**Cactus Pediatric Orthopaedics**

# PATIENT INFORMATION

| Appointment Date |
|---|
| |

| LAST NAME | FIRST NAME | MI | DATE OF BIRTH | ❑ MALE ❑ FEMALE |
|---|---|---|---|---|
| NICKNAME | CHILD LIVES WITH ❑ MOTHER ❑ FATHER ❑ GUARDIAN | PREFERRED LANGUAGE | SCHOOL NAME | GRADE |
| PHYSICAL ADDRESS | CITY | STATE | ZIP CODE | HOME PHONE ( ) |
| PEDIATRICIAN / FAMILY PHYSICIAN NAME AND PHONE NUMBER | | | PARENT EMAIL (OPTIONAL) | |
| WHO IS ACCOMPANYING THE CHILD TODAY (NAME AND RELATIONSHIP) | | | Do you have Custody of this child? ❑ Yes ❑ No | |
| PARENT'S MARITAL STATUS ❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Divorced ❑ Separated | | EMERGENCY CONTACT NAME | | PHONE ( ) |

## PARENT'S INFORMATION

❑ *FATHER* ❑ *STEPFATHER* ❑ *GUARDIAN*

| LAST NAME | FIRST NAME | MI | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|
| EMPLOYER | OCCUPATION | DRIVER'S LICENSE NUMBER | | WORK PHONE ( ) |
| MAILING ADDRESS IF DIFFERENT THAN CHILD'S | CITY | STATE | ZIP CODE | CELL PHONE ( ) |

❑ *MOTHER* ❑ *STEPMOTHER* ❑ *GUARDIAN*

| LAST NAME | FIRST NAME | MI | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|
| EMPLOYER | OCCUPATION | DRIVER LICENSE NUMBER | | WORK PHONE ( ) |
| HOME/MAILING ADDRESS IF DIFFERENT THAN CHILD'S | CITY | STATE | ZIP CODE | CELL PHONE ( ) |

## PRIMARY INSURANCE INFORMATION

| INSURANCE COMPANY NAME | MEMBER I.D. NUMBER | GROUP NUMBER | | COPAY | DEDUCTIBLE |
|---|---|---|---|---|---|
| CLAIMS ADDRESS | CITY | STATE | ZIP CODE | INS. PHONE ( ) | |
| POLICY HOLDER (FULL NAME) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | | RELATIONSHIP TO PATIENT | |

## OTHER INSURANCE INFORMATION

_____**Initial if you do not have any other healthcare coverage**

| INSURANCE COMPANY NAME | MEMBER I.D. NUMBER | GROUP NUMBER | | COPAY | DEDUCTIBLE |
|---|---|---|---|---|---|
| CLAIMS ADDRESS | CITY | STATE | ZIP CODE | INS. PHONE ( ) | |
| POLICY HOLDER (FULL NAME) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | | RELATIONSHIP TO PATIENT | |

**NOTICE: The parent /guardian bringing the child for treatment is responsible for all charges incurred.**

**ASSIGNMENT OF BENEFITS/FINANCIAL ARRANGEMENT:** I authorize Cactus Pediatric Orthopaedics those insurance benefit payments due for services rendered and hereby authorize my insurance company to make payment directly to Cactus Pediatric Orthopaedics. I understand that regardless of this assignment, I remain primarily responsible to Cactus Pediatric Orthopaedics for payment of all actual charges incurred. A copy of this assignment shall be as valid as the original. I fully understand I am financially responsible for and agree to pay all charges not paid by my health insurance plans or payors, including deductibles and co-insurance regardless of reason given for non-payment. I understand that a $5 fee will be assessed to account balances over 30 days past due and an additional $25 for account balances over 60 days past due. In the event that I fail to pay for the services provided by this office, and the account is placed for collections, I further agree to pay all attorneys fees and court costs necessary to collect this balance. I agree to pay a penalty fee of $25.00 for each bounced check I issue to the facility.

I hereby authorize this healthcare provider/facility to release all information necessary to secure payment of benefits.

