OrthoArizona

Vincent J. Russo, M.D.
Matthew W. Russo, M.D.

10290 N. 92nd Street, Suite 103
Scottsdale, AZ 85258
Office: 480-860-1322
Fax: 480-860-4062

Welcome,

Thank you for choosing our practice for your orthopedic care. We would like to make your experience with our office a pleasant one.

In order to better serve you, please bring the following with you to your appointment:

- Insurance cards – current primary and secondary insurance
- Driver's License or another Valid Government-Issued Photo I.D.
- If your insurance company requires you to have a referral from your primary care physician, please obtain a copy from their office or call us to verify that we have it prior to your appointment. **The doctor will be unable to see you if we do not have this referral at the time of your appointment**.
- Medical records pertaining to the reason for your appointment. This includes copies of recent x-rays and MRI reports.

It is important for the doctor to know about any medical conditions and previous surgeries you have had, as well as all medications you are currently taking.

Please complete the General Patient Information and Patient Medical History forms completely.

RETURN YOUR COMPLETED FORMS AS SOON AS POSSIBLE. We must receive the forms prior to your appointment to expedite you being seen by the doctor in a timely manner. If you are unable to return the forms in advance, please plan to arrive at least 20 minutes before your appointment to allow our staff time to process your information.

Be prepared to pay your co-pay, if you have one, at the time of check-in for your visit.
Our office accepts cash, checks, Visa, MasterCard, American Express and Discover cards.

If you are unable to keep your scheduled appointment, please call our office at least 24 hours in advance. If you fail to arrive for your scheduled appointment, you may be charged a $50. Fee. Missed appointment charges are not covered by insurance.

Thank you. We look forward to seeing you.

OrthoArizona

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PLEASE COMPLETE ALL 3 PAGES OF PATIENT REGISTRATION FORMS:

Patient General Information

Patient Intake & Review of Systems

Patient Health History

PLEASE **FAX BACK** OR **DROP OFF** ALL COMPLETED FORMS AT LEAST **3 DAYS PRIOR** TO YOUR APPOINTMENT.

FAX # 480-860-4062

The *Patient General Information* form should be signed where indicated. Please include your Primary and Secondary Insurance information.

Please review the *Notice of Privacy Practices, Patient Financial Policy, Notice to Patients,* and *ACO Beneficiary Notice.*

OrthoArizona

PATIENT GENERAL INFORMATION

Patient name: *(First, Middle, Last)* _____

Preferred name: *(optional)* _____ **Date of birth:** _____/_____/_____ (month / day / year)

Sex: Male / Female / Unidentified **Marital status:** Single / Married / Widowed / Separated / Divorced

Primary address: _____ **City:** _____ **State:** ____ **Zip:** _____

Secondary address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell phone: (_____)_____ **Home phone:** (_____)_____ **Work phone:** (_____)_____

E-Mail: _____ **Preferred contact method:** Cell / Home / Work / E-Mail

Would you like to be registered for our Patient Portal to view your medical information? ***(email required)*** Yes / No

May we leave a voice message? Yes / No **Preferred language:** English / Spanish / Other:_____

Employment status: Employed / Retired / Unemployed **If "Employed", occupation:**_____

Race / Ethnicity: White / Hispanic / African American / Asian / Native American / Other_____

Primary physician: *(blank if none)* _____ **Referring physician:** *(blank if none)* _____

Emergency contact name: _____ **Relationship:** _____ **Phone #:** (____)_____

Preferred pharmacy: _____ **Major crossroads:** _____

Pharmacy phone #: *(optional)* (____)_____ **Pharmacy address:** ***(optional):*** _____

PRIMARY Insurance Policy holder? Self / Spouse / Child / Other **Primary Insurance Company:** _____

If PRIMARY policy holder is NOT "Self", Holder Name: _____ **Date of birth:** ____/____/____

SECONDARY Insurance Policy holder? Self / Spouse / Child / Other **Secondary Insurance Company:** _____

If SECONDARY policy holder is NOT "Self", Holder Name: _____ **Date of birth:** ____/____/____

