Genesis ORTHOPEDIC SINCE 1989

WELCOME TO OUR OFFICE

Genesis Orthopedic specializes in Orthopedic Surgery and Sports Medicine. Dr. Bruce Perry attended Michigan State University of Human Medicine. His internship was at Henry Ford Hospital in Detroit and his orthopedic residency was at the University of Kansas School of Medicine, St. Francis Regional Medical Center in Wichita, Kansas. He has practiced in Grants Pass for more than 28 years.

Appointments Our scheduler makes these and occasionally she will have to call and change your appointment if Dr. Perry is called in to the hospital for an emergency. In the event that he is called away, our scheduler will make every effort to contact you prior to your appointment to reschedule.

Back Office Our medical assistants handle all medical duties, including surgery scheduling, and will be happy to assist you in any way they can.

Pharmacy Refills Call your pharmacy by 12:00 noon, two days before you will need a refill. If the pharmacy cannot refill your prescription, they will fax us with a request. Please allow 48 hours for us to process your prescription.

Billing All copays are due at the time of service. A statement of fees owed is sent to you regularly. Regardless of your medical insurance coverage, our office relies on you to settle your account. You are ultimately responsible for all office and surgery fees related to your care. Your health insurance policy is an agreement between you and your insurance carrier. We bill your insurance as a courtesy to you. Our office manager will assist you with any questions you have about your bill and/or make payment arrangements if necessary. We accept credit cards, debit cards, checks, and cash. **Please note: We expect account balances to be paid in full within three months of date of service.** If payment arrangements have been made and the balance will exceed 90 days there is a charge of 18% per year on the balance. If your account becomes delinquent, we will be forced to turn it over to a collection agency and this will affect your credit rating.

FINANCIAL POLICY

We participate in a variety of health care insurance programs that aid in the payment of your medical costs. Should there be problems with an insurance claim, we suggest that you direct your questions to your insurance carrier first. Our office manager can help you if you need assistance in resolving a claim.

Patients with Medicare We accept Medicare assignment but not Medicare payment as full payment. Medicare covers 80% of the allowed charges. Patients without a secondary insurance will be expected to pay their portion of Medicare's allowed charges at the time of visit (20% of Medicare allowed charges). If you have insurance secondary to Medicare, we will also bill them. We do not bill tertiary insurance.

Patients with Commercial Insurance We will bill your insurance for you. Your copay will be expected at the time of service. There can be a $10 charge on any co-pay not taken care of on the date of service. Please be aware that it is your responsibility to pay any deductible amount, co-insurance, or any balance left unpaid by your insurance company. If no payment is received from your insurance company within 90 days of the date of service, we will expect you to pay the account in full. We know that questions can arise on insurance matters. Feel fee to call our office manager to discuss any questions you might have.

Patients with Oregon Health Plan (OHP) We will bill your insurance for you. It is your responsibility to have a referral in place for your visit. If your insurance denies charges for not having a referral in place, the bill will become yours to pay. It is the your responsibility to know what OHP plan you have.

Patients with Work Comp We will bill your insurance for you. It is your responsibility to give the correct workers comp insurance carrier to our front office, along with your claim number and insurance adjuster's name and phone number.

Patients with Auto or Third Party Billing We will bill your insurance for you. It is your responsibility to give the correct insurance information to the front desk. We require claim number, billing address, and adjuster's name and phone number.

Patients without Insurance Payment of $250 will be expected at the time of service. If the charges are more, we will bill the difference. If the charges are less, we will apply the balance to your next visit.

Charges Charges for services, including office visits and surgery, are based on the Federal Register, the severity and complexity of your injury and the time spent treating you. Most surgeries include a 90-day global follow-up appointment at no additional cost to the patient. This does not include any supplies, braces, or post-surgical complications.

Bank Returned Checks There will be a service charge for all returned checks.

Forms If your insurance carrier, disability carrier, or employer (FMLA) requests a special form, other than a CMS 1510, you will be charged a small fee. The charge will be due the day the forms are picked up.

Appointment Changes Please grant us at least a 24-hour notice if you need to reschedule or cancel your appointment. There is a $50 charge for missed appointments that are not covered by your insurance company. These charges are the responsibility of the patient.

PATIENT RESPONSIBILITIES

1. Contact our office IMMEDIATELY at 541-471-6033 when:
   a. you have increased pain, a fever, or flu-like symptoms
   b. your wound changes for the worse (unusual drainage, foul smell, heat, or redness)
2. Follow the care plan given by Dr. Perry.

We will do everything we can to make your visits to our office as pleasant at possible. We will be sensitive to your financial circumstances within the framework of sound business practices. We want to focus on your orthopedic needs, not your financial responsibilities.