Signature (Parent or Guardian) ______________________________ Print Name ________________________

# Medical History

Patient Name: ______________________ Date of Birth: ______________ Dominant Hand: ○ Right ○ Left

Pediatrician/Family Physician: ______________________ Age: ______ Weight: ________ Height: ________

**List All Allergies** (State Drug/Food/Animal/Etc. and reaction): ______________________

**List all Daily / Seasonal medications** (name/dose/and reason for taking): ______________________

## CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS

What is the reason for your visit today? ______________________

Date of accident or date symptoms began: ______________ How long ago did it start: ____Days ____Weeks ____Months ____Years

**BODY PART:** ○ Arm ○ Elbow ○ Wrist ○ Hand ○ Leg ○ Knee ○ Ankle ○ Foot ○ Shoulder ○ Hip ○ Back ○ Neck

**SIDE:** ○ Right ○ Left ○ Both On a scale of 1-10 (10 is the worst) how severe is your pain? (circle) 1 2 3 4 5 6 7 8 9 10

Describe the symptoms you are having: ______________________

What is the quality of the pain? ○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Achy ○ Other ______________

Who have you seen prior to today? ○ Hospital ○ Urgent Care ○ Pediatrician/Family Physician ○ Today is first day of treatment

Hospital, Urgent Care, or Provider Name: ______________________

○ INJURY
○ ACCIDENT ○ Auto ○ Sports ○ School ○ Home ○ Other? ______________

Please specify where and how it happened: ______________________

______________________

Is another party responsible for causing the accident? ○ No ○ Yes Whom:

## PAST MEDICAL, FAMILY & SOCIAL HISTORY

Did mom have any illnesses during pregnancy? Y N if yes, List: ______________________

Medications taken by mom during pregnancy? Y N if yes, below: ______________________

Was patient born ○ early (<37 weeks) ○ term ○ late (>42 weeks?)

**Delivery:** ○ Vaginal ○ Breach ○ C-Section **Birth Weight** ____ lbs ____ oz

| HOSPITALIZATIONS Major Illnesses, Injuries or Surgeries | | |
|---|---|---|
| Year | Major Illness/Injury/Surgery | Hospital if required |
| | | |
| | | |
| | | |

| Developmental History Milestones | | | |
|---|---|---|---|
| Rolled Over | ○ Early | ○ Normal | ○ Delayed |
| Sat Alone | ○ Early | ○ Normal | ○ Delayed |
| Crawled | ○ Early | ○ Normal | ○ Delayed |
| Walked | ○ Early | ○ Normal | ○ Delayed |

| Family History | | |
|---|---|---|
| ○ Diabetes | ○ Stoke | ○ Osteoarthritis |
| ○ Cancer | ○ Heart Disease | ○ High Blood Pressure |
| ○ Other: | | |

| MEDICAL CONDITIONS/ILLNESSES | | | | | |
|---|---|---|---|---|---|
| Asthma / Wheezing | Y N | Congenital Heart Disease | Y N | Seizures / Epilepsy | Y N |
| Heart Murmur | Y N | Infections of Bone / Joint | Y N | Bleeding Tendencies | Y N |
| Arthritis | Y N | Other: | | | |

## REVIEW OF SYSTEMS (Check all that apply)

| | | | | |
|---|---|---|---|---|
| CONSTITUTIONAL | ☐ Fever<br>☐ Recurrent fever | ☐ Change in appetite<br>☐ Changes in weight | ☐ Headache<br>☐ Chills | ☐ Changes in energy<br>☐ Other |
| EYES / EARS<br>NOSE / THROAT | ☐ Blurred vision<br>☐ Double vision | ☐ Ear Infection<br>☐ Bleeding from ear | ☐ Sinus problem<br>☐ Bleeding from nose | ☐ Sore throat<br>☐ Bleeding gums |
| CARDIOVASCULAR | ☐ Chest pain | ☐ Rapid heart beat | ☐ High blood pressure | ☐ Other |
| RESPIRATORY | ☐ Wheezing | ☐ Frequent cough | ☐ Shortness of breath | ☐ Other |
| GASTROINTESTINAL | ☐ Abdominal pain | ☐ Nausea / vomiting | ☐ Indigestion / heartburn | ☐ Pain with swallowing |
| GENITOURINARY | ☐ Blood in urine | ☐ Painful urination | ☐ Frequent urination | ☐ Other |
| MUSCULOSKELETAL | ☐ Neck pain<br>☐ Bone pain | ☐ Joint swelling<br>☐ Joint pain | ☐ Back pain<br>☐ Broken Bones | ☐ Sprains / Dislocations<br>☐ Other |
| SKIN | ☐ Skin rash | ☐ Boils | ☐ Persistent itch | ☐ Other |
| NEUROLOGIC | ☐ Numbness<br>☐ Tingling | ☐ Weakness<br>☐ Tremors | ☐ Siezures<br>☐ Dizzy Spells | ☐ Loss of consciousness<br>☐ Other |
| PSYCHIATRIC | ☐ Depression | ☐ Drug / Alcohol addition | ☐ Sleep disorder | ☐ Other |
| HEMATOLOGIC | ☐ Anemia | ☐ Bleeding disorder | ☐ Sickle cell anemia | ☐ Lymphoma |
| ENDOCRINE | ☐ Excessive thirst | ☐ Too hot / cold | ☐ Tired / sluggish | ☐ Other |

*The information on this form is accurate and to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.*

Patient /Legal Guardian Signature ______________________ Date: ______________

Cactus Pediatric Orthopaedics

## PATIENT FINANCIAL POLICY

Thank you for choosing Cactus Pediatric Orthopaedics for your health care. The following is information about our financial policy. Please read, sign and return it to the receptionist.