Is this injury related to an accident? Yes / No **If "Yes",** Work Related / Auto Accident / Other:_____

If "Work Related", Employer: _____ **Social Security #** ____-____-____

Legal action pending for this injury? Yes / No **If "Yes", Attorney Name**:_____ **Phone:** _____

GUARANTOR (Person responsible for the non-insurance covered medical expenses. Can not be a minor or incapacitated adult)

Social Security # of Guarantor: _____ - ____- _____ **Is Guarantor the patient?** Yes / No If "Yes", skip to next section

Guarantor name: *(First, Last)* _____ **Phone:** (_____)_____

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

List persons authorized to discuss your protected health information with our staff and/or pick up prescriptions, x-rays, lab slips. *(optional)*

Name:_____ **Relationship:**_____ **Phone #:** (____)_____

Name:_____ **Relationship:**_____ **Phone #:** (____)_____

- **I AUTHORIZE AND REQUEST ORTHOARIZONA AND ITS DIVISIONS TO:**
  - **PERFORM DIAGNOSTIC PROCEDURES AND TREATMENTS AS MAY BE NECESSARY FOR PROPER MEDICAL CARE.**
  - **RELEASE MY MEDICAL RECORDS TO ANY OTHER PHYSICIAN OR MEDICAL FACILITIES DIRECTLY INVOLVED IN MY CARE AND FOR THE PURPOSE OF ADMINISTERING CLAIMS AND TO OBTAIN MEDICATION HISTORY FOR THE PURPOSE OF TREATMENT.**
  - **ASSIGN PAYMENT OF MY MEDICAL BENEFITS TO ORTHOARIZONA.**

I HAVE BEEN MADE AWARE OF AND UNDERSTAND ORTHOARIZONA'S: NOTICE OF PRIVACY PRACTICES, PATIENT FINANCIAL POLICY, NOTICE TO PATIENTS AND ACO BENEFICIARY NOTICE. THE NOTICE TO PATIENTS DISCLOSES THAT ORTHOARIZONA PROVIDERS HAVE A DIRECT FINANCIAL INTEREST IN SEPARATE DIAGNOSTIC OR TREATMENT AGENCIES OR IN NONROUTINE GOODS OR SERVICES THAT THE PATIENT IS BEING PRESCRIBED AND THAT PRESCRIBED TREATMENTS, GOODS OR SERVICES ARE AVAILABLE ON A COMPETITIVE BASIS. THE ACO BENEFICIARY NOTICE STATES THAT ORTHOPEDIC SPECIALISTS OF NORTH AMERICA, PLLC (ORTHOARIZONA) IS PARTICIPATING IN A MEDICARE SHARED SAVINGS PROGRAM ACCOUNTABLE CARE ORGANIZATION.

PATIENT / PARENT / GUARDIAN SIGNATURE: _____ **TODAY'S DATE:** _____/_____/_____ (month / day / year)

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PATIENT INTAKE & REVIEW OF SYSTEMS

Patient name: *(First, Last)* _____ **Occupation:** _____

Height: ____**ft** _____**in** **Weight:** _____ **lbs** **Hand dominance:** LEFT / RIGHT / AMBIDEXTROUS

Any recent falls? YES / NO **If "Yes", were you injured?** YES / NO

Did you have a flu shot in past year? YES / NO **Did you have a Pneumonia vaccination?** YES / NO **If "Yes", when**_____

INJURY / PAIN / CONCERN - INFORMATION

Body part: _____ **Side of the body affected:** LEFT / RIGHT / BOTH

Reason for visit:_____ **When did the problem start / date of injury?** _____ ____ _____
month day year

How did it happen? _____

What makes it better? _____

What makes it worse? _____

Pain frequency: RARE / SOMETIMES / ALWAYS **Pain scale:** *(circle)* 1 (mild) 2 3 4 5 (moderate) 6 7 8 9 10 (severe)

Received previous treatment for this problem? YES / NO **If "Yes", Provider:**_____ **Month/Year:**_____

