OrthoArizona
John K Bradway, MD
10213 N. 92nd Street, Suite 101 ◆ Scottsdale, AZ 85258 ◆ Phone: (480) 860-6005 ◆ Fax: (480) 860-1882

PATIENT INFORMATION Date: _____

Soc Sec # _____ Last Name: _____ First Name: _____ Mi: ____

Birthdate: _____ Age: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary MD Name: _____ Primary MD phone number: _____

Referring MD Name:_____ Referring MD Phone number: _____

Primary Address: _____ City: _____ State: _____ Zip: _____

Secondary/Seasonal Address:_____ City: _____ State: _____ Zip: _____

Day Ph: _____ Cell Ph: _____ Work Phone: _____ Ext: _____

E-mail:_____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ White/Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Native American

May our office leave messages on voice mail or answering machine regarding your healthcare including, but not limited to, appointments, surgery, test results, or other necessary treatment information at the above listed numbers? ☐ Yes ☐ No

May our office leave messages with family members, friends, or other individuals that answer calls at the above listed numbers? ☐ Yes ☐ No

If NO, whom are we authorized to leave messages with? _____

Primary Emergency Contact Name: _____ Relation: _____ Phone: _____

Is patient: ☐ Full Time Student ☐ Employed ☐ Self Employed ☐ Retired ☐ Not employed Patient Occupation: _____

Patient Employer Name: _____ Address: _____

GUARANTOR INFORMATION (The guarantor is the person that holds the policy. This information is required in order to bill your insurance.)

Soc Sec # _____ Last Name: _____ First Name: _____ Mi: _____

Birthdate: _____ Age: _____ Sex: ☐ M ☐ F Relation to patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION (This information needs to be filled out even though the office obtained a copy of your insurance card.)

PRIMARY INSURANCE

Insurance Co. Name: _____

Ins. Co. Address: _____

City, State, Zip: _____

Ins. Co. Phone: _____

Policy Holder Name: _____

Employer: _____

Relation to Patient: _____

ID NO: _____ Group: _____

Policy Holder Sex: ☐ Male ☐ Female DOB: _____

SECONDARY INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

City, State, Zip: _____

Ins. Co. Phone: _____

Policy Holder Name: _____

Employer: _____

Relation to Patient: _____

ID NO: _____ Group: _____

Policy Holder Sex: ☐ Male ☐ Female DOB: _____

Patient Signature: _____ Date: _____

Revised 4-6-12

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Patient Name: _____ DOB: _____ SSN: _____

Previous Name (if applicable): _____ Date:_____

I understand my/the patient's health information is private and confidential. I understand that John K. Bradway, M.D., A Division of OSNA, PLLC, works hard to protect my/the patient's privacy and preserve the confidentiality of my/the patient's health information.

I understand that John K. Bradway, M.D., A Division of OSNA, PLLC, has a detailed document called the "Notice of Privacy Practices". It contains more detailed information about how we may use and disclose patient health information. I understand that I have a legal right to read the "Notice of Privacy Practices" before I sign this consent.

John K. Bradway, M.D., A Division of OSNA, PLLC, may update this "Notice of Privacy Practices". If I ask John K. Bradway, M.D., A Division of OSNA, PLLC, he will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask John K. Bradway, M.D., A Division of OSNA, PLLC, to restrict how my/the patient's health information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that John K. Bradway, M.D., A Division of OSNA, PLLC, does not have to agree to my/the patient's request. If John K. Bradway, M.D., A Division of OSNA, PLLC, does agree to my/the patient's request, I understand that John K. Bradway, M.D., A Division of OSNA, PLLC, will follow the agreed limits.

I may cancel this consent in writing at any time by doing the following: Writing, signing and dating a letter to John K. Bradway, M.D., A Division of OSNA, PLLC. If I write a letter, it must say that I want to revoke my/the patient's consent to authorize the use and disclosure of my/the patient's health information for treatment, payment, and healthcare operations.

If I revoke this consent, John K. Bradway, M.D., A Division of OSNA, PLLC, does not have to provide any further healthcare services to me/the patient.

My signature below indicates that a copy of John K. Bradway, M.D., A Division of OSNA, PLLC, "Notice of Privacy Practices" has been made available to me today. My signature means that I agree and consent to allow John K. Bradway, M.D., A Division of OSNA, PLLC, to use and disclose my/the patient's protected health information to carry out treatment, payment, and healthcare operations.

