Your appointment is scheduled

with: Craig Gillis, DO

Date:_____ **Time:**_____

Location: ❒ Summit Lake Oswego
4103 Mercantile Drive
Lake Oswego, OR 97035
503-850-9940 Phone
503-850-6709 Fax

The following are a few reminders for your upcoming appointment at our office:

- Please fill out the attached paperwork before coming in to your appointment. Don't forget to bring it with you!

- Please arrive at your scheduled appointment time, or a few minutes prior.

- Your visit may include these steps in addition to the evaluation by the surgeon:
  •X-rays
  •Evaluation by a medical assistant and/or physician assistant
  •Durable Medical Equipment placement and fitting
  •Scheduling for a surgery or procedure
  •Scheduling for any needed tests or outside consultations
  •Meeting with a billing specialist

- **Bring all current insurance cards and a driver's license or form of identification.** Failure to present current insurance cards may cause a delay in obtaining authorizations or getting your bills paid. You will be billed directly if you are unable to provide proof of insurance.

- **All co-payments are due at the time of service.** Please bring a form of payment with you to your appointment.

- Bring all diagnostic testing films and reports with you that pertain to your appointment, including any current x-rays, MRI films, or CT scans (from within the past 3 months) that were not taken at our office. **New x-rays may still be taken by our facility**

SUMMIT ORTHOPAEDICS

DEMOGRAPHIC INFORMATION

Name (First):_____(MI):_____(Last):_____

Address (Street):_____

(City/State/Zip/Country):_____

Home Phone: (_____)_____Mobile Phone: (_____)_____

Email: _____

Date of Birth:_____/_____/_____ **SSN:**_____–_____–_____ **Gender:** · Male · Female

Marital Status: · Married · Divorced · Widowed · Separated · Single · Unmarried Partner

Race: · White · Black or African American · Hispanic · American Indian, Alaska Native
· Asian · Native Hawaiian or Other Pacific Islander · Other (please specify): _____

Contact Person in Case of Emergency (Other Than Person With Whom You Reside)

Name (other than person you live with): _____

Relationship:_____Telephone: (_____)_____

Referring Physician

***Please Note*: We will be sending letters to both your referring and family physicians. Please provide complete information with respect to your physician's full name, degree (MD or DO), address, city, state and zip code. Thank you for your assistance.**

Name:_____Degree:_____

Address (Street): _____

City/State/Zip:_____

Telephone: (_____)_____Date of your last visit:_____

Current Family Physician

Name:_____Degree:_____

Address (Street): _____

City/State/Zip:_____

Telephone: (_____)_____Date of your last visit: _____

Referred by Former/Current Patient

Name: _____

Employment Information

· Employed · Disabled · Unemployed · Retired
· Self-employed · Student · Leave of Absence Date:_____

Employer:_____

Address (Street): _____

City/State/Zip:_____Telephone: (_____)_____

Spouse Information

Name: _____

SSN: _____ Date of Birth: _____

- Employed
- Disabled
- Unemployed
- Retired
- Self-employed
- Student
- Leave of Absence

Date: _____

Employer: _____

Address (Street): _____

City/State/Zip: _____ Telephone: (_____) _____

Primary Insurance Carrier

Please bring your insurance cards to the appointment. Please complete all information as fully as possible.

Insurance Company: _____

Company's Address: _____

City/State/Zip: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's Address: _____ Insured's SSN:

City/State/Zip: _____ Insured's Phone: (_____) _____

Insured's Date of Birth: _____ ID#: _____ Group #: _____

Secondary Insurance Carrier

Insurance Company: _____

Company's Address: _____

City/State/Zip: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's Address: _____ Insured's SSN:

City/State/Zip: _____ Insured's Phone: (_____) _____

Insured's Date of Birth: _____ ID#: _____ Group#: _____

Worker's Compensation Claim, If Applicable

Work Comp Claim Number: _____ Date of Injury: _____

Employer at Time of Injury: _____

Allowed Condition/Injury: _____

Signature of Patient or Authorized Party

I hereby authorize Summit Orthopaedics, and the individuals and/or entities associated with my care to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance company, 3rd party payors, and/or other physicians or healthcare entities required to participate in my care. I hereby authorize assignment of financial benefits directly to Summit Orthopaedics and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

X Signature: _____ Date: _____

Summit Orthopaedics - Patient Health History

This information is very important in your care. Please complete as carefully and accurately as possible.
IF MORE ROOM IS NEEDED, PLEASE ATTACH ADDITIONAL DOCUMENTATION

Name:_____ Date: _____

Height:_____inches Weight:_____lbs

Symptoms:

