

IMS

ORTHOPEDICS

INTEGRATED MEDICAL SERVICES

Welcome to IMS Orthopedics. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

Please check-in 30mins prior to your scheduled appointment with the following packet completed in its entirety. Failure to complete the packet and arrive early to your scheduled appointment may delay your appointment and/or require our office to reschedule your appointment. Your provider may require x-rays for your initial visit with our office to better serve you and establishing a treatment plan – Our office will notify you when your x-ray imaging order has been placed in the system for completion.

You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms annually so we may update your information. All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring a list of all of your prescription and over-the-counter medications with you at each visit.

We understand that appointments sometimes need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

Providing the highest quality of professional care to our patients is very important to us.

Welcome to our practice and thank you for choosing IMS Orthopedics for all your health care needs.

Sincerely,

IMS Orthopedics
A Division of IMS

Name: _____ DOB/Age: _____ Today's Date: ____ / ____ / ____ How did you get referred to this office: _____

Referral Source: Name: _____ Address: _____

Primary Care MD: Name: _____ Address: _____

Preferred Pharmacy Information

Pharmacy Name: _____ Phone #: _____ Fax #: _____

Address: _____ City/State/Zip: _____

REASON FOR TODAY'S VISIT: _____

INJURY HISTORY:

Did the problem result from a specific injury? Yes No

Was the injury due to a: Work Injury Car Accident

Injury/Accident Date: _____

Is / was there a lawyer involved in your injury? Yes No

How did you get injured? _____

How long have you had the condition? _____

Please **rate** your pain on a scale of **0 to 10** (10 being the most painful):

- 1 2 3 4 5 6 7 8 9 10

Is the **pain:** Constant Occasional Sharp Dull

Aching Stabbing Throbbing Burning

Electrical Shooting Spasmodic

What **symptoms** are you experiencing? Numbness Swelling Locking

Catching Giving Way Popping Grinding Stiffness

Weakness Instability Night pain Pain with lifting Tingling

Pain with overhead activity Other _____

What, if anything, makes your symptoms **better**?

What, if anything, makes your symptoms **worse**?

Are you: Improving Getting Worse Staying the same

Have you seen another physician for this problem/injury? Yes No

If yes, who? _____

What **treatments** have you tried? Nothing Physical Therapy Exercise

Acupuncture Chiropractic manipulation Other _____

Injections (*specify:* Cortisone, Supartz, Synvisc, Hyalgan)

Pain medications: _____

IMAGING STUDIES

Test	Date (month/year)	Where were the tests done?
<input type="checkbox"/> X-rays	_____	_____
<input type="checkbox"/> MRI scan	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> EMG/NCV	_____	_____

Other _____

Patient Name: _____ DOB: _____

MEDICAL HISTORY

Please check *current* or *previous* medical conditions:

- | | | | |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke/Seizures | <input type="checkbox"/> Hepatitis B or C |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Pulmonary Embolus | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Other _____ | | | |

Have you ever had a blood transfusion? Yes No If yes, when? _____

MEDICATIONS

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any other over-the-counter medications. Include vitamin, mineral, and herb supplements.

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST SURGICAL HISTORY

Please check any previous surgical procedures. List the date and location.

- Appendectomy _____ Arthroscopy Lower Extremity _____ Arthroscopy Upper Extremity _____
 Hernia Repair _____ Spine/Back Surgery _____ Heart Surgery _____ Fracture Repair _____
 Total Joint Replacement _____ o T&A o BSO o Other _____
 Hospitalizations (When): _____

ALLERGIES

Are you allergic to: Penicillin: Yes No Sulfas: Yes No Latex: Yes No
 No known drug allergies

Please all other allergies: _____

SOCIAL HISTORY

Hand Dominance: Left Right Marital Status: S M W D
What type of work do you do (job title): _____
Tobacco Use: Yes No Type: _____ Duration: _____ Quit Date: _____
Alcohol Use: Yes No Frequency: _____
Street Drug Use: Yes No Frequency: _____

GASTROINTESTINAL HISTORY

Do you have a history of Peptic Ulcer Disease? Yes No If yes, when? _____
Do you have a history of GI, stomach bleed? Yes No If yes, when? _____
Do you take any medications for your stomach? (Please include over the counter medications: i.e. Pepcid, Tums, Zantac, etc.) Include dosage and frequency. _____

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? (Please include over the counter medications such as Advil, Aleve, and previously prescribed medications, such as Celebrex and Vioxx. List all you have tried.)