_____ _____

Patient or legally authorized individual signature Date

_____

Name and relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

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Patient History

Patient Name: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Referred by: _____ Family Physician Name & Phone: _____

Pharmacy Name: _____ Phone Number: _____

Today's ailment (brief description): _____

Date of injury/onset of problem: _____ Work related: ☐ Yes ☐ No Motor Vehicle Accident: ☐ Yes ☐ No

Have you had X-Rays: ☐ Yes ☐ No If yes, where and when: _____

Medication allergies: ☐ None ☐ PCN ☐ Sulfa ☐ Anti-inflammatories ☐ Codeine ☐ Sulfa ☐ Latex ☐ Other: _____

Daily Medications: _____

PREVIOUS SURGERIES (list appx. Dates)

☐ Bone / Joint Surgery Please describe: _____

☐ Heart bypass: _____ ☐ Heart valve: _____ ☐ Gastric surgery: _____

☐ Appendectomy: _____ ☐ Tonsilectomy: _____ ☐ Hysterectomy: _____

☐ Hernia: _____ ☐ Other: _____

PAST MEDICAL HISTORY: Do you currently, or have you ever had any of the following.

☐ Heart disease ☐ High blood pressure ☐ Diabetes ☐ Arthritis ☐ Bleeding disorder ☐ Seizures ☐ Stroke ☐ Cancer ☐ Anemia
☐ Ulcers ☐ Reflux/Heartburn ☐ Hepatitis ☐ Asthma ☐ Shortness of breath ☐ Drug/Alcohol abuse ☐ Blood clots/Circulatory Problems
☐ Other: _____

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day: _____ Did you quit smoking? ☐ Yes ☐ No When: _____

Alcohol use? ☐ Yes ☐ No If yes, how much and how often: _____

Exercise? ☐ Yes ☐ No How often: _____ Do you drink caffeine? ☐ Yes ☐ No How often: _____

REVIEW OF SYSTEMS: Check all that apply – explain below as needed (if normal, leave box blank)

Constitutional	☐	Weight loss ☐ Weight gain ☐ Fever ☐ Chills ☐ Fatigue
HENT	☐	Headache ☐ Sore throat ☐ Dry mouth ☐ Nose bleeds ☐ Nasal drip ☐ Ringing in ears ☐ earaches ☐ congestion
Eyes	☐	Corrective lenses ☐ Blurred/Double vision ☐ Eye pain ☐ Redness ☐ Watering ☐ Dry eye
Neck	☐	Neck pain/stiffness ☐ Thyroid problems
Cardiovascular	☐	Chest pain ☐ History of heart attack ☐ Palpitations ☐ Fainting ☐ Murmurs ☐ Arrhythmia ☐ Phlebitis ☐ Varicosities
Respiratory	☐	Shortness of breath ☐ Wheezing ☐ Cough ☐ Tightness ☐ Chest wall pain
Gastrointestinal	☐	Reflux/Heartburn ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Bleeding/Bloody stools/Hernia
Genitourinary	☐	Urinary frequency ☐ Urgency ☐ Difficult or painful urination ☐ Flank pain ☐ Bleeding ☐ History of UTI
Musculoskeletal	☐	Joint pains ☐ Swelling ☐ Instability ☐ Stiffness ☐ Redness ☐ Heat ☐ Back pain ☐ Muscle pain/fibromyalgia
Skin	☐	Skin changes ☐ Poor healing ☐ Rash ☐ Itching ☐ Redness ☐ Heat ☐ Back pain
Neurological	☐	Numbness/Tingling (where _____) ☐ Unsteady gait ☐ Fainting ☐ Dizziness ☐ Falling/Tremors ☐ Seizure
Psychological	☐	Nervousness ☐ Anxiety ☐ Depression ☐ Alcohol use ☐ Drug use
Hematological	☐	Easy bleeding ☐ Bruising ☐ History of anemia ☐ Clotting disorder
Other		_____

The above information is, to the best of my knowledge a true statement of my current condition.

Patient Signature: _____ Date: _____

Physician/P.A. Signature: _____ Date: _____

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Patient Name: _____ DOB: _____

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointment and arrive in a timely manner. If you are unable to keep your scheduled appointment, please call our scheduler to cancel or reschedule your appointment at least 24 hours prior to your scheduled appointment. This allows Dr. Bradway to offer that time to another patient. If you forget or fail to show up for your scheduled appointment, there will be a **$25.00 fee** charged to your account. Missed appointment charges are not covered by insurance.

_____ _____

Signature of patient or responsible party Date

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APPOINTMENT REQUESTS / PATIENT REGISTRATION FORM

It is important we know if you have been seen by an OSNA physician at any time in the last 3 years.

