

**INITIAL EVALUATION**

**MICHAEL S WENG, MD**

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

AGE \_\_\_\_\_ SEX \_\_\_ M \_\_\_ F      MARITAL STATUS: \_\_\_ S \_\_\_ M \_\_\_ W \_\_\_ D

PRIMARY CARE PHYSICIAN (PCP) \_\_\_\_\_

WHO REFERRED YOU? \_\_\_ PCP      \_\_\_ INSURANCE      \_\_\_ FRIEND/PATIENT

\_\_\_ ER/URGENT CARE/FRIEND/PATIENT WHICH ONE/WHO? \_\_\_\_\_

**YOUR ORTHOPEDIC PROBLEM:**

BODY PART BEING TREATED: \_\_\_ RIGHT \_\_\_ LEFT \_\_\_\_\_

DATE OF INJURY/ONSET: \_\_\_\_\_      \_\_\_ NO DATE OF INJURY/ONSET

HOW LONG HAS THIS BOTHERED YOU? \_\_\_\_\_

HOW OCCURRED: \_\_\_\_\_

\_\_\_\_\_

WHERE OCCURRED: \_\_\_\_\_

**PLEASE CHECK ONLY SIGNIFICANT PROBLEMS**

**PAIN PROBLEMS:**

- NONE
- ACHING
- NUMBNESS
- BURNING
- AT NIGHT
- DURING ACTIVITY
- AFTER ACTIVITY

- ELECTRICAL
- SHARP
- PERIODIC
- SHOOTING
- SPASMODIC
- THROBBING
- TINGLING

**OTHER PROBLEMS:**

- POPPING
- STIFFNESS
- SWELLING
- WEAKNESS
- LIMITED RANGE OF MOTION
- OVERHEAD ACTIVITIES
- GIVING WAY
- GRINDING
- TENDERNESS
- INSTABILITY

OTHER \_\_\_\_\_

ANYTHING MAKE IT BETTER? \_\_\_\_\_

ANYTHING MAKE IT WORSE? \_\_\_\_\_

WERE YOU TREATED WITH MEDICINES? \_\_\_ No \_\_\_ YES WHICH ONE(S)? \_\_\_\_\_

WERE YOU TREATED WITH PHYSICAL THERAPY? \_\_\_ No \_\_\_ YES WHERE? \_\_\_\_\_

WERE YOU TREATED WITH SURGERY? \_\_\_ No \_\_\_ YES WHAT WAS DONE? \_\_\_\_\_

WERE YOU TREATED ANY OTHER WAY (INJECTIONS/CHIROPRACTOR/? \_\_\_ No \_\_\_ YES

DID YOU HAVE X-RAYS TAKEN? \_\_\_ No \_\_\_ YES WHEN /WHERE \_\_\_\_\_

DID YOU HAVE MRI DONE? \_\_\_ No \_\_\_ YES WHEN /WHERE \_\_\_\_\_

**INITIAL EVALUATION**

**MICHAEL S WENG, MD**

**YOUR MEDICAL HISTORY (CHECK ONLY THAT APPLY):**

- HIGH BLOOD PRESSURE                       CHOLESTEROL
- LUNG                       EMBOLUS     COPD         EMPHYSEMA             PNEUMONIA
- HEART                       HEART ATTACK         CONGESTIVE HEART DISEASE             CAD
- GASTROINTESTINAL     ULCERS         GERD             DIVERTICULITIS
- ENDOCRINE                       DIABETES         THYROID DISEASE
- BLOOD VESSELS                       BLOOD CLOTS/DVT     PERIPHERAL VASCULAR DISEASE
- NERVOUS SYSTEM                       STROKES/TIA             SEIZURES     EPILEPSY/SEIZURES     MIGRAINES
- KIDNEY/URINARY                       INCONTINENCE         UTI             PROSTATE(MEN)
- FEMALES                       OVARIAN CYSTS         PELVIC INFECTIONS
- GI PROBLEMS                       CIRRHOSIS             PANCREATITIS             COLITIS
- ORTHOPEDIC                       OSTEOPOROSIS         OSTEO ARTHRITIS
- RHEUMATIC                       RHEUMATOID ARTHRITIS                       GOUT             FIBROMYALGIA
- INFECTIOUS                       HEPATITIS             HIV/AIDS             TB
- PSYCHOLOGICAL                       DEPRESSION             DEMENTIA             BIPOLAR
- CANCER                       KIND? \_\_\_\_\_