Patient Name: _____ DOB: _____

FAMILY HISTORY

Please check family history conditions:

- Blood Clots Diabetes Hypertension Rheumatoid Arthritis
- Cancer Heart Disease Osteoporosis Stroke Seizures

Other: _____

REVIEW OF SYSTEMS

Check if you have *current symptoms or current known* medical problems in the following areas. Please describe. If you do not have any problems, please check the *Normal* box.

- SKELETAL** Arthralgias Joint Swelling Limb pain
- Joint Pain Joint Stiffness Limb Swelling
- CONSTITUTIONAL** Normal Fever Feeling Poorly Recent Weight Gain(____lbs)
- Chills Feeling tired (Fatigue) Recent Weight loss (_lbs)
- EYES** Normal Eye Pain Eyesight Problems Dry Eyes
- Red Eyes Discharge From Eyes Eyes Itch
- EARS, NOSE** Normal Earache Nose Bleeds Sore Throat
- Loss of Hearing Nasal Discharge Horseness
- HEART** Normal Chest Pain Heart Rate is Fast Leg Claudication
- Palpitations Heart rate is slow Lower extremity swelling
- RESPIRATORY** Normal Shortness of Breath Cough Difficulty breathing when lying down
- Wheezing Difficulty Breathing when exercising PND
- GI** Normal Abdominal Pain Constipation Heartburn
- Vomiting Diarrhea Blood in Stool
- GU** Normal Pain while Urinating Pelvic Pain Vaginal / Penile Discharge
- Incontinence Irregular Periods Abn Vaginal Bleeding
- SKIN** Normal Itching Rash Breast Pain
- Skin Wound Change in a Mole Breast Lump
- NEUROLOGICAL** Normal Confused Dizziness Limb Weakness
- Convulsions Fainting Difficulty walking
- PSYCHIATRIC** Normal Suicidal Anxiety Change in Personality
- Sleep Disturbance Depression Emotional Problems
- ENDOCRINE** Normal Proptosis Muscle Weakness Feeling of Weakness
- Hot Flashes Deepening of Voice
- HEMATOLOGY** Normal Easy Bleeding Swollen Glands Easy Bruising
- Other: _____

WOMEN ONLY: Are you, or could you be pregnant? ____ No

____ **YES Please inform the Medical Assistant and Radiology Tech .**

Signature: _____

Date: _____

Print Name: _____

Physician Signature: _____

Date: _____

Personal Information

Today's Date: _____

Patient First Name: _____ Initial: _____ Last Name: _____

DOB: _____ Age: _____ Social Security #: _____ Email: _____

Address: _____ Street

Apt # City/State/Zip

Home Phone: _____ Work Phone: _____ Cell phone: _____

Gender : M F Language: ENG SPAN OTHER: _____ Marital Status: S M W D O

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Declined Unknown

Race: White Asian American Indian/Alaskan Native Black/African American Declined Unknown
 Native Hawaiian/Other Pacific Islander

Financial Responsible Party Information

Responsible Party Name: _____ Relationship to patient: _____

DOB: _____ Age: _____ Social Security #: _____

Emergency Contact Name: _____ DOB _____

Phone Number: _____ Relationship to patient: _____

Insurance Information

Primary Insurance: _____ Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to patient: _____

Secondary Insurance: _____ Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to patient: _____

