John P. Bursell, MD
Gregg Schellack, DO
Gustavo Garcia, MD

Daniel R. Harrah, MD Ted
L. Schwarting, MD

# Health History

Name ______________________________________________ Today's Date ________________
Date of Birth _____________________ Age _____________ Date of Injury _______________
Family Doctor & Clinic ______________________________________________________________
What condition are you seeing the doctor for today? _______________________________________
_____________________________________________________________________________________
Have you seen any other doctor for this condition? ☐ No ☐ Yes, please name ____________________

Past Medical History Conditions: Check (X) any conditions that you currently have or have had in the past:

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Chemical Dependency | ☐ High Blood Pressure | ☐ Psychiatric Care |
| ☐ Alcoholism | ☐ Diabetes | ☐ Kidney Disease | ☐ Rheumatic Fever |
| ☐ Anemia | ☐ Emphysema | ☐ Liver Disease | ☐ Stroke |
| ☐ Arthritis | ☐ Epilepsy | ☐ Multiple Sclerosis | ☐ Suicide Attempt |
| ☐ Asthma | ☐ Gout | ☐ Pacemaker | ☐ Thyroid Problems |
| ☐ Bleeding Disorders | ☐ Heart Disease | ☐ Pneumonia | ☐ Tuberculosis |
| ☐ Bronchitis - chronic | ☐ Hepatitis | ☐ Polio | ☐ Ulcers |
| ☐ Cancer | ☐ Herpes | ☐ Prostate Problem | ☐ Other____________ |

Surgeries/Hospitalizations: ☐ None

| Year: | Operation/Procedure: | Hospital: |
|---|---|---|
| ______________ | ______________________________ | ______________________________ |
| ______________ | ______________________________ | ______________________________ |
| ______________ | ______________________________ | ______________________________ |

Non-Surgical Procedures: ☐ None

| Year: | Procedure: | Hospital: |
|---|---|---|
| ______________ | ______________________________ | ______________________________ |
| ______________ | ______________________________ | ______________________________ |
| ______________ | ______________________________ | ______________________________ |

Have you ever had a blood transfusion? ☐ No ☐ Yes, approximate date ___________________________

Medication: List medications you are currently taking, including non-prescription drugs and dosages ☐ None

_____________________ _____________________ _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________

**** Please complete the backside of this form ****

## Health History

**Drug Allergies:** Please mark any allergies, if there are none known, then mark the box next to none. ☐ None

____________________ ____________________ ____________________

____________________ ____________________ ____________________

**Social History:** Check (X) which substances you use and describe how much you use and how frequently ☐ None

☐ Alcohol ☐ Caffeine ☐ Drugs ☐ Tobacco ☐ Other

__________ __________ __________ __________ __________

**Family History:**

| Relation | Age | Current state of health | Age at death | Cause of death | Check (X) if your blood relatives had any of the following: | |
|---|---|---|---|---|---|---|
| | | | | | | |
| Father | | | | | ☐ Arthritis | |
| Mother | | | | | ☐ Gout | |
| Brothers | | | | | ☐ Cancer | |
| | | | | | ☐ Diabetes | |
| | | | | | ☐ Heart Disease | |
| Sisters | | | | | ☐ High Blood Pressure | |
| | | | | | ☐ Rheumatoid Arthritis | |
| | | | | | ☐ Stroke | |
| | | | | | ☐ Other | |

**Symptoms:** Check (X) symptoms you currently have or have had in the past year. ☐ None

**General**
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

**Gastrointestinal**
- ☐ Poor appetite
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Nausea
- ☐ Stomach pain

**Eye, Ear, Nose, Throat**
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

**Muscle, Joint, Bone**
(pain, weakness, numb)
- ☐ Arm
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

**Genito-Urinary**
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

**Skin**
- ☐ Bruise easily
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

**Cardiovascular**
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

______________________________ ____________________

Patient Signature Date

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## Patient Information

Name ______________________ SSN ______________________

Date of Birth ______________ Sex M / F Married / Single / Divorced / Widowed

Mailing Address ______________________ City/State ______________ Zip ________

Home Phone ______________ Cell ______________ Work ______________

Primary Care Doctor/Clinic ______________________________________

Occupation ______________________ Employer ______________________

Emergency Contact Name ______________________ Phone ______________

## Insurance Information

Do you have: Medical Insurance - Yes / No

- Primary Insurance ______________ Policy Holder ______________ DOB ________

  Policy Number ______________ Group Number ______________

- Secondary Insurance ______________ Policy Holder ______________ DOB ________

  Policy Number ______________ Group Number ______________

Mailing address / phone number of Policy Holder, if different than above ______________________