Patient Name: _____ DOB: _____

Have you been treated for any fractures, joint replacements, pain management, or orthopedic surgery in the last 3 years?

☐ YES ☐ NO

If yes, what is the physician's name? _____

******PLEASE SEE THE FRONT OFFICE RECEPTIONIST FOR A FULL LIST OF OSNA PROVIDERS******

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FINANCIAL POLICY

Patient Name: _____ DOB: _____

Our office is committed to providing you with the best possible care, and we will be happy to discuss our professional fees with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our Financial Policy or your financial responsibility.

ALL PATIENTS MUST COMPLETE OUR PATIENT INFORMATION FORMS BEFORE SEEING THE DOCTOR AND / OR PHYSICIAN ASSISTANT

It is important that you understand that you're responsible for all charges that may occur during your visit. In addition to paying for any insurance co-payment at the time of your appointment, you may also be responsible for charges not covered by your insurance carrier. If your insurance carrier denies the medial claim submitted by our office in its entirety, or any part of the claim, the patient and / or responsible party will be responsible for the bill per the insurance contract regulations. Your insurance company will also notify us of any patient responsibility for deductible or co-insurance. The patient and / or responsible party are ultimately full responsible for the timely payment of the account. All balances are due within 30 days of notification.

Communication with our patients regarding our financial policy is essential. If you have any special needs or concerns regarding this policy, please bring it to our attention. We are here to help you and provide you with the best service.

THE FOLLOWING SECTION MUST BE COMPLETED IN ITS ENTIRITY. PLEASE CALL THE OFFICE PRIOR TO YOUR APPOINTMENT IF YOU HAVE ANY QUESTIONS OR CONCERNS. FAILURE TO DO SO MAY DELAY YOUR SCHEDULED APPOINTMENT TIME.

I have read the financial policy for the office and fully understand that I am ultimately responsible for all charges on my account. It is my financial responsibility to remit payment for any charges not covered by my insurance plan(s) within the insurance contract regulations including, but not limited to, co-insurance, co-payments and deductibles. I understand that co-payments for office visits are due at the time of service and that any other patient balances are due within 30 days of notification (patient statement). Furthermore, I understand that I am fully responsible for the balance on this account, and in the event that this account is turned over to a collection agency, I am aware that I will be responsible for all collection agency fees up to 50% of the outstanding balance plus attorney fees and court costs.

IF I FAIL TO REMIT PAYMENT WITHIN 30 DAYS OF THIS NOTIFICATION, I AUTHORIZE THE OFFICE OF JOHN K. BRADWAY, M.D., A DIVISION OF OSNA, PLLC, TO PROCESS PAYMENT AUTOMATICALLY ON MY ACCOUNT USING THE PAYMENT INFORMATION PROVIDED BY ME BELOW. OUR OFFICE DOES ACCEPT ALL MAJOR CREDIT CARDS: VISA (CREDIT OR DEBIT), MASTERCARD (CREDIT OR DEBIT), AMERICAN EXPRESS AND DISCOVER.

Name on card: _____ Expiration Date: _____

Account #: _____ Billing Zip Code: _____

_____ _____

Patient or Responsible Party Signature Date

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FINANCIAL POLICY Q&A

Q: ***Why do I have to sign and date the Patient Notice of Financial Policy?***

A: It is Dr. Bradway's office policy that the Patient Notice of Financial Policy be completed in full. This way we know that you understand our financial policy.

Q: ***I am worried about the security of my credit card information.***

A: The information is placed in your chart and these are protected by confidentiality and privacy laws. In addition, our employees all sign a Code of Conduct and patient charts are securely filed each day.

Q: ***I don't want to give my credit / debit card information.***

A: It is Dr. Bradway's office policy that the Patient Notice of Financial Policy be completed in full. Patients do have the right to refuse to provide the information. However, Dr. Bradway's office reserves the right to decline service in that case.

Q: ***What do I do if I have questions regarding my account when I receive my statement?***

A: Please call the billing department if you have any questions regarding your account.

