David Thull, M.D.
9220 E. Mountain View Rd. STE 102
Scottsdale AZ 85258
Phone 480-661-8348
Fax 480-661-6971

PATIENT INFORMATION

Date: _____

Demographics:

Name- **Last** , **First** | **D.O.B**

Address | **City** | **State** **Zip**

( ) **Home Phone** ( ) **Cell Phone** ( ) **Work Phone**

Best method to reach you: **HOME** / **CELL** / **EMAIL /WORK (Circle)**
May we text/email appointment reminders? **Yes** **No** **(Circle)**
May we text/email accounts receivable information? **Yes** **No** **(Circle)**

SOCIAL SECURITY #_____

EMAIL ADDRESS: _____ **INSURANCE**:_____
POLICY HOLDER:_____
DATE OF BIRTH:_____

Guarantor Information: (Person Responsible For Patient Bills If NOT Paid By Insurance)

Name- **Last , First** | **DOB** | **Relationship**

Address (If Different from above) | **City** | **State** **Zip**

How were you referred?

Physician_____ / Family/ Friend/Internet_____/Other: _____
(Name) (Name of Site)

PRIMARY CARE PHYSICIAN

Name | **Location (Address or X-Street)** | **Phone**

PHARMACY:

Name | **Location (cross streets)** | **Phone**

Emergency Contact:

NAME | **PHONE** | **Relationship**

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_____
Patient Name

What is your reason for seeing the doctor? _____
(If you have any radiology images or reports with you please give to receptionist)

Past Medical History (Please circle)

Anxiety Autoimmune Disorder Asthma Cancer

High Cholesterol Depression Diabetes High Blood Pressure

Heart Attack Heart Condition Lung Condition Stroke

Other: _____

Past Surgical History:

_____ _____ _____

Medications: *(if you have a medication list please give to receptionist)*

Name of medication	Dose	Frequency taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies/Adverse effects to medication: (if yes please list) *YES* or *NO*

_____ _____
_____ _____

Family History: (full blooded relatives)

	YES	NO		YES	NO
Anesthesia problems	____	____	Seizures	____	____
Lung disease	____	____	Gastro Intestinal	____	____
Arthritis	____	____	Psych history	____	____
Migraines	____	____	Hepatitis	____	____
Back/Neck problems	____	____	Thyroid disease	____	____
Muscle weakness	____	____	Kidney/bladder	____	____
Cancer	____	____	Transfusion Reaction	____	____
Neurological	____	____	Liver disorder	____	____
Cardiac	____	____	Smoker	____	_____

Social History:

What is (or was) your Occupation? _____
When was your last tetanus shot? _____
Do You Drink Alcohol? ____No ____Yes How Much _____
Are You Pregnant: YES / NO

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Office Policies

1. I hereby authorize release of any medical information necessary to process my insurance claims.
Initials _____

2. Balances over 30 days that are patient responsibility will be charged a $25.00/mth administrative fee. Any subsequent payments will be applied to late fees first, if the account is not paid in full the account will be referred to collections. **We do not have the ability to finance patients' balances.** In the rare case of an account being referred to collections, you will be responsible for all fees and collection expenses.
Initials _____

3. All patient balances must be paid in full before any further services are rendered. If the insurance denies your claims due to missing information from the patient, the balance will become patient responsibility. Future visits will also require full payment until the issue with the insurance is resolved.
Initials _____

4. Patient's paying with a credit card will incur a convenience fee of 4%
Initials _____

5. Payment not covered by insurance i.e. coinsurance, co-pays, deductibles, past due balances, and non-insured patient payments are collected at the time of service.
Initials _____

6. In the event that the insurance carrier you initially provided to our office was incorrect and another company is to be rebilled for services rendered, a $75.00 administrative fee will be charged for reworking your account. Until this fee is paid, the account will not be reworked and the balance will be patient responsibility.
Initials _____

7. A returned check charge of $50 will be charged for all returned checks and no further checks will be accepted.
Initials _____

8. There is a charge to obtain copies of medical records. You may request a copy of your office visit note to be sent to you via email at no charge. (If office note is not requested directly after the visit there will be an administrative fee.)
Initials _____

9. If you need to cancel a scheduled surgery you must notify our office 48 hours or more prior to surgery. There is a $75.00 late cancellation fee for surgeries cancelled within 48 hours.
Initials _____

10. Orthopedics of North Scottsdale as a courtesy will check insurance benefits for Dr. Thull's services only. We are not responsible for checking benefits for any other facility.
Initials _____

11. I have read the notice of privacy practice.
Initials _____

Print Name:_____Signature:_____

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State law ARS 32-1401 (24) (ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. We support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that David Thull, MD has a direct financial interest in the GATEWAY SURGERY CENTER. The other available surgery center on a competitive basis is PIPER SURGERY CENTER.

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file. You may receive a copy upon request.

ACKNOWLEDGEMENT; I have read this notice and I understand the disclosures that it contains.

_____
Print Name

_____
Signature of Patient/Guardian/Responsible Party

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This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At Orthopedics of North Scottsdale we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by another physician we may involve in your care.

We participate in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment.

We may use or disclose your health information for your payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example; one of our staff will enter your information into our computer.

We may share your medical information with our business associates such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example; we may call to confirm your appointments. If you are not at home, we may leave this information on your answering machine or with the person who answers the phone

In an emergency, we may disclose your health information to a family member of another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will fax your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy or your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We will include your statement in your file. If we agree to amendment, we will not remove nor alter earlier documents, but will add new information. You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint regarding your personal health information with the Department Of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at the address above.

This notice is effective April 14, 2003.

Print Name:_____ Signature:_____