

PLEASE LIST THE MEDICATIONS OR TREATMENTS HAVE YOU TRIED FOR THIS INJURY/SYMPATOM

_____	REDUCE SYMPTOMS YES / NO
_____	REDUCE SYMPTOMS YES / NO
_____	REDUCE SYMPTOMS YES / NO
_____	REDUCE SYMPTOMS YES / NO

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOUR HEALTH HISTORY & PLEASE EXPLAIN YES RESPONSES

HEART DISEASE/STROKE (HEART ATTACK/ARRHYTHMIA/MURMUR HIGH BLOOD PRESSURE /CHOLESTEROL)	NO	YES	_____
RESPIRATORY (ASTHMA/EMPHEZYMA/COPD/TB)	NO	YES	_____
ENDOCRINE (DIABETES/THYROID DISEASE/ GOITER)	NO	YES	_____
GASTROINTESTINAL (ULCER/REFLUX/HEPATITIS)	NO	YES	_____
NEURO/PSYCHOLOGICAL (DEPRESSION/ANXIETY/SEIZURE)	NO	YES	_____
MUSCULOSKELETAL (RHUMATOID ARTHRITIS/GOUT)	NO	YES	_____
GENITOURINARY (BLADDER PROBLEMS/ENLARGED PROSTATE/HERNIA)	NO	YES	_____
CANCER/ILLNESS (CANCER/AIDS/BLEEDING DISORDER)	NO	YES	_____

PLEASE DESCRIBE ALL SURGERIES & APPROXIMATE YEAR THEY OCCURED

_____	_____
_____	_____
_____	_____

PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO & THE REACTION THAT OCCURS

_____	_____
_____	_____

PLEASE LIST ALL CURRENT MEDICATIONS

_____	_____
_____	_____
_____	_____

DOES ANY FAMILY MEMBER HAVE A HISTORY OF ANY OF THE FOLLOWING
PLEASE CHECK ALL THAT APPLY

<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> LUNG DISEASE
<input type="checkbox"/> CANCER	<input type="checkbox"/> THYROID DISEASE
<input type="checkbox"/> DIABETES	<input type="checkbox"/> TURBERCULOSIS
<input type="checkbox"/> HEPATITIS	
<input type="checkbox"/> OTHER _____	
<input type="checkbox"/> NONE OF THE ABOVE	

**PLEASE ANSWER AND CIRCLE REGARDING YOURSELF:
EMPLOYED / RETIRED / DISABLED / STUDENT**

IF EMPLOYED:

NAME OF EMPLOYER: _____

OCCUPATION: _____

IF STUDENT:

NAME OF SCHOOL: _____

GRADE: _____

DO YOU DRINK ALCOHOL? HOW OFTEN?

___ NONE ___ DAILY ___ OCCASIONALLY

DO YOU CURRENTLY USE TOBACCO? SMOKE / CHEW / NONE

I SMOKE ___ PACKS PER DAY FOR THE PAST ___ YEARS

I QUIT SMOKING ___ YEARS AGO BUT PRIOR TO THAT I SMOKED ___ PACKS PER DAY FOR ___ YEARS

HISTORY OF SUBSTANCE ABUSE? YES / NO IF YES PLEASE DESCRIBE

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS THAT APPLY TO YOU:

GENERAL: WEIGHT GAIN/LOSS / LOSS OF APPETITE / FEVER / CHILLS / NIGHT SWEATS

SKIN: RASHES / EASY BRUSING

HEAD: HEADACHES / MIGRAINE / DIZZINESS / FAINTING

EYES, EARS, NOSE: VISUAL CHANGES / NOSE BLEEDING / RINGING IN EARS

MOUTH & THROAT: HOARSENESS / THROAT PAIN / LUMPS

RESPIRATORY: PERSISTANT COUGH / SHORTNESS OF BREATH / WHEEZE

CARDIOVASCULAR: CHEST PAIN / SHORTNESS OF BREATH ON EXERTION / PALPITATIONS

GASTROINTESTINAL: CONSTIPATION / DIARRHEA / INDIGESTION / BLOOD IN STOOL

GENITOURINARY: URINARY FREQUENCY / PAINFUL URINATION / URGENCY OR HESITANCY / BLOOD
IN URINE / INCONTINENCE

ENDOCRINE: EXCESSIVE THRIST / EXCESSIVE URINATION / EXCESSIVE HUNGER / COLDOR HEAT
INTOLERANCE

MUSCULOSKELETAL: MUSCLE PAIN / JOINT PAIN / JOINT SWELLING

NEUROPSYCHIATRIC: WEAKNESS / MEMORY CHANGES / SLEEP DISTURBANCE

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 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. 3rd Street, Suite 2030, Phoenix, AZ 85020
PHONE: (623) 882-1292 FAX: (623) 882-8184

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 ORTHOPEDIC, P.L.C.

13555 W. McDowell Rd., Suite 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.

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.

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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