

**VALLEY ORTHOPEDICS, P.L.C.**

\_\_\_\_ **LAWRENCE P. SHANK, M.D.** \_\_\_\_ **DOUGLAS B. MANGAN, M.D.**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

Please describe the reason for today's visit:

Current problem is the result of a(n): Check all that apply.

\_\_\_\_ Car Accident \_\_\_\_ Work Accident \_\_\_\_ Other Accident \_\_\_\_\_

Describe injury and/or symptoms: \_\_\_\_\_

Date of injury and/or symptoms: \_\_\_\_\_

Who referred you to our practice: \_\_\_\_\_

Check all the limitations below that apply to your injury and/or symptoms:

- |                         |                       |                       |                |
|-------------------------|-----------------------|-----------------------|----------------|
| ____ Prolong Walking    | ____ Prolong Sitting  | ____ Prolong Standing | ____ Stooping  |
| ____ Pushing/Pulling    | ____ Up/Down Steps    | ____ Lying Down       | ____ Grasping  |
| ____ Lifting            | ____ Bending          | ____ Flexion          | ____ Extension |
| ____ Any Weight Bearing | ____ Any Use Of _____ |                       |                |

LIST ALL CURRENT MEDICATIONS	DOSAGE	REASON FOR MEDICATION

**ALLERGIES: PLEASE LIST HERE ALL MEDICATIONS YOU ARE ALLERGIC TO AND THE REACTION YOU HAVE TO THAT MEDICATION.**

NAME OF MEDICATION	REACTION

**REVIEW OF SYSTEMS**

Are you currently having or have you had problems with any of the following:

	Circle		Describe all Yes responses
Heart Disease/Stroke	No	Yes	_____
Ears,Nose,Throat,Eyes	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Digestive Problems/Ulcers	No	Yes	_____
Emphysems/Asthma	No	Yes	_____
Bladder Problems	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Bleeding Problems	No	Yes	_____
Elevated Cholesterol	No	Yes	_____
Numbness/Tingling	No	Yes	_____
Fainting/Balance Problems	No	Yes	_____
Depression/Anxiety	No	Yes	_____
AIDS/TB/Hepatitis	No	Yes	_____

**VALLEY ORTHOPEDICS, P.L.C.**

\_\_\_\_ **LAWRENCE P. SHANK, M.D.** \_\_\_\_ **DOUGLAS B. MANGAN, M.D.**

**REVIEW OF SYSTEMS CONTINUED**

Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Polio	No	Yes	_____
Hiatal Hernia	No	Yes	_____
Epilepsy/Seizures	No	Yes	_____
Goiter/Thyroid Disease	No	Yes	_____
Other	No	Yes	_____

Have you had past medical treatment for this problem? \_\_\_\_ Yes \_\_\_\_ No If yes, please explain:\_\_\_\_\_

**PAST SURGICAL/HOSPITALIZATIONS HISTORY**

Please describe <b>ALL</b> Surgeries and/or Hospitalizations	Year	Complications

Have you ever had general anesthesia? \_\_\_\_ No \_\_\_\_ Yes

Have you had any problems with anesthesia? \_\_\_\_ No \_\_\_\_ Yes If so, please describe:\_\_\_\_\_

**FAMILY HISTORY**

Does any family member have a history of any of the following: (please check all that apply)

____ Heart Disease	____ Lung Disease
____ Cancer	____ Diabetes
____ Thyroid Disease	____ Hypertension
____ Asthma	____ Tuberculosis
____ Arthritis	____ Hay Fever/Seasonal Allergies
____ Parkinson's Disease	____ Bronchitis
____ Other _____	____ None of the above.

**SOCIAL HISTORY**

Employed	____ No	____ Yes	Employer Name:_____	X	____ Years
Disabled	____ No	____ Yes	Occupation_____		
Student	____ No	____ Yes	School:_____		Grade:_____

\_\_\_\_ Student \_\_\_\_ Daycare \_\_\_\_ Retired \_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Separated

History of substance abuse? \_\_\_\_ No \_\_\_\_ Yes If so, what?\_\_\_\_\_

Smoke Currently? \_\_\_\_ No \_\_\_\_ Yes \_\_\_\_ Packs per day for \_\_\_\_ years.

