Dear Patient,

Thank you for choosing Upper Valley Orthopedics for your bone and joint care. We welcome new and returning patients and hope that your care in our office is both professional and friendly.

Enclosed is new/returning patient information sheets that will help in the care you receive in our office. Also, you will find a brochure of our Privacy Policy. This is required by law and we must have a signed form in our office that we provided you with. If you have any questions regarding our privacy policy, please don't hesitate to ask.

The following is some information that will help you familiarize you with our practice.

Upper Valley Orthopedics
Michael J. Larson, M.D.   Kevin M. Lee, M.D.   Travis R. Torngren, M.D.
360 East Main
Rexburg, ID 83440
(208) 356-9550 Office, (208) 356-8023 Fax
Business Hours: Monday-Thursday 8:00am-5:00pm, Friday 8:00am-1:00pm
Website: uppervalleyortho.com

> **Payment Policy-** it is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered, this may only be your co-payment, deductible, and/or coinsurance, but we do ask for payment at the time of your visit. We accept all major credit cards.
>
> **Co-payment-** this is the cost-sharing part of your bill that is a fixed amount designated by your insurance company that is your responsibility to pay at each visit.
>
> **Deductible-** This is the amount of cost sharing that you must pay for medical services, often before your health insurance company starts to pay.
>
> **Coinsurance-** This is the part of your bill, in addition to a copay, that you must pay. Coinsurance is usually a percentage of the total medical bill.

For Medicaid Patients- we MUST have a Healthy Connections Referral from your primary care physician before your appointment. If you do not have it at the time of your visit, we will have to reschedule your appointment.

If you have any questions after reading this information, we will be happy to answer them for you.

Please bring the following information to your visit:

- Insurance Card(s)
- Driver's License
- Completed Forms
- Any prior exam studies : X-Rays, MRIs, CT scans
- List of current Medications

Thanks you again for choosing Upper Valley Orthopedics for your bone and joint care.

Sincerely,

Upper Valley Orthopedics
Michael J. Larson, M.D.   Kevin M. Lee, M.D.   Travis R. Torngren, M.D.

Name:____
DOB:____
Date:____

PATIENT FINANCIAL POLICY

Upper Valley Orthopedics, PLLC
360 East Main **Tel. 208-356-9550**
Rexburg, ID 83440 **Fax 208-356-8023**

We are committed to providing you with the best possible care and are happy to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, and your financial responsibility. The patient or responsible party is responsible for seeing that the entire bill is paid in full within 30 days of the date of service.

WE WILL ASK TO SEE YOUR INSURANCE CARD ON YOUR FIRST VISIT AND WILL SCAN YOUR CARD INTO OUR SYSTEMS AS WE NEED TO KEEP YOUR INFORMATION CURRENT, WE MAY ASK FOR THIS INFORMATION ON A REGULAR BASIS IN ORDER TO ENSURE THAT NO CHANGE IN BENEFITS OR CARRIER HAS OCCURRED. PLEASE NOTIFY US IF YOUR INSURANCE CARRIER OR POLICY HAS CHANGED.

CO-PAYMENTS: Your insurance REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.
SELF-PAY: Self pay accounts shall exist if a patient has no insurance coverage or no evidence of insurance coverage for new patients, a payment of $200.00 is expected on the day of your appointment before being seen by the health care provider. If you are unable to pay the $200.00, please contact the billing office before your appointment. A discount off regular fees is offered for your payment made at the time of service.
MEDICAID REFERRALS: YOUR insurance requires a **Healthy Connections Referral** from your primary care physician it is **YOUR** responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. If you do not have a referral, you may be required to reschedule.
ACCIDENT/WORKER COMP CASES: For any work comp cases, you will need to provide the work comp insurance carrier, your claim number and your claim adjuster. If this information is not provided, this will be a self-pay account and we will require a payment of $200.00 at the time of service. Patients shall be financially responsible for medical services related to work comp if insurance fails to pay in full. We DO NOT treat Auto Accident cases.
MEDICARE: We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the co-insurance, which can be billed to a secondary insurance if you have one.
RETURNED CHECK FEES: Any returned check from the bank for a non-payment (Insufficient funds) shall result in the patient's account being assessed a $25.00 fee per check returned.
FORMS/PAPERWORK: There is $15.00 per form fee for the completion of paperwork or forms relating to disability. This fee is collected prior to completion of the paperwork, and for each time the paperwork is required. Allow five working days for completion of forms.
SURGERY DEPOSIT: Surgery Deposit is required before surgery. Any balance owing after surgery will need to be paid within 90 days of surgery date.

We accept most forms of payment, including credit and debit cards, cash, and checks. You may also make credit or debit card payments over the phone.
If you have any questions, please call our office at 208-356-9550.

