



Richard A. Wathne, MD., F.A.C.S., A.B.O.S.
Benjamin Blair, M.D., A.B.O.S.
S. Jeffrey Bray, D.P.M., F.A.C.F.A.S.

Eighteenth Avenue Medical Plaza
333 North 18th Avenue, Suite D-1
Pocatello, Idaho 83201
(208) 233-2100
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pocatelloortho.com
www.wathneortho.com

Welcome to Pocatello Orthopaedics & Sports Medicine Institute; Richard A. Wathne, M.D., Benjamin Blair, M.D., and S. Jeffrey Bray, D.P.M. Our staff looks forward to assisting you and making your visit with our organization a pleasant one.

In an effort to prevent passing increased operational costs to our patients, we request a minimum payment of \$50.00 upon your initial visit. We accept cash, check or credit card. We require that 20% of your bill for future visits be paid at the time of service, if you are covered by insurance. If you do not have insurance coverage, we request a minimum payment of \$200.00 upon your initial visit. In addition, you will be asked to make arrangements to pay for future visits at the time of service. Monthly payments are required to keep an account current, regardless of insurance coverage.

All accounts 90 days past due will be assessed a **FINANCE CHARGE** of **1.5%** per month.

We request that any patient covered by a Federally Funded Program, or referral healthcare insurance (i.e., Health & Welfare, Healthy Connections, Indian Health or Idaho Preferred Healthcare) bring a referral form for their services. Without a completed referral form, we may have to reschedule your appointment. If you have questions, please ask for assistance.

If you are being seen due to a Workers Compensation injury, please be sure to inform us of the details of your accident, name of your employer, their Workers Compensation carrier name, and your claim number.

As a courtesy to our patients, we will bill primary and secondary insurance carriers. Our physicians are preferred providers of Regence Blue Shield of Idaho and Blue Cross of Idaho plans. If your plan prefers that the policy holder seeks treatment from a Preferred Provider, please refer to your policy manual for listings of preferred providers in your area. If you are not sure of your physician's preferred provider status, please ask to speak with our billing department. They will be happy to assist you.

Our fees are determined in part by historic "usual, customary and reasonable" methods. We use a regional consulting firm which helps us determine fees, which are considered both fair and representative for our area.

Please feel free to discuss any questions or concerns you may have with the office staff. We will be happy to assist you and if necessary, direct you to Melanie in Accounts Receivable for assistance in payment arrangements. Thank you for choosing Pocatello Orthopaedics & Sports Medicine Institute.

Signed and Acknowledged

Date

Pocatello Orthopaedics & Sports Medicine Institute
333 North 18th Avenue, Suite D-1
Pocatello, Idaho 83201

RICHARD A. WATHNE, M.D.
BRAY, D.P.M.

BENJAMIN BLAIR, M.D.

S. JEFFREY

PATIENT'S LEGAL NAME: _____ DATE: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PHONE: _____ AGE: _____ DATE OF BIRTH: _____ SEX: _____

SOCIAL SECURITY #: _____ MARRIED: _____ SINGLE: _____ DIVORCED: _____
WIDOWED: _____

OCCUPATION: _____ EMPLOYER: _____

BUSINESS PHONE: _____ EMPLOYER'S ADDRESS: _____

SPOUSE/NEAREST RELATIVE: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ PH # _____

OCCUPATION: _____ EMPLOYER: _____

PLEASE COMPLETE THE FOLLOWING IF PATIENT IS A MINOR:

RESPONSIBLE PARTY: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER'S TELEPHONE #: _____ SSN: _____

PRIMARY INSURANCE CO. _____ **ID#** _____

Group # _____ **Policyholder Name** _____ **Policyholder DOB** ___/___/___

If Medicaid Healthy Connections, Name of Primary Care Physician _____

SECONDARY INSURANCE CO. _____ **ID#** _____

Group # _____ **Policyholder Name** _____ **Policyholder DOB** ___/___/___

If Medicaid Healthy Connections, Name of Primary Care Physician _____

ALLERGIES: _____

MEDICATIONS PATIENT NOW TAKING: _____

PREVIOUS SURGERY: _____

PRESENT PROBLEM: _____

REFERRED BY: _____

OTHER MEDICAL PROBLEMS (I.E. DIABETES, HIGH BLOOD PRESSURE, HEART ATTACKS, BLEEDING TENDENCY,
CLOTS IN LEG...) _____

YES NO

COMMENTS

- Muscle weakness _____
- Loss of bladder/bowel control _____
- Fevers _____
- Chills _____
- Weight loss greater than 10 lbs in one month _____
- History of cancer _____
- Night pain _____
- Rash _____
- Joint Pain _____
- Abdominal pain _____
- Morning stiffness _____
- History of rheumatic disease _____
- History of bleeding disorder _____
- Family history of bleeding disorder _____
- History of anesthetic complications _____
- Family history of anesthetic complications _____
- History of iritis or conjunctivitis (eye infections) _____
- Diabetes _____
- Headaches _____
- Dizziness _____
- Tremors _____
- Depression _____
- Change in hearing _____
- Cough _____
- Chest pain _____
- Swollen ankles _____
- Trouble swallowing _____
- Urinary stones _____