Circle any type of images or tests you've had for this problem? X-RAYS / CAT SCAN (CT)/ MRI / EMG / LAB WORK / ULTRASOUND

If you had images or tests, which location / facility / company did them:_____

Current treatment of problem: BRACING / CANE / CRUTCHES / WALKER / INJECTION / MEDICATION / SURGERY / THERAPY / NONE

List any medications or supplements you are currently taking:
*** if taking more than below, ask the front desk for the medication form*

MEDICATION / SUPPLEMENT	DOSE

List any allergies you may have (medications, food, latex, iodine, nuts, etc) and the reaction to each:

ALLERGIC TO:	REACTION

Pain description: ACHY / BURNING / DULL / SHARP / THROBBING / OTHER_____

Associated symptoms: CATCHING / POPPING / LOCKING / GRINDING / SWELLING / STIFFNESS / INSTABILITY / WEAKNESS / TINGLING / NIGHT PAIN / OTHER_____

Check only the symptoms that are affecting you TODAY: ***(**any symptoms left unmarked below will be regarded as negative/not applicable)***

GENERAL
- □ Fever
- □ Chills
- □ Fatigue
- □ Sleep problems
- □ Weight loss

EYES
- □ Blurry vision
- □ Double vision
- □ Eye pain
- □ Eye redness
- □ Watering

EAR, NOSE, THROAT:
- □ Decreased hearing
- □ Sore throat
- □ Ears ringing
- □ Nose bleeds
- □ Difficulty swallowing

CARDIOVASCULAR
- □ Chest pain
- □ Fainting
- □ Murmurs
- □ Palpitations

RESPIRATORY
- □ Shortness of breath
- □ Coughing
- □ Wheezing
- □ Tightness
- □ Snoring

GASTROENTEROLOGY
- □ Heartburn
- □ Constipation
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Blood/tarry stools

GENITOURINARY
- □ Pain on urination
- □ Incontinence
- □ Increased frequency
- □ Urgency

MUSCULOSKELETAL
- □ Joint pain
- □ Stiffness
- □ Joint swelling
- □ Cramps
- □ Weakness
- □ Muscle pain

DERMATOLOGY
- □ Redness
- □ Rash
- □ Itching
- □ Skin changes

NEUROLOGY
- □ Numbness
- □ Tingling
- □ Loss of balance
- □ History of seizure
- □ Tremors
- □ Unsteady gait

PSYCHOLOGICAL
- □ Anxiety
- □ Depression
- □ Nervousness
- □ Hallucinations

ENDOCINOLOGY
- □ Weight change
- □ Thirsty all the time
- □ Excessive urination

HEMATOLOGY
- □ Easy bruising
- □ Easy bleeding
- □ Enlarged lymph nodes

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First Name: _____

Last Name: _____

PATIENT HEALTH HISTORY

PERSONAL MEDICAL HISTORY - Check all that apply to you ***(**any items left unmarked below will be regarded as negative/not applicable)***

- ☐ Alcohol abuse
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back pain
- ☐ Birth defect
- ☐ Bladder disease
- ☐ Bleeding disorder
- ☐ Blood clots / DVT
- ☐ Blood pressure – high
- ☐ Blood pressure – low
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cellulitis
- ☐ Cerebral palsy
- ☐ Chronic pain
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes – type I
- ☐ Diabetes – type II
- ☐ Diverticulitis
- ☐ Drug abuse
- ☐ Eczema
- ☐ Emphysema
- ☐ End State Renal Disease
- ☐ Epilepsy / seizures
- ☐ Esophageal reflux
- ☐ Fibromyalgia
- ☐ Facture / broken bone
- ☐ Gastric ulcers
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay fever
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart valve disease
- ☐ Hepatitis / jaundice
- ☐ Hiatal hernia
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Leukemia
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ MRSA
- ☐ Multiple sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Pneumonia
- ☐ Prostrate disorder
- ☐ Psychiatric illness
- ☐ Pulmonary embolism
- ☐ Rheumatoid arthritis
- ☐ Scoliosis
- ☐ Seizure disorder
- ☐ Sickle cell
- ☐ Sleep apnea – CPAP
- ☐ Sleep apnea – no CPAP
- ☐ Stomach disease / ulcers
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Valley fever
- ☐ Vascular disease
- ☐ Wound healing

