John P. Bursell, MD
Daniel R. Harrah, MD
Ted L. Schwarting, MD

Gustavo Garcia, MD
Gregg Schellack, DO

Patient Information

Name ____ SSN ________________________________

Date of Birth ___________________ Sex M___ F___ Married___ Single___ Divorced___Widowed___

Mailing Address ________________________________ City/State ____________________ Zip ___________

Primary Phone _________________ Secondary Phone __________________ Email ___________________

Primary Care Doctor/Clinic_________________________________ Pharmacy for eRX _____________________

Emergency Contact Name ___________________________Relationship ____________Phone _____________

The above contact has authorization to make medical decisions: Yes No

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 ____________________________

John P. Bursell, MD
Daniel R. Harrah, MD
Ted L. Schwarting, MD

Gustavo Garcia, MD
Gregg Schellack, DO

Notice of Privacy Practices

Juneau Bone & Joint Center

This notice describes how medical information about you may be used and disclosed and how you can get access to this information, please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for the health care operations as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe those rights in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information

The following paragraphs describe different ways that we use and disclose your protected health information, we have provided an example for each category, but these examples are not meant to be exhaustive. All the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you, additionally we may from time to time disclose your health information to another physician whom we have requested to be involved In your care. For example -- we would disclose your heath information to a specialist whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for health care services we provide you. For example – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedure performed, and suppose used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities of our practice. For example – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to a third-party business associate who perform billing, consulting, or transcription, or other services for our practice.

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives. We will use and disclose your protected health information to tell you about or recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care. We will use and disclose your protected health information to an immediate family member, a relative, a close friend, or any other person that you identify to be involved in your medical care or payment of care.

Research. We will use and disclose your protected health information to researchers, provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We will use and disclose your protected health information when required to by federal, state, or local law.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed buy health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the practitioner or facility that compiled it, the information belongs to you. Your rights include:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medial and billing records as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling you request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our office. You may mail your request or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information I stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.

We are permitted to deny your request if:

- It is not in writing or does not include a reason to support the request.
- The information was not created by us or the person who created it is no longer available to make the amendment.
- The information is not part of the record which you are permitted to inspect and copy.
- The information is not part of the designated records kept by this practice
- It the opinion of the health care provider that the information is accurate and complete.

Request Restrictions. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. If we do agree, we will comply with your request except for emergency treatment.

Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be in writing and must state the dates of service for the requested information. Records from 7 or more years ago may be unavailable* and we may be unable to complete those requests.

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first requires, we may charge you a free for the costs of providing the subsequent list. We will notify you of such costs and grant you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice directly to the HIPAA Compliance Officer.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Office Manager.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

Effective 08/06/2007-Updated 08/18/2020

John P. Bursell, MD
Daniel R. Harrah, MD
Ted L. Schwarting, MD

Gustavo Garcia, MD
Gregg Schellack, DO

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have received a copy of the Juneau Bone & Joint Center (JBJC) Privacy Notice that describes how my health information is used and shared. I understand that JBJC 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

---

I understand my HIPAA 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) ________________________________

I give the above contact authorization to receive verbal medical information Yes No

____ ______________________

Signature of patient or legal representative Relationship to patient

Signature of JBJC employee/witness: ____

John P. Bursell, MD
Daniel R. Harrah, MD
Ted L. Schwarting, MD

Gustavo Garcia, MD
Gregg Schellack, DO

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. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. 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 insurance card, and provide their $3 co-pay at each visit. Anyone under the age of 18 does not require a $3 co-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 physician no-show appointments, you will no longer be able to be seen at our office. Rehabilitation Department patients should refer to the "*Rhab Consent & Participation Policy*" for additional no show policy guidelines.

Surgery: If your physician recommends surgery, you will be escorted to the Surgery Scheduler(s). They 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.

John P. Bursell, MD
Daniel R. Harrah, MD
Ted L. Schwarting, MD

Gustavo Garcia, MD
Gregg Schellack, DO

Dr. Bursell's Health History

Please note that this form should be updated every six months to ensure proper diagnosis and treatment options

---

Patient Name:____Date:______________________

Date of Birth:_____________ Occupation:____________________ Height:_______ Weight:_________

Primary Care Provider:______________________ Facility of Primary Care Provider:_____________________

Reason for visit:____

When did your pain start?____

Has your pain increased recently? ☐Yes ☐No, How recently? _____________________________________

Is your pain related to a recent injury? ☐Yes ☐No, Please describe:_________________________________

Did you notice any of the following at the time of injury? ☐ A "pop" ☐Tearing sensation ☐Swelling

Which of the following best describes your pain? (Select all that apply)

☐Dull ☐Sharp ☐Aching ☐Burning ☐Numbness ☐Tingling

How often does your pain occur? ☐Constantly ☐Intermittently ☐Awakens me from sleep

What aggravates your symptoms?____

What improves your symptoms?____

Do you have difficulty picking up small objects such as coins or buttons? ☐Yes ☐No

Do you have a problem with balance or tripping? ☐Yes ☐No

Have you had an recent falls? ☐Yes ☐No, How many? ______________________________________

There are (☐Frequent ☐Occasional ☐No) headaches in the back of the head

The pain is present the most while: ☐Standing ☐Sitting ☐Walking ☐Lying Down

How many minutes can you stand in one place without pain? ☐0-10 ☐15-30 ☐30-60 ☐60+

How many minutes can you sit in one place without pain? ☐0-10 ☐15-30 ☐30-60 ☐60+

How many minutes can you walk without pain? ☐0-10 ☐15-30 ☐30-60 ☐60+

Lying down: ☐Increases the pain ☐Decreases the pain ☐Does not affect the pain

Bending over: ☐Increases the pain ☐Decreases the pain ☐Does not affect the pain

---

Current Medications: Please list medications you are currently taking, including non-prescription drugs and dosages ☐ **None**

1.	5.
2.	6.
3.	7.
4.	8.

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

Medication:	Reaction:

Past Surgical History: ☐**None**

Type:	Year:	Type:	Year:
Heart Bypass ☐	______	Spine Surgery ☐Cervical ☐Thoracic☐ Lumbar	______
Pacemaker ☐	______	Hip Surgery ☐Right ☐Left ☐Both	______
Heart Valve ☐	______	Knee Surgery ☐Right ☐Left ☐Both	______
Heart Stent ☐	______	Shoulder Surgery ☐Right ☐Left ☐Both	______
Cancer Surgery ☐	______		
Prostate Surgery ☐	______		

Other Surgeries:____ Year:________
____ Year:________

Prior Treatment: ☐**None**

☐Physical Therapy ☐Oral Steroids ☐Cortisone Injections ☐Surgery ☐Medications

☐Other:____

Prior Diagnostics: ☐**None**

☐X-Ray ☐MRI ☐CT ☐EMG (Nerve Conduction Study)

☐Other:____

Medical History: Please select all that apply ☐**None**

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

☐Other:____

Social History: How often do you use any of the following substances? ☐**None**

Caffeine: ☐Frequently ☐Occasionally ☐Never

Drugs: ☐Frequently ☐Occasionally ☐Never ☐Narcotics ☐Recreational ☐Other:____________

Tobacco: ☐Frequently ☐Occasionally ☐Never

Marijuana: ☐Frequently ☐Occasionally ☐Never

Alcohol: ☐Frequently ☐Occasionally ☐Never _________drinks per week

Cigarettes: ☐Frequently ☐Occasionally ☐Never ________ packs per day

---

Review of Symptoms: ☐**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

Family History:

Relation	Age	Current state of health	Age at death	Cause of death	Check 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	

____ Patient Signature

__________________________ Date