TADJE ORTHOPAEDICS

PLEASE FILL OUT EACH SECTION COMPLETELY AND SIGN ALL 5 PAGES -- THANK YOU

PATIENT'S LEGAL NAME		DATE OF BIRTH	SEX M☐ F☐	AGE	MARITAL STATUS
MAILING ADDRESS		CITY		STATE/ZIP CODE	
PRIMARY PHONE #	CELL PHONE #	WORK PHONE #		SSN #	
PATIENT'S EMPLOYER		EMPLOYER ADDRESS		CITY	STATE/ZIP
RACE	ETHNICITY Hispanic or Latino? YES☐ NO☐ Refuse to report☐			LANGUAGE	
PHARMACY		CROSSROADS OF PHARMACY			
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		EMAIL ADDRESS FOR PATIENT PORTAL			
PLEASE CIRCLE YOUR PREFERRED METHOD FOR AN APPOINTMENT REMINDER: PRIMARY PHONE EMAIL TEXT MESSAGE					

SPOUSE'S NAME (if married)	SPOUSE'S PHONE #	SPOUSE'S DATE OF BIRTH
FATHER'S NAME (if minor)	FATHER'S PHONE #	FATHER'S DATE OF BIRTH
MOTHER'S NAME (if minor)	MOTHER'S PHONE #	MOTHER'S DATE OF BIRTH

INSURANCE COMPANY NAME (PRIMARY)			INSURANCE COMPANY NAME (SECONDARY)		
ADDRESS	PHONE #		ADDRESS	PHONE #	
ID #	GROUP #		ID #	GROUP #	
POLICY HOLDER	RELATIONSHIP	DATE OF BIRTH	POLICY HOLDER	RELATIONSHIP	DATE OF BIRTH

PLEASE CIRCLE ONE: ☐INSURANCE ☐WORKER'S COMP ☐AUTO ☐OTHER ☐SELF-PAY ☐MEDICARE ☐MEDICAID	
IS THIS A WORK-RELATED INJURY? ☐YES ☐NO	IS THIS INJURY RELATED TO AN AUTO-ACCIDENT? ☐YES ☐NO
DATE OF INJURY OR ONSET OF SYMPTOMS:	BODY PART INVOLVED:

EMERGENCY CONTACT NAME	EMERGENCY CONTACT RELATIONSHIP	EMERGENCY CONTACT PHONE #

I authorize Tadje Orthopaedics to render treatment. This authorization shall continue to be in force and effect until revoked in writing by me.
By signing physically or by typing my name, I acknowledge that I am ultimately responsible for any and all charges incurred by this office.
If I submit this document with a typed signature, I acknowledge that this electronic signature serves as my valid signature.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN	DATE

TADJE ORTHOPAEDICS

Past Medical History Record – Confidential

Patient Name: _____ Date of Birth: _____

U.S. Government regulations require that your physician document complete information about your past medical history.

Who is your primary care provider and where are they located? Who referred you? Do you have an Advanced Directive?

_____ _____ ☐ Yes ☐ No

What is the reason for your visit today? Have you had any test/imaging for this problem? If yes, where?

_____ _____

Have you had any prior treatment for this problem? (i.e. physical therapy, injections, etc.)

_____

Please list your medical history (medical problems you are being treated for: i.e. high blood pressure, diabetes, etc.):

_____

_____

_____

Please list your surgical history:

YEAR	DOCTOR	SURGERY PERFORMED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medications you are taking and their respective dosages:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list medications/substances that you have an allergy or sensitivity to:

_____ _____ _____

_____ _____ _____

FOR OFFICE USE ONLY

Height _____

Weight _____

BP _____

Pulse _____

Please list any family history of cancer, heart disease, diabetes, or other significant illness:

_____

Hobbies:

_____

Please circle your use of the following:

Alcohol: Daily ☐ Weekly ☐ Monthly ☐ Never ☐ **Caffeine**: Daily ☐ Weekly ☐ Monthly ☐ Never ☐

Tobacco: Daily ☐ Weekly ☐ Monthly ☐ Never ☐

Are you a:

☐ nonsmoker ☐ **current smoker** ☐ **former smoker** ☐ other form of tobacco user

If you are a '**former smoker'**, how long has it been since you quit?

☐ < 1 month ☐ 1-6 months ☐ 6-12 months ☐ 1-5 years ☐ 5-10 years ☐ 10+ years

If you are a **'current smoker'**, how many cigarettes or e-cigarettes do you smoke per day?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31+

If you are a **'current smoker'**, are you interested in quitting?

☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

REVIEW OF SYSTEMS

Please check all that apply:

1) Constitutional	☐ Unexpected weight loss	☐ Fever/chills	
2) Eyes, Ears, Nose, Throat	☐ Blurred Vision	☐ Ringing in ears	☐ Difficulty swallowing
	☐ Double vision	☐ Nose Bleeds	
3) Cardiovascular	☐ Chest Pain	☐ Palpitations	
4) Respiratory	☐ Shortness of breath	☐ Cough	
5) Endocrine	☐ Excessive thirst/urination	☐ Heat/Cold Intolerance	
6) Gastrointestinal	☐ Nausea/vomiting	☐ Diarrhea	☐ Constipation
7) Infectious Disease	☐ HIV Positive	☐ History of MRSA	
8) Neurological	☐ Tingling/Numbness	☐ Chronic Headaches	
9) Hematologic/Lymphatic	☐ Easy Bleeding	☐ Easy Bruising	
10) Skin	☐ Poor wound healing	☐ Scarring/keloids	
11) Genitourinary	☐ Painful urination	☐ Blood in urine	☐ Urinary frequency
12) Psychiatric	☐ Depression	☐ Anxiety	

We recommend that you follow up with your primary care provider for any positive findings marked above in your review of systems. Please sign below stating the information on this medical history form is accurate to the best of your knowledge.