Other:

- ☐ _____

SURGICAL HISTORY - Check all that apply to you and indicate the Month & Year of the surgery

- ☐ Adenoidectomy *Mo/Yr*: _____
- ☐ Amputation *Mo/Yr*: _____
- ☐ Appendectomy *Mo/Yr*: _____
- ☐ Bladder surgery *Mo/Yr*: _____
- ☐ Brain tumor *Mo/Yr*: _____
- ☐ Cancer *Mo/Yr*: _____
- ☐ Cataracts *Mo/Yr*: _____
- ☐ Craniotomy *Mo/Yr*: _____
- ☐ C-Section *Mo/Yr*: _____
- ☐ Gallbladder *Mo/Yr*: _____
- ☐ Gastric bypass *Mo/Yr*: _____
- ☐ Heart – bypass *Mo/Yr*: _____
- ☐ Heart – carotid *Mo/Yr*: _____
- ☐ Heart – pacemaker *Mo/Yr*: _____
- ☐ Heart – stent *Mo/Yr*: _____
- ☐ Heart - valve *Mo/Yr*: _____
- ☐ Hernia repair *Mo/Yr*: _____
- ☐ Hysterectomy *Mo/Yr*: _____
- ☐ Lung resection *Mo/Yr*: _____
- ☐ Mastectomy *Mo/Yr*: _____
- ☐ Prostate surgery *Mo/Yr*: _____
- ☐ Sinus surgery *Mo/Yr*: _____
- ☐ Thyroid surgery *Mo/Yr*: _____
- ☐ Tonsillectomy *Mo/Yr*: _____
- ☐ Tubal ligation *Mo/Yr*: _____
- ☐ Vasectomy *Mo/Yr*: _____
- ☐ Vision correction *Mo/Yr*: _____

Other:

- ☐ _____ *Mo/Yr*: _____
- ☐ _____ *Mo/Yr*: _____

- ☐ Knee: Left / Right / Total Joint *Mo/Yr*: _____
- ☐ Ankle: Left / Right / Total Joint *Mo/Yr*: _____
- ☐ Hip: Left / Right / Total Joint *Mo/Yr*: _____
- ☐ Elbow: Left / Right / Total Joint *Mo/Yr*: _____
- ☐ Shoulder: Left / Right / Total Joint *Mo/Yr*: _____
- ☐ Hand: Left / Right *Mo/Yr*: _____
- ☐ Spine: Cervical / Thoracic / Lumbar *Mo/Yr*: _____
- ☐ Other Orthopedic Surgery / Procedure: _____ *Mo/Yr*: _____

FAMILY MEDICAL HISTORY

Do you know your family history? YES / NO / ADOPTED

As best as possible, check all that apply to your IMMEDIATE FAMILY and circle who in your family has the checked condition

- ☐ Anesthesia complications Mom / Dad / Siblings / Kids
- ☐ Asthma Mom / Dad / Siblings / Kids
- ☐ Arthritis – Rheumatoid Mom / Dad / Siblings / Kids
- ☐ Arthritis – Osteoarthritis Mom / Dad / Siblings / Kids
- ☐ Arthritis - Osteoporosis Mom / Dad / Siblings / Kids
- ☐ Bleeding disorder Mom / Dad / Siblings / Kids
- ☐ Cancer Mom / Dad / Siblings / Kids
- ☐ Coronary heart disease Mom / Dad / Siblings / Kids
- ☐ Deep Vein Thrombosis (DVT) Mom / Dad / Siblings / Kids
- ☐ Diabetes Mom / Dad / Siblings / Kids
- ☐ Hemophilia Mom / Dad / Siblings / Kids
- ☐ Hypertension Mom / Dad / Siblings / Kids
- ☐ Kidney disease Mom / Dad / Siblings / Kids
- ☐ Pulmonary embolism Mom / Dad / Siblings / Kids
- ☐ Seizures Mom / Dad / Siblings / Kids
- ☐ Stroke Mom / Dad / Siblings / Kids