If you were a previous smoker, how long ago did you quit? \_\_\_\_ This year \_\_\_\_ >1yr \_\_\_\_ >5yrs \_\_\_\_ >10yrs.

Do you drink alcohol? If so, how often? \_\_\_\_ Daily \_\_\_\_ Occasionally \_\_\_\_ Socially \_\_\_\_ None.

Did you bring your X-Rays and/or MRI's? \_\_\_\_ No \_\_\_\_ Yes. If so, please document information below.

X-Rays/MRI's/Other: Date taken:\_\_\_\_\_ Place:\_\_\_\_\_ Area:\_\_\_\_\_

# PATIENT REGISTRATION FORM

PATIENT NAME: \_\_\_\_\_ RESPONSIBLE PARTY NAME: \_\_\_\_\_ BILLING  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

PERMANENT ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PT SOC SEC#: \_\_\_\_\_ RESP PARTY SOC SEC# \_\_\_\_\_  
SEX: MALE FEMALE

PT BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ RESP PARTY RELATIONSHIP TO PT: SELF SPOUSE CHILD OTHER  
(PLEASE CIRCLE OPTION)

E-MAIL ADDRESS: \_\_\_\_\_

WHO REFERRED YOU TO OUR PRACTICE?: \_\_\_\_\_

WHAT IS YOUR PRIMARY CARE PHYSICIANS FULL NAME?: \_\_\_\_\_

WHAT ARE YOU BEING SEEN FOR?: \_\_\_\_\_

IF YOUR VISIT IS INJURY RELATED, WAS IT: AN AUTO ACCIDENT OR JOB RELATED? DATE OF INJURY: \_\_\_\_\_  
(PLEASE CIRCLE OPTION)

IS PATIENT: SINGLE MARRIED WIDOWED DIVORCED OTHER IS PATIENT PREGNANT: YES NO  
(PLEASE CIRCLE OPTION)

IS PATIENT: EMPLOYED RETIRED F.T./P.T. STUDENT UNEMPLOYED SELF-EMPLOYED OTHER  
(PLEASE CIRCLE OPTION)

EMPLOYER NAME/ADDRESS/PHONE#: \_\_\_\_\_

NEAREST RELATIVE OR FRIEND NAME/PHONE#: \_\_\_\_\_  
(SOMEONE OTHER THAN YOUR SPOUSE)

## INSURANCE INFORMATION

PRIMARY INSURANCE: \_\_\_\_\_ SECONDARY INSURANCE: \_\_\_\_\_  
INSURANCE CO. NAME: \_\_\_\_\_ INSURANCE CO. NAME: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_ INSURANCE ADDRESS: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_ POLICY HOLDER NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

SUBSCRIBER ID#: \_\_\_\_\_ SUBSCRIBER ID#: \_\_\_\_\_

GROUP/CLAIM#: \_\_\_\_\_ GROUP/CLAIM#: \_\_\_\_\_

POLICYHOLDER SEX: F OR M BIRTHDATE: \_\_\_\_\_ POLICYHOLDER SEX: F OR M BIRTHDATE: \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE VALLEY ORTHOPEDICS, P.L.C. TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT WHICH COULD INCLUDE HIV, COMMUNICABLE DISEASE OR DRUG ABUSE INFORMATION.

**AUTHORIZATION TO PAY:** I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BUSINESS OFFICE OF WEST VALLEY ORTHOPEDICS, P.L.C. FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE.

PATIENT OR RESPONSIBLE PARTY SIGNATURE IF MINOR: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_

# VALLEY ORTHOPEDIC, P.L.C.

13555 W. McDowell Rd., Suite 302, Goodyear, AZ 85395  
9250 N. 3<sup>rd</sup> Street, Suite 2030, Phoenix, AZ 85020  
Phone: 623-882-1292 Fax: 623-932-1045

LAWRENCE SHANK, M.D.    GREGORY SIROUNIAN, M.D.    DOUGLAS MANGAN, M.D.  
GRANT PADLEY, D.O.    KRIS PARCHURI, D.O.  
MICHELLE KUHN, P.A.-C.    JULIE PERRY P.A.-C.

