

Alaska Orthopaedic Specialists, Inc.

David A. McGuire, MD – Michael G. McNamara, MD – Doug A. Vermillion, MD
(907)562-4142 FAX (907)563-8824

PATIENT: _____ DOB: _____ Sex: M F Marital Status: S M W D

Mailing address: _____ City: _____ State: _____ Zip: _____

Street address: _____ Home Phone: _____ Cell Phone: _____

Social Security #: _____ Drivers License #: _____ State: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

Spouse or Parent: _____ DOB: _____ SS#: _____

Employer: _____ Home Phone: _____ Cell Phone: _____

Employer Address: _____ Work Phone: _____

Responsible Party: _____ DOB: _____ SS#: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

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

Primary Insurance: _____ Phone: _____

Address: _____

Subscriber Name: _____ DOB: _____ SS#: _____

Subscriber ID #: _____ Group #: _____

Secondary Insurance: _____

Address: _____

Subscriber Name: _____ DOB: _____ SS#: _____

Subscriber ID #: _____ Group #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Right To Privacy: May we share your health information with your spouse or a designated party?

Name: _____ Relationship: _____ Phone: _____

Referred By (circle or fill in): Friend/Co-worker Relative Patient Hospital _____

Health Care Provider _____ Other _____

Accident/Injury Information: Were you on the job? Y N Auto Accident? Y N What state? _____

Date of Accident/Injury: _____ Is there an attorney? Y N Attorney Name: _____

How did it happen? _____

I verify that the above information is true and correct and that I will keep AOS informed of any changes in the above.

Signature (responsible party): _____ Date: _____

Welcome to Alaska Orthopaedic Specialist

David A. McGuire, M. D. – Michael G. McNamara, M. D.

Thank you for choosing us for your orthopaedic needs.

LOCATION: Alaska Orthopaedic Specialists, Inc. is located in the Lake Otis Medical Plaza at 4100 Lake Otis Parkway, Suite 320, Anchorage, AK 99508

OFFICE HOURS: Our office hours are from 8 AM to 5 PM Monday – Thursday and 8AM to 4:30 PM on Friday

CHARGES: A new patient visit can range in cost from \$100.00 to \$320.00. This charge does not include x-rays, injections or nerve conduction testing if necessary at the time of your first visit. We require **payment in full** for the first visit.

X-RAYS: A visit with Dr. McGuire does require specific 5 view x-rays. A visit with Dr. McNamara requires x-rays depending on the injury site and age of the injury. You will be directed at the time of your visit to the x-ray department. You may pre-register with Healthsouth X-ray @ 550-6322.

INSURANCE BILLING: As a **courtesy** we will bill your insurance company for your visit. We will request your insurance company to reimburse you for your first visit. Be aware it is your responsibility to know your co-pay and/or deductible information. We do require a deposit for surgery. This deposit is dependent on your insurance coverage and will be discussed at your pre-operative appointment. We do not accept auto accident insurance or homeowners policy insurance.

APPOINTMENT RESCHEDULE OR CANCELLATIONS: The surgeons at Alaska Orthopaedic Specialists, Inc. are normally scheduled in advance. If it is necessary to reschedule or cancel your appointment please allow 48 hours notice. You may contact the receptionist at 562-4142, Option 1.

TELEPHONE: For your convenience our phones are automated. Please call our main number: 562-4142

For receptionist, to schedule or change appointments	Press 1
To speak to a nurse, schedule surgery or medication refills	Press 2 and follow prompts
For Patient accounts	Press 3

THINGS TO BRING: The forms that need to be **completed** and brought with you to your first appointment are as follows. Please arrive 45 minutes prior to appointment time for your registration and getting x-rays. The following is a checklist of things to bring to your appointment.

- Patient Registration
- Financial Information / Protected Health Information
- Health History
- Knee Questionnaire (McGuire patients)
- Upper Extremity History (McNamara patients)
- Healthsouth Patient Intake form
- Pair of shorts (McGuire patients)
- Drivers license
- Insurance cards
- Payment is accepted by cash, check, Visa or Mastercard

FINANCIAL INFORMATION

Charges:

- We expect payment in full for your first visit.
- If your injury is related to an auto accident or third party injury we require payment in full at **each** visit.

Insurance billing

- It is your responsibility to provide us with correct insurance information for billing purposes.
- Alaska Orthopaedic Specialists, Inc. is not a preferred provider with any insurance company. We will bill your insurance as a courtesy. All balances not paid by your insurance are due upon receipt of bill from AOS.
- We will bill your insurance for surgical procedures, but may require a deposit prior to your surgery. A patient account representative will discuss this in detail if surgery is required.
- It is your responsibility to contact your insurance company if a claim is denied, paid at a lower rate than you expected or if it has not been paid within 60 days. Charges not paid timely by your insurance will become your responsibility.
- It is your responsibility to contact your insurance company for benefit verification. It is also your responsibility to respond to all request for information you receive from your insurance company.

Overdue Accounts

- If your account has a patient balance, it is your responsibility to make arrangements to pay the balance.
- Accounts with a patient balance that are not paid within 90 days may be turned over to an outside collection agency. This action may affect your credit.

Authorization and Release

I have read and understand the information above. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance. I authorize this clinic to release to my insurance carrier any medical information needed to obtain payment for services rendered. I hereby assign to the physician payments for medical services rendered to myself or my dependents.

