

PEDIATRIC

**LILJENQUIST, OLSON & REDD
ORTHOPEDIC SURGERY**



PATIENT INFORMATION

Last name:	First:	Middle:	Preferred Name:	
E-mail address:	Ethnicity and preferred language:		Birth date: / /	Legal Gender: Gender Identity:
Mailing address:	City:		State:	Zip code:
Social Security #:	Occupation:		Employer:	
Cell Phone #:	Home Phone #:		Work Phone #:	
Consent to Text/ Call: Yes No				
Referred to clinic by (please check one box):		☐ Dr.	☐ Hospital	☐ Insurance Plan
☐ Friend	☐ Family	☐ Yellow Pages	☐ Other Patient	☐ Other
Preferred Pharmacy:			Family Doctor:	

INSURANCE INFORMATION

Name on Insurance Card:	Social Security #:	Birth date: / /	Phone #:
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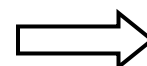
EMERGENCY CONTACT

Name of local friend or relative:	Relationship to patient	Primary phone #:
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I authorize Liljenquist, Olson & Redd Orthopedic Surgery to release any information required to process my claim as necessary in the course of examination and treatment. I hereby assign and transfer to Liljenquist Olson & Redd Orthopedic Surgery any and all rights to receive payment of insurance benefits. This assignment covers all benefits under private insurance and/or any other health plan. I understand that this document constitutes a legally binding assignment and is not a mere authorization to collect benefits on my behalf.

I understand that I am financially responsible for all charges whether or not paid by my insurance and/or any other health plan (including Medicaid), and that Liljenquist Olson & Redd Orthopedic Surgery will submit billings to my insurance company and/or health plan but only as a courtesy for me.

X _____ Date: _____



BILLING POLICY

I understand that I am responsible for all charges at the time of service. I understand that it is my responsibility to provide Liljenquist, Olson & Redd Orthopedic Surgery (LOROS) with current, accurate billing information at the time of check-in and to notify the office of any changes. LOROS may submit claim information to my insurance company for processing but does so only as a courtesy for me. LOROS will try and verify that the providers are in-network with your insurance company, however I understand that I am ultimately responsible for knowing my plan and knowing what providers are in-network. I am responsible for paying all charges before my insurance company pays or determines the amount I owe after insurance regardless of any billing mistakes or disputes. I understand that it is my responsibility to know my specialist co pay and pay it on the day services are rendered because it is a contractual agreement with my health care plan.

I understand that if I do not have insurance, I am required to pay 100% of my responsibility in advance for services that will be rendered. This includes but is not limited to, office visits, x-rays, procedures, and surgery.

I understand that it is my responsibility to know my specialist co pay and pay it on the day services are rendered because it is a contractual agreement with my health care plan.

I understand that if I present an insufficient funds check for payment on my account, I will be charged a fee by this office and will be required to rectify my account by paying with cash, money order or credit card.

I understand that LOROS will verify my insurance eligibility, deductible and coinsurance amounts prior to any elective surgery that I may have. I understand that receipt of a prior authorization is not a guarantee of payment, and I will be responsible for any bills not paid by insurance carrier. I understand that it is the policy of LOROS to collect at least 50% of the estimated deductible and co-insurance amount prior to surgery unless other arrangements are made prior to surgery. I further understand that the fee I am quoted is an estimate based on the anticipated surgery to be performed, and the current information made available by my insurance carrier.

I understand that I have a financial obligation and responsibility to pay all deductible and co-insurance amounts as promptly as possible following the rendering of services. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if no payment is made following receipt of the second statement that my account may be sent to a collection service for further legal action. I understand that I will be responsible for any collection, interest, or legal expenses associated with these collection actions. I understand that if sent to collections there will be 12% annual interest added to balance and a 35% collections fee.

I understand that if I cannot pay my balance in full then an auto-pay payment plan will be arranged. I understand that the only way a payment plan can be made is by autopay with a credit or debit card securely on file.

LOROS charges \$20 for completion of patient forms such as FMLA and disability paperwork. Payment is to be made before the completion and return of requested documents.

I understand that if I have Medicaid insurance and services rendered are denied, uncovered, out of network or my Medicaid is inactive at time of service I am financially responsible for all services rendered.

My signature below confirms that I have read these billing policies and understand my financial obligations as pertaining to LOROS, Joseph R. Liljenquist, MD, Brigham B. Redd, MD, Jonathan Olson, DO, Chase Hanson PA-C and Austin Campbell PA-C, Trae Pilster PA-C.

Signature X_____ Date _____

LILJENQUIST, OLSON & REDD ORTHOPEDIC SURGERY



ACKNOWLEDGEMENT OF DISCLOSURE OF NOTICE OF PRIVACY PRACTICES

I have read the Notice of Privacy Practices provided to me by Liljenquist Olson & Redd Orthopedic Surgery. LOROS and I have been given the opportunity to discuss the privacy practices at LOROS. I understand that the practice may, at its discretion, change the terms and conditions of this notice. Any questions I may have will be answered to my satisfaction. I understand the content of this Notice of Privacy. I have been provided with a copy of the same.