Q: ***What if an error is made on my account by a member of your staff or by the insurance carrier?***

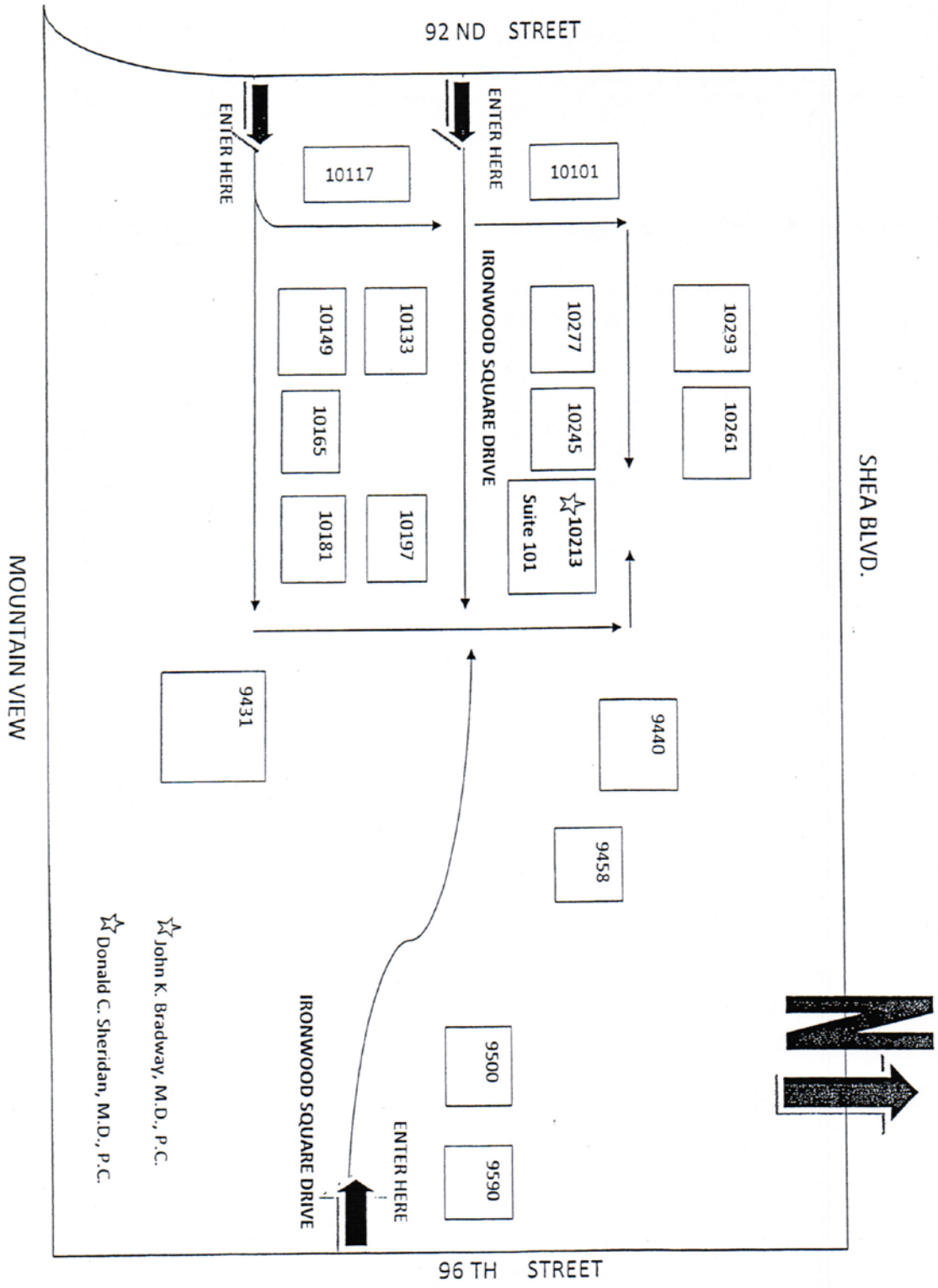
A: If it is our error, we will work diligently to correct the problem. If the error is with your insurance carrier, we will work with you to solve the problem.

Q: ***Why do I have to provide you with authorization and account information to process a payment?***

A: Your authorization and account information allows us to keep your account accurate with your notification.

Q: ***Where do you keep the authorization and how will I be notified if you process a payment?***

A: The authorization is kept in the patient record as part of their healthcare record. This information is guarded in our office under the federal guidelines of the Health Insurance Portability and Accountability Act as well as our patient Notice of Privacy Practice. You will be notified in writing about any payment processed to your account.


92 ND STREET
SHEA BLVD.
MOUNTAIN VIEW
96 TH STREET
ENTER HERE
ENTER HERE
IRONWOOD SQUARE DRIVE
IRONWOOD SQUARE DRIVE
ENTER HERE
10117
10101
10293
10261
10277
10245
10213
Suite 101
10149
10133
10165
10181
10197
9431
9440
9458
9500
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John K. Bradway, M.D., P.C.
Donald C. Sheridan, M.D., P.C.