I understand all of the above information.

Signature (person completing form) _____ Date _____

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Use and Disclosure of Your Health Information Your protected health information will be used by Bruce E. Perry MD or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this practice.

Notice of Privacy Practices You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information You may request a restriction on the use or disclosure of your protected health information. Bruce E. Perry MD may or may not agree to restrict the use or disclosure of your protected health information. If Bruce E. Perry MD agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

Revocation of Consent You may revoke the consent to the use and disclosure of your protected health information. You must revoke this request in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices Bruce E. Perry MD reserves the right to modify the privacy practices outlined in this notice.

I have reviewed this consent form and give permission to Bruce E. Perry MD to use and disclose my health information in accordance with it. I also acknowledge I have been given a copy of Dr. Perry's Privacy Practices.

_____

Name of Patient (please print)

_____ _____

Patient Signature Date

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) TO A FAMILY MEMBER OR FRIEND

The protected health information Genesis Orthopedic is authorized to disclose includes:

_____

_____

PERSON/ORGANIZATION AUTHORIZED TO RECEIVE PHI

Dr. Bruce E. Perry and staff are authorized to disclose the above information to the following:

_____

_____

EXPIRATION OF AUTHORIZATION

This authorization is effective through _____ / _____ / _____ unless revoked or terminated by the patient or patients personal representative.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written revocation to Genesis Orthopedic. Contact our Privacy official to terminate this authorization.

POTENTIAL FOR RE-DISCLOSURE

The persons or organization to which PHI is sent may disclose information that is disclosed under this authorization again. The privacy of this information may not be protected under federal privacy regulations.

_____
Name of Patient (please print)

_____ _____
Patient Signature Date

_____ _____
Name of Representative (please print) Relationship to patient

_____ _____
Signature of Representative Date

PERMISSION TO LEAVE PHONE MESSAGES

In accordance with the Data Protection Act, Genesis Orthopedic requires written or verbal consent to leave a message on a patient's phone. If we do not have written or verbal consent, we will be unable to leave a message on your phone or leave a message with a third party.

Please complete the following:

I give consent for Genesis Orthopedic to leave voice mail on the following phone lines:

Home _____

Mobile _____

Work _____

I give consent for Genesis Orthopedic to leave a message about any aspect of my medical treatment with:

Name _____ Phone _____

This consent is to remain in force from the date written below until further notice of cancellation by me.

I have reviewed this consent form and give permission to Bruce E. Perry MD to use and disclose my health information in accordance with it. I also acknowledge I have been given a copy of Dr. Perry's Privacy Practices.

_____ _____

Patient Signature Date

_____ _____

Name of Patient (please print) Date of Birth

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PATIENT INFORMATION

Patient's Last Name _____ First _____ Middle Initial _____

Date of Birth _____ Gender ☐ M ☐ F MRN _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

SS# _____ Email _____

Maiden Name _____ Mother's First Name _____ Father's First Name _____

Race _____ Ethnicity _____ Marital status ☐ Single ☐ Married

Employer Name _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

SPOUSE'S INFORMATION

Spouse's Last Name _____ First _____ Middle Initial _____

Date of Birth _____ Gender ☐ M ☐ F

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

SS# _____ Email _____

Maiden Name _____ Mother's First Name _____ Father's First Name _____

Race _____ Ethnicity _____ Marital status ☐ Single ☐ Married

Employer Name _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

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Name _____

MRN _____ Date of Birth _____

INSURANCE

Primary Insurance Company _____ Phone _____

Insurance Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Date of Birth _____

Patient's Relationship to Policy Holder _____ Group # _____ ID # _____

Employer of Policy Holder _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance Company _____ Phone _____

Insurance Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Date of Birth _____

Patient's Relationship to Policy Holder _____ Group # _____ ID # _____

Employer of Policy Holder _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

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INTAKE FORM

Today's date _____ Name _____

MRN _____ Date of Birth _____

Preferred language _____ Age _____ Gender ☐ M ☐ F Height _____ Weight _____

Referring Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Primary Care Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Pharmacy of Choice _____ Phone _____

Address _____ City _____ State _____ Zip _____

What is the reason for your visit today? _____

Location of pain (include side) _____ Are you right or left hand dominant? ☐ R ☐ L

How long have you had this pain? _____ Kind of pain: ☐ Dull ☐ Sharp ☐ Tingling ☐ Other

When does the pain occur? ☐ At rest ☐ With activity ☐ At night ☐ Other

List any other symptoms associated with current problem? _____

How severe is the pain? *(very little pain)* **1 2 3 4 5 6 7 8 9 10** *(excruciating/I can't function)*

What makes it feel better? ☐ Pain medicine ☐ Ice ☐ Heat ☐ Rest ☐ Elevation ☐ Other

What brought on the pain? _____

If the result of an injury, date occurred _____ Is is better? ☐ Y ☐ N It is worse? ☐ Y ☐ N

MEDICAL HISTORY

Please list all past medical conditions, whether they relate to your current condition or not.

