McKinley
Orthopedic & Sports Medicine

Welcome to McKinley Orthopedic and Sports Medicine.

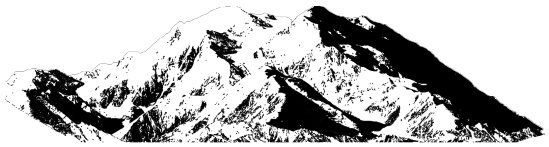
We look forward to helping with your medical needs.
If you are a new patient, please complete the forms below and bring them to your appointment.

If you have any questions or concerns, please call 907-456-3338 or email us at info@mckinleyortho.com.

Yours in good health,

Dr. Timothy Carey
Dr. Daniel Johnson
Dr. Jennifer Malcolm
Ambria "Tommie" Ptacek

Timothy Carey, DO | **Daniel Johnson, DO** | **Jennifer Malcom, DO** | **Tommie Ptacek, PA-C**
3745 Geist Road, Fairbanks, Ak 99709 | Office: 907.456.3338 | Billing: 907.456.3341 | Fax: 907.456.3443



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PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, please fill out ALL the following information.

Patient Information: Last Name: _____ First Name: _____ MI: _____

Birthdate: _____ Sex: Male Female SSN: _____ Marital Status: _____

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

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

Email Address: _____

Race: _____ Ethnicity: _____ Language Preference: _____

Responsible Party: Person responsible for this account: _____ Relation to patient: _____

Address: _____ City: _____ State: ____ Zip: ____

Preferred Phone: _____ Email Address: _____

Driver's License #: _____ Birthdate: _____ SSN: _____

Patient or Parent/Guardian's Employer: _____ Day Phone: _____

Spouse or Parent/Guardien's Name: _____ Employer: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Please fill out insurance information – IS THIS A WORKMEN'S COMP CLAIM? Yes No (if yes complete form)

1st Insurance: _____ **Relation to patient:** _____

Name of Insured: _____ DOB: _____ SSN: _____

2nd Insurance: _____ **Relation to patient:** _____

Name of Insured: _____ DOB: _____ SSN: _____

_____ _____

Signature (Patient or Guardian if Minor) Print Name Date

MEDICAL HISTORY FORM

Timothy Carey, DO | Daniel Johnson, DO | Jennifer Malcom, DO | Tommie Ptacek, PA-C
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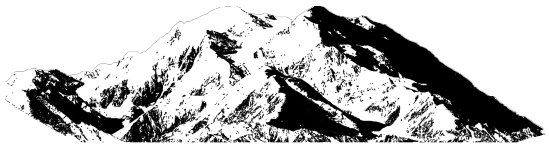

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PATIENT NAME: _____

Have you ever had any of the following problems? If yes, Please give details.

High blood pressure	Yes No When _____
Heart attack	Yes No When _____
Congestive Heart Failure	Yes No When _____
Angina	Yes No When _____
Irregular Heart Beat	Yes No When _____
Do you have a Pacemaker or Stents?	Yes No How Long? _____
High Cholesterol	Yes No When _____
Stroke or "mini stroke"	Yes No When _____
Diabetes	Yes No When _____ Do you take insulin? _____
Emphysema	Yes No When _____
COPD	Yes No When _____
Asthma	Yes No When _____
Cancer	Yes No When _____ What Type _____
Arthritis	Yes No Where _____
Seizures	Yes No When _____
Blood Clots	Yes No When _____ Where _____
Were you treated with blood thinners?	Yes No When _____
Sleep Apnea	Yes No If yes, do you use a CPAP machine? _____
Other:	_____

SOCIAL HISTORY :

Occupation: _____

Do you drink alcohol? Y N How much per week? _____

Do you smoke? Y N Street Drug? Y N

FAMILY HISTORY: Please list any current medical problems or causes of death in close relatives:

Mother _____ ☐ Deceased Sister _____ ☐ Deceased

Father _____ ☐ Deceased Brother _____ ☐ Deceased

MEDICATION ALLERGIES: Y N If yes, please List _____

LATEX ALLGERY: Y N

MEDICATIONS:

Currently Taking	**Dose**	**Times/Day**

PATIENT SIGNATURE: _____ **DATE:** _____

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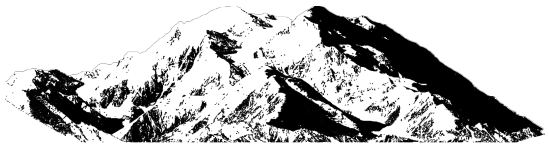

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PATIENT NAME: _____

REASON FOR SEEING THE DOCTOR TODAY?

What is your chief complaint? _____

How did injury occur? _____ Date of Injury? _____

Location of chief complaint: LEFT OR RIGHT

Please circle all that applies:

Do you have: Pain Stiffness Instability Swelling

The pain is Constant Comes and goes Mild Moderate Severe Occasional

What is the character of the pain: Aching Burning Sharp Pressure

What makes it **worse**? ☐Standing ☐Lifting ☐Exercise ☐Bending ☐Kneeling ☐Sitting ☐Other_____

What makes it **better?** ☐Rest ☐Elevation ☐ Heat ☐ Ice ☐Other _____

Were you seen in the E.R. for this problem? ☐Y ☐N Which E.R.? _____ Date_____

What other treatments have you had for this problem? _____

What tests have you had for this problem ☐ X-Rays ☐MRI ☐CAT scan ☐Bone scan ☐ Nerve Test(EMG/NCV)

