Physician Name: Jeffrey E. Budoff, M.D.

PATIENT DEMOGRAPHIC INFORMATION SHEET

Last Name | First Name | Middle | Social Security No.

Date of Birth | Age | Male or Female *(Please circle one)* | Marital Status: M S W D *(Please circle one)*

Home Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Contact Preference: *(Please Check One)* Home Work Cell Mail | Email Address

Referred By: | Phone #:

EMERGENCY CONTACT INFORMATION

Name | Phone No. | Alt. Phone | Relationship

PATIENT EMPLOYER INFORMATION

Employer Name | Phone | Fax

Address | City | State | Zip

GUARANTOR / POLICY HOLDER INFORMATION

Last Name | First Name | Middle | Social Security No.

Date of Birth | Patient's Relationship to Policy Holder | Home Phone | Cell Phone

Employer Name | Phone | Fax

Employer Address | City | State | Zip

INSURANCE INFORMATION

Primary Insurance	Name of Primary Insurance	ID/Policy Number	Group Number	Customer Service No.
Secondary Insurance	Name of Secondary Insurance	ID/Policy Number	Group Number	Customer Service No.
Work Comp Insurance	Name of WC Insurance	Claim #	Adjuster Name	Adjuster Phone No.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. **AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OF TREATMENT.

Signature: _____ **Date:** _____

JEFFREY E. BUDOFF, M.D.

Patient Name: _____ Today's Date:_____

Age: _____ Birth Date: _____ Sex: M F

I am: Right-Handed Left-Handed Injured Arm: Right Left

Occupation_____Employer_____
Major Hobbies_____
Referring Physician and **Phone Number**_____
Is this the result of an accident? YES ____ NO ____ PERSONAL? ____ WORK RELATED? ___
Date of Injury_____
Reason for Your Visit Today_____
_____

PMH: Please Circle Any of the Following Conditions That You **CURRENTLY** Have:

Insulin Dependent Diabetes	High Blood Pressure	Heart Disease
Non-Insulin Dependent Diabetes	Blood Clots	Heart Attacks
Hypothyroidism/Hyperthyroidism	Bleeding Disorder	Lung Disease
Reaction to Anesthesia	Kidney Disease	Hepatitis
HIV/AIDS	Peptic Ulcer Disease	Liver Disease
Rheumatoid Arthritis	Drug Abuse	Alcoholism
Asthma	Cholesterol	

Psychiatric Disorder: What type?_____

Cancer: What Type?_____ Are You Pregnant: Y N

Any Other Medical Problems?_____

PSH: Please List Each Surgery (Procedure and Date) That You Have Had:

_____
_____
_____
_____
_____

Allergies: Please List Any MEDICATIONS That You Are Allergic to and What Happens When You Take Them:

_____
_____
_____

Medications: Please List ALL Medications You Take. Including Aspirin, Motrin, etc:

_____

_____

_____

Review of Systems: Please Circle Any of the Following that You **CURRENTLY** Have:

Fever	Dizziness	Fingertip Cold Intolerance
Rash	Depression	Fingertip Ulcers
Blood in Stool	Productive Cough	Shortness of Breath
Tingling or Numbness in your Feet		Difficulty Urinating
Tingling or Numbness in your Hand		Chest Pain

Joint Aches: Which Joints? _____

Social History:

Do You Smoke?	Y	N	How much? _____
Do You Drink Alcohol?	Y	N	How much? _____
Do You Use Recreational Drugs?	Y	N	What Kind? _____

Family History: Please Circle Any of the Following Medical Problems in Your Immediate Family (Mother, Father, Sister, Brother):

Reaction to Anesthesia	Hypertension	Rheumatoid Arthritis
Bleeding Problems	Heart Problems	Diabetes
HIV/AIDS	Lung Disease	Cancer: What Type? _____

Other Diseases that Run in the Family:_____

Please List Any Other Information That You Feel The Doctor Needs to Know:

_____

_____

_____

Please list the contact information for the Pharmacy you prefer to use:

Pharmacy Name: _____ Phone #: _____ Fax #: _____

Pharmacy Name: _____ Phone #: _____ Fax #: _____

SOUTHWEST ORTHOPEDIC GROUP, LLP

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Patient or Personal Representative **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____.