Asthma	☐ Y	☐ N	DVT/PE (Blood clot)	☐ Y	☐ N
Blood/plasma transfusion	☐ Y	☐ N	Heart disease	☐ Y	☐ N
Cancer	☐ Y	☐ N	Lung disorder	☐ Y	☐ N
Cholesterol	☐ Y	☐ N	Stomach/intestinal disorder	☐ Y	☐ N
Clotting disorder	☐ Y	☐ N	Thyroid problems	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Other _____		
Hypertension	☐ Y	☐ N	Other _____		

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Name _____

MRN _____ Date of Birth _____

ALLERGIES

List anything you are allergic to, including medications, environmental agents, food, etc.

☐ No allergies

Allergic to:	Reaction	Allergic to:	Reaction

SURGICAL HISTORY

Have you ever had general anesthesia? ☐ Y ☐ N

Have you had any problems with anesthesia? ☐ Y ☐ N If yes, what? _____

List below all surgeries you have had.

Surgery/Procedure	Approx. Date	Physician/Surgeon	Complications, if any

MEDICATIONS

List anything you are taking, including prescriptions, over-the-counter medications, and herbal/vitamin supplements.

Name	Prescribed by	For what condition?	Dose	Frequency

FAMILY HISTORY

Please indicate any major illnesses or health conditions for family members.

	Alive	Age	Health Problems	Deceased	Cause of Death
Mother	☐			☐	
Father	☐			☐	

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Name _____

MRN _____ Date of Birth _____

SOCIAL HISTORY

Occupation _____ Marital status ☐ Single ☐ Married ☐ Other

Home: ☐ 1 story ☐ 2 story (# of stairs: _____) ☐ Apartment (Elevator ☐ Y ☐ N) ☐ Motor/RV

How often do you exercise? _____ times per week School sports _____

Tobacco use: ☐ None ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco

Average/day: _____ # of years: _____ If not currently, have you previously? ☐ Y ☐ N

Alcohol use: Average per week: _____ If not currently, have you previously? ☐ Y ☐ N

Marijuana use: ☐ Y ☐ N Do you have a medical marijuana card? ☐ Y ☐ N

REVIEW OF SYSTEMS

Constitutional ☐ None ☐ Fatigue ☐ Headache ☐ Weakness ☐ Recent weight change

Eyes ☐ None ☐ Glasses ☐ Surgery _____
☐ Blurred vision ☐ Cataracts ☐ Floaters

Ears, Nose, Throat ☐ None ☐ Congestion ☐ Hearing loss ☐ Sinus pain ☐ Tinitus ☐ Dentures

Lungs/Breathing ☐ None ☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Hoarseness ☐ COPD
☐ CPAI ☐ Oxygen

Heart ☐ None ☐ Murmurs ☐ Irregular heartbeat ☐ Pacemaker ☐ Stent ☐ Surgery

Gastrointestinal ☐ None ☐ Nausea ☐ Vomiting ☐ Surgery _____
☐ Stomach aches ☐ Constipation ☐ Diarrhea ☐ GERD ☐ Diverticulitis

Bladder ☐ None ☐ Incontinence ☐ Frequency ☐ Pain ☐ Difficulty urinating ☐ History of UTI

Endocrine ☐ None ☐ Diabetes ☐ Thyroid problems ☐ Delays in growth ☐ Growth problems

Musculoskeletal ☐ None ☐ Joint pain (location _____) ☐ Broken bones (location _____)

Bleeding ☐ None ☐ Anemia ☐ Easy bleeding ☐ Easy bruising ☐ History of DVT

Neurological ☐ None ☐ Dizziness ☐ Numbness/tingling (location _____) ☐ Tremors
☐ Frequent falls ☐ Seizures (date of last seizure _____)

Integumentary ☐ None ☐ Rashes ☐ Skin cancer (location _____)
☐ Skin disorders ☐ Connective tissue disorders

Psychiatric ☐ None ☐ Anxiety ☐ Depression ☐ Mood swings ☐ Trouble sleeping ☐ Bipolar

Immunologic ☐ None ☐ Asthma ☐ Hay fever ☐ Chronic rashes ☐ Communicable diseases

☐ Other _____

_____ _____
Signature (person completing form) Date

_____ _____
Physician signature Date