Dr. Patrick D. Devanny, M.D.

Certified American Board

Hand & Upper Extremity Orthopaedic Surgeon

PHONE - (719) 471-4994

We are pleased that you have chosen Incline Orthopaedics for your medical care. We are providing this information to you ahead of time to make your visit to our office as convenient as possible. Our office hours are 8:00 am to 5:00 pm Monday thru Friday.

Patient Registration Forms: Please complete these forms before you arrive and bring them with you to your visit.

Referrals: If you have HMO insurance, you will need a referral from your primary care physician (PCP) to see an orthopedic physician. Referrals are **your responsibility** and are generated by your PCP's office, then submitted to the insurance company. Once approved, the insurance company will send you a copy—**Please bring a copy of your referral with you.** Your appointment will be rescheduled if you do not have a valid referral.

Insurance Cards: Please bring your card with you. We must be able to make a copy of it. **If you do not bring your insurance card, you will be Self Pay for your visit.**

Co-Payments: These are the amount that you have agreed with your insurance company to pay at each doctor's office visit. If you do not have the required co-payment with you, our agreement with your insurance company will force us to reschedule your appointment.

Insurance Claims: We will, for your convenience, submit your health claims using the insurance information that you have provided. If you change insurance coverage, please be sure to let us know when you come in. Be aware that many insurance plans include deductible amounts that are also your responsibility. Please be prepared to pay these amounts at your next visit. Our billing department at 719-471-4994. We can answer questions regarding these amounts.

Late, Cancelled, or Missed Appointments: We take great care in scheduling around your needs and Dr. Devanny's availabilty to accommo-date as many people as possible. If you are late for your appointment, we will do our best to work you in when you arrive. To avoid a $25 service fee, please call 24 hours prior to the date/ time of the appoitment if you must cancelled/reschedule. Please call our team at 719-471-4994 for all appoitment questions.

Surgery: Be sure to ask for any appropriate "after care" instruction to take with you for later reference. Also be aware that many insurance companies have separate surgery deductible amounts that the patient must pay prior to surgery.

Prescriptions and Medical Records: Your Driver's License or Government issued photo ID is required when picking up prescriptions and medical records.

Prescription Refills: Please call your pharmacy for all medication refills.

Patient Health History

Part 1 of 3

Today's Date: _____

Patient's Last Name: _____ First: _____ MI: ____

DOB: _____ Age: _____ Height: _____ Weight: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you hear about us? ☐ Friend/Family ☐ Physician ☐ Web ☐ TV ☐ Seminar ☐ School ☐ Other _____

If other than a physician, to whom may we thank for your referral? _____

Employer: _____ Occupation: _____

Pharmacy Preference & Address: _____

TODAY'S VISIT

Reason for today's visit: _____

What date did the current pain/injury start? _____ How long have your had these symptoms? _____

Describe the injury or symptoms and include where it is located (specify left or right side) _____

_____

_____

Is this a work-related injury/pain? ☐ Yes ☐ No Have you had surgery for this problem? ☐ Yes ☐ No

If yes, when (date)? _____ What surgical procedure was performed? _____

MEDICATIONS — Please list any medication(s) you are currently taking including prescribed medications, vitamins, supplements and over-the-counter medications.

Medication	Dosage/Directions	Problem Being Treated	Prescribing Physician

ALLERGIES — Please list all medical allergies and tell us how you react to them.

Allergy	Reaction

Are you allergic to latex? ☐ Yes ☐ No
Are you allergic to adhesive tape? ☐ Yes ☐ No
Are you allergic to contrast dye? ☐ Yes ☐ No

Are you allergic to Iodine or Betadine? ☐ Yes ☐ No
Are you allergic to metal? ☐ Yes ☐ No
Are you allergic to birds/feathers/eggs? ☐ Yes_____ ☐ No

