8205 N. Via De Negocio Dr.
Scottsdale, AZ 85258
Phone: 480-451-3668
Fax: 480-451-3669

2019 PATIENT INFORMATION RECORD

Please complete, print and bring this form with you to your next appointment.

To remain HIPPA compliant, this form is not automatically saved.
If the form is not completed in advance and printed, you will have to complete it at the time of your appointment which may delay your appointment

JOHN A. NASSAR, M.D.
Orthopaedic Foot & Ankle Surgery

8205 N. Via De Negocio Dr.Scottsdale, AZ 85258
Phone 480-451-3668 **Fax** 480-451-3669

2019 PATIENT INFORMATION RECORD

Patient Name: _____ _____ _____
FIRST LAST MI

Mailing Address: _____
STREET CITY ST ZIP

Out of State Address: _____
STREET CITY ST ZIP

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐M ☐F Marital Status: ☐S ☐M ☐W ☐D

S.S.#: _____-_____-_____ Home Phone:_____ Cell Phone: _____

Employer: _____ _____
OCCUPATION / PHONE

Employer Address: _____
STREET CITY ST ZIP

Emergency Contact: _____ _____
RELATIONSHIP / PHONE

Referred by: _____
NAME PHONE

Primary Care Physician: _____
NAME PHONE

Spouse (or Parent, if minor): _____

Phone:_____ Date of Birth: _____/_____/_____ S.S.#: _____-_____-_____

Address: _____
STREET CITY ST ZIP

Employer: _____ Occupation: _____ Phone: _____

INSURANCE INFORMATION *(It is our office policy to obtain a copy of both your insurance card(s) and a valid photo ID)*

Primary Insurance Co: _____	Secondary Insurance Co: _____
Phone: _____	Phone: _____
Claims Address: _____	Claims Address: _____
Policy/ID #: _____	Policy/ID #: _____
Group/Claim #: _____	Group/Claim #: _____
Policyholder's Name: _____	**Policyholder's Name**:_____
Relationship to Patient: _____	Relationship to Patient: _____
Date of Birth: ____/____/____ Phone: _____	Date of Birth: ____/____/____ Phone: _____
S.S. #: _____	S.S. #: _____
Employer: _____	Employer: _____

Authorization to Release Information & Assignment of Benefits: *I hereby authorize and assign payment of medical benefits to the provider of services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature will bind me as though I personally signed each claim.* ***I also authorize the release of any medical information necessary. I understand that I am responsible for all charges.*** *If my account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understood this office policy.*

Patient/Responsible Party Signature: _____ Date: _____

John A. Nassar, M.D., P.C.
FINANCIAL POLICY

Dear Patient:

Thank you for choosing John A. Nassar, M.D., P.C. for your orthopaedic care. We realize that questions may arise about our payment and collection policies and this notice is designed to provide an overview of these policies. Our goal is to provide quality medical care for our patients and it is important that we work together to assure that reimbursement for our services is straightforward and timely. Our office manager or billing department will be happy to discuss these policies with you. In compliance with Arizona law, you are being advised Dr. Nassar has a direct financial interest in San Tan Surgery Center. The services provided at San Tan Surgery Center are available elsewhere (Honor Health) on a competitive basis.

INSURANCE:

1. You are directly responsible for payment of your medical care and you are expected to pay for any co-payment, deductible, or non-covered amounts at the time of service. Your insurance company may not pay for all of your health care costs. Insurance policies exclude some non-covered services; however, this does not mean that the services or tests are not necessary. It means that the insurance company may not pay for it. Please keep in mind that your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover. For your convenience, we accept VISA and MASTERCARD.
2. PRIVATE PAY patients must pay in full at time of service.
3. In order to bill your insurance company for your medical services, you must provide our office with accurate billing information and your insurance card. If you do not provide this information at each visit, please expect to pay in full at the time of the office visit for the services rendered. We reserve the right to reschedule your appointment if the applicable co-payment is not paid in full at the time of your appointment.

