TRI-STATE SPECIALISTS

2730 PIERCE ST * STE 300 * SIOUX CITY, IA 51104 * PHONE 712-224-8677 * FAX 712 277-1662

Patient Registration

LAST NAME: _____ FIRST: _____ M.I.____

**IF PATIENT IS A MINOR, RESPONSIBLE PARTY IS: _____

D.O.B.: _____/_____/_____ AGE: _____ SEX: MALE / FEMALE **SSN#:** _____

MARITAL STATUS: S M D W SPOUSE'S NAME_____

*RACE: _____ ETHNICITY: _____ LANGUAGE: _____

STREET ADDRESS: _____ APT/LOT #_____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____

EMAIL: _____ METHOD OF CONTACT: _____

NAME OF EMPLOYER/SCHOOL: _____

PRIMARY CARE PHYSICIAN: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: (NAME) _____ ID#_____

SUBSCRIBER: Y / N **IF NO ---PLEASE PROVIDE INFORMATION BELOW:

NAME OF POLICY HOLDER: _____ D.O.B.: _____/_____/_____

SSN: _____ RELATIONSHIP TO POLICY HOLDER: _____

SECONDARY INSURANCE: (NAME) _____ ID#_____

** SUBSCRIBER Y / N **IF NO ---PLEASE PROVIDE INFORMATION BELOW:**

NAME OF POLICY HOLDER: _____D.O.B.:_____/_____/_____

SSN: _____RELATIONSHIP TO POLICY HOLDER: _____

WAS THIS AN ON THE JOB INJURY? YES NO IF YES, _____ (DATE OF INJURY)

NAME & ADDRESS OF EMPLOYER AT THE TIME OF ACCIDENT_____

WORKERS COMP. INSURANCE CO., NAME & ADDRESS_____

_____ CLAIM # _____

ARE YOU BEING REPRESENTED BY AN ATTORNEY? YES OR NO

IF YES, NAME AND ADDDRESS OF ATTORNEY_____

I hereby authorize Tri-State Specialists, LLP to release any information acquired in the course of my examination and treatment to the insurance company. This authorization is valid for the type of coverage I have reported to Tri-State Specialists, LLP, coverages to include group, private, auto homeowners, Medicare or Medicaid. This authorization permits release of any and all information EXCEPT substance abuse (drug and alcohol), mental health and AIDS-related information which must be specifically authorized by a separate form. If this is a work comp claim, the authorization extends to my employer, work comp insurance, adjuster, rehabilitation specialist or representive of my employer. I permit a copy of this authorization to be used in place of the original. I also authorize the insurance company to make payment of the surgical and/or medical benefits directly to Tri-State Specialists, LLP.

SIGNED: _____ DATE: _____

TRI-STATE SPECIALISTS, LLP **Patient Medical History Form**

Today's Date_____ **Patient Information**

First Name: _____ Last: _____ Age: ____ Sex: ____ Wt: ____ Ht: ____ R or L Handed

Employer:_____ Occupation: _____ Years ____ Circle: Nonmanual Light Heavy Manual

If a student, what school are you attending: _____ Grade: _____

Family Dr. or Internist:_____ How were you referred to us? _____

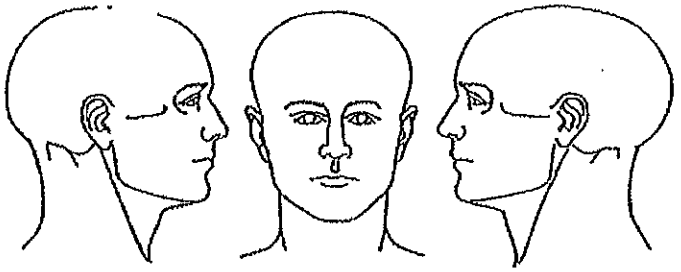
(i.e., Doctor, Self, Advertisement, Friend, Family, Phone Book)