NAME _____

DATE _____

Pocatello Orthopaedics & Sports Medicine Institute
Orthopaedic Surgery
333 North 18th Avenue, Suite D-1
Pocatello, Idaho 83201

Date of injury: _____

Place of accident: _____

Describe briefly how the accident occurred and what caused the accident.

Was the injury or illness sustained while performing work required by your employment? _____

If so, are you covered by Worker's Compensation _____

Name of Worker's Compensation Carrier _____

If accident was not work related, to what insurance carrier do you want charges submitted? _____

Address of insurance carrier and insurance contact person: _____

Policy holder and policy number: _____

Did the injury result from an automobile accident? _____

a. Give names and addresses of drivers involved.

Name: _____

Address: _____

Name: _____

Address: _____

b. Are you covered for medical expenses through any automobile insurance policy

Give name of automobile insurance company and local agent.

Have they been notified of this accident? _____

c. Do any other persons responsible for this accident have liability insurance coverage? _____

Name of insurance company and local agent: _____

Are you claiming damages from them? _____

To the best of your knowledge, who was responsible for the accident? (Please give name and address) _____

Signature: _____ Date: _____

Home Phone: _____ Business Phone: _____

RICHARD A. WATHNE, M.D.

BENJAMIN BLAIR, M.D.

S. JEFFREY BRAY, D.P.M.

I hereby authorize Pocatello Orthopaedics & Sports Medicine Institute, P.A., and/or staff to provide any or all information to my insurance carriers in connection with my history, diagnosis, and treatment of any condition, illness, or injury with respect to the medical care provided by the above named physicians. I hereby authorize Pocatello Orthopaedics to provide information to other healthcare providers as it relates to continuity of care.

Signature

I hereby assign to Pocatello Orthopaedics & Sports Medicine Institute, P.A., all benefits for surgical and medical care payable under my insurance policy.

Signature

I understand that if for any reason benefits are not payable by my insurance carrier, I am responsible for payment of the services provided to me by Pocatello Orthopaedics & Sports Medicine Institute, P.A. I verify that the information completed on this form is correct to the best of my knowledge.

Signature

FOR MEDICARE PATIENTS ONLY:

Name (print)

Medicare number

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF FOR ANY SERVICES FURNISHED ME BY RICHARD WATHNE, M.D., BENJAMIN BLAIR, M.D., OR S. JEFFREY BRAY, D.P.M., INCLUDING PHYSICIAN SERVICES. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS FOR RELATED SERVICES.

Signature

Date

Pocatello Orthopaedics & Sports Medicine Institute, P.A.

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The "Act" gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your Protected Health Information ("PHI") only for each of the following purposes: Treatment, Payment and Health Care Operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be a referral to another provider for diagnostic testing, pain control, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance for payment.
- **Health Care Operations** includes the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute *De-Identified Health Information* by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives, diagnostic test results, or other health related services that may be of interest to you.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing at any time and we are required to honor that written request, except to the extent that action has already been taken in reliance on its contents.

You have the following rights with respect to your "PHI", which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of "PHI", including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not required, however, to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of "PHI" from us by alternative means or at alternative locations.
- The right to inspect and copy your Protected Health Information ("PHI").
- The right to amend your Protected Health Information ("PHI").
- The right to receive an accounting of disclosures of your Protected Health Information ("PHI")
- The right to obtain a paper copy of this notice upon request.

We are required by law to maintain the privacy of your "PHI" and to provide you with notice of our legal duties and privacy practices with respect to that information.

This Notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all "PHI" that we maintain. We will post and you may request a written copy of any revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have a right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak with our Privacy Officer or for written inquiries, note "Attention Privacy Officer".

For more information about "HIPAA" or to file a complaint:
U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 or Toll Free (877) 696-6775



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up, among the multiple healthcare providers who may be involved in that treatment, whether directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessment and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Pocatello Orthopaedics & Sports Medicine Institute, P.A. has the right to change its *Notice of Privacy Practices* from time to time and that I may contact them at any time at the address above to obtain a current copy of the *Notice*.

I understand that I may request in writing that you restrict how my private information may be used or disclosed to carry out Treatment, Payment or Health Care Operations. I also understand that you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain this patients signature in acknowledgement of the *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____