______________________________________________________________

## Worker's Compensation

Is this a Worker's Comp Injury - Yes / No Date of Injury ______________

WC Insurance Carrier ______________________ Adjustor ______________

Claim Number ______________________ Phone ______________

## Authorization

I, the undersigned, have insurance, and assign directly to Juneau Bone & Joint Center all medical benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize JBJC to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signed ______________________________ Date ______________

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## Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have received a copy of the Juneau Bone & Joint Center (JB&JC) Privacy Notice that describes how my health information is used and shared. I understand that JB&JC has the right to change this notice at any time.

My signature below, constitutes my acknowledgement that I have received a copy of the notice of privacy practices.

| | |
|---|---|
| ______________________________ Patient name | ______________ Date |
| ______________________________ Signature of patient or legal representative | ______________ Relationship to patient |

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I understand my HIPPA rights and I request Juneau Bone & Joint Center to leave messages, including those containing personal health information for me, with either of the two individuals listed below, or by fax, voicemail, answering machine at the numbers below:

Fax ______________________________

Voicemail / Answering Machine ______________________________

Relative / Friend
1) ______________________________
2) ______________________________

| | |
|---|---|
| ______________________________ Signature of patient or legal representative | ______________ Relationship to patient |

Signature of JB&JC employee/witness: ______________________________

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# Patient Payment Policy
# ** Signature Required **

Thank you for choosing our practice! We are committed to providing you with quality health care. Some of our patients have had questions regarding patient and insurance responsibility for services rendered; we have developed this financial policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**Insurance:** We participate in most insurance plans. We will bill your insurance company as a courtesy to our patients. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You are required to pay any co-pay and/or deductible.

**Copayments and Deductible:** It is the patient's responsibility to know information regarding deductible and co-pay. Please contact your insurance company to determine these amounts. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. This is a requirement for all patients. If you do not know what your co-pay amount is, you will be charged 20% of the visit fee at the time of service.

**Medicaid:** All Medicaid patients must provide their Medicaid coupon each month, and provide their $3 co-pay at each visit. If we do not have a Medicaid coupon, the patient's services will be considered self-pay.

**Medicare:** Payment is not required at the time of service for Medicare patients. We will submit your claim to Medicare and your supplementary insurance. You will be responsible for any deductible co-pay left over.

**Non-covered services:** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered necessary by Medicare or other insurers. This is something decided by your insurance company and it will still be your responsibility to pay for these services.

**Proof of Insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**~ continued on back ~**

**Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you do not notify us of changes, any balances of services will be the patient's responsibility to pay.

**Methods of Payments:** We accept payment by cash, check, VISA, and Mastercard.

**Patient Statements:** Unless other arrangements are approved by us in writing, the balance on your statement is due 30 days from when the statement is issued.

**Nonpayment:** If your account is past due, you will receive a letter from us stating you have 10 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this is to occur, you will not be able to be seen in the office until your balance is paid in full and all charges for future visits will be collected upfront. Until the balance is paid in full, our physicians will only be able to treat you on an emergency basis.

**Returned Checks:** There is a fee of $25 for any checks returned by the bank.

**Divorce:** In case of divorce or separation, the party responsible for the account is the parent authorizing treatment for a child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Worker's Compensation:** We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

**Personal Injury:** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

**Missed Appointments:** Our policy is 24-hours notice on an appointment change. We understand emergencies arise. If an emergency keeps you from keeping your appointment, please contact us as soon as you know you will not be able to keep the scheduled appointment. Please help us to serve you better by keeping your regularly scheduled appointments. After 3 no-show appointments, you will no longer be able to be seen at our office.

**Surgery:** If your physician recommends surgery, you will be escorted to the Surgery Scheduler. She will answer any specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. If you do not have insurance coverage, you will be required to pay at least 75% of the surgery cost before your surgery, unless otherwise arranged with your physician.

**By signing below, I agree to the payment policy of Juneau Bone & Joint Center**

**Patient Name:** ________________________________________

(If patient is under the age of 18, parent or legal guardian sign below)

**Patient Signature:** ____________________________________ **Date** ________________

**Please return this signed form to the front desk receptionist. A copy of this form will be kept in your patient chart. You will be provided a copy of this form upon your request.**