REVIEW OF SYSTEMS/PAST MEDICAL HISTORY

Primary Care Physician _____ Referring Physician _____

Patient Name _____ Age _____

Reason for this visit _____ Date of Injury _____

How did this happen _____

Dominant Hand □ Right □ Left Height: _____ Weight: _____lbs

PLEASE CIRCLE THE FOLLOWING WHICH APPLY

Right or Left ~ Shoulder ~ Elbow ~ Wrist ~ Hand ~ Finger ~ Back ~ Hip ~ Knee ~ Ankle ~ Foot ~ Toe

PATIENT PAST MEDICAL HISTORY

Ongoing Medical Problems _____

_____

Prior Surgeries & Hospitalizations _____

_____

Current Medications (List Dosages) _____

_____

Allergies _____

Alcohol Use	□ Yes	□ No
Tobacco Use	□ Yes	□ No
Drug Use	□ Yes	□ No

If yes, amount of alcohol per week? _____

Number of packs per day _____ Number of years _____

If yes, please describe _____

REVIEW OF SYSTEMS

Check Y or N if you have any of the following symptoms

Fever	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Fractures	□ Yes	□ No
Weight Loss	□ Yes	□ No	Irregular Heart Beats	□ Yes	□ No	Sprains	□ Yes	□ No
Weight Change	□ Yes	□ No	Asthma	□ Yes	□ No	Joint Pain	□ Yes	□ No
Changes in Appetite	□ Yes	□ No	Cough	□ Yes	□ No	Joint Swelling	□ Yes	□ No
Depression	□ Yes	□ No	Shortness of Breath	□ Yes	□ No	Arthritis	□ Yes	□ No
Mood Change	□ Yes	□ No	Coughing Up Blood	□ Yes	□ No	Stiffness	□ Yes	□ No
Visual Changes	□ Yes	□ No	Diarrhea	□ Yes	□ No	Changes in Sensation	□ Yes	□ No
Double Vision	□ Yes	□ No	Constipation	□ Yes	□ No	Seizures	□ Yes	□ No
Burning Eyes	□ Yes	□ No	Abdominal Pain	□ Yes	□ No	Weakness	□ Yes	□ No
Blurred Vision	□ Yes	□ No	Hallucinations	□ Yes	□ No	Balance	□ Yes	□ No
Eye Trauma	□ Yes	□ No	Sleep Disturbances	□ Yes	□ No	Memory	□ Yes	□ No
Eye Glasses/Contacts	□ Yes	□ No	Bleeding Tendency	□ Yes	□ No	Incoordination Problems	□ Yes	□ No
Deafness	□ Yes	□ No	Lymph Node Pain	□ Yes	□ No	Hyper/Hypo Activity	□ Yes	□ No
Sinusitis	□ Yes	□ No	Anemia	□ Yes	□ No	Hair Changes	□ Yes	□ No
Ringing in the ears	□ Yes	□ No	Urinary Hesitancy	□ Yes	□ No	Skin Changes	□ Yes	□ No
Hoarseness	□ Yes	□ No	Incontinence	□ Yes	□ No	Eczema	□ Yes	□ No
Dizziness	□ Yes	□ No	Painful Urination	□ Yes	□ No	Latex, Drug or Other Allergies	□ Yes	□ No
Chest Pain	□ Yes	□ No	Menstrual Abnormalities	□ Yes	□ No	Inability to move arms or legs	□ Yes	□ No
Heart Palpitations	□ Yes	□ No	Pregnancies # of	□ Yes	□ No	Difficulty in speech or swallowing	□ Yes	□ No
Changes in skin color, temperature, rashes, lesions, scars, masses				□ Yes	□ No	Sleep Apnea	□ Yes	□ No
Difficulty with anesthesia				□ Yes	□ No			

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY - Page 2

CHECK ANY FAMILY HISTORY OF THE FOLLOWING

Diabetes	□ Yes	□ No	Heart Disease	□ Yes	□ No
Arthritis	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Strokes	□ Yes	□ No	Problems w/ Anesthesia	□ Yes	□ No
Cancer	□ Yes	□ No	What type? _____		

