Dear Patient,

Welcome to and thank you for selecting the Helena Orthopaedic Clinic. Our physicians and personnel strive to offer the most complete and advanced orthopaedic and physiatric care, while meeting our patients' individual needs.

Our team of trained physicians, provide unmatched care in all areas of orthopaedic and rehabilitative medicine. Our physicians are committed to continuing their education and are constantly working to expand their knowledge of medical, scientific, and technological advancements in order to bring you the very best care.

Our clinic provides EMG and nerve conduction studies performed by a board-certified physiatrist. We have registered radiological technologists who administer X-ray services daily and qualified medical assistants who work with our physicians. We arrange for physical therapy, extended radiographic studies and fitting of prosthetics and braces.

We sincerely respect the value of your time. We make every effort to maintain our appointment schedules. Unfortunately, untimely emergencies do occur which demand immediate attention and cause delay for both of us. If at all possible, when a delay occurs, we make every attempt to notify you in advance.

Our fees are set according to prevailing rates in our region. ***Copayments are due at the time of service, or your appointment will be rescheduled.*** We participate with various managed care plans and the amount your insurance company will pay is determined by the terms of your policy with them. Responsibility for payment of your bill is yours regardless of insurance, litigation, or other circumstances.

Please complete the enclosed forms and bring them with you to your first visit. Also, bring your insurance card(s), photo ID and office co-pays per your insurance contract. Arrive at least 10-15 minutes early for registration. Bring a list of all current medications both, prescription and nonprescription, as well as the name of the prescribing physician.

If you have questions or concerns, please do not hesitate to call.

Sincerely,
Helena Orthopaedic Clinic

HELENA ORTHOPAEDIC CLINIC
NEW FINANCIAL POLICY 2013
*****Please Keep for your Records*****

Payment for Services

We will bill your insurance for you as a courtesy, if we're supplied with this information at check-in. Please note we do not participate with every insurance company and it's the patient's responsibility to inquire with their insurance prior to scheduling an appointment. If patient co-pays are included in your policy, please be aware those will be collected at the time of service. If you are a personal-pay patient we do require that a $60 *down-payment* be made at the time of service. If these co-pays are not made upon arrival, your appointment will be rescheduled. Effective 9-1-2013 a $5 processing fee will be added to all patient balances after 30 days. Our office does not charge interest and all major credit cards are accepted. A 5% discount is given for all balances paid off in full once insurance has processed the claim.

Our Fees

Our fees are considered to be within the usual and customary range by most insurance carriers. You are responsible for payment regardless of your insurance company's arbitrary determination of "usual and customary" or "allowable" rates, unless your insurance is one we participate with.

Workers Compensation

If your injury or condition is work-related, it is your responsibility to file a First Report of Injury with your employer and give all necessary information to our Workers' Compensation Specialist. If we are unable to obtain authorization from the workers' compensation insurance carrier *prior to* your visit, your appointment will be rescheduled.

Motor Vehicle Insurance

If your injury is auto related, it is your responsibility to have all the information with you at check-in for your appointment. If the information is incomplete, your appointment will be rescheduled. Information required is the name and address of insurance, date of injury, claims adjusters name and phone number, claim number, and name of insured person.

Responsible Party

Any patient age eighteen (18) and over is financially responsible for all charges incurred. If a patient is under the age of eighteen and is not legally emancipated, a parent or legal guardian must accompany them for each visit unless other arrangements are made with the clinic.

Miscellaneous Policies

A $20 returned check fee will be assessed to the account for every check returned for insufficient funds, stopped payment, or closed account.

If you file bankruptcy or have excessive checks returned for insufficient funds, all future services will be on a cash only basis.

EFFECTIVE 1/1/2009 Disability insurance forms will be completed following prepayment of $20.00 per form. Completion of these forms takes between 7-10 business days.

No-show/Late Cancellation Policy

If you no-show or have a "late cancellation" (x3 visits in a calendar year), you will be discharged from our practice. If there is some type of emergency please inform the secretary regarding your situation. A
48-hour notice of cancellation is required or it will be considered a "late cancellation".

