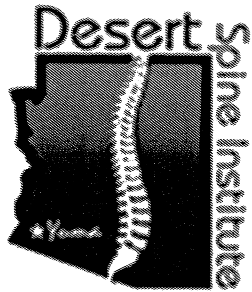



**DESERT SPINE INSTITUTE**
**Shawn F. Hermenau, M.D.**
**2851 S. Avenue B, Building 24 Suite 2401**
**Yuma, Arizona 85364**

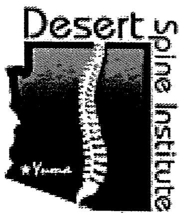
# NEW PATIENT AGREEMENT

By signing this form you are allowing Shawn Hermenau, M.D. to care for you as a patient under the patient-physician relationship model. The patient-physician model enables sensitive information about your medical condition to be shared between the patient and the treating physician in confidential manner. Your medical and demographic information will not be shared without your expressed written consent. Dr. Hermenau or his staff will only discuss issues with you unless you first give specific written or verbal consent to speak with others in your place or in addition to you.

All communications between the physician and the patient or patient designees will be documented in the medical record for completeness. No test results, imaging results, or laboratory findings will be given over the phone. Discussions regarding medical information will be done in person. It will be our policy that any significant abnormal finding(s) during medical examinations such as labs or imaging will generate a registered or certified letter of such finding(s) to the patient. It is imperative to keep up-to-date demographic information with our office for this reason and to avoid delay in medical care.

In the event that the patient-physician relationship needs to be terminated, written notification of the termination will be completed. The patient has the right to terminate the relationship and our staff will be able to assist in finding follow-up care for the patient to the best of our ability. In the case Dr. Hermenau needs to terminate the relationship, a certified letter will be sent to the patient explaining the reason(s) and will provide names of other providers that would be able to better care for the patient. Reasons for termination of the relationship on behalf of Dr. Hermenau include but are not limited to fraud, verbal/physical abuse toward the staff or provider, non-compliance with care plans, drug seeking, or failure of payment for services.

______________________________ ______________
Patient/Guardian Signature Date




## FINANCIAL POLICY and NEW PATIENT AGREEMENT

Thank you for choosing us as your orthopaedic provider. We are committed to your care and treatment. Please understand that our practice has bills and overhead just like any other business, so we must ask you to consent to the following:

**Payment of your co-pay and/or deductible is due at the time of service. If you do not have insurance the visit must be paid up front, in full with either credit card or cash.** We will submit all charges to your insurance company as a courtesy, please ask if we are contracted with your insurance provider.

We ask that if you can't keep an appointment, please notify us at least 48 hours in advance so that we are able to give your time to another patient on a cancellation list. **If you do not inform us that you will not be keeping your appointment there will be a no-show fee of $50.00 that must be paid prior to us rescheduling your appointment.** If you consistently fail to keep appointments, the doctor may terminate you from care. It is your responsibility as a patient to keep all scheduled appointments and comply with the treatment the doctor has recommended. Likewise, it is our responsibility to inform you of any changes in our schedule as soon as we become aware of those changes.

Finally, we welcome you to our family here at Desert Spine and hope to meet all your orthopaedic healthcare needs. Please feel free to call anytime with questions or concerns.

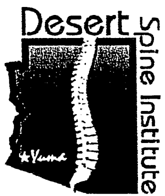
Patient/Guardian Signature ________________________ Date________________

## PATIENT OBLIGATIONS IF SENT TO COLLECTIONS:

In the event the patient or responsible party have failed to pay for the services provided by this office and the account is placed in collections, the patient or responsible party understand and agree that an additional amount equal to 40% of the balance owing at the time the account is placed for collection will be added to the current balance. (*For EX: If a patient owes $100.00 there would be an additional ($40.00) added to the balance sent to collections. The total amount owing is now $140.00)* Patient od responsible party also agree to pay interest at 10% until the amount is paid in full. Patient or responsible party also agree to pay all attorney's fees and court costs necessary to collect this balance.

Patient/Guardia Signature__________________________ Date___________________

**Dr.Hermenau is actively involved in clinical research and is a consultant for different medical device companies, currently Depuy Spine and Stryker Spine. Full disclosure of his financial relationships is available upon request. If you are invited to become a participant in a clinical trial a comprehensive consent will be obtained prior to your enrollment.




## PATIENT RECORD OF DISCLOSURES

HIPPA regulations require our office to obtain the information listed on this form for your protection. You have the right to request a restriction on uses and disclosures of your health information. Also, you are provided the right to request confidential communications of your health information.