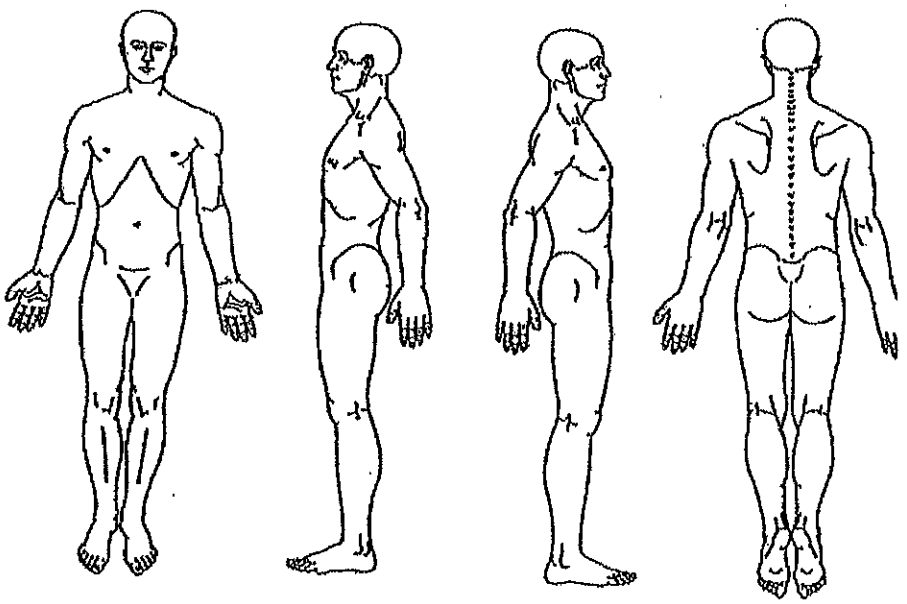
Chief Complaint: _____ Draw in areas of concern

Duration _____ Quality ❑ Itchy ❑ Scaly ❑ Other_____

Location _____ What makes it better/worse?_____ Severity ❑ Mild ❑ Mod ❑ Severe

Do you have a history of skin cancer? ❑ Yes ❑ No pre-cancer / basal cell / squamous cell / melenoma





Are you **ALLERGIC** or Sensitive to any medications? ❑ Yes ❑ No

If so, please list: _____

MEDICATIONS (list any you are taking and dosage)

_____

_____

_____

_____

_____

See Reverse Side

MD's Initials: _____ Page 2

Past Medical History:

Please list any medical problems: _____

_____

_____

Do you have a pacemaker? ❑ Yes ❑ No

Have you had any anesthesia problems in the past? ❑ Yes ❑ No If yes, please explain below:

_____

Please list your surgeries and hospitalizations with dates: (❑ Please check if extra space needed and use back of page one)

_____ _____ _____

_____ _____ _____

Social History:

I. Do you smoke? ❑ Yes ❑ No How much do you smoke daily? _____

II. Have you ever smoked? ❑ Yes ❑ No How much did you used to smoke?_____ When quit? _____

III. Current Marital Status: S M D W

IV. How often do you drink alcohol?_____ Amount _____

V. How many children do you have?_____

Family Medical History:

I. Are your parents still living? Mother ❑ Yes ❑ No Age at death:_____ Cause: _____

Father ❑ Yes ❑ No Age at death:_____ Cause: _____

II. Please list anyone in your **Immediate** family who have any of the below conditions: (mother father, brother, sister)

	Who		Who
High Blood Pressure:		Heart Disease:	
Diabetes:		Cancer:	
Anesthesia Problems:		Seizures:	
Migraines:		Strokes:	
Alzheimer's		Skin Cancers:	
Multiple Sclerosis:		Arthritis (rheumatoid, osteo):	

Review of Systems: (Have you ever had any of the following?)

Constitutional
Weight Loss ❑ Yes ❑ No
Eye Problems ❑ Yes ❑ No
Ears, Nose, Mouth, Throat Problems ❑ Yes ❑ No
Cardiovascular
Blood Clots ❑ Yes ❑ No
Rheumatic Fever ❑ Yes ❑ No
Heart Attack ❑ Yes ❑ No
High Blood Pressure ❑ Yes ❑ No
Heart Problems ❑ Yes ❑ No
High Cholesterol ❑ Yes ❑ No

Respiratory
TB ❑ Yes ❑ No
Asthma ❑ Yes ❑ No
Lung Problems ❑ Yes ❑ No
Psychological Problems ❑ Yes ❑ No
Endocrine
Diabetes ❑ Yes ❑ No
Thyroid Problems ❑ Yes ❑ No
Allergy
Anesthesia Problems ❑ Yes ❑ No
Infection/MRSA ❑ Yes ❑ No