OTHER CONDITIONS:

\_\_\_\_\_

SURGERIES:  NONE  OTHER ORTHOPEDIC \_\_\_\_\_

ANGIOPLASTY  APENDECTOMY  BSO  C SECTION  CABG  GALLBLADDER

COSMETIC  HERNIA  HYSTERECTOMY  EAR TUBES  SINUS  T & A  TUBAL  TURP

OTHER \_\_\_\_\_

HOSPITALIZATIONS:  NONE  AFTER SURGERIES LISTED ABOVE  CHILDBIRTH

OTHER DESCRIBE: \_\_\_\_\_

**YOUR MEDICINES:**

PRESCRIPTION MEDICATIONS:  NONE PLEASE LIST: \_\_\_\_\_

\_\_\_\_\_

IF YOU ARE TAKING ANY HERBALS OR OVER-THE-COUNTER DRUGS:  NONE PLEASE LIST \_\_\_\_\_

\_\_\_\_\_

DRUG ALLERGIES:  NONE IF ALLERGIC, WHAT MEDICINES AND WHAT HAPPENS:

\_\_\_\_\_

PHARMACY NAME & ADDRESS \_\_\_\_\_

**INITIAL EVALUATION**  
**SOCIAL HISTORY**

**MICHAEL S WENG, MD**

OCCUPATION/FORMER OCCUPATION: \_\_\_\_\_

RETIRED \_\_\_ ON DISABILITY REASONS? \_\_\_\_\_

DO YOU SMOKE: \_\_\_ NO \_\_\_ YES HOW MUCH? \_\_\_ PACKS PER DAY FOR \_\_\_ YEARS

ALCOHOL USAGE: \_\_\_ NONE \_\_\_ SOCIAL \_\_\_ DAILY

HOW MUCH? \_\_\_ DRINKS/BEERS PER \_\_\_ WEEK \_\_\_ MO

STREET DRUGS WITHIN PAST TWO YEARS? \_\_\_ No \_\_\_ YES TYPE \_\_\_\_\_

HAND DOMINANT \_\_\_ RIGHT \_\_\_ LEFT

DO YOU EXERCISE REGULARLY? \_\_\_ No \_\_\_ YES IF SO HOW MUCH? \_\_\_\_\_

**FAMILY MEDICAL HISTORY CHECK ONLY THAT APPLY):**

\_\_\_ HIGH BLOOD PRESSURE

\_\_\_ CHOLESTEROL

LUNG \_\_\_ EMBOLUS \_\_\_ COPD \_\_\_ EMPHYSEMA \_\_\_ PNEUMONIA

HEART \_\_\_ HEART ATTACK \_\_\_ CONGESTIVE HEART DISEASE \_\_\_ CAD

GASTROINTESTINAL \_\_\_ ULCERS \_\_\_ GERD \_\_\_ DIVERTICULITIS

ENDOCRINE \_\_\_ DIABETES \_\_\_ THYROID DISEASE

BLOOD VESSELS \_\_\_ BLOOD CLOTS/DVT \_\_\_ PERIPHERAL VASCULAR DISEASE

NERVOUS SYSTEM \_\_\_ STROKES/TIA \_\_\_ SEIZURES \_\_\_ EPILEPSY/SEIZURES \_\_\_ MIGRAINES

KIDNEY/URINARY \_\_\_ INCONTINENCE \_\_\_ UTI \_\_\_ PROSTATE(MEN)