Ever have complications during surgery? YES / NO **Ever have complications with anesthesia?** YES / NO

Do you smoke tobacco? YES / NO / QUIT **If "Yes",** # of packs per week____ **If "Quit",** year quit_____& # of packs per week____

Do you chew tobacco? YES / NO / QUIT **If "Yes",** # of times per week____ **If "Quit",** year quit_____& # of times per week____

Do you drink alcohol? YES / NO **If "Yes",** # drinks per week____ **Do you exercise regularly?** YES / NO

Do you use medical marijuana? YES / NO **Do you use recreational drugs?** YES / NO **If "Yes", what drug(s)**_____

Marital status: SINGLE / MARRIED / WIDOWED / SEPARATED / DIVORCED **Work type:** PHYSICAL / SEDENTARY (SEATED)

Work status: RETIRED / STAY AT HOME / REGULAR DUTY / LIGHT DUTY / OUT OF WORK **Do you live alone?** YES / NO

- **NOTICE OF PRIVACY PRACTICES**
- **PATIENT FINANCIAL POLICY**
- **NOTICE TO PATIENTS**
- **ACO BENEFICIARY NOTICE**

Notice of Privacy Practices

This notice describes how OrthoArizona may use and disclose patients' healthcare information and how a patient can obtain access to this information. Please review it carefully.

OrthoArizona is required to provide patients with notice of its legal duties and privacy practices with respect to patients' protected health information. "Protected Health Information (PHI)" is information, including demographic information, which relates to: the patient's past, present, or future physical or mental health or condition; the provision of health care to the patient; or the past, present, or future payment for the provision of health care to the patient, and that identifies the patient or for which there is a reasonable basis to believe can be used to identify the patient. Protected health information includes many common identifiers (e.g., name, address, birth date, Social Security Number) when they can be associated with the health information listed above.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

OrthoArizona may use and disclose protected health information without the patient's written consent or authorization for certain treatment, payment, healthcare operations or other uses required by law. There are certain restrictions on uses and disclosures of treatment records which include registration and all other records concerning patients who are receiving or who may have received services related to mental illness, developmental disabilities, alcoholism, drug dependence or HIV.

TREATMENT

OrthoArizona will use and disclose protected health information internally and with other healthcare entities to provide, coordinate, refer or manage the patient's health care and any related services.

PAYMENT

Protected health information will be used, as needed, to obtain payment for the patient's health care services. Payment activities may include contacting the patient's insurance company for benefits eligibility, health insurance coverage, payment, medical necessity of services or procedures, appropriateness of care or justification of charges as well as managing claims or collection activities to obtain payment for services provided to the patient.

HEALTHCARE OPERATIONS

OrthoArizona may use or disclose, as needed, protected health information to support their business activities. These activities include but are not limited to: contacting healthcare providers and patients with information about treatment alternatives, quality assessments, improvement activities, outcomes evaluation, development of clinical guidelines, protocol development, case management, care coordination, conducting or arranging for medical review, legal services, auditing functions, or training medical students.

OrthoArizona may contact patients by telephone, e-mail, text, or mail unless otherwise notified by the patient.

OrthoArizona may not disclose protected health information to family members or friends who may be involved with the patient's treatment or care without the patient's written permission. Health information may be released without written permission to a parent, guardian, legal custodian of a child, guardian of an incompetent adult, the designated healthcare agent of an incapacitated patient, power of attorney, or personal representative or spouse of a deceased patient.

OrthoArizona may use or disclose protected health information without consent or authorization as permitted for:

Health oversight activities: OrthoArizona may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as: management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

Judicial and administrative proceedings: Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

For activities related to death: OrthoArizona may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

For research: Under certain circumstances, and only after a special approval process, OrthoArizona may use and disclose a patient's health information to help conduct research.