I authorize LOROS to release the following healthcare information to the following individuals:

____ Relationship: _____

____ Relationship: _____

____ Relationship: _____

____ Relationship: _____

____ Relationship: _____

(Please check one of the following):

- ☐ My complete health record.
- ☐ To schedule, change, and verify my appointments.
- ☐ Any billing correspondence

Please list any specific restrictions: _____

☐ **My information is NOT to be released to anyone.**

I understand that my records are protected by; The Health Insurance Portability and Accountability Act (HIPPA) and cannot be disclosed without my written consent unless it is providing a continuity of care. I also understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

X _____ Print Name: _____ Date: _____



Minor's Name: _____ DOB: _____

By law, any child under the age of 18 must be accompanied by a parent or legal guardian to all patient appointments.

If the minor arrives with someone other than a parent or legal guardian, we must have written consent from the parent or legal guardian that this person has been appointed by you to act on your behalf. For those occasions when you may not be able to be with your child, please list the individuals who may give us consent to see your child:

Name: _____ Relationship to Patient: _____

____ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult. **This consent may ONLY apply to minors age 16 and older.** This consent shall be in effect for:

Date : _____ (only) or _____ Indefinitely, until revoked by written communication.

Limitations:

Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none") _____

CONSENT TO TREAT:

I (parent / legal guardian name) _____ request and authorize Liljenquist, Olson and Redd Orthopaedic Surgery and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. As part of your medical care, we may use a HIPAA compliant AI- Powered scribe to record and document our conversations during this visit. This tool will help capture key details of your health information, allowing us to focus on your needs. I am also aware that the adult presenting the minor child or the minor child that is alone (16 or older) is responsible for payment of the patient portion at the time of service. I have read, understand and give my consent as stipulated above. My signature means that I have read this form and/ or have had it read to me and explained in the language that I can understand.

Authorization & Acknowledgment:

Parent or Legal Guardian (please print): _____ Relationship: _____

Parent or Legal Guardian Signature: _____ Date: _____

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The information listed below is the information for the parent/guardian who brings the child to their initial appointment. We CANNOT send bills to a parent or guardian who is not present with the child. We CANNOT do separate billing for different parent/guardians based off custody agreements.

GUARANTOR INFORMATION

Parent / Guardian Responsible for bills	
Social Security #	
Date of Birth	
Phone #	
Street Address	
City, State, Zip Code	

I understand that Liljenquist Olson & Redd Orthopedic Surgery will be sending all billing correspondents to me. I understand I am responsible for making all outstanding balances are paid.

X Guarantor Signature: _____ Date: _____

Print Minor's Name: _____ Date of Birth: _____

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Minor's Name _____ DOB: _____ Date: _____

What are we seeing you for today? _____

Please list your primary Pharmacy: _____ Primary care physician: _____

Height: _____ Weight: _____ Pain level now (0-10): _____ Date of Injury/Symptoms Start: _____

Please list any **ALLERGIES** medication, cortisone, latex, or Metal. _____

Please list your current **medications** including strength _____

Please check if any family member has had any of the following diseases.

	Mother	Father	Brother	Sister	Grandparents Mother's side	Grandparents Father's side
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐

Tobacco Use History:

☐ Never smoked/vaped ☐ Former smoker/vapor Years of tobacco use _____

☐ Current smoker/vapor How long? _____ How much a day? _____

Do you currently chew tobacco? _____

Do you drink alcoholic beverages? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Do you drink caffeine? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Please list any surgeries you have had in your lifetime. Include the year of the surgery as well.

Do you currently have bed bugs? YES NO

Have you had bed bugs in the past? YES NO

Please check if you have or have had any of these conditions:

- | | |
|--|---|
| ☐ AIDS/HIV | ☐ Coronary artery disease |
| ☐ Anemia | ☐ Diabetes |
| ☐ Anxiety/Depression | ☐ Hepatitis |
| ☐ Asthma | ☐ Hernia |
| ☐ Bleeding disorder | ☐ Hypertension (high blood pressure) |
| ☐ Blood clot | ☐ Migraines |
| ☐ Blood transfusion | ☐ Orthotics |
| ☐ Cancer, specify _____ | ☐ Seizures/Epilepsy |

Any other health condition:

Please check if you currently have any of the following symptoms:

Constitutional

- ☐ Fever
- ☐ Night sweats
- ☐ Abnormal Weight gain
- ☐ Abnormal Weight loss

Persona/Social

- ☐ Concerns Regarding Hearing
- ☐ Concerns Regarding Vision
- ☐ Hearing Impaired
- ☐ Visually Impaired

Language

- ☐ Non-Verbal
- ☐ Speech Delay
- ☐ Receives Speech Therapy

Behavior

- ☐ Impulsive
- ☐ Anxious
- ☐ Depressed
- ☐ Aggressive
- ☐ Suicidal Thoughts

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty Breathing
- ☐ Difficulty Swallowing

MUSCULOSKELETAL

- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Joint pain
- ☐ Back pain
- ☐ Swelling in extremities

NEUROLOGIC

- ☐ Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches

ALLERGIC/IMMUNOLOGIC

- ☐ Runny nose
- ☐ Sinus pressure
- ☐ Itching
- ☐ Hives
- ☐ Frequent sneezing

Patient Name: _____

Date of Birth: _____