Financial Policy Statement

It is the policy of Southwest Orthopedic Group, LLP, to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, LLP, you recognize an obligation to promptly remit payment to Southwest Orthopedic Group, L.L.P.

The above does not apply to those patients that are considered Workers' Compensation. However, be advised as a Workers' Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, LLP, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

_____ _____

Responsible Party Print Name **Date**

_____

Responsible Party Signature

SOUTHWEST ORTHOPEDIC GROUP, L.L.P.

AUTHORIZATION FOR COMMUNICATION OF MEDICAL INFORMATION

Patient Name: _____ *DOB:* _____

Address: _____ *Telephone#*_____

In order for our practice to respond promptly and accurately to your needs, Please list any person(s) whom you would like to have access to your medical information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization is valid for 90 days from the date of my signature. I understand that this authorization authorizes the release of all my medical records. I further understand that I can revoke this authorization in writing at any time prior to the expiration date. In addition, I understand that any release of this information by the recipient without my further consent is prohibited. Finally, I understand that a photocopy of this authorization may be considered valid.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Informed Decision

In recent years, declining reimbursements have led to many hospitals resorting to significant cost cutting measures. One popular strategy for this has been to restrict the use of the latest, cutting edge surgical equipment and implants because, being new and often better, they are also usually more expensive. Other hospital strategies include decreasing the input surgeons have on the care their patients receive before, during, and after surgical procedures.

In response, some surgeons have established surgical centers for outpatient procedures. These are not only more convenient for patients, they are also associated with lower surgical infection rates and a much lower prevalence of multiple antibiotic-resistant bacteria. Having ownership of such centers gives surgeons much more input in the quality of care provided to their patients.

But, this can lead to increased costs to insurance companies, who have negotiated low payment rates with most hospitals. As a result, for profit insurance companies try to direct care towards in network surgical facilities with which they have contracted low rates of payment. If you and/or your employer have been paying higher health insurance premiums in order to have an insurance plan with out of network benefits, you have a choice to have your procedure at any facility your surgeon uses and feels comfortable with, regardless of whether or not it has a contract with your insurance company.

Disclosure of Physician Ownership

Dr. Jeffrey Budoff has an ownership interest in *Highland Surgical Center*.

Dr. Budoff believes that this interest allows him greater influence over the care provided to his patients.

In the event that you are referred for surgery at this center, you do have the option of using another health care facility if you choose. You will not be treated differently by Dr. Budoff if you choose a different facility.

If you have any questions or concerns, please feel free to discuss them with Dr. Budoff or his office staff.

Acknowledgement of Disclosure

Your signature on the bottom of this form signifies that you have read and understand this disclosure and that you know you can direct any questions and/or concerns regarding this disclosure to Dr. Budoff or his office staff.

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Printed Patient Name	Time

EMAIL USE

This practice may send email notification to you regarding appointment reminders or general health information you may be interested in. By giving us your email address, you have consented to receiving information from us.

Email Address: _____

Consent to Obtain Medication History

Our practice is moving toward an electronic medical records environment. We have enabled new functionality where we are able to obtain your medication history from a pharmacy clearinghouse called Surescripts. Surescripts will provide your provider a 2 year medication history if you give consent for us to obtain this information. Please check the box below indicating your consent.

____ I give consent to Southwest Orthopedic Group to obtain my 2 year medication history from Surescripts.

____ I DO NOT wish to allow Southwest Orthopedic Group to obtain my 2 year medication history from Surescripts.

_____ _____

Printed Name of Patient Signature of Patient or Guardian