To avoid a serious threat to health or safety: OrthoArizona may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

For worker's compensation: OrthoArizona may disclose patient's health information to the extent such records are reasonably related to any injury for which worker's compensation is claimed.

USES AND DISCLOSURES THAT REQUIRE PATIENTS' PROTECTED AUTHORIZATION

Other permitted and required uses and disclosures will be made only with patient consent, authorization, or opportunity to object unless required by law. Without patient authorization, OrthoArizona is expressly prohibited to use, sell or disclose patients' protected health information for marketing and no patient genetic information will be disclosed for underwriting purposes. Patients may revoke the authorization at any time in writing. OrthoArizona is not responsible for action taken between when the authorization was received to when the revocation received.

PATIENTS' RIGHTS REGARDING PROTECTED HEALTH INFORMATION

- Patients are permitted, in writing, to request restrictions on certain uses or disclosures of patients' protected health information by OrthoArizona to carry out treatment, payment, or healthcare operation. OrthoArizona is not required to agree to restriction requests. Agreed upon restrictions will be adhered to except when patients' protected health information is needed in an emergency treatment situation, at which time, information may be disclosed only to healthcare providers treating the patient. Restrictions also do not apply when OrthoArizona is required by law to disclose certain healthcare information.
- Patients have the right to review and/or obtain a copy of their healthcare records, except for the following: psychotherapy notes, information compiled for use (or in anticipation of use) in a civil, criminal, or administrative action or proceeding; protected health information restricted by law, medical research in which the patient agreed to participate; information that may harm or injury the patient or other people; or information that was obtained under the promise of confidentiality. OrthoArizona may deny access under other circumstances, in which case, the patient has the right to have such a denial reviewed. OrthoArizona may charge a reasonable fee for copying patient records.
- Patients may request, in writing, OrthoArizona send protected health information, including billing information, to the patient by alternative means or to alternative locations. Patients may also request, in writing, OrthoArizona not send information to a particular address or location or contact them at a specific location (i.e. patient's place of employment). OrthoArizona will accommodate reasonable requests by patients.
- Patients may request that any part of their protected health information not be disclosed to family members or friends who may be involved in their care or for notification purposes as described in this notice of Privacy Practices. Patient requests must state the specific restriction requested and to whom they want the restriction to apply. The patient's physician is not required to agree to the requested restriction except if the patient requested the physician not disclose protected health information to the patient's health plan with respect to healthcare for which the patient paid for out-of-pocket in full.
- Patients have the right to obtain a paper copy of this notice from OrthoArizona, even if the patient agreed to accept this notice alternatively (i.e. electronically).
- Patients have the right to request an amendment to their protected health information. If OrthoArizona deny a patient's request for an amendment, the patient has the right to file a statement of disagreement and OrthoArizona may prepare a rebuttal to the patient's statement and will provide the patient a copy of any such rebuttal.
- Patients have the right to receive accounting of disclosures, paper or electronic, of their protected health information made by OrthoArizona for the six years prior to the date of the request. OrthoArizona is not required to record disclosures pursuant to a signed consent or authorization.
- OrthoArizona will notify patients if their protected health information has been breached.

OrthoArizona reserves the right to change this notice at any time and will provide the most-up-to-date version for patients to review at any time.

COMPLAINTS

Any person or patient may file a complaint with OrthoArizona and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with OrthoArizona, please contact our HIPPAA Compliance Officer:

Jennifer Doyle 602-772-3799 jdoyle@orthoarizona.org

NO retaliatory action will be made by OrthoArizona against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

This Notice of Privacy Practices is effective April 15, 2018.