Hematology/Lymphatic
Cancer ❑ Yes ❑ No
AIDS ❑ Yes ❑ No
Bleeding Problems ❑ Yes ❑ No
Gastrointestinal
Ulcers ❑ Yes ❑ No
Bowel Problems ❑ Yes ❑ No
Hepatitis ❑ Yes ❑ No
Liver Disease ❑ Yes ❑ No
Genitourinary
Bladder Problems ❑ Yes ❑ No
Sexual Problems ❑ Yes ❑ No
Kidney Problems ❑ Yes ❑ No

Musculoskeletal
Prev. Back/Neck Prob. ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No
Broken Bones ❑ Yes ❑ No
Metal Implants ❑ Yes ❑ No
Integumentary
Skin Disease ❑ Yes ❑ No
Neurologic
Seizure/Epilepsy ❑ Yes ❑ No
Head Injury ❑ Yes ❑ No
Migraine Headaches ❑ Yes ❑ No

All other medical problems: _____

Please be advised that by signing this you authorize the physicians of Tri-State Specialists, LLP to release all medical records (or my child's) to my family physician, requesting physician, and to any facility in which further testings or surgeries may be performed.

Signed: _____ Date_____

(Patient unless a minor)

TRI-STATE
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ORTHOPAEDIC SURGERY
DERMATOLOGY
GENERAL SURGERY
PLASTIC SURGERY

Main Office
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Physical Therapy
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PATIENT NAME _____ **DOB** _____

Please read the following, sign and date at the bottom. Thank you

I acknowledge that I have received the Notice of Privacy Practices.

I understand that I am financially responsible to pay Tri-State Specialists, LLP its usual charges for all services rendered. This may include any balances not covered by my insurance carrier(s). I hereby assign all my rights to receive any and all insurance proceeds, otherwise paid to me, for coverage(s) provided by my health insurance carrier(s) to Tri-State Specialists, LLP and direct that payment of proceeds be made directly to Tri-State Specialists, LLP.

I authorize the release of medical record information or excerpts thereof to any insurance company or third party payor for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to the authorization.

Tri-State Orthopaedic Physicians, PLC formed September 1, 2005, and Tri-State Specialists, LLP formed January 1, 2010 to include all physicians in offices referenced above. If you have received treatment in the past by one or more of these physicians listed, please be advised that those medical records could be available today for your physician's review.

To be in compliance with federal guidelines, we are required to submit your medical records (or your child's) to your requesting physician. Please be advised that the physician's of Tri-State Orthopaedic Physicians, PLC and Tri-State Specialists, LLP may release your medical records (or your child's) to your family physician, requesting physician and to any facility in which further testing or surgeries may be performed.

This authorization will remain in effect for one year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

SIGNATURE_____**DATE**_____

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Patient Name_____ **Patient Date of Birth**_____,

authorizes Tri-State Specialists, LLP to discuss with and release my medical information to the following individuals:

Name	Relationship to Patient	Phone Number

Signature of Patient or Legal Guardian

Date of Signing

Relationship, if NOT the Patient

Date of Signing

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Patient Financial Policy

Co-pays

The patient is expected to present an insurance card at each visit. **All co-payments and past due balances are due at time of check-out unless previous arrangements have been made with a billing coordinator.** We accept cash, check or credit cards.

Insurance claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Referrals and Preauthorizations

Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Self Pay Accounts

Self-pay patients will be required to bring $200 to the initial appointment and will be asked to make payment arrangements for any remaining balance. We offer a 50% discount on the total charge if payment arrangements have been made and approved by a billing coordinator.

Returned Checks

The charge for a returned check is $25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Motor Vehicle Accident (MVA) and Third Party Billing

We do **not** bill third party insurance companies. Our relationship is with you and not with the third party liability insurance (auto, homeowner, etc.) It is your responsibility to seek reimbursement from them. However, at your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from them to be completed by you. If the questionnaire is not returned to your medical insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

I, _____ hereby acknowledge the Patient Financial Policy and agree to its terms.
Printed patient name/legal guardian

_____ _____
Signature of patient/legal guardian & Relationship, if NOT the patient *Date signed*