

Miller Orthopedic Specialists
1 Edmundson Place, Suite 500
Council Bluffs, IA 51503
712-323-5333

AUTHORIZATION FOR CONSENT TO TREATMENT

I consent to treatment and to the use or disclosure of my protected health information by Miller Orthopedic Specialists for the purpose of diagnosing or providing treatment to me and obtaining payment for my health care operations of Miller Orthopedic Specialists as may be deemed necessary or desirable by my attending physician, their assistants and designees. This authorization includes, but is not limited to, evaluation, routine diagnostic procedures, laboratory tests and operative procedures.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the examination and treatment in this facility. I acknowledge that my care is under the direction of my attending physician, and the facility will follow the instructions of my physician in the provision of said care.

I hereby authorize Miller Orthopedic Specialists to release any medical information to my referring and/or family doctor and any information to insurance that is necessary to process and consider health insurance claims, including workers' compensation carriers and/or employers. I hereby assign my insurance benefits to be paid directly to Miller Orthopedic Specialists Physicians or Physician Assistants for service rendered for which Miller Orthopedic Specialists participates. I also accept responsibility for all charges provided by Miller Orthopedic Specialists Physicians or Physician Assistants not covered by this assignment for lack of referral or prior workers' compensation authorization.

I hereby proclaim that the above information is accurate and complete.

Patients, Parent/Legal guardian or Power of Attorney signature:

X_____ Date:_____

Print Name: _____

Our Office/Financial Policy

Welcome to Miller Orthopedic Specialists. We look forward to providing you with the best Orthopedic care available. We hope the information provided in this financial policy will offer the answers to some of the questions you may have.

Services
We offer complete Orthopedic and Podiatric, care. We also offer on-site Physical and Occupational Therapy, bracing, and MRI testing.

Insurance
If you are currently insured, we will file your insurance claims for you. For the benefit of our patients, the physicians at Miller Orthopedic Specialists have enrolled in many of the insurance networks. However, if we are not enrolled in your particular plan, you will be required to assign benefits to us. If for any reason your insurance carrier does not remit the benefits to us in a reasonable amount of time, you will be responsible for the outstanding balance. In the event your health plan determines a service to be "non-covered, "or you did not receive the required authorization, you will be responsible for the entire charge.

Note: Outstanding balances must be paid in full prior to receiving treatment.

If you do not have insurance, a $200.00 deposit is required prior to an office visit. If a balance remains, it is due, in full, within 30 days. If surgery or an MRI is required, 100% of the fee is due prior to performing the procedure.

If your plan requires a referral, you are responsible for obtaining them.

MVA's (Motor Vehicle Accidents)
Your auto insurance usually has a "Med Pay" clause in the policy. This is money allotted for medical benefits from injuries you sustain during the accident. There is usually a $5,000.00 limit on each policy. Miller Orthopedic Specialists will submit all claims to your Auto carrier first. If/When your Med-Pay reaches the maximum amount; we will begin to submit your insurance claims to your personal insurance. We do not bill attorneys, submit liens, or wait until settlement for the balance owed.

Payments and Co-payments
Most health plans have deductibles and co-payments or co-insurance. These amounts are due at the time of service. If you are unable to remit this amount, our staff will be happy to assist in rescheduling your appointment for a more convenient time. Our contracts with insurance plans require us to collect the deductibles and co-payments specified by your policy, in full.
For your convenience, we accept personal checks, money orders, Visa/MasterCard.

Delinquent accounts are subject to collection proceedings. If your account is sent to collection, all fee's including, but not limited to, collection fees, attorney fees, interest and court fees shall become your responsibility in addition to the balance due our office.

Special Payments
Payments marked as "Paid in Full" or any similar terms on amounts owed must be sent directly to Miller Orthopedic Specialists, 1 Edmundson Place, Suite 500, Council Bluffs, Iowa 51503. We accept these payments without losing our right to receive the full amount owing on your account.

Service Fee's

Disability Forms:	There is a $10.00 fee for this service. (Pre-payment is required)
ISF Checks:	The amount of $25.00 will be assessed towards your account for each insufficient fund check.
Interest:	There will be an additional interest fee (1.50%) attached monthly to all balances which remain unpaid longer than 30 days. That is an 18% annual fee.
X-rays:	Copies of your X-ray's are available on a disc for a fee of $5.00. (Pre-payment is required)
Medical Records:	Please contact our Medical Records specialist for the current copying rate. She may be reached at (712)388-0155

Workman's Compensation
Appointments for injuries received during your employment may only be made by your employer or their work comp insurance carrier. (Please Note: Your medical records are released to your work comp insurance carrier/employer with each claim submitted.)

Appointments
Appointments are required and may be made during regular business hours. You may call (712)323-5333 from 7:30am to 5:00 pm, Monday through Friday. If you are unable to keep your appointment, please notify us as soon as possible. **If we are not notified of a cancellation, there will be a $35.00 fee assessed to your account.**
Please note: Your insurance carrier will not cover this fee.

Practitioners
Members of our staff providing services to you may include Physician Assistants and Nurse Practitioners. These professionals have had specialized instruction and training which enable them to assist our physicians in many areas of care, and qualifies them to provide a variety of services in addition to answering your questions.

Prescriptions
Prescriptions and refills are issued during business hours only. **There is no exception.** We request that you contact us prior to noon the day before you require additional medication. This will allow your physician time to review your file and contact your pharmacy.

Minors
Minors must be accompanied by a parent/legal guardian as we are legally unable to provide care without the proper consent. The parent who authorizes treatment must be the parent that is also financially responsible. There is **not** an exception with regard to divorce or court orders.

I acknowledge the receipt of this policy. I understand its contents and agree to abide by its terms for the duration of treatment or payment obligations to Miller Orthopedic Specialists.

Signature of Patient or Responsible Party:

_____ _____
Printed Name Date

_____
Signature