I hereby authorize IMS to release any information required in the course of my examination or treatment to my insurance(s). I also hereby authorize payment directly to IMS for the surgical and/or medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by my insurance. Further, I understand that I am responsible for all charges incurred in the collection of my account(s) and will pay all fees involved should my account(s) be placed with a collection service. Finance charges will begin to accrue on any unpaid patient responsibility balance after 90 days old

Patient/Guardian Signature

Printed Name

Date



Patient Financial Responsibility Agreement

Patient Name:

Date of Birth:

Account #:

We at Integrated Medical Services, Inc. ("IMS") are committed to providing quality care and service to all of our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient and sign and date the bottom.

Insurance Information: You are responsible for making sure we have all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you. We ask that you update and verify your record at each visit.

Health Plan Deductibles, Co-Payments and Coinsurance: If you have not met your health plan's deductible on the date of service, we will collect an estimated amount before you are seen towards your deductible. Please note you may receive a bill for additional charges for services rendered. You are responsible for any co-payments and co-insurance required by your insurance carrier at the time of service. Payments received in excess of charges may be applied to subsequent services.

Non-Covered Services: We will do our best to verify coverage before you are seen, but it is ultimately your responsibility to ensure payment of your bill. Any service performed by our providers that is not covered by your insurance is your responsibility. It is your responsibility to know your benefits prior to being seen. Verification of benefits and insurance coverage is not a guarantee of payment.

Referrals: We will do our best to ensure we have a valid referral for services on file. However, if your insurance policy requires a referral, you are responsible for making sure there is a current and valid referral on file prior to being seen.

Self-Pay: If you don't have health insurance, are on a plan we are not contracted with, or if we are unable to verify your coverage at the time of service, we will collect an estimated payment before you are seen by a provider. There may be additional charges depending on the services actually provided for which you may receive a bill.

Returned Checks: We charge a \$25.00 fee for any returned checks.

No Show Policy: If you are unable to make your appointment, we ask that you cancel your appointment at least 24 hours before they are to be seen in our office. Failure to cancel an appointment in a timely manner will result in a No Show fee of \$25.00. Multiple No Shows may result in the patient being discharged from IMS.

Minors: For all services rendered to minor patients, the parent, guardian or responsible party who brings the patient to the appointment is responsible for all payments due at the time of service.

Delinquent Accounts: Additional fees, including collection fees and finance charges may be added to unpaid delinquent accounts. Finance fees of \$5 will accrue each time a new statement is generated after the first statement was sent out and partial or no payments have been made. Your account may be sent to a collection agency if the balance is 90 days old and partial or no payment has been made towards the balance.

Contact: If you have any questions regarding your bill, please contact the IMS billing office at **(602) 633-3838**.

I have read the above financial policies of IMS and agree to be bound by its terms. I also understand that IMS has the right to amend these policies at any time.

