

Michael J. Larson, M.D.
Board Certified
Orthopedic Surgeon

Upper Valley Orthopedics, PLLC
360 East Main • Rexburg, Idaho 83440
208-356-9550
Fax: 208-356-8023

Kevin M. Lee, M.D.
Board Certified
Orthopedic Surgeon

Dear Patient,

Thank you for choosing Upper Valley Orthopedics for your bone and joint care. We welcome new and returning patients and hope that your care in our office is both professional and friendly.

Enclosed is new/returning patient information sheets that will help in the care you receive in our office. Also, you will find a brochure of our Privacy Policy. This is required by law and we must have a signed form in our office that we provided this for you. If you have any questions regarding our privacy policy, please don't hesitate to ask.

The following is some information that will help familiarize you with our practice.

Upper Valley Orthopedics
Michael J. Larson, M.D. Kevin M. Lee, M.D.
360 East Main
Rexburg, ID 83440
(208) 356-9550 Office, (208) 359-8023 Fax
Business Hours: Monday-Thursday 8:30am-5:00 pm, Friday 8:30am-12:00pm
Website: uppervalleyortho.com

Payment Policy- It is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered. This may only be your co-payment, deductible, and/or coinsurance, but we do ask for payment at the time of your visit. We accept all major credit cards.

Co-payment- This is the cost-sharing part of your bill that is a fixed amount designated by your insurance company that is your responsibility to pay at each visit.

Deductible- This is the amount of cost sharing that you must pay for medical services, often before your health insurance company starts to pay.

Coinsurance- the part of your bill, in addition to a copay, that you must pay. Coinsurance is usually a percentage of the total medical bill.

For Medicaid patients, we must have a Healthy Connections Referral from your primary care physician before your appointment. If you do not have it at the time of your visit, we will have to reschedule your appointment.

If you have any questions after reading this information, we will be happy to answer them for you.

Please bring the following information to your visit:

- Insurance card(s)
- Driver's license
- Completed forms
- Any prior exam studies: X-rays, MRIs, CT scans
- List of current Medications

Thank you again for choosing Upper Valley Orthopedics for your bone and joint care.

Sincerely,

Upper Valley Orthopedics
Michael J. Larson, M.D. Kevin M. Lee, M.D.

UPPER VALLEY ORTHOPEDICS, PLLC
Board Certified Orthopaedic Surgeons

MICHAEL J LARSON, M.D.

KEVIN M. LEE, M.D.

PATIENT'S NAME _____ M _____ F _____ Date of Birth _____ Age _____
Address _____
STREET PO BOX CITY STATE ZIP CODE
Phone # Work _____ Home _____ Cell _____
Social Security # _____ Employer _____ Who referred you to us? _____
Nearest Relative _____ Phone # _____

PARENT/PERSON RESPONSIBLE FOR BILLING

NAME _____ AGE _____
Address _____
STREET PO BOX CITY STATE ZIP CODE
Phone # Work _____ Home _____ Cell _____
Social Security # _____ Date of Birth _____
Employer _____ E-mail _____

IF YOU HAVE YOUR INSURANCE CARD, WE WOULD LIKE TO MAKE A COPY OF IT FOR OUR RECORDS.

HEALTH INSURANCE INFORMATION:

Name of Primary Health Insurance Company _____
Policy # _____ Group # _____ Name of Insured _____
Name of Secondary Health Insurance Company _____
Policy # _____ Group # _____ Name of Insured _____

WAS THIS INJURY THE RESULT OF AN ACCIDENT? _____ **IF YES, GIVE DATE** _____

(In order for your insurance company to pay as an accident, we must have an **EXACT** date)

Type of Accident:

- Auto Name of responsible Party _____ Agent _____
 Work Employer _____ Phone _____
 Other Describe _____

Is there any Attorney involved? _____ Name _____

All medical care is due and payable upon completion unless prior arrangements have been made. I hereby authorize the release of any and all necessary information to my/the medical insurance program, or their representatives, for the purpose of submitting a claim against my medical insurance policy.
I hereby request and direct that all payments due under my/the medical insurance program be made directly to MICHAEL J LARSON, M.D./KEVIN M LEE, M.D. for any unpaid bills furnished me or my/the insurance program by the above physician during the time I am under this care. I understand that I am responsible for this bill REGARDLESS OF INSURANCE COVERAGE, and do also understand that I am personally liable for all costs of a collection in case of default.