OSTEOPOROSIS CHECK LIST

Have either of your parents broken a hip after a minor bump or fall?	□ Yes	□ No
Have you broken a bone after a minor bump or fall?	□ Yes	□ No
Did you undergo menopause before age 45?	□ Yes	□ No
Have you taken a corticosteroid tablet (prednisone, cortisone) for more than six months?	□ Yes	□ No
Have you lost more than 5cm (2 inches) in height?	□ Yes	□ No
Have your periods ever stopped for 12 months or more for reasons other than pregnancy or menopause?	□ Yes	□ No
Do you regularly drink heavily?	□ Yes	□ No
Do you suffer frequently from diarrhea (caused by problems such as coeliac disease or Crohn's disease)?	□ Yes	□ No
Have you had obesity surgery?	□ Yes	□ No

_____ _____ _____ _____

Physician Signature Date Patient Signature Date

PATIENT INFORMATION

Please complete this form in its entirety as well as having your insurance and ID cards ready to copy

PATIENT INFORMATION

Referred By_____ Primary Care Physician_____

Name _____ Soc. Sec. # _____

Last Name First Name Initial

Mailing Address _____

City _____ State _____ Zip _____

Sex □ M □ F Age_____ Birth Date_____ □ Single □ Married □ Widowed □ Divorced

Primary Phone _____ Secondary Phone _____ Work Phone _____

Patient Employed By_____ Occupation_____

In case of emergency, who should be notified? _____ Phone _____

Date of Injury _____ Reason for this visit_____

PERSON RESPONSIBLE FOR ACCOUNT

Person Responsible for Account _____

Last Name First Name Initial

Relationship to Patient _____ Birth Date _____ Soc. Sec. # _____

Address (if different from patient's) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation_____

Business Address _____ Business Phone _____

PRIMARY INSURANCE

Insurance Company _____ Insurance ID # _____ Group #_____

Subscriber Name _____

Relationship to Patient _____ Birth Date _____ Soc. Sec. # _____

Address (if different from patient's) _____

City _____ State _____ Zip _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? □ Y □ N

Insurance Company _____ Insurance ID # _____ Group #_____

Subscriber Name _____ Relationship to Patient _____ Birth Date _____

Address (if different from patient's) _____

City _____ State _____ Zip _____

WORKMANS COMPENSATION INSURANCE IF WORK RELATED INJURY

Employer _____ Employer Phone _____

Insurance Carrier Name _____ Insurance Carrier Phone _____

Date of Injury _____ Claim # _____ Adjustor Name _____

AUTOMOBILE INSURANCE IF AUTOMOBILE ACCIDENT RELATED

Insurance Carrier Name _____ Insurance Carrier Phone _____

Insurance Billing Address _____ Adjustor Name _____

Date of Accident _____ Claim # _____

CONTINUED ON PAGE 2

PEOPLE AUTHORIZED TO RECEIVE INFORMATION

(Only people listed below will be able to receive your medical information)

Name and Relationship to Patient _____ Phone # _____

Name and Relationship to Patient _____ Phone # _____

Name and Relationship to Patient _____ Phone # _____

MEDICAL APPOINTMENT CANCELLATION POLICY

Due to busy scheduling, we require 24 hour notice of cancellation. Failure to notify the office will result in a $50.00 fee. This charge cannot be billed to your insurance carrier, therefore you will be responsible for the payment.

If you are continually unable to notify the office of a cancellation in a timely fashion we may be unable to continue to provide services.

MEDICATION REFILL POLICY

Please allow 48-72 business hours for medication refills. Please have your pharmacy fax the medication refill request. We will only prescribe pain medication for the acute post fracture or postoperative period.

THERE WILL BE NO MEDICATION REFILLS DURING WEEKEND AND NON-BUSINESS HOURS.

ASSIGNMENT AND RELEASE

- **PLEASE BRING AND PRESENT INSURANCE CARDS AT THE TIME OF YOUR VISIT**
- **ALL CO-PAYMENTS OR DEPOSITS ARE DUE AT THE TIME OF YOUR VISIT**
- If you have no health insurance to bill, you will be required to make a deposit of $170.00 on your first visit. A deposit of $75.00 is required for all follow-up visits. (Auto PIP/MedPay is not considered health insurance).