**I wish to be contacted in the following manner (check all that apply):**

| | |
|---|---|
| ___ *Home Telephone* | ___ *Written Correspondence* |
| ___ OK to leave message with detail | ___ OK to mail home address |
| ___ Leave message to call office back ONLY | ___ OK to mail work address |
| ___ *Work Telephone* | ___ *Other* ______________ |
| ___ OK to leave message with detail | ______________________ |
| ___ Leave message to call office back ONLY | |

______________________ __________ ______________________

Patient Name Date Patient Signature

Privacy rules require our office to keep record of disclosures of your health information. Records of any release of medical records will be properly documented in your records and will be adequate record of disclosures. **Note: Disclosures of your health information may be made in an emergency without prior consent.**

**If you wish any member of your family to have access to your health information <u>without prior consent from you</u>, you MUST list their full name below in order for us to give any disclosures:**

______________________ ______________________

Name Name

______________________ ______________________

Name Name

## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

*Original will be maintained in Patient's permanent record.*

I acknowledge that I have received a copy of Desert Spine Institute's Notice of Privacy Practices.

______________________________ ______________

Signature of Patient or Legally authorized individual Date

______________________________ ______________

Print name if signed on behalf of the patient Relationship

12/11aj

# DESERT SPINE INSTITUTE REGISTRATION FORM

PATIENT'S LAST NAME: ____________________ FIRST NAME: ______________________ MI: _____

DATE OF BIRTH: ___________ AGE: ______ SEX: M____ F ____ MOTHER'S MAIDEN NAME__________

MARITAL STATUS: ____ SINGLE ____ MARRIED _____ DIVORCED ____ SEPARATED ____ WIDOWED

SOCIAL SECURITY NO.: ______________________ EMAIL: ____________________________________

STREET ADDRESS: ________________________________________ PO BOX: ______________________

CITY: ___________________ STATE: __________ ZIP CODE: _________________

HOME PHONE: ________________________ CELL PHONE: ________________________

EMPLOYER NAME: ________________________ EMPLOYER PHONE NUMBER: _________________

REFERRING PROVIDER: DR. __________________ PRIMARY CARE PHYSICIAN: _________________

PREFERRED LANGUAGE: ______________________ INTERPRETER NEEDED: ___________________

*IF AN INTERPRETER IS NEEDED FOR THE PATIENT PLEASE BE SURE ONE ACCOMPANIES THE PATIENT ON THE DAY OF THE APPOINTMENT OTHERWISE THE APPOINTMENT MAY BE RESCHEDULED

ETHNICITY: _________________ RELIGION: ___________________

IS THIS APPOINTMENT WORK RELATED: YES_________ NO__________

GUARANTOR NAME: ______________________________ DATE OF BIRTH ______________________

ADDRESS (IF DIFFERENT): ____________________________ CITY: _________________

STATE: _________ ZIP CODE: ___________ HOME PHONE: _____________________

CELL PHONE: _____________________ SOCIAL SECURITY NO: ______________________________

PATIENT'S RELATIONSHIP: ______ SELF ______ SPOUSE _______ CHILD _____ OTHER

NAME OF PRIMARY INSURANCE: ____________________________________

POLICY NUMBER: _____________________ GROUP NUMBER: ____________________

NAME OF SECONDARY INSURANCE: __________________________________

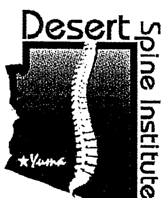
POLICY NUMBER: ___________________ GROUP NUMBER: _____________________

EMERGENCY CONTACT: ______________________ RELATIONSHIP TO PATIENT: ________________

HOME PHONE: __________________ CELL PHONE: ________________ WORK PHONE: _____________

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCES. I ALSO AUTHORIZE DESERT SPINE INSTITUTE OR INSURANCE COMPANY TO RELEASE ANY INFORMATION NEEDED TO PROCESS MY CLAIMS.

PATIENT/GUARDIAN SIGNATURE: ___________________________ DATE: __________________




# NOTICE OF INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IT.

**Understanding your Orthopaedic Health Record information.**

Each time you visit a hospital, physician, or other healthcare provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your medical records serves as:

1) Basis for planning your care and treatment.
2) Means of communication among the many health professionals who contribute to your care.
3) Legal document describing the care you received.
4) Means by which you or a third-party payer can verify that you actually received the services billed for.
5) A tool to assess the appropriateness and quality of care you received.

Understanding what is in your health records and how your health information is used helps you to ensure its accuracy and completeness and make informed decisions about authorizing disclosure to others.

**Your Rights Under the Federal Privacy Standard**

Although your health records are the physical property of the healthcare provider who completed it, you have certain rights with regard to the information contained therein. You have the right to obtain a copy of this notice of information practices upon request.