OrthoArizona

FINANCIAL POLICY

- The patient/guarantor is directly responsible for payment of medical care provided by OrthoArizona.
- Self-pay patients are responsible to pay all balances in full at the time of service.
- An insurance policy is a contract between patient/guarantor and their insurer. OrthoArizona has no control over what is or is not covered by the insurer of the patient/guarantor.
- All patient/guarantor liable expenses (co-payments, deductibles, co-insurance, etc) are due and will be collected before or at the time of service. (appt, procedure, surgery, etc.) OrthoArizona reserves the right to reschedule or cancel an appointment, procedure or surgery if the applicable patient/guarantor liable expenses are not paid in full prior to the time of service.
- Any remaining balances will be billed to the insurer of the patient/guarantor by OrthoArizona, so it is the responsibility of the patient to ensure OrthoArizona always has the most current insurance billing information.
- The patient/guarantor may be responsible for charges, services or deductibles not covered by the insurer.
- OrthoArizona providers may be considered “out of network” by the insurer of the patient/guarantor. Out-of-pocket expenses are typically higher when a provider is considered “out of network” by the insurer. It is ultimately the responsibility of the patient to know their insurance carrier and provider network.
- OrthoArizona only bills for services rendered by an OrthoArizona provider. The patient/guarantor may receive laboratory, radiology, anesthesiology or hospital billings from separate entities. It is the responsibility of the patient/guarantor to contact these separate entities or the insurer with questions or concerns about these services, regardless of whether the services were ordered by a OrthoArizona provider.
- If a patient/guarantor’s insurance plan requires pre-authorization or referral from a primary care physician, it is the responsibility of the patient/guarantor to obtain this authorization prior to the office visit . If the authorization is not provided, the charges will be the responsibility of the patient/guarantor.
- OrthoArizona does not accept any third-party billing / liability.
- Arizona law requires insurance companies operating in Arizona to process claims within 30 days. It is the responsibility of the patient/guarantor to promptly provide the insurer with any requested information needed to process the claim.
- OrthoArizona will send a billing statement at least monthly and after every visit which indicates the balance due from the patient/guarantor and which claim(s) are still being processed by the insurer. All patient/guarantor balances are due and payable in full upon receipt of the billing statement.
- Prior to surgery, OrthoArizona will contact the insurer to verify the benefits of the patient/guarantor and obtain authorization. Prior authorization or pre-certification does not guarantee payment from patient/guarantor’s insurance company. Patient/guarantor is responsible for any balances not covered by insurance.
- OrthoArizona considers balances 60 days past due as delinquent and reserves the right to have all past-due balances collected by a third-party service. Past due amounts collected by third-party services usually become public record.
- OrthoArizona reserves the right to charge an administrative fee for:
    - completing medical record requests; insurance, FMLA or disability forms
    - transferring records to a non-OrthoArizona provider or location
    - appointments that are cancelled with less than 24-hour notice. This fee must be paid before a new appointment is scheduled.
    - returned checks due to insufficient funds
    - Accounts not paid within terms are subject to a collection fee of 25% added to the balance due when assigned to a collection agency.
- OrthoArizona realizes that sometimes the patient/guarantor may not be able to pay the full amount at the time of service. Please ask to speak to our Billing Office at any time to make suitable payment plan arrangements.
- Workers Compensation cases: It is the responsibility of the patient/guarantor to inform the insurer of the accident date, claim number, primary care physician and any other needed information for a claim.
- Personal Injury cases: If the patient is being treated as part of a personal injury lawsuit or claim, OrthoArizona requires verification from an attorney prior to the initial visit. All OrthoArizona expenses are the responsibility of the patient/guarantor and must be paid in full by an insurer or the patient/guarantor and cannot be billed to an attorney. The patient/guarantor acknowledges that OrthoArizona has a lien on any personal injury settlement or recovery pursuant to N.C.G.S 44-49, et seq and the patient/guarantor authorizes the attorney or liability carrier to pay owed lien amounts out of settlement proceeds without further authorization.

NOTICE TO PATIENTS

State law, A.R.S 32-1401 (25)(ff), requires that a physician notify patients that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and where these are available elsewhere on a competitive basis. OrthoArizona supports this law because it helps patients make reasonable financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that some of the physicians at OrthoArizona have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services that OrthoArizona physicians may/have prescribed are available elsewhere on a competitive basis.