RESPONSIBLE PARTY____**DATE**__________________

PATIENT NAME____

UPPER VALLEY ORTHOPEDICS, PLLC
BOARD CERTIFIED ORTHOPEDIC SURGEONS

MICHAEL J. LARSON, M.D.　　**TRAVIS R. TORNGREN**　　**KEVIN M. LEE, M.D.**

PATIENT NAME ________________________ M ___ F___ DATE OF BIRTH___________ AGE_____

ADDRESS ____
STREET　PO BOX　CITY　STATE　ZIP CODE

PHONE WORK ___________________HOME________________ CELL_______________________

SOCIAL SECURITY_________________EMPLOYER__________________REFERRED BY?______________

EMERGENCY CONTACT/RELATIONSHIP_________________________PHONE_____________________

E-MAIL____

PARENT/PERSON RESPONSIBLE FOR BILLING____
NAME

ADDRESS____
STREET　PO BOX　CITY　STATE　ZIP CODE

PHONE WORK___________________ HOME__________________ CELL____________________

SOCIAL SECURITY______________DATE OF BIRTH_________RELATIONSHIP TO PATIENT__________

EMPLOYER___________________________________E-MAIL________________________________

HEALTH INSURANCE INFORMATION ***Is your insurance purchased through the Affordable Care Ins. Exchange Y/N***

Primary Health Insurance____
Policy # ____Group #____________________
Name of Insured____Date of Birth______________
Address of Insured____
Secondary Health Insurance____
Policy # ____Group #____________________
Name of Insured____Date of Birth______________
Address of Insured____

INJURY INFORMATION

If this visit is due to an injury, please provide exact date of injury: Date_______________________________

Please indicate what type of Accident: ____________Auto ____________Work __________Other

Is there an Attorney Involved? ___________Yes _________No Name of Attorney: ________________

All medical care is due and payable upon completion unless prior arrangements have been made. I hereby authorize the release of any and all necessary information to my/the medical insurance program, or their representatives, for the purpose of submitting a claim against my medical insurance policy. I hereby request and direct that all payments due under my/the medical insurance program be made directly to Michael J. Larson, MD/Kevin M. Lee, MD/Travis R. Torngren, MD for any unpaid bills furnished me or my/the insurance program by the above physician during the time I am under this care. I understand that I am responsible for this bill REGARDLESS OF INSURANCE COVERAGE, including any fee and cost associated with the collecting if debt.

____ Date ______________________________
Signature of Patient/Responsible Party

____
Signature of Responsible party (if patient is a minor)

Name: ________________________________ **Age**: ______ **Date**: ____________

To properly care for you at the time of your visit, we need a complete summary of your medical history.

Family Doctor/Internist: ____________________________

Pharmacy: ____________________________

Tape Allergy: ☐Yes ☐No

Latex Allergy: ☐Yes ☐No

Drug Allergies: ☐ Yes (if yes, please list below) ☐ No

____

____

____

Demographic Information:

Race (Check One)

☐ American Indian ☐ Asian ☐ Black

☐ White ☐ Hispanic ☐ Non-Hispanic

☐ Other ☐ Unknown

Current Medications and Dosages:

____

____

____

____

Primary Language (Check One)

☐ English ☐ Spanish ☐ Chinese ☐French

☐Hebrew ☐Hindi ☐Japanese ☐Portuguese

☐ Russian ☐Yiddish ☐ Other

Past Surgical/Hospitalization History:

Date	Surgery/Illness	Doctor	Hospital, City, State

Past Medical History: Have you ever had any of the following? Please check all pertinent boxes:

☐Cancer: What type? ______________________________

☐ Chest Pain/Angina	☐Pacemaker	☐High Cholesterol	☐Bleeding Disorder	☐Migraine Headaches
☐Atrial Fibrillation	☐Rheumatic Fever	☐Overactive Thyroid	☐Blood Transfusions	☐Stroke
☐Heart/Cardiac Artery Dis.	☐Asthma	☐Under active Thyroid	☐Chicken Pox	☐Glaucoma
☐Congestive Heart Failure	☐Bronchitis	☐Hemorrhoids	☐HIV or AIDS	☐Other: (please list)
☐Blood Clot (DVT)	☐COPD (chronic lung dis.)	☐Hepatitis	☐MRSA	______________
☐Heart Attack	☐Emphysema	☐Ulcer	☐Measles	______________
☐Heart Murmur	☐Pneumonia	☐Bladder Infections	☐Tuberculosis	______________
☐High Blood Pressure	☐Pulmonary Embolus	☐Kidney Infections	☐Arthritis	______________
☐Low Blood Pressure	☐Sleep Apnea	☐Venereal Disease	☐Back Trouble	______________
☐Mitral Valve Prolepse	☐Diabetes	☐Anemia	☐Epilepsy/Seizure	

Additional Medical conditions currently being treated:

____

Social History:

Marital Status	**Use of Alcohol**	**Smoking Status** (Check One)
☐Single	☐Never	☐Current every day smoker
☐Married	☐Rarely	☐Former smoker _______ yrs
☐Divorced	☐Moderately	☐Occasional smoker
☐Widowed	☐Daily	☐Never Smoker
		☐Unknown