Signature of Patient or Responsible Party: _____ Date: _____

Printed Name of Patient: _____

Printed Name of Responsible Party: _____ Relation to Patient: _____

Contact Phone Number of Responsible Party: _____

IMS ORTHOPEDICS

INTEGRATED MEDICAL SERVICES

A DIVISION OF IMS

Expert orthopedic care in your neighborhood

PHONE: (623) 882-1292 FAX: (623) 882-8184

Patient Name: _____ DOB: _____

OFFICE POLICY

- No patients under the age of 18 will be seen in our office without a written note from legal guardian.
- In the event a patient is unable to keep their scheduled medical appointment with their provider, a phone call must be received by our office 24 hours prior to appointment; otherwise an automatic \$25.00 administrative fee may be charged to the patient account.
- We do not bill for co-pays. **PAYMENT IS EXPECTED AT DAY OF SERVICE.**
- There is a \$25.00 fee for any paperwork that is to be completed by your orthopedic physician; this includes but is not limited to FMLA paperwork, Disability paperwork, and physical capacity statements. Payment is required prior to completion.
- Should a patient leave a message with our office, they can anticipate a return call by the next business day.
- No pain medications or routine medications will be called in **AFTER HOURS**. Patients will have to wait until the next working day to discuss with their provider. **NO EXCEPTIONS.**
- All patients are responsible for making their follow-up appointments and must arrive on time.
- Any patient that arrives 15 minutes after their scheduled appointment time may be asked to reschedule at the discretion of the provider.
- As a courtesy to our patients; our office makes every attempt to verify benefits and coverage for services provided and/or recommended. However, it is the patient's responsibility to know, understand, and be responsible for their insurance coverage.
- Inappropriate language and/or behavior while on the premises or by phone to any of IMS Orthopedics staff will not be tolerated at any time and **WILL RESULT IN DISCHARGE FROM THE PRACTICE IMMEDIATELY.**
- Should the patient need a copy of their medical records for personal use or continuity of care; please contact our office and allow 5-7 business days for processing. **(Release of information form will be required).**

I have read the IMS Orthopedics, office policy. I will have a copy only if I asked for one. I agree to follow this policy at all times.

Patient or Guardian Signature

_____/_____/_____
Date

Integrated Medical Services, Inc.

HIPAA NOTICE OF PRIVACY PRACTICES

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

Integrated Medical Services, Inc. (“IMS”) is committed to protecting the confidentiality of its patients’ health information. This Notice of Privacy Practices describes how we may use and disclose your health information and the rights that you have regarding your health information.

HOW WILL WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use or disclose your health information without your authorization for the following purposes:

Treatment: We will use and disclose your health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third-party. For example, we may disclose your health information, as necessary, to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your health information will be used or disclosed, as needed, to obtain payment for your health care services. For example, we may bill your health plan for the cost of the services we provide to you. We may also contact your health plan to determine whether it will authorize payment for services, to determine the amount of your co-payment or to obtain approval for a hospital admission.

Healthcare Operations: We may use or disclose your health information, as needed, in order to support the business activities of your physician’s practice. These activities include, but are not limited to, training and education, quality assessment activities, risk management, claims management, legal consultation, physician and employee review activities, licensing, regulatory surveys, and other business planning activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

Appointments and Health-Related Services: We may use your health information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you.

Family and Friends: We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. If you do not want us to disclose your medical information to family members or others involved in your care, please contact our Privacy Officer.

Business Associates: We enter into contracts with third-party entities known as business associates. These business associates provide services to or perform functions on our behalf, such as our accountants, consultants and attorneys. We may disclose your relevant health information to our business associates once they have agreed in writing to safeguard your medical information. Business associates are also required by law to protect the privacy of your health information.

Required by Law: We will disclose your health information when we are required to do so by federal, state or local law.

Public Health Activities: We may use your health information for public health activities such as reporting births, deaths, communicable diseases, injuries, or disabilities and ensuring the safety of drugs and medical devices.

Health Oversight Activities: We may disclose your health information to a health oversight agency for activities such as audits; civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law.

Food and Drug Administration (FDA): We may disclose your health information to a person or company subject to the FDA to report adverse events, product defects or problems or biologic product deviations; to track FDA-regulated products; to enable product recalls; to make repairs or replacements; to conduct post-marketing surveillance information or for other purposes related to the quality, safety or effectiveness of a product or activity regulated by the FDA.

Law Enforcement: We may disclose your health information to law enforcement in limited circumstances, such as to identify or locate suspects, fugitives, witnesses or victims of a crime, to report deaths from a crime, to report crime on our premises or in emergency treatmentsituations.

Judicial and Administrative Proceedings: We may disclose information about you in response to an order of a court or administrative tribunal as expressly authorized by such order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process not accompanied by an order of a court or administrative tribunal, under certain circumstances as permitted by law.

To Avert a Serious Threat to Health or Safety: We may use or disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. We may also disclose information about you if it is necessary for law enforcement authorities to identify or apprehend an individual.