Patient Health History

Part 2 of 3

Patient's Last Name: _____ First: _____ MI: ____

REVIEW OF SYMPTOMS — Please check all conditions you are currently experiencing

- ☐ Muscle pain or cramps
- ☐ Joint pain or stiffness
- ☐ Swelling in arms or legs
- ☐ Back pain
- ☐ Spasms
- ☐ Balance problems
- ☐ Numbness in any area of the body
- ☐ Frequent headaches
- ☐ Slurred speech
- ☐ Memory problems
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stomach aches
- ☐ Vomiting
- ☐ Bleeding from rectum
- ☐ Blood in bowel movement
- ☐ Nausea
- ☐ Neck pain
- ☐ Jaw pain
- ☐ Chest pain
- ☐ Difficulty urinating
- ☐ Burning on urination
- ☐ Difficulty holding urine (leaking, especially at night)
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Nasal bleeding
- ☐ Sores in mouth
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Blurring vision
- ☐ Double vision
- ☐ Difficulty breathing
- ☐ Difficulty breathing after activity only
- ☐ Coughing frequently
- ☐ Coughing up blood
- ☐ Asthmatic attacks
- ☐ Cold-like symptoms
- ☐ Rashes, specify location: _____
- ☐ Tendency to bleed or bruise easily
- ☐ Open sores or cuts, specify location: _____
- ☐ Nervousness/emotional mood swings
- ☐ Weakness
- ☐ Excessive thirst
- ☐ Dizziness
- ☐ Fainting/blacking out
- ☐ Lack of appetite
- ☐ Weight change: ☐ Gain ☐ Loss:
  - ☐ 5 lb ☐ 10 lb ☐ 20 lb ☐ More
  - ☐ Within last month
  - ☐ 3 months

PAST MEDICAL HISTORY — Please check all conditions you have now, or have had in the past.

CARDIOVASCULAR
- ☐ Angina (chest pain)
- ☐ Arrhythmia/Irregular Heartbeat
- ☐ Blood Clot/DVT (Deep Vein Thrombosis)
  Date Occurred: _____
- ☐ Heart Disease/Coronary Artery Disease
- ☐ High Cholesterol/Hyperlipidemia
- ☐ MVP (Mitral Valve Prolapse)
- ☐ Pacemaker
- ☐ Varicose Veins/Peripheral Vascular Disease
- ☐ Hypertension/High Blood Pressure
- ☐ Stent - Date Inserted: _____
- ☐ AICD (Automatic Implantable Cardioverter Defibrillator

BONES, JOINTS & MUSCLES
- ☐ Arthritis
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoporosis
- ☐ Scoliosis

PSYCHIATRIC DISORDER (Mental Health)
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression

HEENT (Head, Ears, Eyes, Nose & Throat)
- ☐ Blind
- ☐ Deaf
- ☐ Hearing Loss

PULMONARY (Lungs & Respiratory)
- ☐ Asthma
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ PE (Pulmonary Embolism/Blood Cot in Lung)
  Date Occurred: _____
- ☐ Sleep Apnea
- ☐ TB (Tuberculosis)

GENITOURINARY (Kidneys & Urinary Tract)
- ☐ Renal Failure
- ☐ Renal Insufficiency
- ☐ UTI (Urinary Tract Infection)
- ☐ Currently Pregnant

NEUROLOGIC DISORDER (Brain & Nervous System)
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ MD (Multiple Sclerosis)
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Stroke/CVA—Date Occurred: _____
- ☐ Myasthenia Gravis
- ☐ Muscular Dystrophy

HEMATOLOGIC (Blood & Lymph Node)
- ☐ Anemia
- ☐ Edema
- ☐ Lupus
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Clotting Disorders

GASTROINTESTINAL
- ☐ Gastric Ulcer
- ☐ GERD
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hepatitis—Type Unknown
- ☐ Hernia
- ☐ Peptic Ulcer
- ☐ Liver Disease

CANCER
- ☐ Type: _____

METABOLIC (Endocrine, Hormones & Metabolic)
- ☐ Diabetes—Type I
- ☐ Diabetes—Type II
- ☐ Diabetes— Type Unknown
- ☐ Thyroid Dysfunction
  - ☐ Hypothyroidism
  - ☐ Hyperthyroidism

IMMUNE/AUTOIMMUNE & INFECTIOUS PROBLEMS
- ☐ AIDS
- ☐ HIV Positive
- ☐ Rheumatoid Arthritis
- ☐ MRSA (Methicillin Resistant Staph Aureus)

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: _____

Patient Health History

Part 3 of 3

Patient's Last Name: _____ First: _____ MI: ____

PAST SURGICAL HISTORY — Check all that apply and indicate which R/L as appropriate.

