9499 W. CHARLESTON, SUITE 200
LAS VEGAS, NEVADA 89117
702 933-9393 fax 702 933-6789

THOMAS & BIGLER
KNEE & SHOULDER INSTITUTE

☐ Gregory T. Bigler, M.D.
☐ Steven C. Thomas, M.D.

PATIENT INFORMATION

Acct #: ____________________

Last Name: ____________________ Home Tel #: ____________________

First Name: ____________________ Middle Initial ______ Work Tel #: ____________________

Social Security: ____________________ Cell #: ____________________

Address: ____________________ Sex: ☐ M ☐ F

City: ____________________ State: ________ Birth Date: ____________________

Zip: ____________________ Email: ____________________

Race: ____________________ Marital Status: ☐ M ☐ S ☐ D ☐ W

Language Spoken: ____________________ Patient's Employer: ____________________

Ethnicity: ☐ Hispanic/Latino ☐ Not-Hispanic/Latino ☐ Refuse to Report

Occupation: ____________________

Referred By: ____________________

Patient's Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Self Employed ☐ M Active Duty ☐ Not Employed

Your Primary Care Physician: ____________________

How did you hear about us? ____________________

Patient's Student Status: ☐ Full-Time ☐ Part-Time ☐ Not a Student

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(If Patient is a minor)

Responsible Party: ____________________

Address: ____________________ City: ____________ State: ________ Zip Code: ____________

Phone: ____________________ Employer: ____________________

Email: ____________________

NEXT OF KIN INFORMATION OR EMERGENCY CONTACT

Name: ____________________ Relationship: ____________________

Address: ____________________ Phone (please circle) ____________________ Home/Cell

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Date of Injury: ____________ Body Part: ____________________ Attorney Name: ____________________

Work Comp? ☐ Yes or ☐ No Is this an Auto Accident? ☐ Yes or ☐ No State where accident occured ____________

PRIMARY INSURANCE INFORMATION			SECONDARY INSURANCE INFORMATION		
Name of Insurance Co.	Phone Number	Effective Date	Name of Insurance Co.	Phone Number	Effective Date
Insurance Company Claims Address			Insurance Company Claims Address		
Name of Policy Holder	Relationship to Patient		Name of Policy Holder	Relationship to Patient	
Policy Holder's SS#	Date of Birth of Policy Holder		Policy Holder's SS#	Date of Birth of Policy Holder	
Policy ID	Group ID		Policy ID	Group ID	
Policy Holder's Employer			Policy Holder's Employer		
Employer Address			Employer Address		

I hereby authorize payment of medical benefits to KNEE & SHOULDER INSTITUTE for services furnished me. I also authorize the physician to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I hereby consent to and authorize medical treatments, tests, and procedures that my physician deems advisable and necessary based on his judgement.

Patient's Signature or Responsible Party Signature ____________________ Date ____________

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HISTORY FORM

Name: ______________________ Today's Date: __________

Height: __________ Weight: __________

CHIEF COMPLAINT

Area of body you are being seen for? ______________________ Date of Injury: __________
(please specify LEFT or RIGHT if applicable)

Describe injury/ accident in detail: ______________________

Have you been to a physician previously for this problem? ________ If so, when? __________

Have you had an MRI for this condition within the last year? ________ If so, where and when? __________

Pharmacy Name: __________ Address: __________ Phone: __________

LIST ALLERGIES:

Betadine: ☐Yes ☐No
Mastisol: ☐Yes ☐No

Medication	Dose/mg	Taken How Often	Duration: How long have you been taking this?	Side Effects

NSAID ACKNOWLEDGEMENT

Commonly used in an orthopedic practice are the nonsteroidal anti-inflammatories (NSAIDS). Aspirin, Ibuprofen, Naprosyn, and many others in this class of medications help in not only decreasing pain but also in decreasing inflammation and swelling which is often the cause of pain. As with all medications, they present certain risks. The most common side effect is stomach upset or irritation. In the extreme they can cause ulcers and even bleeding ulcers. One of the warning signs is stomach pain or "heart burn". Taking the anti-inflammatory with meals or a snack will often help prevent this. The medicine should be stopped at the first sign of stomach or gastrointestinal upset.

Another side effect is that of increasing the time it takes to stop bleeding when cut. This is usually only a minor increase, but 5 days before surgery, the patient should stop all anti-inflammatory type medicine to avoid any increase blood loss during the procedure.

There are many other possible, though rare, side effects of NSAIDS. Kidney (renal) injury, interaction with other medications such as high blood pressure medicines or diuretics, and other so-called idiosyncratic reactions have been reported in isolated cases. Some of these medicines have also been shown to cause heart and stroke problems. *As with all medicines, you should read the literature and the potential risks of this type of medicine and consult your family doctor or internal medicine doctor about any concerns you have.

