Bryan Matanky, M.D
Vanessa Gordon, PA-C Kristi Preston, PA-C
1760 E Florence Blvd, Suite 120 Casa Grande, Az 85122

Today's Date: _____

PATIENT INFORMATION

Patient Name (**Last, First, MI**): _____ Gender: □ M □ F

Mailing Address: _____ City, State, Zip: _____

Primary Phone: _____ □ Cell □ Home

Alternate Phone: _____ □ Cell □ Other

Email Address: _____ □ No Email

Marital Status: □M □D □W □S

Date of Birth: _____ SSN: _____

Language: _____ **Ethnicity**: □ Hispanic □ Non Hispanic **Race**: _____

Employer: _____ Occupation: _____

Work Address: _____ City, State, Zip: _____

Work Phone: _____ Hours per day/week: _____

Emergency Contact: _____ Phone: _____

Relationship to patient: _____ May we discuss your injury with this person? □Y □ N

INDUSTRIAL OR WORKERS COMP

Industrial Insurance Name: _____

Claim Number: _____

Adjustor's Name: _____

Adjustor's Phone Number: _____

Adjustor's Fax Number: _____

Date of Injury: _____

Injured Body Part: _____

Preferred Method of Contact (check all that apply):

□ **Primary phone on file** □ **Alternate phone on file** □ **Text to cell phone** □ **Email on file**

□ **I authorize Advanced Orthopaedics & Sports Medicine to send automated reminders regarding my appointment to my preferred method of contact.**

By signing below, I certify all information is true and correct to the best of my knowledge:

_____ _____

Signature ***Today's Date***

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NOTICE OF PRIVACY PRACTICES

To our patients:
This notice describes how health information about you(as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclose of your health information under special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. Or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
8. For Workers Compensation and similar programs

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Medical Records.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be in writing and submitted to Jennifer, Office Manager.
5. Right to copy of this notice. You are entitled to receive a copy of this NOTICE OF PRIVACY PRACTICES. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please contact Jennifer, Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Jennifer, Office Manager.

I hereby acknowledge that I have read and understand the Advanced Orthopaedics and Sports Medicine, P.C. **Notice of Privacy Practices.**

Print Patient Name: _____

Signature: _____ Today's Date: _____

I authorize AOSM to discuss above named patient's health/medical and or billing information with the following person(s):

(If left blank, we are unable to discuss your information with anyone.)

Name: Relationship to patient:

1. _____ _____

2. _____ _____

3. _____ _____

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AUTHORIZATION FOR:

ASSIGNMENT OF BENEFITS, RESPONSIBILITY FOR NON-COVERED SERVICES, RELEASE OF INFORMATION

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS PAYABLE BY ANY FEDERAL OR STATE HEALTH CARE PROGRAM OR COMMERCIAL PAYER BE MADE EITHER TO ME ON MY BEHALF TO ADVANCED ORTHOPAEDICS & SPORTS MEDICINE, P C FOR ANY SERVICES FURNISHED TO ME BY ITS PHYSICIANS OR EMPLOYEE AT ANY LOCATION. I AUTHORIZE ADVANCED ORTHOPAEDICS & SPORTS MEDICINE P C TO REALEASE TO ITS BILLING AGENTS. THE HEALTH CARE FINANCING ADMINISTRATION. ITS AGENTS AND MY INSURER AS APPLICABLE, ANY INFORMATION (INCLUDING, BUT NOT LIMITED TO INFORMATION REGARDING DRUG AND ALCOHOL PROGRAM PARTICIPATION, DIAGNOSIS, PROGNOSIS, TREATMENT OR REFERRAL) NEEDED TO DETERMINE THESE BENEFITS, THE BENEFITS PAYABLE FOR RELATED SERVICES OR TO OBTAIN PAYMENT FOR SERVICES PROVIDED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT TO THE RELEASE AT ANYTIME, EXCEPT TO THE EXTENT RELIED UPON BY ADVANCED ORTHOPAEDICS & SPORTS MEDICINE, P C OR THE DISCLOSURE IS AUTHORIZED BY LAW. THIS CONSENT TO THE RELEASE OR PAYMENT INFORMATION REMAINS VALID UNTIL EXPRESSINGLY REVOKED BY ME IN WRITING I UNDERSTAND THAT I AM PRIMARILY FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF ANY SERVICES PROVIDED.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN ANY AUTHORIZATIONS OR REFERRALS REQUIRED BY MY INSURANCE, AS WELL AS KNOW MY COPAYS AND DEDUCTIBLES REQUIRED BY MY INSURANCE.

I UNDERSTAND THAT IF MY COPAY IS NOT LISTED ON MY INSURANCE CARD THAT I WILL BE BILLED FOR IT.

