HUMPHREY SHOULDER CLINIC

3381 West Bavaria Street, Eagle, ID 83616 ● Phone (208) 639-4800 ● Fax (208)639-4801 ● humphrey@boiseshoulderclinic.net

C. SCOTT HUMPHREY, MD
Orthopaedic Surgeon

PATIENT INFORMATION

PATIENT NAME:

_____
LAST FIRST MIDDLE

ADDRESS:

_____

ZIP CODE: _____ **CITY:** _____ **STATE** _____

HOME PHONE #: _____ **WORK PHONE #:** _____ **CELL PHONE#:**_____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ **SOCIAL SECURITY NUMBER:** _____-_____-_____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED

SEX: (circle one) FEMALE MALE

PRIMARY CARE PHYSICIAN: _____ **REFERRED BY:** _____

PATIENT'S EMPLOYER INFORMATION:

POSITION: _____ **COMPANY:** _____

CITY: _____ **PHONE #:**_____

ACCIDENT INFORMATION:

DATE OF ACCIDENT: _____ WORK RELATED? _____ AUTO: _____OTHER:_____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

_____**SELF** **(PLEASE MARK IF YOU ARE THE RESPONSIBLE PARTY)**

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER

RESP. PARTY NAME:

_____
LAST FIRST MIDDLE

ADDRESS:

_____

DATE OF BIRTH: _____/_____/_____ **SEX:** (circle one) **FEMALE** **MALE**

HOME PHONE #: (_____) _____-_____ **WORK PHONE #:** (_____) _____-_____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____**PHONE #:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:
_____

ADDRESS: _____ **PHONE:** _____

CONTRACT (ID#) NUMBER: _____ **SUBSCRIBER'S NAME:** _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) **SELF** **SPOUSE** **CHILD** **OTHER**

GROUP NAME: _____ **GROUP NUMBER:** _____

COPAYMENT AMOUNT: $ _____ **INSURED'S DATE OF BIRTH:** _____/_____/_____

SECONDARY INSURANCE COMPANY:
_____

ADDRESS: _____ **PHONE:** _____

CONTRACT (ID#) NUMBER: _____ **SUBSCRIBER'S NAME:** _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) **SELF** **SPOUSE** **CHILD** **OTHER**

GROUP NAME: _____ **GROUP NUMBER:** _____

COPAYMENT AMOUNT: $ _____ **INSURED'S DATE OF BIRTH:** _____/_____/_____

IN CASE OF EMERGENCY PLEASE CONTACT

NAME: _____

PHONE NUMBER: _____ **RELATIONSHIP:** _____

ADDRESS: _____

THE HUMPHREY SHOULDER CLINIC APPRECIATES THE OPPORTUNITY OF SERVING YOU.

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

This is an agreement between Humphrey Shoulder Clinic and the patient/guarantor named below. By signing this agreement you are acknowledging that you understand our financial and payment policies and are agreeing to pay for all services that are received.

OFFICE POLICY ON PAYMENT:

All deductibles, co-payments, and patient responsibility payments are due and payable at the time of service. We accept Visa, MasterCard, Discover, American Express and Care Credit. All returned checks are subject to a $30 service charge. All accounts over 60 days will be charged an interest rate of 1 1/2 percent per month, 18% annually. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company.

PREPAYMENT FOR SURGICAL CARE:

If you require surgery, Humphrey Shoulder Clinic requires a deposit based on your deductable. Deposit will be collected at your pre-operative appointment. The actual charges billed for your surgery will reflect the procedures performed. We accept Visa, MasterCard, Discover, American Express and Care Credit.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. We will be happy to submit your claim(s) to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

_____ **INITIALS**

NO SHOW- CANCELLATION POLICY:

It is required that a 24 hour notice be given to cancel any scheduled appointment. If a 24 hour notice is not given, Humphrey Shoulder Clinic reserves the right to charge the patient or responsible party a $50.00 fee per occurrence. Upon third violation, dismissal from the practice will occur.

HIPPA POLICY:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest. We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purpose: treatment, payment or health care operations. These entities are most often not required to obtain patient consent. You may refuse consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

_____ **INITIALS**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____**DATE:** _____

Patient, Parent, or Guardian