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
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
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    ___Depression      ___Osteoporosis  
___Alcoholism    ___Diabetes      ___Rheumatoid Arthritis  
___Arthritis     ___Heart Disease   ___Seizure  
___Asthma        ___High Blood Pressure  ___Stroke  
___Blood Clots   ___High Cholesterol  ___Thyroid Disease  
___Cancer (Type) ___Kidney Disease  ___Other_________  
___Congestive Heart Failure  ___Lupus  ___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  
☐ Multiple Sclerosis  
☐ Neuropathy  
☐ Osteoarthritis  
☐ MRSA  
☐ Neutropathy  
☐ Osteoporosis  
☐ Past Blood Transfusions  
☐ Previous Blood Clots  
☐ Previous Fractures  
☐ Rheumatoid Arthritis  
☐ Seizure Disorder  
☐ Skin Infection  
☐ Sleep Apnea/CPAP  
☐ Stroke  
☐ Systemic Lupus  
☐ Thyroid Disease  
☐ Other

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  
☐ Skin Changes  
☐ Stiffness  
☐ Swelling in Hands  
☐ Swelling in Feet  
☐ Tingling  
☐ Weight Gain  
☐ Weight Loss  
☐ Other  
☐ None

Patient Signature  Date  

Office Use_________