Disaster Relief Efforts: We may use or disclose your health information to an authorized public or private entity to assist in disaster relief efforts. You may have the opportunity to object unless it would impede our ability to respond to emergency circumstances.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information consistent with applicable law to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

Organ and Tissue Donation: We may disclose health information consistent with applicable law to organizations that handle organ, eye or tissue donation or transplantation.

Fundraising: We may use certain information to contact you as part of our fundraising efforts. If you receive such a communication from us, you will be provided an opportunity to opt-out of receiving such communications in the future.

Workers' Compensation: We may disclose your health information as authorized to comply with workers' compensation laws and other similar programs established by law.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your health information as required by military command authorities or to the Department of Veterans Affairs. We may also disclose medical information to authorized federal officials for intelligence and national security purposes.

Correctional Institutions: If you are or become an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose to the institution or law enforcement official information necessary for the provision of health services to you, your health and safety, the health and safety of other individuals and law enforcement on the premises of the institution and the administration and maintenance of the safety, security and good order of the institution.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect or domestic violence.

Research: Under certain circumstances, we may also use and disclose information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information and balances the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process. However, we may disclose your PHI to people preparing to conduct a research project, so long as the PHI they review is not removed from us. We may also use or disclose your PHI to contact you (or, under certain circumstances, to allow a research entity with whom we contract to contact you) about the possibility of enrolling in a research study.

If you do not want to be contacted about the possibility of enrolling in a research study (as described above), please initial here: _____

Other Uses and Disclosures: If we wish to use or disclose your health information for a purpose not discussed in this Notice, we will seek your authorization. Specific examples of uses and disclosures of your health information requiring your authorization include: (i) most uses and disclosures of psychotherapy notes (private notes of a mental health professional kept separately from

a medical record); (ii) most uses and disclosures of your health information for marketing purposes; and (iii) disclosures of your health information that constitute the sale of your health information. You may revoke your authorization at any time in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

YOUR HEALTH INFORMATION RIGHTS

Although your health information is our property, you have the right to:

Request access to your health information. You may request to inspect and/or obtain a copy of your health information. If we maintain your health information electronically, you may obtain an electronic copy of the information or ask us to send it to a person or organization that you identify. If you request a copy (paper or electronic), we may charge you a reasonable, cost-based fee. Any request to access your health information must be in writing and submitted to our Privacy Officer.

Request a restriction on the use or disclosure of your health information. You may ask us not to use or disclose any part of your health information for a particular reason related to treatment, payment or health care operations. We will consider your request, but we are not legally obligated to agree to a requested restriction except for in the following situation: If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We are required to abide by such a request, except where we are required by law to make the disclosure. Any request for a restriction must be in writing and submitted to our Privacy Officer. We will notify you if we cannot accommodate your request.

Request to receive confidential communications. You have the right to receive confidential communications from us by alternative means or at an alternative location. Such a request must be made in writing and submitted to our Privacy Officer. We will notify you if we cannot accommodate your request.

Request an amendment to your medical information. If you believe that any information in your medical record is incorrect, or if you believe important information is missing, you may request that we correct the existing information or add the missing information. Such a request must be in writing and submitted to our Privacy Officer. We will notify you if we cannot accommodate your request.

Request an accounting of certain disclosures. You have the right to request a list of certain disclosures we have made of your health information. Any request for an accounting must be in writing and submitted to our Privacy Officer. The first list in any 12-month period will be provided to you for free, but you may be charged for any additional lists requested during the same 12-month period.

Receive a paper copy of this Notice. You have the right to receive a paper copy of this Notice upon request, even if you agreed to accept this Notice electronically.

OUR RESPONSIBILITIES

We are required to (i) maintain the privacy of your health information as required by law; (ii) provide you with notice of our legal duties and privacy practices with respect to your health information, and to abide by the terms of such notice; and (iii) notify you following a breach of your health information that is not secured in accordance with certain security standards.