If you are pregnant or breast-feeding, you must consult your obstetrician or pediatrician prior to taking NSAIDS. If you are presently on prescription medicines from another physician, you should consult him/her concerning possible drug interactions prior to taking NSAIDS. Aspirin or ibuprofen (Motrin or Advil) should not be taken while taking other NSAIDS.

Finally, if you are taking NSAIDS for longer than 3 months, you should consult your doctor about possible blood tests to assure that there has been no renal (kidney) impairment or other side effects.

*****From FDA Drug Safety Communication (http://www.fda.gov/Druqs/DrugSafety/ucm451800.htm)**
The risk of heart attack or stroke can occur as early as the first weeks of using an NSAID. The risk may increase with longer use of the NSAID. The risk appears greater at higher doses. It was previously thought that all NSAIDs may have a similar risk. Newer information makes it less clear that the risk for heart attack or stroke is similar for all NSAIDs; however, this newer information is not sufficient for us to determine that the risk of any particular NSAID is definitely higher or lower than that of any other particular NSAID.
NSAIDs can increase the risk of heart attack or stroke in patients with or without heart disease or risk factors for heart disease. A large number of studies support this finding, with varying estimates of how much the risk is increased, depending on the drugs and the doses studied. In general, patients with heart disease or risk factors for it have a greater likelihood of heart attack or stroke following NSAID use than patients without these risk factors because they have a higher risk at baseline. Patients treated with NSAIDs following a first heart attack were more likely to die in the first year alter the heart attack compared to patients who were not treated with NSAIDs after their first heart attack. There is an increased risk of heart failure with NSAID use.

I acknowledge I have read the above.

Printed Name __________ Signature __________ Date __________

THOMAS & BIGLER
KNEE & SHOULDER INSTITUTE

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

PAYMENT FOR MEDICAL SERVICES RENDERED ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. **Unpaid balances will be assessed a 12% Annual Percentage Rate (1% per month) on any unpaid balances after 120 days. These balances may include insurance balances that have not been paid by your insurance company.** There will be a $25.00 service charge for any checks returned to our office. ALL ACCOUNTS 90 DAYS PAST DUE MAY BE ASSIGNED TO A COLLECTION AGENCY UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. In the event of collection proceedings due to lack of payment on my part or my insurance company, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor or group.

Our office verifies eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your status. We will do all we can to assist you with your insurance claims; however, insurance is a contract between you and your insurance carrier. Final responsibility for payment of your account rests with you. The exception is for those patients with injuries that are work-related and are covered by Worker's Compensation. These patients are not responsible for their bills unless their claim is denied.

Prior authorizations obtained for procedures by this office on your behalf do not guarantee payment but rather are based on medical necessity. Claims are subject to policy provisions, and your insurance carrier determines final payment. A deposit is required if you are being scheduled for surgery. If an assistant is required at the time of surgery to improve the quality of your surgical outcome, the assistant's fee is in addition to the surgeon's fee. ***If your insurance company requires a referral from your Primary-care physician, it is your responsibility to obtain the referral from your primary-care physician and bring it with you prior to your visit. If you do not have a referral number, and your insurance company requires it, you will be responsible to pay your visit in full.***

Having read the above, I hereby authorize payment by my insurance carrier or other designated payor of medical benefits to KNEE AND SHOULDER INSTITUTE for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of the assignment is considered as valid as the original.

I also authorize KNEE AND SHOULDER INSTITUTE to release to my insurance carrier or their agents any medical information about me needed to determine these benefits or the benefits payable for service.

I hereby consent to and authorize medical treatment, tests, and procedures performed in the office that my physician deems advisable and necessary based on his judgement. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

PHYSICAL THERAPY DISCLOSURES

The physical therapy department is owned by the physicians at Knee and Shoulder Institute. It is your choice to attend any licensed physical therapist for your rehabilitation needs; however, we feel that your care can best be managed at this facility under the physicians at Knee and Shoulder Institute's direction and guidance by their rehabilitative protocols.

MRI DISCLOSURE

The physicians at Knee and Shoulder Institute own the MRI center, called Mirror Imaging. It is your choice to have your image performed at any qualified MRI center, however, for your convenience as well as to control the high quality and therefore the usefulness of the MRI, we feel utilizing Mirror Imaging may best serve you for your study.

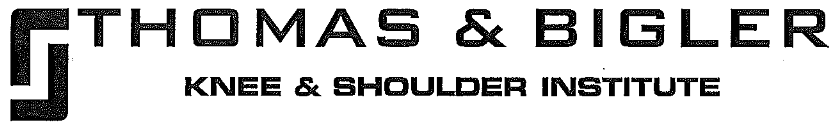
SURGICAL CENTER DISCLOSURE

Surgical Arts Center is partly owned by the physicians at Knee and Shoulder Institute. Should you have a concern about where your treatment is performed, please discuss with the physicians at Knee and Shoulder Institute and they will advise you of the alternatives. We do feel that the best possible surgical care is available at Surgical Arts Center under the physicians at Knee and Shoulder Institute's direction.