Birthplace: ____________________ City of Residence: ______________

Occupation: ______________________ How long? _________

Education: ____________________________

General:

Height: ___________ Weight: ___________

Dominant Hand: ☐Right ☐Left

Name: ______________________________ **Date:** ____________________

Family Medical History:

	Age	Conditions or Disease	If Deceased, Cause of Death
Father	______	______________________	______________________
Mother	______	______________________	______________________
Siblings'	______	______________________	______________________
	______	______________________	______________________

Systems Review: Please indicate any personal history below. (Please check mark all that applies)

General Health: ☐Good ☐Fair ☐Poor

Reaction to Aesthesia: ☐Yes ☐No ☐Malignant Hypothermia

Tendency to bleed excessively: ☐Yes ☐No

Central Nervous and Psychiatric

Difficulty sleeping: ☐Yes ☐No

Troubled by depression: ☐Yes ☐No

Troubled by anxiety: ☐Yes ☐No

Uncorrectable vision: ☐Yes ☐No

Uncorrectable hearing: ☐Yes ☐No

Severe headaches: ☐Yes ☐No

Fainting spells: ☐Yes ☐No

Seizures or convulsions: ☐Yes ☐No

Urinary and Gastrointestinal

Burning with urination: ☐Yes ☐No

Frequent urination: ☐Yes ☐No

Decreased urination force: ☐Yes ☐No

Stomach pain or burning: ☐Yes ☐No

Frequent loose stools: ☐Yes ☐No

Frequent constipation: ☐Yes ☐No

Skin

Frequent rashes: ☐Yes ☐No

Bruise easily: ☐Yes ☐No

History of skin cancer: ☐Yes ☐No

Endocrine

Diabetes: ☐Yes ☐No

Excessive thirst: ☐Yes ☐No

Excessive urination: ☐Yes ☐No

Heent

Difficulty swallowing: ☐Yes ☐No

Ear drainage: ☐Yes ☐No

Frequent earaches: ☐Yes ☐No

Wear glasses/contacts: ☐Yes ☐No

Double or blurry vision: ☐Yes ☐No

Respiratory and Cardiovascular

Cough: ☐Yes ☐No

Shortness of breath: ☐Yes ☐No

Chest pain: ☐Yes ☐No

Palpitation /
Fluttering heart: ☐Yes ☐No

High blood pressure: ☐Yes ☐No

Musculoskeletal

Osteoarthritis: ☐Yes ☐No

Rheumatoid Arthritis: ☐Yes ☐No

Gout: ☐Yes ☐No

Back problem: ☐Yes ☐No

Carpal tunnel: ☐Yes ☐No

Joint stiffness: ☐Yes ☐No

Leg cramps: ☐Yes ☐No

Muscle aches: ☐Yes ☐No

Pain in shoulder(s): ☐Yes ☐No

Painful joints: ☐Yes ☐No

Sciatica: ☐Yes ☐No

Swollen joints: ☐Yes ☐No

Trauma to arm(s): ☐Yes ☐No

Trauma to hip(s): ☐Yes ☐No

Trauma to knee(s): ☐Yes ☐No

Trauma to ankle(s): ☐Yes ☐No

Weakness: ☐Yes ☐No

Patient's Signature: ____________________

MD Date & Initials:	

Patient Name____Date of Birth____________________

HISTORY OF CURRENT PROBLEM

- **When did symptoms first occur or the accident happen?______________________________**
- **If this is an accident, how did it happen?____**
- ____
- **Have you ever had these symptoms before? Yes_________No______**

WHAT ARE YOU SEEING THE PHYSICIAN FOR TODAY? (mark specific complaint?)

- **Arm: Right_____Left_____**
  Shoulder_______Elbow_________Forearm________Wrist_____Hand_______

- **Leg: Right_________Left_________**
  Hip________Knee______Calf/Shin_______Ankle______Foot_______

Describe the problem you are having____
Have you had previous treatment for your current problem? Yes____No______
Describe what was done____
Were x-rays taken? Yes_____No______ If yes, where_____________________________________

Medical History Update

Allergies:____

Medications:____

Medical, Surgical
History____

Patient Signature____
Provider Signature____

CIGNA HEALTHCARE MEDICARE ADMINISTRATION

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to *Upper Valley Orthopedics* for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature ___________________________________ Date______________

Sample Patient's Assignment Authorization

NAME OF BENEFICIARY, HEALTH INSURANCE CLAIM NUMBER (HICN), MEDIGAP POLICY NUMBER

I request that payment of authorized Medigap Benefits be made on my behalf to *UPPER VALLEY ORTHOPEDICS* for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to _______________________________________ any information needed to determine these benefits.

Signature _______________________________________ Date _______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

UPPER VALLEY ORTHOPEDICS, PLLC

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of *UPPER VALLEY ORTHOPEDICS, PLLC's* "NOTICE OF PRIVACY PRACTICES"

Signature ______________________________________ Date ________________