BILLING:

1. As a courtesy to you, we will bill your insurance company for services rendered. In order to do so, we must have complete billing information, picture identification, and your insurance card. If your insurance changes, it is your responsibility to provide us with updated insurance information.
2. Arizona law requires insurance companies operating in the state to process claims within 30 days. It is your responsibility to promptly provide your insurance company with any requested information needed to process your claim.
3. In addition to co-payments and deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our physician is an "out of network provider" for your insurance, the deductibles and co-insurance amounts are usually higher. Your insurance policy, not our office, determines these amounts.
4. You will receive a statement every month from our office showing your account balance. Your statement will indicate which portion of the balance is due from you, and which is still being processed by your insurance company. Patient balances are due and payable in full upon receipt of your statement.
5. Delinquent accounts will be transferred to a collection agency or our attorney when payments are not made in accordance with our policy. In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for seven years.
6. FMLA and/or DISABILITY Paperwork. As a courtesy to you, we will complete the initial form. Any subsequent forms to be completed will have a charge of $25.00 each, to be paid at the time of completion. There is no completion charge for WORKER'S COMPENSATION FORMS.
7. We require a minimum of 24 hours notice of cancellation or rescheduling of your appointment. A late cancellation and/or a no-show appointment will have a $25.00 fee.

SURGERY:

Prior to surgery, our office verifies your insurance benefits and obtains appropriate authorizations from your insurance company. Once your insurance company determines your deductible, co-payment, and/or co-insurance amounts due for your planned surgical procedure, our office will collect the full amount of your expected patient liability, prior to your planned surgical procedure.

Please understand that maintaining financial viability is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enables us to deliver the quality healthcare you deserve and expect.

I UNDERSTAND AND ACKNOWLEDGE THIS FINANCIAL POLICY.

_____ _____ _____

Patient/Responsible Party Signature Printed Name Date

John A. Nassar, M.D., P.C.

HIPAA and Notice of Privacy Practices

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have a right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. **You have the right to request to receive confidential communications from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us.** Upon request, even if you have agreed to accept this notice alternatively (i.e. electronically), you may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. **Complaints:** you may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaints. We will not retaliate against you for filing a complaint. This notice was published and became effective on or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:

Signature _____ Date_____

Printed Name: _____

John A. Nassar, M.D., P.C.

Patient Name: Age: Today's Date:

How did you find out about Dr. Nassar/who referred you?

Why are you here today?

How long have you had this problem? Which side is involved? ☐ right ☐ left

What is your main problem?

☐ pain ☐ grinding ☐ weakness ☐ increased warmth
☐ deformity ☐ popping ☐ limp ☐ collapsing arch
☐ instability ☐ stiffness ☐ ulcer/sore ☐ numbness/tingling
☐ catching ☐ swelling ☐ redness ☐ open wound

What type of pain are you having?

☐ sharp ☐ aching ☐ throbbing ☐ burning ☐ tearing

How did it start? ☐ gradually ☐ suddenly

What could have caused this? ☐ injury ☐ accident ☐ activity ☐ unknown

Have you had the same or similar problem in the past? ☐ no ☐ yes

How severe is the pain/problem? ☐ mild ☐ moderate ☐ severe

The pain/problem is:

☐ present during activity ☐ present at rest ☐ present at night
☐ worse when starting up after rest

The pain/problem is: ☐ constant ☐ intermittent

The pain/problem is:

☐ not changing ☐ gradually getting worse ☐ rapidly getting worse
☐ gradually getting better ☐ rapidly getting better

What makes your pain/problem worse?

☐ standing ☐ walking ☐ running ☐ jumping ☐ stairs
☐ uneven ground ☐ hard surfaces ☐ dress shoes ☐ any shoes ☐ barefoot

What makes your problem better?

☐ rest ☐ elevation ☐ ice ☐ heat ☐ stretching
☐ removing shoe ☐ rubbing foot ☐ comfortable shoes ☐ avoiding aggravating activities

What types of treatments have you had?	Does this help?		
☐ anti-inflammatory medication	☐ no	☐ a little	☐ a lot
☐ pain medication	☐ no	☐ a little	☐ a lot
☐ compressive wrap	☐ no	☐ a little	☐ a lot
☐ brace	☐ no	☐ a little	☐ a lot
☐ physical therapy	☐ no	☐ a little	☐ a lot
☐ cortisone shot	☐ no	☐ a little	☐ a lot
☐ shoe insert	☐ no	☐ a little	☐ a lot
☐ custom orthotics	☐ no	☐ a little	☐ a lot
☐ cast	☐ no	☐ a little	☐ a lot
☐ cane/crutches/walker	☐ no	☐ a little	☐ a lot

Reviewed by:_____

John A. Nassar, M.D., P.C.