Thank you for reading and understanding our financial policy.
Helena Orthopaedic Clinic

Date_____

Email_____
(for appointment reminders and office summary)
Pharmacy_____

Name(Last, First, MI): _____ Nickname:_____

DOB: _____ Age: _____ SS #:_____ M F

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

Home #: _____ Cell #: _____ Work #: _____

Emergency Contact_____ Phone #:_____Relationship:_____

Responsible Party(if under 18yrs): _____ Phone #:_____

Relationship to patient: _____DOB: _____ SS #: _____

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

Primary Care Physician:_____
Were you referred here? Yes No Referring Physician:_____
Is this a work related injury? Yes No If so, name of Employer:_____
Hand Dominant : Right Left Ambidextrous
Height: _____ Weight:_____
Race:_____ Ethnicity: Latino/Hispanic Other:_____
Primary Language: English Other_____ Interpreter Needed Yes No
Employer:_____ Occupation:_____ Years:_____

Chief Complaint

Reason you are being seen today: _____

Which side of your body: Right Left Bilateral When did it start_____

Medications (List name, dose and how often)

_____ _____
_____ _____
_____ _____

Allergies

Latex □Yes □No

_____ _____
_____ _____
_____ _____

Operations/Surgeries

_____ _____
_____ _____
_____ _____

See Back Side

Social History

Tobacco: N/A Cigarettes Chew Cigar Amount per Day____ If stopped, when?_____
Alcohol: N/A Beer Wine Liquor Amount per Day_____ If stopped, when?_____
Other: Marijuana Other Illegal Drugs Amount per Day_____ If stopped, when?_____
Marital Status: Single Married Divorced Separated Widow (er)
You live at: Home Apartment Retirement complex Other _____
Highest level of Education you have completed: _____

Family History (Blood-related family members)

Please specify which family member, using key
M=Mother, F=Father, D=Daughter, S=Son,B=Brother, S=Sister

___Addiction
___Alcoholism
___Arthritis
___Asthma
___Blood Clots
___Cancer (Type)_____
___Congestive Heart Failure
___Depression
___Diabetes
___Heart Disease
___High Blood Pressure
___High Cholesterol
___Kidney Disease
___Lupus
___Osteoporosis
___Rheumatoid Arthritis
___Seizure
___Stroke
___Thyroid Disease
___Other_____
___Adopted

Past Medical History

□AIDS
□Alcoholism
□Arthritis
□Asthma/COPD
□Atrial Fibrillation
□Bladder Infections
□ Blood Disorders
□ Bone Infection_____
□ Cancer (Type)_____
□ Diabetes
□ Fibromyalgia
□ Gout/Pseudo gout
□ Hepatitis (Type)_____
□ HIV
□ Heart Attack
□ High Blood Pressure
□ High Cholesterol
□ Hypertension
□ Joint Infection_____
□ Joint Replacement
□ Mental Illness
□ MRSA
□ Multiple Sclerosis
□ Neuropathy
□ Osteoarthritis
□ Osteoporosis
□ Past Blood Transfusions
□ Previous Blood Clots
□ Previous Fractures
□ Rheumatoid Arthritis
□ Seizure Disorder
□ Skin Infection
□ Sleep Apnea/CPAP
□ Stroke
□ Substance Abuse
□ Systemic Lupus
□ Thyroid Disease
□ Other
□ None

Current Symptoms

□ Back Pain
□ Bleeding
□ Bruising
□ Chest Pain
□ Confusion
□ Fainting
□ Fatigue
□ Fever
□ Frequent Falls
□ Headache
□ Incontinence
□ Irregular Heart Beat
□ Itchiness
□ Joint Pain_____
□ Joint Swelling
□ Leg Pain
□ Leg Ulcer
□ Limping
□ Muscle Aches
□ Muscle Spasms
□ Muscle Weakness
□ Nausea
□ Neck Pain
□ Night Sweats
□ Numbness
□ Slurred Speech
□ Skin Changes
□ Stiffness
□ Swelling in Hands
□ Swelling in Feet
□ Tingling
□ Weight Gain
□ Weight Loss
□ Other
□ None

_____ Office Use_____
Patient Signature Date