- Parents/Guardians are required to provide insurance card & photo identification to every appointment.
- All outstanding patient balances are due at check in. We accept cash, checks, Visa, Mastercard and Discover.
- Patients without insurance are required to pay in full on date of service.
- All co-pays, unmet deductibles (a minimum of $500 for large deductibles), co-insurance, & non-covered services, supplies or materials are due at the time of service unless payment arrangements have been made PRIOR TO YOUR APPOINTMENT.
- If your co-pay/co-insurance is based on a %, a minimum payment of $25.00 is required on date of service.
- In the event surgery is needed & you do not have insurance coverage, full payment of the estimated surgeon's fees is required before the surgery is scheduled.
- Billing statements are issued after the insurance carrier pays its portion; payment is due upon receipt.
- Your insurance policy is a contract between you and your insurance company. As a courtesy we will file the claims for you, however we will not become involved in disputes between you and your insurance carrier; this includes, but is not limited to, deductibles, co-payments, co-insurance, denied or non-covered charges. Direct any questions and or complaints about how your claim was processed to your insurance company.
- Referrals & Authorizations: If your insurance requires a referral or authorization to a specialist, you are required to obtain the referral/authorization *prior to your appointment*. If you do not have a current, valid referral/authorization, we may ask you to either reschedule your appointment or pay for the visit at the time of service. *If Cactus Pediatric Orthopaedics is not contracted with your insurance plan, authorization is required*. Without authorization you will be responsible for any balance not picked up by your insurance, primary or secondary. It is the patient's responsibility to know their insurance benefits.
- Divorce & Custody: In regards to a minor the parent who brings the child to the office for care is responsible for payment of all charges incurred. We will not bill a divorced spouse for the patient's services. The clinic does not honor divorce specifics.
- Liability Injury: Cactus Pediatric Orthopaedics does not provide deferred billing for liability cases.
- Patient ensures to provide accurate, correct information for proper billing at all times and notify Cactus Pediatric Orthopaedics of any changes at any time a change occurs.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our policies.
Please contact our Billing Service, AR Medical Solutions 480-289-5224 with any questions or concerns.

*I hereby certify that I as the parent/guardian of;*

*Patient Name*_________________________________ *Date of Birth* __________________________ *am authorized to act on the patient's behalf and that I have read and understand the policy and by signing agree to abide by these guidelines.*

___________________________________ ___________________________________ ____________________

Print Name of Parent/Legal Guardian | Signature of Parent/Legal Guardian | Date

# Cactus Pediatric Orthopaedics

## CONSENT FOR MEDICAL TREATMENT:

I, the Parent or Legal Guardian of patient authorize Cactus Pediatric Orthopedic, physicians and personnel to render medical treatment and evaluation to (Patient Name): ____________________________ . I further authorize x-rays, injections, casting, or other diagnostic tests and treatments that may be necessary. This consent shall remain in effect until written revocation hereof is delivered to Cactus Pediatric Orthopedics. Should I be unble to bring my child I will send a representative of mine with a signed Third Party Consent.

## AUTHORIZATION TO RELEASE INFORMATION: **This is not a Third Party Consent.**

Please keep in mind that our office will not give out any information, including, reasons for a particular visit, billing information, etc., to anyone other than the patient or patient legal guardian.

Additional Personal Representative to receive information. (Check each that is subject to this authorization)

☐ Leave information on the voice mail ☐ Release/discuss information to the following persons:

______________________________ ____________________________ ___________________________

## PRIVACY NOTICE:

I hereby authorize Cactus Pediatric Orthopedic to use and disclose my health information, which specifically identifies me or which can be reasonably be used to identify me to carry out my treatment, payment, and healthcare operation. I understand that while this consent is voluntary, if I refuse to sign this consent Cactus Pediatric Orthopedic can refuse to treat me.

I acknowledge that I have received a copy of the Notice of Privacy Standards ("HIPAA"), which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and healthcare operations.