_____ _____

Signature of Patient or Legal Guardian *Date*

FINANCIAL POLICY

Welcome to Tadje Orthopaedics. We are dedicated to ensuring you will receive the best care available. We believe your understanding of your financial responsibilities is an important element of the treatment process.

Your health insurance policy is a contract between you and your insurance company. It is your responsibility to know the specifics of your insurance coverage and benefits. Your insurance policy may require that a referral be submitted to your insurance carrier by your primary care provider to approve services rendered by a specialist. Certain services, IE: injections, imaging, durable medical equipment, may require that a prior authorization be submitted to your insurance carrier for approval of these services prior to rendering. It is also wise to check network – is the doctor in network with your specific policy? It is your responsibility to ensure that all criteria required by your insurance carrier has been met prior to services being rendered.

PATIENT INFORMATION: Please be sure to fill out all patient information as accurately as possible. Please print clearly. Please give us your given name as it appears on your insurance card. Please present all ***current*** insurance cards and personal identification for your file. Please keep billing informed of any changes.

HOSPITAL OWNERSHIP DISCLOSURE: Dr Tadje has a small ownership interest in Treasure Valley Hospital. It is a surgical hospital jointly owned and operated by approximately 60 local physicians. As physician owners, we are very cost-conscious, and we have strived to keep the cost of care as low as possible. We believe that we are the best value in town. As an independent physician, I am able to provide care at a variety of facilities within the valley. As the patient, it is your right to choose where to receive your care. I encourage you to actively research the various facilities available to you within your network and communicate your preference to me.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payers to Tadje Orthopaedics. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

FINANCIAL POLICY STATEMENT

Your health insurance policy is a contract between you and your insurance company. We bill your insurance as a courtesy to you. Although we are contracted with **MOST** insurance carriers, our services may not be covered with your particular plan. It is your responsibility to know the specifics of your insurance benefits. Ultimately you, the patient, is responsible for any unpaid balances by your insurance plan. **ALL CO-PAYS, CO-INSURANCE, and DEDUCTIBLES are due at the start of each visit.** All other balances are due within 30 days of patient statement release. We accept debit cards, checks, money orders, VISA, MasterCard, American Express and cash. If you **DO NOT** have health insurance, you are considered **SELF PAY.** You will be required to pay a reduced rate of $135.00 upfront to Tadje Orthopaedics for your initial office visit. If there is a remaining balance, in addition to your office visit charge of $135.00, IE: X-rays, injections, durable medical equipment, regular monthly payments are required. If the account is paid in full within 30 days, there will be a 50% self-pay discount applied to your account.

You will receive an itemized statement from Tadje Orthopaedics. The statement will indicate if your insurance has been billed and what payments have been made on your behalf. Please do not ignore the bill. Tadje Orthopaedics is willing to allow you to make monthly payments, but those payments must be arranged through our billing office. **Please call the office at (208) 515-2654 to make payment arrangements**. Our billing staff is available to answer all your billing/insurance questions.

I understand and agree that my account will be interest free, if paid within 90 days of my discharge, after 90 days, my account will be subject to 12% interest (APR). If I fail to make any payments for which I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

_____ _____

Patient and/or Guardian Signature Today's Date

Patient's Name	Date of Birth	Today's Date
_____	_____	_____

HIPAA
Health Insurance Portability and Accountability Act
Acknowledgement of Receipt of Notice

I hereby acknowledge that a copy of this medical practice's Notice of Privacy Practices was made available to me.

Patient and/or Guardian Signature	Relationship to patient (if patient not signing for self)
_____	_____

Patient's Rights
Acknowledgement of Receipt of Notice

I hereby acknowledge that a copy of this medical practice's Notice of Patient's Rights was made available to me.

Patient and/or Guardian Signature	Relationship to patient (if patient not signing for self)
_____	_____

TADJE ORTHOPAEDICS

Authorization/Declination for Use and Disclosure of Patient Information for Educational and Marketing Purposes

I, _____, voluntarily authorize Tadje Orthopaedics to use and disclose the following information to the general public for both educational and marketing purposes, including use on social media. I understand that the information disclosed pursuant to this authorization is subject to uncontrolled redisclosure by others and may no longer be protected by HIPAA privacy regulations. I acknowledge that I will not be compensated for the use of my time or information.

If you would like to see examples of our social media posts, please visit the following links:

http://www.tadjeortho.com/blog

https://www.facebook.com/TadjeOrthopaedics/

@tadje_ortho

I give permission for the following to be released:

_____ My name

_____ Photographic/video images of myself and/or procedures performed on me including surgery

_____ Testimonial information about treatments and/or my experience with Tadje Orthopaedics

_____ The nature of my injury/condition and the type of treatments recommended and used

I give permission for the above selected information to be released to the general public by means of:

_____ Social Media/Online Platforms

_____ Tadjeortho.com Website/Blog

_____ Display on the Tadje Orthopaedics' Photo Wall

I decline to have all of the above to be released _____

In addition, I understand that I may revoke this authorization at any time by notifying Tadje Orthopaedics in writing; however, this revocation will only affect uses and disclosures after the date the notice is received by Tadje Orthopaedics. Revocation of this authorization is not retroactive and does not apply to previously released information.

_____ _____

Signature of Patient/Legal Guardian Date