I HAVE READ THE FINANCIAL POLICY DESCRIBED ABOVE, I UNDERSTAND AND AGREE TO ALL PROVISIONS OF THIS FINANCIAL POLICY.

______________________________ ______________
Patient's or Responsible Party's Signature Date

____
Patient's or Responsible Party's Printed Name



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HIPAA NOTICE OF PRIVACY PRACTICES

Effective May 15, 2009

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The following notice is the privacy policy of the physicians at Knee & Shoulder Institute as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. We are required by law to maintain the privacy of your personal health information and to provide you with this notice of our legal duties, privacy practices, your rights with respect to your personal health information and to abide by the terms of this Privacy Notice.

Your Personal Health Information
We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses and Disclosures of Your Personal Health Information
The following are the circumstances under which we are permitted by law to use and disclose your personal health information:

- **Treatment:** *Examples of treatment activities include*: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

- **Payment:** *Examples of payment activities include*: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

- **Healthcare Operations:** *Examples of healthcare operations include*: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and give your address, phone number, insurance company name, and part of body being treated. We may also call you by name in the waiting room when your physician is ready to see you.

- **Persons Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. If you are in the hospital, we may also tell your family or friends your condition and that you are in a hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Your Authorization:** Except as otherwise permitted or required as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

- **As Required by Law:** We may use or disclose your health information when we are required to do so by law.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

- **Right to Request Restrictions on Use or Disclosure:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by your agreement (except in an emergency or as required by law).

- **Right to Receive Confidential Communications:** You have the right to receive confidential communications of your personal health information. You must make your request in writing. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

- **Right to Inspect and Copy Your Personal Health Information:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance.

- **Right to Amend Your Personal Health Information**: You have the right to request that we amend your personal health information. Your request must be in writing and it must explain why the information should be amended. We have the right to deny your request for amendment under certain circumstances.

- **Right to Receive an Accounting of Disclosures of Your Personal Health Information:** Your have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

- **Right to a Paper Copy of This Notice:** You have a right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please request one from our Privacy Officer.

Complaints

You may file a complaint with us and with the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You may submit your complaint in writing to our Privacy Officer at the address listed above. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will always have available the current notice at or near the front desk. The notice will contain, on the first page, the effective date.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to KSI. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our Privacy Officer, at the address and telephone number listed above.

I acknowledge that I have received, read and understand the physicians at Knee & Shoulder Institute's Notice of Privacy Practices.

______________________________ ____________

Signature of Patient or Legal Representative | Date

____

Printed Name of Patient or Legal Representative

______________________________ ____________

Witness Signature | Date

9499 W. Charleston, Suite #200
Las Vegas, NV 89117
P:702.933.9393 | F:702.933.6789
Email: ksi@knees-shoulders.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PERSONAL HEALTH INFORMTION

(OFFICE: USE WHEN PATIENT REQUESTS MEDICAL RECORDS/PHI BE SENT TO ANOTHER ENTITY)

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320D, et.seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing. Knee and Shoulder Institute (also known as covered entity) will not condition treatment payment, enrollment in a health plan, or eligibility benefits, as applicable, on your providing authorization for requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Knee and Shoulder Institute may use or disclose ____ (describe information)
For the purpose(s) of ____ (describe intended use).

By signing this authorization you agree that Knee and Shoulder Institute or its Business Associates may disclose your personal health care information to
____ (identify intended recipient)

Additional recipients please list below:
____
____
____

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Knee and Shoulder Institute HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Knee and Shoulder Institute has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Knee and Shoulder Institute at any of its offices or by sending a written return address on top of this form.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Knee and Shoulder Institute has taken action in reliance on it. A revocation is effective upon receipt by Knee and Shoulder Institute of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

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Email: ksi@knees-shoulders.com

HIPAA PRIVACY
AUTHORIZATION FOR RLEASE OF MEDICAL RECORDS/PERSONAL HEALTH INFORMATION
KNEE AND SHOULDER INSTITUTE

This authorization shall expire upon the earlier occurrence of: (a) revocation of authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Knee and Shoulder Institute, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for disclosure by the recipient and no longer protected under HIPAA.

Knee and Shoulder Institute will provide ______________________________with a copy of this signed authorization.

Acknowledged and agreed to by:

Patient Name: ____
DOB: ______________

If on behalf of patient: Name of guardian or POA: ________________________________

Patient/POA/ Guardian Signature: __________________________________**Date:**________________