- Type of symptoms related to your visit: · Pain · Instability · Infection
- Other symptoms: _____
- Location of symptoms: · Right Shoulder · Left Shoulder · Right Hand · Left Hand · Other:
- Severity of symptoms: · Mild · Moderate · Severe · Constant · Intermittent · With Activity
- Duration of symptoms: Days:_____Weeks:_____Months:_____Years: _____

Please list all prior surgeries OR · No previous surgeries

	Type of surgery including **Side/Area**	Estimated Year
A.	_____	_____
B.	_____	_____
C.	_____	_____
D.	_____	_____
E.	_____	_____
F.	_____	_____
G.	_____	_____

- Prior Hospitalizations other than surgery OR · No previous hospitalizations

Reason for Hospitalization:		Estimated Year
A.	_____	_____
B.	_____	_____
C.	_____	_____
D.	_____	_____

- **Medical Illnesses** for which you are currently being treated for (i.e. high blood pressure, diabetes, heart disease, etc.) **Please list on the next page the name of the medication that you take for this condition**.

Condition:		Estimated year at onset
A.	_____	_____
B.	_____	_____
C.	_____	_____
D.	_____	_____
E.	_____	_____

- **Medication Allergies** or Sensitivities (example: Penicillin causes rash) **OR** · **NONE**
  (NO KNOWN ALLERGIES)

Name of Medication Reaction

A. _____ _____

B. _____ _____

C. _____ _____

D. _____ _____

- **Metal Allergies** or Sensitivities
  (example: rash or blistering with any type of jewelry or metal framed eye glasses)
  - No known metal allergies
  - **Metal allergies**
    - Aluminum · Nickel
    - Other _____
    - Other _____
    - Other _____

  Additional Notes _____

  _____

- List **All Current Medications** you are now taking or have taken in the last two weeks; **including over the counter medications, herbal medications, inhalers, breathing machines, and/or oxygen.**

Medication name	Strength or dosage	Time of day taken (AM, PM, bedtime)	Number of pills taken each time	Reason for use
Example: Lipitor	*20 mg*	*Bedtime*	*One*	*High cholesterol*

Please continue on a separate piece of paper if you run out of room

- Have you ever received a blood transfusion in the past? Yes · No ·
  If yes, did you have an adverse reaction to the blood transfusion?

- Do you have any religious beliefs against receiving blood? Yes · No ·

- Have you ever had difficulty with anesthesia? Yes · No ·
  If yes, please explain

- Do you have any bleeding tendencies? (Example: bloody urine, bloody stools) Yes · No ·
  If yes, please explain _____

- Have any of your primary/direct **family** members (mother, father, brother, sister) had any of the following:
  NOT yourself --your family member
  · **Unknown**

Blood clots in the legs or lungs	Yes · No ·
Surgical complications	Yes · No ·
Difficulty with anesthesia	Yes · No ·
Heart disease (heart attack, angina, or chest pain) — prior to age 60	Yes · No ·
Diabetes	Yes · No ·
Bleeding tendencies or disorders	Yes · No ·

If you answered yes to any of the questions about your family history in number 15 please explain:

_____

_____

_____

- Do you currently smoke or chew tobacco products? Yes · No ·
  If yes, year you started? Number of packs per day at most were you smoking? _____
  Have you ever been a smoker in the past? Yes · No ·
  How many years did you smoke?_____
  If you quit smoking, what year did you quit? _____
  Never used tobacco products ·

- Do you currently drink alcohol? Yes · No · Never ·
  Number of drinks per day_____Number of drinks per week _____
  Number of years of alcohol use _____

Have you had any medical complications from alcohol	Yes · No ·
Have you had any withdrawal symptoms when not drinking?	Yes · No ·

- Do you have any history of substance abuse or drug addiction? Yes · No ·
- Do you have any history of MRSA? Yes · No ·
- Have you had a recent illness for which you were prescribed antibiotics for? Yes · No ·

Review of Systems: Do you have a personal history of the following?

General

Recent unexplained weight loss	Yes · No ·
Recent unexplained weight gain	Yes · No ·
Recent unexplained fevers or chills	Yes · No ·
Do you exercise?	Yes · No ·
If yes, how long and how often? _____	

HEENT

Glasses	Yes · No ·
Cataracts	Yes · No ·
Glaucoma	Yes · No ·
Hearing loss or wear hearing aids	Yes · No ·
Dentures or partials Upper · Lower · Both ·	Yes · No ·
Active dental infection or tooth pain	Yes · No ·