We reserve the right to change the terms of this Notice and to make the provisions of the new Notice effective for all health information that we maintain. If we change the terms of this Notice, the revised Notice will be made available upon request and posted in our practice locations. Copies of the current Notice may be obtained by contacting our Privacy Officer.

QUESTIONS, CONCERNS OR COMPLAINTS

If you have any questions or want more information about this Notice or how to exercise your privacy rights, please contact our Privacy Officer at 1-888-787-9845 or by mail at 9250 N. 3rd Street, Suite 4010, Phoenix, Arizona 85020

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with us, you may contact our Privacy Officer. To file a complaint with HHS, you may contact the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F HHH Bldg., Washington DC 20201 (OCRComplaint@hhs.gov). **We will not retaliate against you for filing a complaint.**

Effective Date: September 23, 2013

Signature below is acknowledgment that you have read and understand this Notice.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

RELEASE OF INFORMATION

I _____ hereby authorize IMS to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: _____ Relationship: _____ Phone
Number _____

Name: _____ Relationship: _____ Phone
Number _____

Name: _____ Relationship: _____ Phone
Number _____

I authorize IMS to contact me at:

Home Phone _____ Work Phone _____

May we leave a message on machine? Yes No

Cell Phone _____ Alternate Phone _____

Patient Signature _____ **Date** _____

Witness: _____ Date _____

IMS Orthopedics
Expert orthopedic care in your neighborhood

PHONE: (623) 882-1292 FAX: (623) 882-8184

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____ to disclose the following information from the health record of:

PATIENT INFORMATION		/ _ / _
	Patient Name	Date of Birth
		()
	Address	Phone Number
	City State	Zip Code
Dates of Service: From _____ To_____		
INFORMATION REQUESTED	<input type="checkbox"/> All Pertinent Records <input type="checkbox"/> Operative Report <input type="checkbox"/> Assessment(s) <input type="checkbox"/> Pathology Report <input type="checkbox"/> Consultation <input type="checkbox"/> X-Ray Films <input type="checkbox"/> Discharge Summary <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> ER Report <input type="checkbox"/> Billing Record <input type="checkbox"/> History & Physical <input type="checkbox"/> Specify:	
PURPOSE	<input type="checkbox"/> Self <input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Attorney Request <input type="checkbox"/> Other (specify reason)	
INFORMATION TO BE GIVEN TO:	<div style="display: flex; justify-content: space-between;"> () () </div> <hr/> <div style="display: flex; justify-content: space-between;"> Company, Person, Facility Phone Number Fax Number </div> <hr/> <div style="display: flex; justify-content: space-between;"> Address City State Zip Code </div>	

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The general authorization for the release of medical and other information is not sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. IMS Orthopedics Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, it will expire 12 months from the date signed or as specified: _____:.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release IMS Orthopedics, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient

Date

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

Signature of Legal Represents Relation to Patient or Description of Authority to Act for Patient

Date



Living Will and Advance Directives I n f o r m a t i o n

Patient Name: _____ DOB: _____

In efforts to comply with insurance guidelines; please read and answer the questions below.

Living wills and other advance directives are written, legal instructions regarding your preferences for medical care if you are unable to make decisions for yourself. Advance directives guide choices for doctors and caregivers if you're terminally ill and/or seriously injured. By planning ahead, you can get the medical care you want.

I decline to provide and/ or receive any living will or advanced directive information:

Do you have a living will: Yes: _____ No: _____

If you answered yes; would you like to provide a copy to have in your patient file?

Yes _____ No: _____

If you answered no; would you like our office to provide you with information?

Yes: _____ No: _____

Do you have written Advanced Directives: Yes: _____ No: _____

If you answered yes; would you like to provide a copy to have in your patient file?

Yes _____ No: _____

If you answered no; would you like our office to provide you with information?

Yes: _____ No: _____

Patient or Parent/ Guardian Signature: _____ Date: _____

We appreciate you taking the time to complete this form.

IMS Orthopedics