FEMALES \_\_\_ OVARIAN CYSTS \_\_\_ PELVIC INFECTIONS

GI PROBLEMS \_\_\_ CIRRHOSIS \_\_\_ PANCREATITIS \_\_\_ COLITIS

ORTHOPEDIC \_\_\_ OSTEOPOROSIS \_\_\_ OSTEO ARTHRITIS

RHEUMATIC \_\_\_ RHEUMATOID ARTHRITIS \_\_\_ GOUT \_\_\_ FIBROMYALGIA

INFECTIOUS \_\_\_ HEPATITIS \_\_\_ HIV/AIDS \_\_\_ TB

PSYCHOLOGICAL \_\_\_ DEPRESSION \_\_\_ DEMENTIA \_\_\_ BIPOLAR

CANCER \_\_\_ KIND? \_\_\_\_\_

OTHER CONDITIONS: \_\_\_\_\_

**BECAUSE OF YOUR BONE/JOINT PROBLEM, (DO YOU CHECK ONLY THAT APPLY):**

GENERAL \_\_\_ FEVER/CHILLS \_\_\_ WEIGHT LOSS \_\_\_ APPETITE CHANGES

ENT/MOUTH \_\_\_ NOSE BLEEDS

LUNGS \_\_\_ COUGH \_\_\_ PHLEGM \_\_\_ WHEEZES \_\_\_ SHORTNESS OF BREATH

CARDIOVASCULAR \_\_\_ CHEST PAIN

GASTRO INTESTINAL \_\_\_ VOMITING \_\_\_ ABDOMINAL PAIN \_\_\_ DIARRHEA/CONSTIPATION

**BECAUSE OF YOUR BONE/JOINT PROBLEM(CONT.)**

- SKIN                     RASHES     NON HEALING AREAS
- NERVOUS SYSTEM     HEADACHE  VISION CHANGES
- ENDOCRINE             HAIR LOSS  HEAT/COLD INTOLERANCE
- KIDNEY/URINE         CHANGES IN URINATION  PAIN WITH URINATION
- PSYCHOLOGIC          MOOD CHANGES  AGITATION  DEMENTIA
- HEMATOLOGICAL       EASY BRUISING/BRUISING

WOMEN ONLY: ARE YOU, OR COULD YOU BE PREGNANT?                     No

**YES    PLEASE LET THE MEDICAL ASSISTANT AND/OR RADIOLOGY TECH  
KNOW IF YOU ARE.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

**YOUR ORTHOPEDIC PROBLEM:**

BODY PART BEING TREATED:  RIGHT  LEFT \_\_\_\_\_

DATE OF INJURY/ONSET: \_\_\_\_\_  NO DATE OF INJURY/ONSET

HOW LONG HAS THIS BOTHERED YOU? \_\_\_\_\_

HOW OCCURRED: \_\_\_\_\_

\_\_\_\_\_

WHERE OCCURRED: \_\_\_\_\_

**PLEASE CHECK ONLY SIGNIFICANT PROBLEMS**

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- GRINDING
- TENDERNESS
- INSTABILITY
- LIMITED RANGE OF MOTION

OTHER \_\_\_\_\_

ANYTHING MAKE IT BETTER? \_\_\_\_\_

ANYTHING MAKE IT WORSE? \_\_\_\_\_

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WERE YOU TREATED WITH PHYSICAL THERAPY?  No  Yes WHERE? \_\_\_\_\_

WERE YOU TREATED WITH SURGERY?  No  Yes WHAT WAS DONE? \_\_\_\_\_

WERE YOU TREATED ANY OTHER WAY (INJECTIONS/CHIROPRACTOR/?  No  Yes

DID YOU HAVE X-RAYS TAKEN?  No  Yes WHEN /WHERE \_\_\_\_\_

DID YOU HAVE MRI DONE?  No  Yes WHEN /WHERE \_\_\_\_\_

ANY CHANGES IN YOUR MEDICAL CONDITION?  No

IF YES , DESCRIBE: \_\_\_\_\_

ANY ADDITIONAL SURGERIES SINCE YOUR INITIAL EVALUATION:  No

IF YES , DESCRIBE: \_\_\_\_\_

**NEW PROBLEM EVALUATION**

**MICHAEL S WENG, MD**

ANY CHANGES TO YOUR PRESCRIPTION MEDICATIONS?:  NONE

IF YES , DESCRIBE: \_\_\_\_\_

ANY HERBALS OR OVER-THE-COUNTER DRUGSCHANGES?  NO

IF YES , DESCRIBE: \_\_\_\_\_

ANY DRUG ALLERGIES CHANGES?  NO

IF YES , DESCRIBE: \_\_\_\_\_

ANY CHANGES IN YOUR SOCIAL HISTORY (OCCUPATION/SMOKE/ALCOHAL/STREET DRUGS/EXERCISE)?