## OFFICE POLICY EFFECTIVE IMMEDIATELY

- 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.**
- Should a patient leave a message with our office, they can anticipate a return call with 24 hours.
- No pain medications or routine medications will be called in by the **ON CALL PROVIDER**. Patients will have to wait until the next working day to discuss with their provider.
- 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 may be asked to reschedule. If the patient must be seen secondary to an acute illness, he/she may have to wait to be seen by another provider after his/her case has been reviewed.
- Walk-in patients will be seen only with the provider's authorization.
- At no time, will medical information be shared with another individual/party unless explicitly specified by the patient. ( A consent form providing authorization to release medical information must be signed).
- **This office is not responsible for your insurance benefits.** Should a diagnostic test and/or procedure be recommended by your provider but is **NOT** covered by your insurance, you will be responsible for **ALL CHARGES**: This also includes charges related to "weight or obesity management".
- If the medical provider feels that you need further diagnostic work up (xrays, etc) or refers to a specialist, it is your responsibility to ensure that those test and/or office visits are completed.
- **AT NO TIME** will inappropriate language be tolerated while on the premises or by phone to any of West Valley Orthopedics staff.
- If a patient misses 3 visits within a year, West Valley Orthopedics reserves the right to discontinue the provider-patient relationship. A letter will be sent to the patient to notify of such.

I \_\_\_\_\_ have read Valley 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

\_\_\_\_\_  
Printed Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Printed Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

# VALLEY ORTHOPEDIC, P.L.C.

13555 W. McDowell Rd #302, Goodyear, AZ 85395  
9250 N. 3rd Street, Suite 2030, Phoenix, AZ 85020  
Phone: 623-882-1292 Fax: 623-932-1045

LAWRENCE SHANK, M.D.    GREGORY SIROUNIAN, M.D.    DOUGLAS MANGAN, M.D.  
GRANT PADLEY, D.O.    KRIS PARCHURI, D.O.  
MICHELLE KUHN, P.A.-C.    JULIE PERRY P.A.-C.

## POLITCA DE LA OFICINA EFECTIVO INMEDIATAMENTE

- Ningún paciente bajo la edad de 18 años será atendido sin autorización escrita del padre/guardian legal.
- En caso de imprevisto si usted no puede asistir a su cita con su doctor(a), necesitamos recibir una llamada para notificarnos 24 horas antes de su cita, de lo contrario tendrá un cargo administrativo de \$25.00.
- Nosotros no mandamos cobros por su co-pago. El pago se espera el mismo día de servicio.
- Si un paciente deja un mensaje para nuestra oficina, pueden esperar una llamada dentro de 24 horas.
- El doctor(a) de guardia después de horas de servicio no podrá hablar para surtir medicinas para el dolor. Pacientes tendrán que esperar para el próximo día de servicio de su doctor(a).
- El doctor(a) de guardia no surtirá rellenos en sus medicamentos rutinarios. Pacientes tendrán que esperar para el próximo día de servicios.
- Todos los pacientes son responsables de hacer sus citas y llegar a tiempo.
- Cualquier paciente que llegue 15 minutos tarde se le pedirá que re-programe su cita. Si el paciente necesita atención médica debido a una enfermedad aguda, tendrá que esperar para ser atendido por otro doctor(a) después de revisar su caso.
- Pacientes sin cita solo serán atendidos si obtienen autorización por el doctor(a).
- En ningún momento su historial médico será compartido con ningún grupo/individuo al menos que sea especificado explícitamente por el paciente. (La forma de consentimiento autorizando a cierta persona tendrá que ser firmada)
- Esta oficina no es responsable de sus beneficios de seguridad, usted será responsable de cubrir todos los cargos. Esto incluye "el manejo de peso/obesidad".
- En ningún momento lenguaje inapropiado será tolerado en la oficina o por teléfono a cualquier empleado de West Valley Orthopedics. Tal comportamiento causará la terminación de su relación con su doctor(a).
- Si el proveedor médico siente que usted necesita estudios adicionales, o lo refiere a otro especialista usted es responsable de asegurar que esos estudios o citas de oficina son completadas.
- Si un paciente falta a 3 visitas consecutivas, West Valley Orthopedics reserva el derecho de discontinuar la relación entre doctor(a) y paciente. Una carta será enviada al paciente para notificar de tal procedimiento.