I UNDERSTAND THAT IT IS MY RESPONSIBLITY TO NOTIFY AOSM OF ANY AND ALL INSURANCE CHANGES PRIOR TO MY APPOINTMENT.

Financial Agreement

Patient/Guarantor agrees to pay all costs of collection, including attorney fees, collection fees, and contingent fees to collection agencies which may be more than 35% of the delinquent balance, such contingency fee to be added by the provider and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

Print Patient Name: _____

Signature: _____ Today's Date: _____

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Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

PERSONAL MEDICAL HISTORY

(Please check all that apply)

□NONE

- ☐ Anemia
- ☐ Aneurysm
- ☐ Arrhinia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorders
- ☐ Blood Clots (Thromboembolism)
- ☐ Blood Transfusion
- ☐ Bulging Disc
- ☐ Cancer
- ☐ Cardiac Pacemaker
- ☐ Cardiomyopathy
- ☐ Carotid Artery Stricture
- ☐ Carpal Tunnel Syndrome
- ☐ Cellulitis
- ☐ Cerebral Palsy
- ☐ Cerebrovascular Accident (CVA)/ Stroke/ Transient Ischemic Attack (TIA)
- ☐ Cholesterol
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ CPOD
- ☐ Coronary Artery Disease (CAD)
- ☐ Deep Venous Thrombosis
- ☐ Degenerative Disc Disease
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gastroesophageal Reflux Disease (Heartburn)
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Palpitations
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herniated Disc
- ☐ HIV/AIDS
- ☐ Hypertension (High Blood Pressure)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Incontinence
- ☐ Irregular Heart Beat
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Retardation
- ☐ Myocardial Infraction (MI) (Heart Attack)
- ☐ No Personal Illnesses Reported
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Peripheral Vascular Disease
- ☐ Prostate Cancer
- ☐ Pulmonary Disease
- ☐ Reflux Sympathetic Dystrophy
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Seizure Disorder
- ☐ Spinal Stenosis
- ☐ Varicose Veins
- ☐ Venous Insufficiencies
- ☐ Vertigo

Local Pharmacy Name: _____ Nearest cross-streets: _____

City: _____

DRUG ALLERGIES □ NONE	**CURRENT MEDICATIONS** □ NONE □ COPY ATTACHED
NAME: REACTION:	NAME: DOSAGE:
ARE YOU ALLERGIC TO LATEX? □ Y □ N	*ARE YOU CURRENTLY TAKING A BLOOD THINNER? □ Y □ N*

FEMALES: ARE YOU PREGNANT? □ YES □NO □POSSIBLY IF YES: DUE DATE:_____

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Today's Date: _____

MEDICAL HISTORY

Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____(pounds) □ male □ female

Patient is: □ right handed □ left handed

Reason for visit today: Extremity: □ Left □ Right _____

If accident or injury, type and date: _____

Primary Care Physician:_____ Phone: _____ □ No Primary Care Physician

Specialist:

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

HABITS

Please mark at least one box on each line.

SMOKING:	□ CURRENTLY	□ PREVIOUSLY	□ NEVER	
ALCOHOL:	□ SOCIAL	□ PREVIOUSLY	□ NEVER	□ OTHER_____
ASPIRIN:	□ CURRENTLY	□ PREVIOUSLY	□ NEVER	
COFFEE:	□ CURRENTLY	□ PREVIOUSLY	□ NEVER	
DRUG USE (ILLICIT):	□ CURRENTLY	□ PREVIOUSLY	□ NEVER	□ MEDICAL
MARJUANA:	□ CURRENTLY	□ PREVIOUSLY	□ NEVER	□ MEDICAL
STEROIDS:	□ CURRENTLY	□ PREVIOUSLY	□ NEVER	□ MEDICAL

FAMILY HISTORY

(Please check all that apply)

□ **NONE**

- □ Anemia
- □ Arrhythmia
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation
- □ Bleeding Disorders
- □ Blood Clots
- □ Cancer
- □ Circulatory Problems
- □ Diabetes Mellitus
- □ Liver Disease
- □ Epilepsy
- □ Genetic/Hereditary Disorders
- □ Gout
- □ Heart Disease
- □ Heart Murmur
- □ Hemophilia
- □ HIV/AIDS
- □ Hypertension
- □ Kidney Disease
- □ Leukemia
- □ Malignant Hyperthermia
- □ No Family History Reported
- □ Obesity
- □ Osteogenesis Imperfecta
- □ Psychiatric Disorders
- □ Rheumatoid Arthritis
- □ Seizure Disorder
- □ Stroke
- □ Thyroid Disease

SURGICAL HISTORY

□ **NONE**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____