☐ ACL Surgery: year _____ R/L
☐ Angioplasty
☐ Angio w/Stent
☐ Appendectomy
☐ Arthroscopy Ankle: year _____ R/L
☐ Arthroscopy Elbow: year _____ R/L
☐ Arthroscopy Hip: year _____ R/L
☐ Arthroscopy Knee: year _____ R/L
☐ Arthroscopy Wrist: year _____ R/L
☐ Arthroscopy Shoulder: year _____ R/L
☐ Back Surgery: year _____ R/L
☐ CABG: year _____
☐ Carpal Tunnel Release: year _____ R/L
☐ Cataract Extraction
☐ Cholecystectomy
☐ Colectomy
☐ Gastric Bypass
☐ Hernia Repair
☐ Hip Replacement: year _____ R/L
☐ Knee Replacement: year _____ R/L
☐ Laminectomy: year _____
☐ LASIK
☐ Meniscus Surgery: year _____ R/L
☐ ORIF: year _____
☐ Pacemaker
☐ Rotator Cuff Repair: year _____ R/L
☐ Small Bowel Resection
☐ Tonsillectomy
☐ Thyroidectomy
☐ Transplant: _____

GENDER SPECIFIC ☐ Tubal Ligation ☐ Cesarean Section ☐ Mastectomy ☐ Hysterectomy

☐ **OTHER SURGERIES NOT LISTED ABOVE**: _____

☐ **FRACTURES**: _____

☐ **PROBLEMS WITH PAST ANESTHESIA (IF YES, PLEASE LIST):** _____

☐ **CURRENTLY BEING TREATED WITH**: ☐ Dialysis ☐ Chemotherapy ☐ Radiation ☐ Oxygen: Day/Night _____ # liters

FAMILY HISTORY — Check the boxes if a **blood relative** has been diagnosed with the following and indicate if s/he is deceased Y/N

	Relationship	Deceased		Relationship	Deceased
☐ Anesthesia Problems	_____	Y/N	☐ Osteoporosis	_____	Y/N
☐ Arthritis	_____	Y/N	☐ Diabetes	_____	Y/N
☐ Bleeding/Clotting Problems	_____	Y/N	☐ Family History Unknown		
☐ Cancer: type _____	_____	Y/N	☐ No Significant Family History		

SOCIAL HISTORY

HAND DOMINANCE
☐ Right
☐ Left
☐ Ambidextrous

DO YOU DRINK ALCOHOL?
☐ Yes
☐ No
What kind & how much?
_____
_____

DO YOU USE TOBACCO?
☐ Yes: type of tobacco ____
☐ No
☐ Formerly Used:
Type of tobacco _____
Age Quit _____

CURRENT/FORMER ILLICIT DRUG USE
☐ None
☐ Current: Type _____
☐ Former: Type _____
Date quit: _____

BONE HEALTH HISTORY — Please check all the boxes that apply now, or have applied in the past:

☐ I have a family history of osteoporosis
☐ I have broken a bone
☐ I have been prescribed chronic steroid medication
☐ I have had a bone density check
☐ I have been diagnosed with osteopenia by a doctor
☐ I have been diagnosed with osteoporosis by a doctor
☐ I am currently taking medication for osteoporosis

Patient Registration

Today's Date: _____

Patient's Last Name: _____ First: _____ MI: _____ DOB: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ SSN: _____ ☐ Male ☐ Female

Best Daytime Phone Number: _____ Secondary Phone Number: _____

Email Address: _____

Emergency Contact: _____ Phone Number: _____ Relationship to Patient: _____

Demographic Information: (We are required to collect this information as part of the government's Meaningful Use Initiative)

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race:
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Decline to Specify

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Specify

Insurance Information

Primary Insurance: _____

Policy Holder: ☐ Self ☐ Other

If other, policy holder name: _____

DOB: _____ Member ID #: _____

Mailing Address (if different than above):

_____

Secondary Insurance: _____

Policy Holder: ☐ Self ☐ Other

If other, policy holder name: _____

DOB: _____ Member ID #: _____

Mailing Address (if different than above):

_____

Minor Information

Responsible Party Name: _____ DOB: _____

Best Contact Number: _____ Relationship to Patient: _____

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

Insurance Authorization

Insurance Authorization and Assignment of Benefits:

I authorize the medical staff at Incline Orthopaedics to treat my illness or injury. I hereby authorize the release of any medical information necessary to process my claim and I authorize payment of medical and surgical benefit to Incline Orthopaedics.