In other situations, the provider may deny you access but, if it does, the provider must provide you with a review of the decision denying access. A potential reason for grounds of denial would be if the request is made by the individual's personal representative and a licensed healthcare professional has determined, in the exercise of professional judgment, that the provider of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person. For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what , if anything, you have to do to get access. **We reserve the right to charge a reasonable, cost-based fee for making copies.**.

If you request amendment/correction of your health information, we do not have to grant the request if the records are not available to you as discussed immediately above, or the record is accurate and complete.

If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those you identify to us that you want to receive the corrected information.

You have the right to obtain an accounting of "non-routine" uses and disclosures - those other than for treatment, payment and health operations. We must provide the accounting within 60 days. The accounting must include the date of each disclosure, name and address of the organization of person who received the protected health information, and a brief statement of the purpose of the disclosure or, in lieu of such statement, a copy of your written authorization, or a copy of the written request for disclosure. **The first accounting in a 12 month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.**

You have the right to revoke your consent or authorization to use or disclose health information except to the extent that we have already taken action in reliance on the consent or authorization.

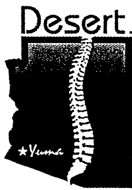
**Our Responsibilities Under the Federal Privacy Standard**

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information; provide you with this notice as to our legal duties and privacy practices with respect to individually identifiable health information we collect and maintain about you; abide by the terms of this notice, train our personnel concerning privacy and confidentiality; implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto; mitigate (lessen the harm of) any breach of privacy/confidentiality.

**We reserve the right to change our practices and to make the new provisions effective for all individually identifiable health information we maintain. Should we change our information practices, we will mail a revised notice to the address you have supplied us.**

We will not disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

**How to Get More Information or Report a Problem**
If you have questions or would like more information please call (928) 247-9714.




Desert Spine Institute
2851 S. Ave B
Suite 2401
Yuma, AZ 85364

# PEDIATRIC New Patient Evaluation Form

**Name:** ____________________ **Date of visit:** __________

**Consultation from:** ____________________ **Pediatrician / primary:** ____________________

**Date of birth:** ____________________ **Age:** _____ **years** _____ **months**

**Mother's name** ____________________ **Father's name** ____________________
Work number ____________________ Work number ____________________
Other number ____________________ Other number ____________________

**Reason for visit:** □ Scoliosis, □ Back pain, □ Other ____________________

**How was diagnosis made?** □ School screening, □ Pediatrician, □ Family, □ Other __________

**Other health problems:** (check all that apply):

| | | | |
|---|---|---|---|
| □ recurrent ear infections | □ skin condition | □ peptic ulcer disease | □ anemia |
| □ asthma | □ inflam bowel | □ diabetes | □ headaches |
| □ heart condition | □ seizure disorder | □ depression | □ hay fever/sinus |

□ Other ____________________

**Family history of scoliosis:** ____________________

**Previous hospitalizations / surgery:** ____________________

| **Medications** | **Reason** | **Medicine** | **Reason** |
|---|---|---|---|
| | | | |
| | | | |

**Do you have any allergies?** □ No, □ Yes. If yes, to what ____________________

**Social:** School: ____________________ Grade: ________
Siblings: ____________________
Sports / activities: ____________________

Development

Birth history ______________________________
Milestones ______________________________
Menarche ______________________________
Special needs ______________________________
Prior imaging ______________________________

Height: ________
Weight: _________
Growth chart started

**PAIN SCALE**
**ESCALA DE DOLOR**

Select the number on the scale that indicates your pain level 0=None 10=Max
Seleccione el numero en la escala que indique su nivel de dolor. 0=Ninguno 10=Maximo

Back Pain
> 0__.__1__.__2__.__3__.__4__.__5__.__6__.__7__.__8__.__9__.__10
*Dolor de*
*Espalda*

Neck Pain
> 0__.__1__.__2__.__3__.__4__.__5__.__6__.__7__.__8__.__9__.__10
*Dolor de*
*Cuello*

Leg Pain
> 0__.__1__.__2__.__3__.__4__.__5__.__6__.__7__.__8__.__9__.__10
*Dolor en*
*la pierna*

Arm Pain
> 0__.__1__.__2__.__3__.__4__.__5__.__6__.__7__.__8__.__9__.__10
*Dolor en*
*el brazo*

Other/*Otro* >0__.__1__.__2__.__3__.__4__.__5__.__6__.__7__.__8__.__9__.__10

______________________
(Describe)

Name:____________________________________ Date:________________

Please complete the following drawing to show where your pain is. You do not need to use all of the symbols, just those that apply. I understand the difficulty with pain descriptions, but please do the best that you can.

Sharp pain= XXXXXXX

Dull pain= +++++++++

Tingling=/ / / / / / / / / / / /

Numbness= OOOOOOO