Patient Name:	Today's Date:

Who is your Primary Care Physician?	☐ none
Date last seen?	

Height:	Weight:

List all your **MEDICAL** problems:	currently being treated?
1.	☐ yes ☐ no
2.	☐ yes ☐ no
3.	☐ yes ☐ no
4.	☐ yes ☐ no
5.	☐ yes ☐ no

List all your past **SURGERIES**:	Year	Complications?
1.		☐ yes ☐ no
2.		☐ yes ☐ no
3.		☐ yes ☐ no
4.		☐ yes ☐ no
5.		☐ yes ☐ no

List all your current **MEDICATIONS**:	dose/frequency?	how long taking?
1.		
2.		
3.		
4.		
5.		

List all your past **ALLERGIES** to medications:	reaction
1.	
2.	
3.	

Have you experienced **ANY PROBLEMS** with the following?

General health	☐ current	☐ previously	Circulation	☐ current	☐ previously
Eyes	☐ current	☐ previously	Stroke	☐ current	☐ previously
Ear, Nose, Throat	☐ current	☐ previously	Seizures	☐ current	☐ previously
Heart Attack	☐ current	☐ previously	Diabetes	☐ current	☐ previously
Irregular heart beat	☐ current	☐ previously	Thyroid	☐ current	☐ previously
High blood pressure	☐ current	☐ previously	Infection	☐ current	☐ previously
Lungs	☐ current	☐ previously	Cancer	☐ current	☐ previously
Pneumonia	☐ current	☐ previously	Anemia	☐ current	☐ previously
Shortness of breath	☐ current	☐ previously	Blood Clots	☐ current	☐ previously
Stomach Ulcers	☐ current	☐ previously	Easy bleeding	☐ current	☐ previously
Acid Reflux	☐ current	☐ previously	Hepatitis	☐ current	☐ previously
Osteoarthritis	☐ current	☐ previously	HIV	☐ current	☐ previously
Rheumatoid Arthritis	☐ current	☐ previously	Drug abuse	☐ current	☐ previously
Gout	☐ current	☐ previously	Alcohol abuse	☐ current	☐ previously
Emotional problems	☐ current	☐ previously	Liver	☐ current	☐ previously
Pyschiatric disorders	☐ current	☐ previously	Kidneys	☐ current	☐ previously
Artificial bone/joints	☐ current	☐ previously	Urinary Tract	☐ current	☐ previously
Bone Infection	☐ current	☐ previously	Bowels	☐ current	☐ previously

Reviewed by:_____

John A. Nassar, M.D., P.C.

Patient Name:	Today's Date:

Surgical Risk Factors:

Have you experienced any of the following?			Please Explain any yes answers:
Blood clot in your legs or lungs	☐no	☐yes	
Problems with excessive bleeding	☐no	☐yes	
Latex allergy	☐no	☐yes	
Sleep Apnea	☐no	☐yes	Do you use a CPAP? ☐no ☐yes
Problems with anesthesia	☐no	☐yes	
MRSA Infection	☐no	☐yes	

Women only:

Are you pregnant?	☐no	☐yes
Have you reached menopause?	☐no	☐yes

FamilyHistory:

Family History of: ☐ Anesthesia Problems ☐ Abnormal Blood Clots ☐ Abnormal Bleeding

	Major Medical Problems	Age of Death	Cause of Death
Father			
Mother			
Siblings			
Children			

Social History:

Occupation:					
Work Status:	☐full time	☐part time	☐disabled		
Marital Status:	☐single	☐married	☐divorced	☐separated	☐widowed
Do you have children?	☐no	☐yes	How many?		
Do you live alone?	☐no	☐yes			

Do you exercise? no yes

How often? daily weekly rarely never

What type of exercise?

Do you smoke? ☐no ☐yes

How many packs per day?			For how many years?	
Previously smoked	packs per day, for		years.	
Quit smoking?	☐this year	☐1 year ago	☐5 years ago	☐>10 years ago

Do you drink alcoholic beverages?	☐no	☐yes		
How often?	☐daily	☐weekly	☐monthly	☐rarely
How many drinks?	☐1	☐1-3	☐3-6	☐>6

Do you have a history of any alcohol, substance, or drug abuse?

☐no ☐yes ☐current ☐previous

My signature below indicates that I have provided an accurate and complete medical history:

Signature _____ **Date**_____

Printed Name _____

Rev 01.19

Reviewed by:_____