MVP Orthopedics and Sports Medicine

TODAY'S DATE _____

ACCOUNT # _____

DR # _____ BC # _____

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)				LIST ANY ALLERGIES
PATIENT'S CURRENT ADDRESS	APT. #	CITY, STATE	ZIP CODE	HOME W/AREA CODE — —
PATIENT'S PERMANENT ADDRESS (if other than current)		CITY, STATE	ZIP CODE	MOBILE

SEX	MARITAL STATUS	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER	OCCUPATION
☐M ☐F	☐M ☐S ☐D ☐W				

PATIENT'S EMPLOYER/SCHOOL	EMPLOYER'S/SCHOOL ADDRESS	WORK/SCHOOL PHONE

SPOUSE/NEAREST RELATIVE	RELATIONSHIP	ADDRESS/CITY/STATE/ZIP	CONTACT NUMBER

RESPONSIBLE PARTY - PERSON WHO CARRIES INSURANCE	RELATIONSHIP	**SOCIAL SECURITY NUMBER**	**RESP. PARTY DOB**

RESPONSIBLE PARTY ADDRESS	CITY, STATE	ZIP CODE	CONTACT NUMBER
RESPONSIBLE PARTY EMPLOYER	EMPLOYER'S ADDRESS		CONTACT NUMBER
NAME OF RELATIVE NOT LIVING WITH YOU	ADDRESS		CONTACT NUMBER

REFERRED BY:

☐ PHYSICIAN (name) _____ ☐ FRIEND (name) _____ ☐ SCHOOL (name) _____

FAMILY PHYSICIAN (if other than referring doctor)	AREA OF COMPLAINT
	INJURY? (Please Circle) SPORTS WORK AUTO SCHOOL

DATE OF INJURY	PREVIOUSLY TREATED HERE? ☐ YES ☐ NO BY WHOM?	DOMINANT HAND? ☐ LEFT ☐ RIGHT

PRIMARY INSURANCE	CONTACT NUMBER	SECONDARY INSURANCE	CONTACT NUMBER
ADDRESS		ADDRESS	
CITY, STATE	ZIP CODE	CITY, STATE	ZIP CODE

POLICY #	ID #/GROUP #	POLICY #	ID #/GROUP #
NAME OF POLICYHOLDER DOB:	RELATIONSHIP TO POLICYHOLDER	NAME OF POLICYHOLDER DOB:	RELATIONSHIP TO POLICYHOLDER
SOCIAL SECURITY #	POLICYHOLDER'S EMPLOYER	SOCIAL SECURITY #	POLICYHOLDER'S EMPLOYER

FORM # MVPO-101 REV. 7/18

MUST PROVIDE COPY OF INSURANCE CARD!

MVP Orthopedics and Sports Medicine

4344 W. Bell Road, Suite 102, Glendale, AZ 85308 • 602-588-4040 • Fax 602-588-4034

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received
(Name of Patient)

a copy of MVP/DR. MADDOX's **'Notice of Privacy Practices'.** This Notice describes how MVP/DR. MADDOX may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

I authorize the release of my protected health information to:

- ☐ SPOUSE _____
- ☐ CHILD _____
- ☐ PARENT _____
- ☐ VOICE MAIL _____

_____ _____
(Signature) (Date)

MVP Orthopedics and Sports Medicine

D. Matthew Maddox, D.O., F.A.O.A.S.M., F.A.O.A.O.

Gordon D. Hart, PA-C

Lynzi K. Warner, PA-C

The Patient and Financial Responsibility

This document is merely information for the patient. First and foremost, it is the patient's acceptance of medical services that creates the obligation to MVP/Dr. Maddox.

OUR MISSION is to provide you, the individual patient, with resources to process your claim efficiently and expediently. Unfortunately, we cannot possibly have all the information regarding your insurance company's policies, which differ significantly between insurance companies and group policies.

YOUR RESPONSIBILITY, in order for our office to receive appropriate payment, is to contact your insurance company for the correct and complete requirements such as coverage parameters, pre-certification and pre-authorization policies, deductibles, copayments, group number and a correct billing address.