****Signature**:** _____
Patient / Responsible party

Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- I hereby acknowledge that I have been offered, received or viewed a copy of Alaska Orthopaedic Specialists, Inc (AOS) Notice of Privacy Practices (NPP).
- With my consent, AOS may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as discussed in the NPP.
- With my consent AOS may call my home or other designated location and leave a message on voice mail or in person in reference to any items that may assist the practice in providing my healthcare.
- With my consent, AOS may mail or email to my home or other designated location any items that assist the practice in providing my healthcare.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures relying upon my prior consent. If I do not sign this consent, AOS may decline to provide treatment to me.

****Signature**:** _____
Patient / Responsible party

Date: _____

For Clinic Use

_____ Patient refused to sign Patient unable to sign because _____

Employee Signature: _____

Date: _____

KNEE QUESTIONNAIRE

X-Ray # _____

Name _____ Date of Exam _____ Chart # _____

Which Knee? (L) _____ (R) _____ Occupation _____

If injured, date of injury _____ If not injured, date of onset of symptoms _____ Duration of symptoms _____

Is this injury due to an accident? Yes No An on the job injury? Yes No Related to a motor vehicle accident? Yes No

Please write a description of your injury and/or symptoms in the space provided below:

Please mark the boxes that apply:

DO YOU HAVE	YES		ONLY WITH ACTIVITY	RARELY	WEEKLY	DAILY
	L	R				
LOCKING						
GIVING WAY						
CATCHING						
SWELLING						
PAIN AT NIGHT						
MORNING STIFFNESS						
CLICKING						
POPPING						
GRINDING						
CHANGES WITH WEATHER						

Please mark the boxes that apply:

DIFFICULTY WITH:	YES	
	L	R
STAIR/HILLS		
UNEVEN TERRAIN		
RUNNING		
CUTTING (changing direction)		
KNEELING		

Do you consider your symptoms: (Circle one) Annoying Inconvenient Restricting Disabling

Past history of knee problems: yes no (If yes, please explain)

Any prior knee surgery: Procedure _____ Which Knee? _____

When? _____ Where? _____ Doctor's Name _____

Have you seen another physician for this injury? _____ When? _____ Dr. Name _____

Is this appointment for a second opinion? _____ Name of doctor you saw for initial opinion _____

All medications you have taken for this injury (include over the counter medications) _____

Have you had any physical therapy for this injury? (this would include home therapy or formal therapy) _____

Are you currently out of work or on limited duty due to this injury/problem? _____ Do we need to address duty status today? _____

Please sign your name _____ Date _____

EXAM

Name _____ R or L _____ Chart # _____ Date _____

Summary:

		0-5	5-10	>10					
Valgus	0				Lachman	0-2	2-5	5-10	>10
	30					Ant. Drw.	45		
Varus	0				Post Drw.	90			
	30					45			
						90			

ALRI: no mild moderate severe

PLRI: no mild moderate severe

Artic. Crep.: no mild moderate severe

Hemarthrosis: _____ x _____ cc

Effusion: _____ x _____ cc

Val. St. Appr.: no mild moderate severe

Pat. Med. Facet: normal slightly vertical

Pat. Crep.: no mild moderate gross

Quad atrophy: no mild moderate severe

McMurray: neg indet suggest defin

Comments:

Lat. Circ.: neg indet suggest defin

Mod. Losee's:

Flex. Rot. Drw./Pivot Shift:

External Rotation Recurvatum:

Posterior Sag Test:

Given to Pt: Exercise Sheet Surgery Folder

Scars: PM AM PL AL

Tenderness (Locat):

Degree: mild moderate severe

Masses (Locat):

Size:

Quad Circ: R _____ L _____

Range of motion: R _____ to _____

L _____ to _____

Other:

X-Ray Findings:

Diagnosis:

Plan:

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____
SSN _____ Date of Birth _____ Age _____ Patient Account # _____
Marital Status: SINGLE MARRIED DIVORCED WIDOWED Gender: MALE FEMALE
Address _____ City _____ State _____ Zip _____
Home Phone _____ Mobile Phone _____ Other _____

EMPLOYER INFORMATION

Employment Status: FULL-TIME PART-TIME STUDENT UNEMPLOYED RETIRED CHILD OTHER _____
Employer _____ Job Title _____
Employer Address _____ Work Phone: _____
City _____ State: _____ Zip _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name _____ Date of Birth _____ SSN _____
Address _____ City _____ State _____ Zip _____
Employer _____ Telephone _____
Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient: _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Mobile Phone _____ Other _____

PRIMARY INSURANCE INFORMATION

Last Name _____ First Name _____ MI _____ Insured Date of Birth _____
SSN _____ Relationship to Patient SELF SPOUSE PARENT OTHER _____
Employer _____
Insurance Company Policy _____ Telephone _____
Policy Number _____ Subscriber / Member ID _____
Group Name / Number _____ On-the-Job-Injury? _____ Motor Vehicle Accident? _____
Worker's Comp Claim Number _____ Date of Injury _____ State _____
Worker's Comp Contact Name _____ Telephone _____

SECONDARY INSURANCE INFORMATION

Last Name _____ First Name _____ MI _____ Date of Birth _____
SSN _____ Relationship to Patient SELF SPOUSE PARENT OTHER _____
Employer _____
Insurance Company Policy _____ Telephone _____
Policy Number _____
Subscriber / Member ID _____ Group Name / Number _____

I have reviewed the above information and verify that it is accurate.

Patient Signature _____
Witness Signature _____

Date ____/____/____
Date ____/____/____