Signature of Patient/Responsible Party

Date

Signature of Responsible (if patient is a minor)

MEDICARE PATIENTS - PLEASE COMPLETE THE MEDICARE AUTHORIZATION ON THE BACK OF THIS FORM.

CIGNA HealthCare Medicare Administration

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to **MICHAEL J. LARSON, MD / KEVIN M. LEE, MD** for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____

Date _____

Sample Patient's Assignment Authorization

NAME OF BENEFICIARY, HEALTH INSURANCE CLAIM NUMBER (HICN), MEDIGAP POLICY NUMBER

I request that payment of authorized Medigap Benefits be made on my behalf to **MICHAEL J. LARSON, MD / KEVIN M. LEE, MD** for any services furnished be by that physician/supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits.

Signature _____

Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE UPPER VALLEY ORTHOPEDICS, PLLC

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Upper Valley Orthopedics, PLLC's "NOTICE OF PRIVACY PRACTICES."**

Signature _____

Date _____

Patient's Name _____

Date: _____

Address: _____

Date of Birth _____ / _____ / _____

Pharmacy: _____

Family Doctor _____

HISTORY OF CURRENT PROBLEM

When did symptoms first occur or the accident happen? _____

If this was an accident, how did it happen? _____

Have you ever had these symptoms before? Yes ___ No ___

WHAT IS THE DOCTOR SEEING YOU FOR TODAY?(mark specific complaint)

ARM: Right ___ Left ___

Shoulder ___ Elbow ___ Forearm ___ Wrist ___ Hand ___

Leg: Right ___ Left ___

Hip ___ Knee ___ Calf/Shin ___ Ankle ___ Foot ___

Describe the problem you are having: _____

Have you had previous treatment for your current problem? Yes ___ No ___

Describe what was done: _____

Were X-rays taken? Yes ___ No ___ If yes, where _____

Name: _____ Age: _____ Date: _____

To properly care for you at the time of your visit, we need a complete summary of your medical history.

Family Doctor/Internist: _____

Drug Allergies: _____

Current medications, dosages, and prescribing doctor: _____

Pharmacy _____

PAST MEDICAL HISTORY

List all previous surgeries, year, and surgeon: _____

Medical conditions currently being treated: _____

SOCIAL HISTORY

Birthplace: _____ Married? _____

Occupation: _____ How Long? _____

City of residence: _____

Education: _____

Tobacco use? Yes No

If yes: Packs per day: _____ Years of use: _____

Alcohol use? None Rarely Moderate Daily

GENERAL

Height: _____ Weight: _____

Dominant hand: Right Left

FAMILY HISTORY

Any history of osteo arthritis, rheumatoid arthrities, gout, back surgeries, disc disease, anesthetic problems, diabetes, bleeding disorders, mental illness, heart or stroke problems?

Mother: _____

Father: _____

Maternal Grandparents: _____

Paternal Grandparents: _____

MD Notes: _____

Systems Review: (circle)

General Health: Good Fair Poor

Reaction to anesthesia: Yes No

Tendency to bleed excessively: Yes No

CENTRAL NERVOUS & PSYCHIATRIC

Difficulty sleeping: Yes No

Troubled by depression: Yes No

Troubled by anxiety: Yes No

Uncorrectable vision: Yes No

Uncorrectable hearing: Yes No

Severe headaches: Yes No

Fainting spells: Yes No

Seizures or convulsions: Yes No

RESPIRATORY & CARDIOVASCULAR

Cough: Yes No

Shortness of breath: Yes No

Chest pain: Yes No

Palpitation/fluttering heart: Yes No

High blood pressure: Yes No

URINARY & GASTROINTESTINAL

Burning with urination: Yes No

Frequent urination: Yes No

Decreased urination force: Yes No

Stomach pain or burning: Yes No

Frequent loose stools: Yes No

Frequent constipation: Yes No

MUSCULOSKELETAL

Osteo arthritis: Yes No

Rheumatoid Arthritis: Yes No

Gout: Yes No

Back problems: Yes No

SKIN

Frequent rashes: Yes No

Bruise easily: Yes No

History of skin cancer: Yes No

ENDOCRINE

Excessive thirst: Yes No

Excessive urination: Yes No

HEENT

Difficulty swallowing: Yes No

Ear drainage: Yes No

Frequent earaches: Yes No

Wear glasses/contacts: Yes No

Double or blurry vision: Yes No

Patient's Signature: _____

MD Date & Initials:	