YOUR FINANCIAL RESPONSIBILITY is clear. Once you have received any type of medical treatment or service, you are responsible for any and all sums due for those services. MVP/Dr. Maddox bills the insurance company as a courtesy to the patient. However, insurance was designed to be used as reimbursement for payment, not a substitute. The patient is therefore always ultimately responsible for payment. Claims will be filed by MVP/Dr. Maddox's staff and we anticipate payment within sixty (60) days of service to the patient.

FAILURE TO REMIT PAYMENT for which you are deemed responsible, in a timely manner, can have many negative implications for the patient. These include but are not limited to referral to a collections agency and to MVP/Dr. Maddox's attorney for possible litigation. If such action is necessary, the patient will be responsible for all costs associated with collection of fees whether through an agency or through legal means, including but not limited to attorney's fees, court costs and costs for collection agencies. Any account sent to the collection agency will be charged an additional 35% fee of the balance due.

FAILED APPOINTMENTS Failed appointments (less than 24 hours notice) are a significant contributor to rising health care costs. Individuals who fail to show for a confirmed appointment may be assessed a fee based on the length of the missed appointment.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide us. Methods of contact my include using pre-recorded/artificial voice messages and/or use an automatic dialing device, as applicable.

I understand the procedures and responsibility to ensure my claim is processed promptly and accurately for payment within sixty (60) days. I also understand that I am responsible for any denials, copayments or deductibles.

_____

Patient/responsible party signature and date

4344 W. Bell Road, #102
Glendale, AZ 85308-3589
(602) 588-4040
FAX (602) 588-4034

D. Matthew Maddox, D.O., F.A.O.A.S.M., F.A.O.A.O
Gordon D. Hart, PA-C
Lynzi K. Warner, PA-C

FINANCIAL AGREEMENT
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby request and consent that my medical records and non written records be sent to my referring physician, those physicians or ancillary facilities that I am referred to by the MVP/Dr. Maddox and to my insurance company or its agents that may be authorizing treatment.I further understand that my medical records may contain sensitive information and hereby authorize the release of all confidential HIV related information, communicable diseases related information, drug and alcohol abuse/treatment information and mental health diagnosis/treatment information to the above.

I hereby authorize payment directly to the attending physician for medical and/or surgical benefits, if any, from the insurance carrier. If paying cash, I am responsible to pay at the time of service.

_____
PATIENT'S PRINTED NAME

_____
PATIENT'S SIGNATURE (OR LEGAL GUARDIAN IF PATIENT IS A MINOR) DATE

4344 W. Bell Road, #102
Glendale, AZ 85308-3589
(602) 588-4040
FAX (602) 588-4034

MEDICAL ALLERGIES:

◯ No Known Drug Allergies ◯ Drug allergies:_____ Reaction:_____

Medications: NONE ◯ Addition sheet attached ***Pain Contract:*** ◯ ***Yes*** ◯ ***No*** ***Initial*** _____

Medication	Condition / Reason	Dose

SURGICAL HISTORY: NONE. Circle all that apply. ◯ **NONE**

◯ Cancer: skin, breast ◯ RT ◯ LT other:_____
◯ ENT/Eyes: Cataracts, vision correction, sleep apnea, tonsils, sinus surgery, thyroid, other:_____
◯ GI: Appendix, gall bladder, hernia, other: _____
◯ Gynecologic: C-section, hysterectomy, tubal ligation, other: _____
◯ Heart: Bypass, valve replacement, stent, other:_____
◯ Lung: Resection, other:_____
◯ Neurosurgical: Aneurysm, tumor, craniotomy, other:_____
◯ Orthopedic: Joint replacement, arthroscopy, fracture surgery, spine, other:_____
◯ Urologic: Prostate, bladder, vasectomy, other: _____
◯ Vascular: Carotid, aneurysm, bypass, other:_____