Cardiac

High blood pressure	Yes · No ·
Heart attack	Yes · No ·
Congestive heart failure	Yes · No ·
Heart valve replacement	Yes · No ·
Open-heart surgery for bypass	Yes · No ·
Did your heart doctor balloon open any of your heart arteries?	Yes · No ·
Did your heart doctor stent any of your heart arteries?	Yes · No ·
Do you have chest pain with exertion?	Yes · No ·
Do you have swelling in your legs?	Yes · No ·
Have you ever been told that you have a heart murmur?	Yes · No ·
Do you have palpitations or rhythm disturbances?	Yes · No ·

Heart Tests

Have you ever had a cardiac stress test?	Yes · No ·
Heart catheterization/ angiogram	Yes · No ·
Echocardiogram (an ultrasound of your heart)	Yes · No ·

If you answered yes, please state what year and the name of where you had the test performed:

_____

Name of Cardiologist (if applies) _____

Date of Last Visit _____

Pulmonary

Asthma, COPD, emphysema, or chronic bronchitis?	Yes · No ·
Do you experience shortness of breath with exertion?	Yes · No ·
Need to sleep propped up on 2 or more pillows due to breathing?	Yes · No ·
Do you wake up at night with shortness of breath?	Yes · No ·
Have you ever required treatment with oxygen at home?	Yes · No ·
Do you have sleep apnea?	Yes · No ·
If yes, do you use C-PAP · or Bi-PAP ·	
Have you ever tested positive for tuberculosis (TB)?	Yes · No ·
Do you have seasonal allergies or hayfever	Yes · No ·

GI

Frequent diarrhea	Yes · No ·
Frequent constipation	Yes · No ·
Diverticulitis	Yes · No ·
Irritable bowel syndrome	Yes · No ·
Crohn's disease	Yes · No ·
Ever had part of your colon removed or an intestinal surgery?	Yes · No ·
Peptic ulcer disease/ Duodenal ulcer	Yes · No ·
Intestinal bleeding	Yes · No ·
Difficulty with swallowing	Yes · No ·
Heartburn or gastro-esophageal reflux disease	Yes · No ·
Abdominal pain	Yes · No ·
History of severe post-operative constipation/ileus	Yes · No ·
Liver disease or cirrhosis	Yes · No ·

Genitourinary

Frequent urination	Yes · No ·
Urinary incontinence	Yes · No ·
Prostate enlargement (if you're a man)	Yes · No ·
Have you ever donated a kidney or had one removed?	Yes · No ·
Kidney stones	Yes · No ·
Have you ever been told that your kidneys weren't working as well as they should or that you have Chronic Kidney Disease?	Yes · No ·
Receiving dialysis?	Yes · No ·

If so, who is your kidney doctor?_____

Where do you go for dialysis _____

What days do you receive dialysis? _____

Musculoskeletal

Have you ever been told that you have Rheumatoid Arthritis?	Yes · No ·
Have you ever been told that you have Osteoporosis**?**	**Yes · No ·**

Neurologic

Stroke or TIA (mini stroke)	Yes · No ·
Paralysis or temporary loss of strength, sensation, or vision	Yes · No ·
Were you ever told that you are legally blind?	Yes · No ·
Frequent fainting spells or dizziness	Yes · No ·
Seizures	Yes · No ·
Frequent headaches or migraine headaches	Yes · No ·
Chronic neck or back pain	Yes · No ·
Chronic pain syndrome	Yes · No ·

Emotion/Mood

Confusion or disorientation	Yes · No ·
Anxiety for which you are being treated or are taking medicines	Yes · No
· Depression for which you are being treated or are taking medicines	Yes · No ·
Any other emotional problems	Yes · No ·

Endocrine

High cholesterol	Yes · No ·
Thyroid problems (underactive or overactive thyroid)	Yes · No ·
Diabetes (this includes being borderline)	Yes · No ·
Have you ever been in DKA (diabetic ketoacidosis)?	Yes · No ·

If Diabetic HgBA1c (date/level) _____

Typical AM fasting blood sugar _____

Vascular

Blood clots in your legs/lungs (DVT, phlebitis, pulmonary embolism) Yes · No ·

If yes, what was your treatment and for how long? _____

Aneurysm, if yes where _____

Have you ever had surgery on any of your arteries? Yes · No ·

(This includes stent, balloon procedure, or bypass of the leg arteries)

If yes, where was your surgery? _____

Do you have pain in the legs, buttocks or calves with walking? Yes · No ·

Other

Unusual or frequent infections Yes · No ·

Poor wound healing Yes · No ·

Current open wound Yes · No ·

Pressure ulcers/ bed sores Yes · No ·

Currently pregnant or have been in the last 3 months Yes · No ·

If you're a woman, have you gone through menopause? Yes · No ·

Do you take hormone replacement therapy or birth control? Yes · No ·

Have you ever had cancer of any kind? Yes · No ·

If you answered yes, where was/is the cancer? _____

What was/is your treatment? _____

Who was/is your cancer doctor? _____

Have you ever had an organ transplant? Yes · No ·

If yes, when and what organ? _____

Who is the doctor that follows your progress? _____

If you have answered yes to any of the above mentioned questions please explain:

_____

_____

_____

Form Completed By: _____ ***Date:*** _____

If other than patient, please identify relationship to patient: _____

Summit Orthopaedics, LLP | Go To Ortho
Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is a part of this treatment and care. Our fees for services, including office visits and surgeries, are based on the level of professional skill required, the severity and complexity of the injury or illness as well as the time spent treating you. Please do not hesitate to inquire about the charges for our services; however, a precise estimate in advance may not be possible.

Insurance & Insurance Collection:

We make every effort to make sure your paperwork is filed accurately and promptly. We may bill your insurance as a courtesy at no expense to you. However, we will only bill insurance that has appropriate documentation presented at the ***time of service***. Secondary or other insurances that you may have must be presented at ***time of service*** if it is to be billed.

Each physician in this practice bills separately. You will not receive a statement until there is a patient balance. You may receive more than one statement if you see more than one physician in our office.

It is the patient's responsibility to inform us of any changes in insurance and to present the appropriate documentation. Failure to do so could result in any balance being transferred to patient responsibility.

If your insurance company does not respond within 30 days, as required by law, you may be held responsible for all charges. We will not submit more than two claims to your insurance company. Failure of your insurance company to respond will result in automatic transfer of the balance to your responsibility.

In order to provide you with the highest quality service, while keeping our billing costs low, we offer paperless patient billing through Breeze, our online patient portal.

WE ACCEPT ALL MAJOR CREDIT CARDS, DEBIT CARDS,
CHECK CARDS, CHECKS* AND CASH.

Please understand that all personal balances are due within 30 days of receipt of the statement or at your next scheduled visit, whichever comes first. We strongly recommend that you use the Breeze Patient Portal to satisfy your balance as it becomes due. *Any returned checks will result in a $25.00 charge to your account and no further checks will be accepted.

Participating Provider Plans:

HMO | Managed Care PLANS: All co-pays must be satisfied each and every visit. ***You*** are responsible for getting proper authorization/referral information in advance of your appointment. In the event that you do not have a valid authorization/referral at time of service, you may reschedule or sign a disclaimer that states you understand that there is not a valid referral in our office and that you will be responsible for the charges in the event your insurance company does not pay for the services. Failure to obtain a referral or refusal to sign the disclaimer may result in rescheduling your appointment until this procedure is complete.

PPO PLANS. We have agreed to accept the discounted rate from some PPO plans, however all co-insurance, co-payments and deductible balances are patient responsibility. Patient balances are due within 30 days of receipt of the statement or next office visit, whichever is earlier.

Non-Contracted or Indemnity Insurance Plans:

We may bill your insurance as a courtesy. Our office, as a convenience and a service to you, will absorb all costs incurred for billing. However, failure to present appropriate documentation regarding your insurance coverage or changes in insurance coverage will result in balances being transferred directly to patient responsibility. In the event your insurance company does not respond within 30 days, as required by law, you may be held responsible for all charges.

Secondary Insurance:

Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy, if ***and only if*** proper information is received ***at time of service***. You are responsible for any balances after your insurance(s) has cleared.

Payments sent directly to Patient:

In the event your insurance company sends funds directly to you instead of the physician, you can endorse the check and send it directly to our office, or forward a personal check for no less than the full amount sent by the insurance company, along with copies of the documentation supporting that payment to insure your account is properly credited. Funds received by the subscriber results in automatic transfer of the complete balance to patient responsibility, no secondary insurance will be billed and no payment plan considerations will be given on the portion of funds received by the patient or subscriber.

Usual & Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

Minor Patients and/or Divorce Decrees:

This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment.

I have read, understand and agree to the above Financial Policy. I understand that the charges not covered by my insurance company, as well as co-payments and deductibles, are my responsibility. I understand that in the event any unpaid balance is placed for collection with any third party collection agency a fee of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees and any other fees so stated elsewhere.

I authorize my insurance benefits be paid directly to the provider.

I authorize my physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I authorize my physician to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

X_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Please print Patient's name Patient Account Number

Patient has refused to sign this agreement: _____

Summit Orthopaedics, LLP Staff Initials/Date

ACKNOWLEDGMENT AND CONSENT

I understand that **Summit Orthopaedics, LLP,** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices, if requested.

X_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Please print Patient's name Patient Account Number

Patient has refused to sign this agreement: _____ Summit Orthopaedics, LLP Staff Initials/Date