North Idaho Orthopedics and Sports Medicine relies on the insurance and billing information provided to us by you or your referring provider. In the event that this information is not accurate a case deposit may be required, or your appointment may need to be rescheduled. After services are provided, we will submit our claim to your insurance carrier if applicable. In the event that payment is denied, the patient is responsible for full payment. All patient balances are due within 30 days of the statement date. It is the patient's responsibility to contact the billing department if this obligation cannot be met. North Idaho Orthopedics and Sports Medicine is committed to assisting our patients in meeting their financial responsibility; however, if arrangements are not made, we will utilize the services of a credit bureau or a collection agency. [Any fees associated with the services of these I hereby assign North Idaho Orthopedics and Sports Medicine all money due for medical and/or surgical services rendered by North Idaho Orthopedics and Sports Medicine in the event of a settlement.] I authorize North Idaho Orthopedics and Sports Medicine to send my medical information to my primary care provider and/or referring provider as necessary.

ASSIGNMENT: I HAVE READ, COMPLETED, AND FULLY UNDERSTAND THE ENTIRE PATIENT INFORMATION PACKET. I HEREBY AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN AND RELEASE OF ANY INFORMATION REQUIRED.

_____ _____ _____

Responsible Party Signature | Relationship | Date

NORTH IDAHO
ORTHOPEDICS & SPORTS MEDICINE
30544 HWY 200 – SUITE 102, PONDERAY, ID 83852 • PHONE: 208-265-9817 • FAX: 208-265-4533

Your Responsibility Regarding Your Insurance

To accommodate the needs and requests of our patients, we participate with certain insurance plans. We are pleased to be able to provide this service to you, yet it is not possible for us to keep track of all the individual requirements of each plan as they are different between individuals and change frequently. Because of this, it is ultimately your responsibility to check with your insurance to understand the contract and coverage.

Each plan has different restrictions regarding how often services may be rendered and more importantly, where you should obtain these services.

North Idaho Orthopedics & Sports Medicine contracts/participates with the following insurance payers:

Blue Cross*
First Choice Health Network
First Health (Altius and Coventry)
Idaho Physicians Network
Medicaid**
Medicare
North Idaho Health Network*
PacificSource
Regence

* Although we are contracted with *most* of these insurance plans, there are still some that we are either not contracted with and/or will need a written referral for prior to your first appointment. These include (but are not limited to) HMO, Managed Care, and Medicare Advantage plans. If you aren't sure about your plan, please don't hesitate to ask us!

** All Medicaid patients will need a Healthy Connections Referral from their PCP prior to their first appointment with us.

Because we are *specialists*, you must have a referral to our facility with all managed care plans. Each authorization will specify the number of visits and expiration date. The patient is responsible for knowing when this authorization expires. Please contact your primary care physician (PCP) to find out the status of your referral before your scheduled appointment.

Providing the highest quality of care for our patients is our primary concern. We are more than willing to provide care within your insurance plan guidelines whenever possible. As a surgeon's office, we will contact your insurance for any pre-authorization for surgical procedures. To be sure there are no surprises, please check with your insurance regarding your benefits.

If you do not inform us of special requirements required by your plan and we perform a service that is not covered by your plan, we will bill you directly for those charges.

By working together, we can assist you in receiving the benefits you are entitled to. Any questions, please contact our office at (208) 265-9817.

By my signature below, I state that I have read and understand my responsibilities regarding my insurance stated above and agree to accept responsibility as described.

_____ _____
Signature Date

_____
Patient's Name

_____
Relationship if signed by another party

Michael R. DiBenedetto, MD, PLLC
30544 Highway 200, Ponderay, ID 83852
208-265-9817

Notice of Privacy Practices and Patient Consent for the Use and Disclosure of Protected Health Information

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Michael R. DiBenedetto, MD, PLLC (DBA North Idaho Orthopedics and Sports Medicine; DBA Woodlands Family Medicine), the "corporation," may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Michael R. DiBenedetto, MD, PLLC (DBA North Idaho Orthopedics and Sports Medicine; DBA Woodlands Family Medicine) has a detailed document called the 'Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. There are copies available in the lobby and on our websites. If I ask, I will be given the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Michael R. DiBenedetto, MD, PLLC (DBA North Idaho Orthopedics and Sports Medicine; DBA Woodlands Family Medicine) to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that the corporation has taken action relying on this consent.

_____ _____
Signature Date

_____
Patient's Name

_____
Relationship if signed by another party

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting us in writing or by phone or on our website at www.woodlandsfamilymed.com or www.niosm.com.