ANESTHESIA COMPLICATIONS: ◯ *NONE. If yes, explain:*_____

Other Current Symptoms: Circle all that apply. ◯ **NONE**

◯ Yes ◯ No Anxiety, Depression _____
◯ Yes ◯ No Cardiovascular: Chest Pain, Palpitations, Fast Heart Rate _____
◯ Yes ◯ No Constitutional: Unexpected Weight Loss, Weight Gain, Fever Chills, Night Sweats, Fatigue _____
◯ Yes ◯ No ENT: Headache, Difficulty Swallowing, Nose Bleeds, Ringing In Ears, Earaches _____
◯ Yes ◯ No Eyes: Blurred/ Double Vision, Eye Pain Redness, Watering _____
◯ Yes ◯ No Gastrointestinal: Heartburn, Nausea, Constipation, Incontinence, Diarrhea, Bloody/Black stool.
◯ Yes ◯ No Hematologic: Easy Bleeding, Bruising _____
◯ Yes ◯ No Musculoskeletal: Joint Pain, Swelling, Instability, Stiffness, Redness, Heat, Muscle Pain _____
◯ Yes ◯ No Respiratory: SOB, Wheezing,Coughing, Painful Breathing, Snoring _____

Family History: Check if applicable.

◯ Arthritis ◯ Cancer ◯ Diabetes
◯ Heart Disease ◯ High blood pressure ◯ Other

Social History:

Marital status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated
Do you use ◯ Alcohol ◯ Drugs ◯ Smoke Recovery date: _____

Additional information you would like us to know: _____

Patient or Responsible party signature _____ Date _____

Physician Review: _____ Date _____

MVP Orthopedics and Sports Medicine
4344 West Bell Rd., Ste. 102, Glendale, AZ 85308
P: (602) 588-4040 I F: (602) 588-4034

Name: _____ Age: ____ DOB: _____ Height: _____ Weight: _____

Consult Requested By: _____ PCP: _____

Workers Compensation Case: ◯ Yes ◯ No DOI: _____ Legal case: ◯ Yes ◯ No

Are you: ◯ Right handed ◯ Left handed ◯ Male ◯ Female Occupation: _____

Why are you here today? ◯ Left ◯ Right ◯ Bilateral:

Body part: (knee/shoulder) _____

When did the problem start? _____

How did it happen? _____

What makes it worse? _____

What makes it better? _____

*In the past **6 months**, have you had X-Ray, MRI/CT or any test to the area of injury?* _____ *Where/what test was performed?* _____ *Do you have the test results/CD/report with you?* _____

For each, circle what **BEST** applies:

- Pain is: RARE INTERMITIENT CONSTANT
- Pain is: DULL SHARP ACHY THROBBING BURNING NUMBNESS OTHER: _____
- On a scale 0-10: (10 = worst) 0 1 2 3 4 5 6 7 8 9 10

Circle **ALL** that apply:

- Catching Popping Locking Grinding Swelling Stiffness Instability Weakness Tingling
- Night Pain Other: _____

Have you ever experienced any injury or symptoms involving this body part? ◯ Yes ◯ No
If so, please provide details. _____

Have you had treatment for this problem? ◯ NONE ◯ Medication ◯ Physical Therapy ◯ Splinting ◯ HEP ◯ Bracing ◯ Injection ◯ Surgery Since your last visit? _____

Medical History: Do you currently, or have you ever had any of the following: ◯ NONE
◯ Anemia ◯ Arthritis ◯ Asthma ◯ COPD ◯ Bleeding Disorder ◯ Blood Clots ◯ Cancer ◯ Gout
◯ Chronic Pain Syndrome ◯ Circulatory Problems ◯ Depression ◯ Diabetes ◯ Fibromyalgia
◯ Heart Disease ◯ Hepatitis A B C ◯ High Blood Pressure ◯ HIV ◯ Kidney Disease
◯ Osteoporosis ◯ Psychiatric Illness ◯ Pregnancy ◯ Reflux/ Heartburn ◯ Seizures ◯ Sleep Apnea
◯ Stomach Ulcers ◯ Stroke ◯ CPAP ◯ Drug/Alcohol Problem ◯ Thyroid disease