If yes, where were these tests done? _____

Do you **CURRENTLY** have:

Fever or Chills	Yes No	
BlurredVision, Changed in visual acuity	Yes No	
Ear Pain or Difficulty Hearing	Yes No	
Palpitaions, Chest Pain, Light Head	Yes No	
Shortness of Breath, Cough, Blood in stool	Yes No	
Abdominal Pain, Nausea	Yes No	
Pain on urination, frequency of urination	YesNo	
Localized numbess, weakness, or Tingling	YesNo	
Depression, anxiety, substance abuse	YesNo	
Heat or Cold intolerance, weight loss or gain	YesNo	
Do you bleed easy?	YesNo	
Do you have any swollen glands?	YesNo	

PAST OPERATIONS: Please list any past operations. **Date or Year?**

_____

_____

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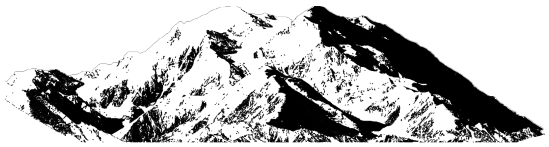

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HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS OF THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage, your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to: quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose, your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must disclosures to you and when required by the Secretary if the Department of Health and Human Services to investigate or determine out compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, expect to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under the federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that nay part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of you protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We have the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaint: You may complain to us or to the Secretary of Health Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **January 01, 2013**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Office or by phone at our phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____ _____

Signature Print Name Date

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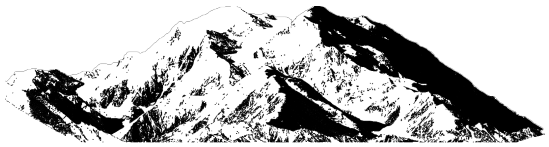

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OFFICE PAYMENT POLICY

OFFICE PAYMENT POLICY: Patients are responsible for payments of services rendered. Please read this form carefully and have questions answered before signing.

CASH ACCOUNT: **Payment is expected in full unless other arrangements have been made.**
INSURANCE: We are contracted ONLY with Blue Cross. You are ultimately responsible for your bill. It is your responsibility to check your coverage thru your insurance. We will bill primary and secondary insurance as a courtesy. **Patients are asked to pay the full amount of deductibles and co-pays at the time of each visit**. Any overpayments will be refunded to the appropriate party.

- **Chief Andrew Isaac Health Center**: Patients are required to bring a purchase order from Contract Health for each visit. If no purchase order is received the patient will be responsible for full payment at the time of the visit.
- **Medicaid:** Please be prepared to pay your $3.00 co-pay at the time of your visit.
- **Medicare**: Please remember there is yearly deductible and possible co-pay for each visit.
- **Veteran's Administration**: Prior authorization is required before each visit. This is the patient's responsibility. If no authorization is received the patient will be responsible for full payment at the time of visit.
- **Workers Compensation**: Paperwork from your employer is required upon the first visit. There will be no retroactive filing done by our office.

Insurance is a contract between you and you insurer. We will be happy to help if we can, but will not become involved in disputes concerning deductibles, co-pays, secondary insurance, or "usual and customary" reductions.

DELINQUENT ACCOUNTS: Past due accounts will be referred to **Cornerstone Credit Services** for collection. You will be responsible for all collection fees incurred, including a 35% referral fee, in addition to the past due balance. Once an account is placed with **Cornerstone**, all questions must be directed to their office at 1-907-770-8100. We will not be liable for any consequences which may result from a collection agency effort to obtain payment.

I authorize direct payments of benefits from my insurance to Daniel Johnson, DO for services rendered. I hereby authorize Daniel Johnson, DO or Ambria Ptacek, PA-C to release to my insurance company any information required to process a claim on my behalf. Photocopies of this form are to be considered to be as valid as the original. **I understand I am financially responsible to Daniel Johnson for charges incurred by me for services rendered regardless of insurance benefits.** I am aware that failure make payment on my account may result in legal or collection action to recover unpaid amounts and may include legal fees, court costs, and other charges as necessary. This authorization shall expire upon written notice.

Signature _____ Print Name _____ Date _____

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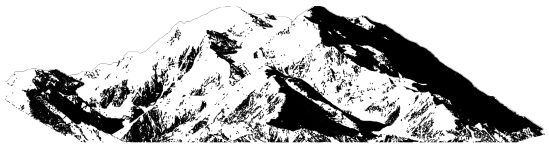

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WORKMEN'S COMPENSATION INFORMATION

Patient's Name: _____ Date: _____

INFORMATION REQUIRED TO BILL WORKMEN'S COMPENSATION CLAIMS:

DATE OF INJURY: _____

Employer at the time of the injury: _____

Workmen's Compensation **CARRIER:** (this is different from your employer)

_____

Workmen's Compensation **CLAIM #: _____**

Workmen's Compensation Carrier Address:

_____

Contact Person: _____ Phone #: _____

ARGEEMENT

The Undersigned hereby agrees to supply Daniel R. Johnson, D.O. with the above (NEEDED) information within 5 days for the medical services provided to the above named patient.

****** IN THE EVENT THE ABOVE INFORMATION IS NOT SUPPLIED TO DANIEL JOHNSON'S OFFICE WITHIN THE SPECIFIED TIME (5DAYS) I UNDERSTAND THAT THE ACCOUNT BALANCE WILL BECOME THE GUARANTORS IMMEDIATE RESPONSIBILITY ******

Signature _____ Print Name Date

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