ORTHOPEDIC PHYSICIANS ALASKA
OrthoAlaska LLC

Orthopedic History Questionnaire

Name _____ **Date of Birth** _____ **Age** _____ **Sex** ☐ Male ☐ Female

Hand Dominance ☐ Right ☐ Left **Referring Physician** _____ **Primary Care Physician** _____

When did your symptoms begin _____ Is this work-related? ☐ Yes ☐ No Pain Contract ☐ Yes ☐ No

Describe your injury/symptoms _____

_____

_____

Check all that apply:	Never	Occasionally	Constant
Pain at rest	☐	☐	☐
Pain with activities	☐	☐	☐
Loss of motion	☐	☐	☐
Night pain	☐	☐	☐
Numbness/tingling	☐	☐	☐
Popping/clicking	☐	☐	☐
Grinding	☐	☐	☐
Instability/looseness	☐	☐	☐
Morning stiffness	☐	☐	☐
Giving way	☐	☐	☐
Swelling	☐	☐	☐

Do you have difficulty with:	Never	Occasionally	Constant
Personal care	☐	☐	☐
Work activities	☐	☐	☐
Lifting	☐	☐	☐
Reaching overhead	☐	☐	☐
Climbing stairs	☐	☐	☐
Weather changes	☐	☐	☐
Kneeling	☐	☐	☐

_____

What makes it worse? ☐ Activity ☐ Overuse ☐ Walking ☐ Lifting ☐ Sitting ☐ Sleeping Other_____

What makes it better? ☐ Ice ☐ Rest ☐ Medication Other_____

Current Medications	**Dose**	**Current Allergies**	**Reaction**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History:

☐ Anemia ☐ Arthritis ☐ Bleeding Disorders/clots ☐ Cancer _____ ☐ Depression ☐ Diabetes
☐ Heart Disease ☐ Hepatitis ☐ A ☐ B ☐ C ☐ High blood pressure ☐ Kidney/Liver Disease ☐ Lung Disease/Difficulty Breathing
☐ MRSA ☐ Thyroid Disease ☐ Trauma/Broken Bones ☐ Tuberculosis ☐ Ulcer/Stomach Problems ☐ Other _____

Prior Hospitalization? _____

Previous Surgeries (Surgery and year) _____

Family Medical History:

☐ Alcoholism ☐ Cancer _____ ☐ Chronic Pain ☐ Diabetes ☐ Disability ☐ Depression
☐ Heart Disease ☐ High blood pressure ☐ Migraine ☐ Stroke ☐ Substance Abuse ☐ Other _____

Social History:

Occupation _____ Currently Working? ☐ Yes ☐ No Education _____

Marital Status ☐ Married ☐ Single Number of Children _____

Tobacco? ☐ Yes ☐ No ☐ Former Smoker How much? _____ packs/day How long? _____ years

Drink Alcohol? ☐ Yes ☐ No How much? _____ How long? _____ years

Caffeine? ☐ Yes ☐ No How much? _____ How long? _____ years

Illegal Drug Use? ☐ Yes ☐ No How much? _____ How long? _____ years

Marijuana Use? ☐ Yes ☐ No How much? _____ How long? _____ years

turn page over and complete the other side

Review of Current Symptoms *Are you currently having or have had problems with your (check boxes that apply and explain)*

Constitutional	☐ Fatigue ☐ Fever ☐ Weight Loss ☐ Headache ☐ Other_____
Eyes	☐ Blurred Vision ☐ Glasses/Contacts ☐ Other_____
Ears, Nose, Throat	☐ Congestion ☐ Hearing Loss ☐ Jaw Discomfort ☐ Other_____
Lungs, Breathing	☐ Shortness of Breath ☐ Wheezing ☐ Cough ☐ Other_____
Heart	☐ Chest Pain ☐ Irregular Heartbeat ☐ Heart Murmurs ☐ Other_____
Gastrointestinal	☐ Nausea ☐ Vomiting ☐ Stomach Aches ☐ Constipation ☐ Diarrhea ☐ Other_____
Bladder	☐ Incontinence ☐ Urinary Tract Infection ☐ Difficulty Urinating ☐ Other_____
Endocrine	☐ Diabetes ☐ Thyroid problems ☐ Delays in growth ☐ Other_____
Musculoskeletal	☐ Joint pain ☐ Leg Pain ☐ History of Broken Bones ☐ Other_____
Bleeding Problems	☐ Anemia ☐ Prolonged Bleeding after Cut/Injury ☐ Other_____
Neurological	☐ Numbness/tingling ☐ Dizziness ☐ Headaches ☐ Frequent Falls ☐ Other_____
Integumentary	☐ Rashes ☐ Skin Disorders ☐ Connective Tissue Disorders ☐ Other_____
Psychiatric	☐ Change of mood behavior ☐ Change in sleep patterns ☐ Other_____
Immunologic/Allergic	☐ Asthma ☐ Communicable Diseases ☐ Chronic Rashes ☐ Hay Fever ☐ Other_____
Gynecologic	Pregnant? ☐ Yes ☐ No ☐ Unsure Regular Menstrual Periods? ☐ Yes ☐ No

Any additional comments or information that you feel is important regarding your current medical condition:

_____
_____
_____
_____
_____
_____
_____

I believe that the information provided above is accurate and complete: _____ _____

Patient Signature Date

Thank you for taking the time to help us better care for you!