I understand that I make revoke this consent at anytime by notifying Cactus Pediatric Orthopaedic in writing, but if I revoke my consent, such revocation will not affect any action that Cactus Pediatric Orthopaedic took before receiving my revocation.

I understand that Cactus Pediatric Orthopaedic has reserved the right to change their privacy practices and that I can obtain a changed notice upon request.

I understand that I have the right to request that Cactus Pediatric Orthopaedic restrict how my individually identifiable information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that Cactus Pediatric Orthopaedic does not have to agree to such restrictions but that once such restrictions are agreed to Cactus Pediatric Orthopaedic must adhere to such restrictions.

*MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO READ OR HAVE HAD THE ABOVE INFORMATION EXPLAINED TO ME, THAT I FULLY UNDERSTAND THE STATEMENTS IN THIS DOCUMENT AND CONSENT TO EACH OF THEM. I CERTIFY THAT I AS THE PARENT/GUARDIAN OF SAID PATIENT AM AUTHORIZED TO ACT ON THE PATIENTS BEHALF TO EXECUTE THE ABOVE AND ACCEPT THE TERMS HEREIN.*

Patient Name: ____________________________________________ Date of Birth: _______________________

________________________________ ________________________________ __________________

Print Name of Parent/Legal Guardian Signature of Parent/Legal Guardian Date

Cactus Pediatric Orthopaedics, PLLC
dba Kids' Fracture Care

**Gregory Hrasky, MD**
**Sarah Bolander, PA-C / Trent Tipton, PA-C**

## DURABLE MEDICAL EQUIPMENT AND ORTHOTICS CHARGE SHEET

**Patient Name:** ______________________________ **Patient DOB:** ______________

### Durable Medical Equipment and Orthotics Patient Consent

~ I understand that my healthcare provider may have prescribed this medical supply as part of my treatment plan
~ I understand that I have a choice in where I receive my prescribed orthopaedic supplies and services
~ I authorize Cactus Pediatric Orthopaedics to furnish this service/product and to provide my insurance company with any information requested for payment.
~ I instruct my insurance provider to pay Cactus Pediatric Orthopaedics directly for these services/products
~ I understand that my insurance company may deny payment for this supply as a non-covered/non-benefit item or deem it not medically necessary
~ I understand that I am fully responsible for any deductable or co-insurance cost related to this service/supply
~ I understand any costs not covered by my insurance provider will be my financial responsibility
~ I have received the prescribed item and have been fully instructed on the use of the above products/services
~ I understand that all medical devices are not returnable unless there is a material defect

**Service Acceptance:**
**Patient/Guarantor Signature:** ______________________________ **Date:** ______________

**Service Refusal:**
I understand that my healthcare provider may prescribe this item as part of my treatment.
I have opted not to receive these item from Cactus Pediatric Orthopaedics.

**Patient/Guarantor Signature:** ______________________________ **Date:** ______________

| KEY CODE | PRODUCT DESCRIPTION | CHARGE |
|---|---|---|
| A4565 | SLING | $20.00 |
| A4590F2 | FIBERGLASS CASTING MATERIAL | $62.00 |
| A4590P2 | PLASTER | $35.00 |
| L1620 | PAVLIK HARNESS | $135.00 |
| L1902 | ANKLE SUPPORT | $125.00 |
| L3260 | DARCO CAST BOOT | $40.00 |
| L3265 | CAST SHOE | $30.00 |
| L3650 | SHOULDER IMMOBILIZER | $50.00 |
| L3660 | CLAVICLE STRAP | $35.00 |
| L3670 | SHURE SHOULDER IMMOBILIZER | $70.00 |
| L3807 | THUMB SPICA EXOS | $275.00 |
| L3908 | WRIST SUPPORT/GUARD | $60.00 |
| L3982 | EXOS WRIST BRACE | $365.00 |
| L3984 | EXOS SHORT ARM FRACTURE BRACE | $325.00 |
| L4360 | CAM BOOT / AIR WALKER | $460.00 |
| L4386 | WEE WALKER BOOT | $425.00 |

Please be advised, your insurance may not issue payment for some of the durable medical equipment and/or supplies used in our office. Should you have any questions about the items your child may receive, please contact your insurance company directly to see what may be applied to your responsibility. Depending on the item you receive, a deposit up to $250 may be required at time of service. This deposit may not cover the entire cost after insurance contracted adjustments.

This list provides the most common items we use along with the corresponding code that will be billed to your insurance. If the item you received is not shown above, please ask for the description and code.

Cactus Pediatric Orthopaedics