Patient Signature: _____ Date: _____

(If a patient is a minor, a parent/legal guardian must sign on his or her behalf)

Relationship to Patient: _____

Personal Health Information Disclosure

Today's Date: _____

Patient's Last Name: _____ First: _____ MI: _____ DOB: _____

Names of family/friends with whom we may discuss your treatment and health information. Please also designate authorization for Medical Records and RX pick up.

Full Name	Phone	Relationship	Medical Records	RX pick up
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

I, _____, agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Personal Health Information (PHI) may be left for me on voicemail systems and answering machines at the above telephone numbers:

Signature: _____ Date: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received Incline Orthopaedics' Notice of Privacy Practices either in person, in the office or on Incline Orthopaedics'website, www.inclineorthopaedics.com.

Signature of patient or patient representative: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining the acknowledgment
- ☐ Other _____

Incline Orthopaedics Employee Signature: _____

Financial Agreement

Thank you for choosing Incline Orthopaedics as your orthopedic provider. We are committed to delivering outstanding healthcare and customer service. The following is our current financial policy.

For patients with health insurance: Incline Orthopaedics will submit an accurate claim to all contracted insurance as a courtesy to our patients. This will require information to be provided by the patient at each visit to ensure timely payment processing . Should the patient not provide accurate insurance data, the bill will become due by the patient at the time the insurance denies payment.

Incline Orthopaedics CANNOT waive copays, deductibles, coinsurance, or non-covered service amounts defined as patient responsibility under the terms of our contact with your health insurance. Patient copays are ex-pected at the time of service.

For out-of-network patients: In cases where Incline Orthopaedics is not recognized as a participating provider and considered Out-of-Network, Incline Orthopaedics may elect to notify and provide full disclosure upon submission of a claim to the patient's insurance carrier that Incline Orthopaedics will offer a discount to the patient as their insured member. Incline Orthopaedics will bill the patient's insurance carrier its full charge and then discount the patient portion of the payment to usual and customary as defined by the insurance carrier. Should the patient's insurance carrier offer payment to Incline Orthopaedics at the discounted rate offered to the patient, Incline Orthopaedics will accept the payment from the insurer as payment in full. At no time, is Incline Orthopaedics charging two different prices for the same service, nor is pricing based on the fact than an insurance company may be paying for all or a part of the service rendered. This is not a waiver or a discount of any copayment, coinsurance or deductible amounts owed for services rendered and is not offered and should not be interpreted as an "inducement" to have services rendered.

I authorize Incline Orthopaedics and their billing company to negotiate, discuss, and in any other way, communicate with my insurance company in those areas relative to Out-of-Network reimbursements, methodology used in Out-of-Network negotiation and affair negotiation of final payment. I authorize Incline Orthopaedics to accept or reject agreements, to enter into contracts binding upon final adjunction of claims and negotiations, and to act in whatever way necessary so as to accomplish that which is being undertaken.

For auto accidents or liability patients: Incline Orthopaedics does not bill third party insurance.

Methods of payment: Incline Orthopaedics accepts all major credit cards, checks and cash.

Past due accounts: All patient responsible balances will become delinquent 15 days after request for payment. After 30 days, your account will be turned over to an outside collection agency. If the account remains delinquent, the patient will be unable to schedule any further appointments until the debt has been settled.

Thank you for your understanding of our financial policy. If you have any questions regarding this policy or your account, please contact 719-471-4994.

I have read and understand the financial policy of the practice and I agree to its terms. I also understand that the terms may be amended by the practice.

Patient Signature: _____ Date: _____

(If a patient is a minor, a parent/legal guardian must sign on his/her behalf)

Patient Name Printed: _____ Date of Birth: _____

Incline Orthopaedic Information

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