Diagnostic, treatment agency or non-routine goods and services that some OrthoArizona physicians have direct financial interest:

- Arizona Spine and Joint Hospital
- Center at Arrowhead Skilled Nursing Facility
- Center at Val Vista Skilled Nursing Facility
- Modern Vascular
- North Valley Surgery Center
- OASIS Hospital
- SurgCenter Camelback
- Surgical Specialty Hospital of Arizona
- The Orthopedic Surgery Center of Arizona (TOSCA)
- Trusted Care Surgery Center

SOME of the alternate health care facilities available to patients are listed below, however, based on a patient's insurance and personal preference, there may be other options:

- Banner Medical Services
- Abrazo Health Medical Services
- HonorHealth Medical Services
- Dignity Health Medical Services
- Phoenix Children's Hospital
- Sante Rehabilitation
- EVDI Medical Imaging
- Simon Med Imaging

INNOVATION CARE PARTNERS
AFFILIATED WITH HONORHEALTH

BENEFICIARY INFORMATION NOTICE:

Orthopedic Specialists of North America, PLLC is Participating in a Medicare Shared Savings Program Accountable Care Organization

Accountable Care Organizations (ACOs): Providing Better, Coordinated Care for You

Orthopedic Specialists of North America, PLLC is participating in Scottsdale Health Partners, LLC, a Medicare Shared Savings Program ACO. An ACO is a group of doctors, hospitals, and/or other health care providers working together with Medicare to give you better, more coordinated service and health care. Think of an ACO as a team made up of your doctors and other health care providers. We are working together to share important information and resources about your individual needs and preferences.

Doctors and hospitals in an ACO communicate with you and with each other to make sure that you get the care you need when you're sick, and the support you need to stay healthy.

You Can Still Choose Any Doctor or Hospital

Your Medicare benefits aren't changing. ACOs are **not** a Medicare Advantage plan, an HMO plan, or an insurance plan of any kind. You still have the right to use any doctor or hospital that accepts Medicare, at any time. Your doctor may recommend that you see particular doctors or health care providers, but it's always your choice about what doctors and providers you use or hospitals you visit.

Having Your Health Information Gives Us a More Complete Picture of Your Health

To help Scottsdale Health Partners, LLC give you better, coordinated care, Medicare will share information with us about your care. The information will include things like dates and times you visited a doctor or hospital, your medical conditions, and a list of past and current prescriptions.

This information from other health care providers will give Orthopedic Specialists of North America, PLLC and other health care providers in ACOs a more complete and up-to-date picture of your health. Over time, you may notice that you don't have to fill out as many medical forms that ask for the same information, you don't need to repeat medical tests because your results are shared among your health team, and other benefits because your providers are communicating with one another.

If you choose to let Medicare share your health care information with Scottsdale Health Partners, LLC, it may also be shared with other ACOs in which your other doctors or health care providers participate. If you don't want your health care information shared, you can ask Medicare not share it.

Your Privacy is Very Important to Us

Just like Medicare, ACOs must put important safeguards in place to make sure all your health care information is safe. ACOs respect your choice on the use of your health care information for care coordination and quality improvement.

Yes, share my information: If you want Medicare to share information about the health care you received with Scottsdale Health Partners, LLC or with other ACOs in which your other doctors or health care providers participate, **there's nothing more you need to do.**

No, please don't share my information: If you do not want Medicare to share your health care information, you **need to** do the following:

- Call 1-800-MEDICARE (1-800-633-4227). Tell the representative that your doctor is part of an ACO and you do not want Medicare to share your health care information. TTY users should call 1-877-486-2048.
- If you change your mind in the future, call 1-800-MEDICARE and tell the representative what you have decided. We can't communicate with Medicare on your behalf.

Even if you decline to share your health care information, Medicare will still use your information for some purposes, like assessing the financial and quality of care performance of the providers participating in ACOs. Also, Medicare may share some of your health care information with ACOs when measuring the quality of care given by health care providers participating in those ACOs.

Questions?

If you have questions or concerns, call us at (602) 772-3800, or we can discuss them next time you're in our office.

You can also call 1-800-MEDICARE and tell the representative you're calling to learn more about ACOs, or visit Medicare.gov/acos.html.