IF YES , DESCRIBE: \_\_\_\_\_

**BECAUSE OF YOUR BONE/JOINT PROBLEM, (DO YOU CHECK ONLY THAT APPLY):**

- GENERAL  FEVER/CHILLS  WEIGHT LOSS  APPETITE CHANGES
- ENT/MOUTH  NOSE BLEEDS
- LUNGS  COUGH  PHLEGM  WHEEZES  SHORTNESS OF BREATH
- CARDIOVASCULAR  CHEST PAIN
- GASTRO INTESTINAL  VOMITING  ABDOMINAL PAIN  DIARRHEA/CONSTIPATION
- SKIN  RASHES  NON HEALING AREAS
- NERVOUS SYSTEM  HEADACHE  VISION CHANGES
- ENDOCRINE  HAIR LOSS  HEAT/COLD INTOLERANCE
- KIDNEY/URINE  CHANGES IN URINATION  PAIN WITH URINATION
- PSYCHOLOGIC  MOOD CHANGES  AGITATION  DEMENTIA
- HEMATOLOGICAL  EASY BRUISING/BRUISING

WOMEN ONLY: ARE YOU, OR COULD YOU BE PREGNANT?  NO

**YES PLEASE LET THE MEDICAL ASSISTANT AND/OR RADIOLOGY TECH KNOW IF YOU ARE.**

SIGNATURE \_\_\_\_\_

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

ANY CHANGES IN YOUR MEDICAL CONDITION?  NO

IF YES , DESCRIBE: \_\_\_\_\_

ANY ADDITIONAL SURGERIES SINCE YOUR INITIAL EVALUATION?:  NO

IF YES , DESCRIBE: \_\_\_\_\_

ANY CHANGES TO YOUR PRESCRIPTION MEDICATIONS?:  NO

NEW MEDICINES: \_\_\_\_\_

DELETED MEDICINES: \_\_\_\_\_

ANY HERBALS OR OVER-THE-COUNTER (OTC) DRUGS CHANGES?  NO

NEW HERBALS OR OVER-THE-COUNTER (OTC) DRUGS: \_\_\_\_\_

DELETED HERBALS OR OVER-THE-COUNTER (OTC) DRUGS: \_\_\_\_\_

ANY DRUG ALLERGIES CHANGES?  NO

IF YES , DESCRIBE: \_\_\_\_\_

ANY CHANGES IN YOUR SOCIAL HISTORY (OCCUPATION/SMOKE/ALCOHAL/STREET DRUGS/EXERCISE)?

NO

IF YES , DESCRIBE: \_\_\_\_\_

WOMEN ONLY: ARE YOU, OR COULD YOU BE PREGNANT?  NO

**YES PLEASE LET THE MEDICAL ASSISTANT AND/OR RADIOLOGY TECH KNOW IF YOU ARE.**

SIGNATURE \_\_\_\_\_

# 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

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## POLITCA DE LA OFICINA EFECTIVO INMEDIATAMENTE

- Ningún paciente bajo la edad de 18 años sera 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 tendra un cargo administrativo de \$25.00.
- Nosotros no mandamos cobros por su co-pago. El pago se espera el mismo dia 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 podra hablar para surtir medicinas para el dolor. Pacientestendran que esperar para el proximo dia de servicio de su doctor(a).
- El doctor(a) de guardia no surtira rellenos en sus medicamentos rutinarios. Pacientes tendran que esperar para el proximo dia de servicios.
- Todos los pacientes son responsables de hacer su citas y llegar a tiempo.
- Cualquier paciente que llegue 15 minutos tarde se le pedira que re-programe su cita. Si el paciente necesita atención medica debido a una enfermedad aguda, tendra que esperar para ser atendido por otro doctor(a) después de revisar su caso.
- Pacientes sin cita solo seran atendidos si obtienen autorización por el doctor(a).
- En ningun momento su historial medico sera compartido con ningun grupo/individuo al menos que sea especificado explícitamente por el paciente. (La forma de consetimeiento autorizando a cierta persona tendra que ser firmada)
- Esta oficina no es responsable or sus beneficios de aseguranza, ustedsera responsable de cubrir todos los cargos. Esto incluye “el manejo de peso/obesidad”.
- En ningun momento lenguaje inapropiado sera tolerado en la oficina o por tlefono a cualquier empleado de West Valley Orthopedics. Tal comptamiento causara la terminacion de su relacion con su doctor(a).
- Si el proveedor medico 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 decontinuar la relacion entre doctor(a) y paciente. Una carta sera enviada al paciente para notificar de tal procedimiento.

Yo \_\_\_\_\_ he leído la poliza de Valley Orthopedics. Yo obtendre 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.

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**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**  
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