Yo \_\_\_\_\_ he leído la póliza de Valley Orthopedics. Yo obtendré una copia solo si lo solicito. Yo acepto seguir esta plaza en todo momento.

\_\_\_\_\_  
Paciente o Guardian Firma

\_\_\_\_\_  
Deletrea

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Testigo

\_\_\_\_\_  
Deletrea

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Fecha

# VALLEY ORTHOPEDICS

## PATIENT COMMUNICATION SHEET

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

The following instructions pertain to the above named patient:

\_\_\_\_\_ OK to call home and leave message.

\_\_\_\_\_ Do not leave message.

\_\_\_\_\_ Do not call home phone- call only this number.  
(\_\_\_\_\_) \_\_\_\_-\_\_\_\_

\_\_\_\_\_ Do not call work number.

\_\_\_\_\_ Call work number only.

\_\_\_\_\_ Permission to speak only with family members listed below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Do not speak to family members.

Patient or responsible party signature: \_\_\_\_\_

**VALLEY ORTHOPEDICS, P.L.C.**  
**FINANCIAL POLICY FORM**

**Valley Orthopedics, P.L.C., the office of Lawrence P. Shank, M.D., P.C., Gregory H. Sirounian, M.D., P.C., Douglas B. Mangan, M.D., P.C., Grant D. Padley, D.O., Kris Parchuri, D.O. expects payment of your care at the time of service. However, with all verifiable insurance information you will only be expected to pay the deductible, co-payment, co-insurance, or those services not covered or allowed by your insurance.**

It is our policy to bill your insurance carrier as a courtesy to you, although you are ultimately responsible for the entire charge when services are rendered. If your insurance carrier does not remit payment within 45 days from the date of service, the balance will be due in full from you. Since we may not be a party to the agreement with you insurance carrier, it is not our policy to contact carriers to establish why they have not paid or why they paid less then originally indicated. Furthermore, your insurance company may have developed a reasonable and customary fee schedule for medical services. These schedules are internal to your insurance company and they may or may not cover all charges incurred during your treatment. These fee schedules often do not reflect standard charges in our geographic area. Please be advised that you are responsible for the total charges or any difference remaining following the payment by your insurance company. Exceptions, if your insurance company is one that **VALLEY ORTHOPEDICS, P.L.C.** participates or holds a contract with, you are only responsible for any patient portion or non-covered service as determined by your insurance carrier.

The above statements do not apply to those patients who are considered **Worker's Compensation**. However, please be advised that as an Industrial Patient, that you may be held responsible for your charges in the event your claim is controverted.

If you fail to make any payments for which you are deemed responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by **VALLEY ORTHOPEDICS, P.L.C.** you will be responsible for all costs of collecting moneys owed, including but not limited to court costs, collection agency and/or attorney fees.

Your signature below indicates that you have read the above information and authorize direct payment from your insurance carrier to **VALLEY ORTHOPEDICS, P.L.C.** and that you understand the financial policy of **VALLEY ORTHOPEDICS, P.L.C.** as it relates to your account.

---

**Patient or Responsible Party**

---

**Date Signed**

**Authorization for release of medical information to the insurance carrier and assignment of benefits to the physician.**

I hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to **VALLEY ORTHOPEDICS, P.L.C.** I understand that I am financially responsible for any balance not covered by my insurance carriers. A copy of this signature is as valid as the original.

**Signature of patient or legal guardian of patient** \_\_\_\_\_

**13555 W. MCDOWELL RD., Suite 302, GOODYEAR, AZ 85395**  
**9250 N. 3<sup>rd</sup> Street, Suite 2030, Phoenix, AZ 85020**  
**PHONE: (623) 882-1292 FAX: (623) 882-8184**