Office Use Only

Reviewed by_____ Date_____ ☐ Scanned

PATIENT FINANCIAL POLICY

ORTHOPEDIC PHYSICIANS ALASKA
OrthoAlaska LLC

Thank you for choosing Orthopedic Physicians Alaska (OPA). We understand that many patients find financial matters surrounding their medical care to be very complex and often confusing. If you ever have a question regarding our billing policies, we will be happy to assist you.

Blue Cross Blue Shield Initial Here _____	We are a contracted, preferred, In-Network provider with Blue Cross Blue Shield as of 1/1/17. You are responsible for deductible, co-pay and/or co-insurance amounts not collected at the time of service.
Private Health Insurance – Initial Here _____	We are ***NOT*** contracted, preferred or considered In-Network with any private health insurance plans with the ***EXCEPTION OF BLUE CROSS BLUE SHIELD***. As the patient you are responsible for requesting prior approval and/or benefit level exceptions from your insurance if required. OPA collects a flat fee of $150.00 for new patients / $75.00 for established patients applied toward your estimated services. You will be balance-billed for any amount not considered by your plan in addition to your deductible, co-pay and/or co-insurance amounts not collected at the time of service.
Medicare – Initial Here _____	We are a contracted provider with Medicare. You must be enrolled in Medicare Part B to be eligible for benefits. We will bill you for any remaining deductible, co-insurance and/or patient notified non-covered services after Medicare processes. No payment is required at the time of service.
Medicaid/Denali Kid Care – Initial Here _____	We are a contracted provider with Medicaid/ Denali Kid Care. You must present a current sticker for each month of eligibility. Please note our office does NOT accept CAMA or Disability Exam benefits. A referral is required if you are in the Lock-In Program, without a referral you will be considered a self-pay. Your co-pay is due at the time of service. Failure to make payment may result in delayed future appointments.
Tricare / Veterans Administration – Initial Here _____	We are a contracted provider with Tricare. *Active Duty Service Members are required to have a referral from your Primary Care Manager and authorization before treatment.* Tricare Prime beneficiaries may self-refer using the Point-of-Service option if a referral has not been obtained. Tricare standard beneficiaries have a fee-for-service option with no referral requirements. Tricare for Life claims are electronically forwarded by Medicare. We will bill the VA for your **prior authorized** treatments.
Workers Compensation – Initial Here _____	We only accept Workers' Compensation claims that were filed with the Alaska Department of Labor. Your claim must be open and accepted. You must provide your carriers information including claim number and date of injury. No payment is required at the time of service. Please note we do **NOT** accept Federal or Out of State Workers' Compensation.
Auto Accident – Initial Here _____	A claim must be established with your auto insurance carrier. We will only bill first party claims (your auto insurance policy) regardless of fault. Once your medical benefits are exhausted your private insurance may be billed. YOU MUST CONTACT YOUR PRIVATE INSURANCE TO DISCLOSE YOUR LIABILITY CLAIM. If you have no other insurance coverage, your account will be transferred to a self pay status and payment will be due upon receipt unless other billing arrangements have been approved by the OPA Billing Department.
Self Pay / Un-Insured – Initial Here _____	Payment is due in full at the time of service unless other billing arrangements have been approved by the OPA Billing Department.
Payment Plans – Initial Here _____	Payment plans must be established through the OPA Billing Department. Payment plans are based on a maximum number of months from the date services are rendered. Once you have reached the maximum length of the payment plan you must obtain alternative financing. All payments are applied toward your oldest services first.
Other – Initial Here _____	_____

- I have read, understand and agree to this Financial Policy.
- I understand that I am ultimately responsible for my balance, not my insurance carrier.
- I authorize Orthopedic Physicians Alaska to release pertinent medical information to my insurance company when requested in order to facilitate payment.
- I understand that my signature authorizes benefits to be paid directly to Orthopedic Physicians Alaska.
- I understand that should this debt become delinquent the balance may be referred to a collection agency. I will be held responsible for all fees associated with the collection of my debt.

_____ _____ _____

Printed Name of Patient **Date of Birth** **Account Number**

_____ _____

Signature of Patient or Patient's Legal Representative **Date**

RELEASE OF PROTECTED HEALTH INFORMATION - FAMILY AND FRIENDS

ORTHOPEDIC PHYSICIANS ALASKA
OrthoAlaska LLC

Patient Account Number _____

Patient Name: _____

I authorize Orthopedic Physicians Anchorage to release my Protected Health Information "PHI" to:

1. _____ DOB: _____ Relationship to Patient: _____
2. _____ DOB: _____ Relationship to Patient: _____
3. _____ DOB: _____ Relationship to Patient: _____

This release authorizes Orthopedic Physicians Anchorage to discuss your Protected Health Information with the above listed individual(s).

Please note: A separate release form (Authorization for the Use and Disclosure of Protected Health Information) is required for Orthopedic Physicians Anchorage to release your medical records to any individual(s).

By signing below, you agree that Orthopedic Physicians Anchorage may release Protected Health Information to the above individual(s). This release will remain in effect for one year from the date signed below. If you wish to revoke this release you must do so in writing directed to: Orthopedic Physicians Anchorage Privacy Officer. Your request will be processed within 48 hours unless otherwise specified. Please call 907-562-2277 if you have additional questions.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Printed Name of Legal Representative