ORTHOPAEDIC INSTITUTE OF HENDERSON
OFFICE POLICIES

10561 Jeffreys Street, Ste 230 Henderson, NV 89052
Phone 702.565.6565
Fax 702.990.5275/702.565.8898

Steven R. Hoer, MD Robert J. Tait, MD R. Jeff Grondel, MD
Richard Woodworth, M.D. William D. Kelley PA-C

To All Patients:

We ask you read the following policy regarding communications with our office. If you are unclear about any of the information, please ask a member of our staff for an explanation.

1. When calling in for a prescription renewal, please refill your medications 24-48 hours before the medication runs out. The pharmacy will contact our office regarding refilling your medication. This process will take approximately 24 hours.

2. When calling in a problem you are having over the phone, please give our office all pertinent information regarding your current health status. The triage personnel will relay this information to the physician. The calls are usually returned after 5:30 p.m. the day the call is received. If the situation is life threatening, go directly to the emergency room and ask them to call us.

3. Referrals commonly require 5-7 business days to complete the cycle. This includes referrals for physicians, diagnostic imaging, therapy, etc. Please allow the office at least 72 hours before calling back unless the referral was an urgent request by your physician.

4. If you need to cancel your appointment please contact us at least 24 hours in advance. **We reserve the right to charge $25.00 for appointments not cancelled within 24 hours of the appointment time.**

5. Office hours are 9:00 a.m. to 5:00 p.m., Monday through Friday. We are closed on Saturday and Sunday. A physician from our office is on call during non-office hours.

6. We require every patient's SSN in order to ensure payment for our services. If you are not willing to provide us with your SSN you have the option of paying for services up front at the time of your visit. You will be reimbursed if we receive payment from your insurance company. Thank you for your cooperation.

______________________________________ __________________________
Signature of Patient (Parent or Guardian if minor) Date

AGREEMENT TO TREAT

Steven R. Hoer, MD   Robert J. Tait, MD   R. Jeff Grondel, MD
Richard Woodworth, MD   William D. Kelley PA-C

Patient's Last Name ______________________________**First** _______________**MI** ___**Phone** ____________________

Cell Phone: __________________________________ **E-Mail:** ________________________________

Sex ☐ **Male** ☐ **Female** **Date of Birth** _______________**(mm/dd/yyyy)** **SSN** ______________________________

Address _________________________________**City** _______________________**State** ________**Zip Code** ____________

Retired: **Y** **N** **Marital Status:** **Married** **Single** **Divorced** **Widowed**

Employer Name: _________________________**Work Phone** ________________**Occupation**________________________

Address _________________________________**City** _______________________**State** ________**Zip Code** ____________

Pharmacy Preference **(name, address, and phone number)** ____

Chief Complaint (reason for visit) ____

Name of Primary Care (Family) Physician ___________________**Name of referring physician** ______________________

Primary Insurance ______________________________ID# ______________________Group# ____________________

Policy Holders Name ___________________________________DOB _______________S.S. # _____________________

Secondary Insurance ____________________________ID# ______________________Group# ____________________

Policy Holders Name ___________________________________DOB _______________S.S. # _____________________

Person Responsible for Payment __________________________DOB _______________S.S. # _____________________

Responsible Party's Address _____________________________City ________________State _________Zip __________

Language____________ Race______________ Ethnicity: Hispanic or Latino_____ Non-Hispanic or Latino_____ Other_____

Is Injury Related to an Auto Accident? YES NO Is this a Liability Injury? YES NO

If YES, Attorney Name ____Phone ___________________________

*****Emergency Contact Name** ______________________________________**Phone** __________________________

Authorization to Treat and Release of Medical Records: My physician is authorized to provide medical care to the above patient and to provide to referring/consulting physicians, insurance companies, their representatives, or my attorney, information they may require regarding my condition while under their treatment or observation, including but not limited to history obtained, medical history, physical findings, diagnosis, prognosis, and treatment recommended.

Financial Agreement: I authorize my insurance company to pay my physician for services rendered, in consideration of the services rendered by my physician at my request and direction. I understand I am responsible for, and agree to pay in full, all charges incurred for services rendered. I further understand that in the event that special arrangements have been made to have payment made through my insurance company, and the carrier elects not to cover any or all of the claim, I am responsible for the balance in full. I further agree to pay lawful and reasonable interest charges after (30) days from date if billing in any unpaid balance.

______________________________________ ______________________________________

Signature of Patient or Guardian **Date**

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CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (narcotics, tranquilizers, and barbiturates) are very useful, but have high potential for misuse and abuse. Therefore, they are clearly controlled by the local, state, and federal government. They are intended to relieve pain, to improve function, and/or ability to work, not simply to feel good. Due to the fact my doctor is now or may be prescribing such medication for me in the future to help manage pain, I agree to the following conditions:

1. **I am responsible for my controlled substance medication.** If the prescription is lost, misplaced, stolen, or if I use it up sooner than prescribed, I understand **it will not be replaced.**

2. **I will not request nor accept** controlled substance medication from any other physician or individual while I am receiving such medication from my doctor at the Orthopaedic Institute of Henderson without informing my doctor immediately. Besides being illegal to do so under NRS 453.391, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.

3. **Refills** of controlled substance medications:

   a. **Will be made only during the hours of 9:00 a. m. to 3:30 p.m.** Refills **will not be made** at night, on holidays, or on weekends.

   b. **Will not be made** if I "run out early." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount left.

   c. **Will not be made** as an "emergency," such as on Friday afternoon because I suddenly realize I will run out "today." I must keep track of my medication and plan ahead. I will call **at least 24 hours ahead if I need assistance** with a controlled substance medication prescription.

4. I understand **if I violate any of the above conditions,** my controlled substance prescription and/or treatment at the Orthopaedic Institute of Henderson may be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to local medical facilities and other authorities.

I understand the **main treatment goal is to improve my ability to function and/or work.** In consideration of this goal and that I have been or may be given potent medication to help me reach that goal, **I agree to help myself by following better health habits,** specifically involving exercise, weight control, and the use of tobacco or alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

____
Patient Name (Print)

____ __________________________
Signature of Patient (Parent or Guardian if minor) Date

ORTHOPAEDIC INSTITUTE OF HENDERSON
ACCIDENT / ILLNESS FORM

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Please complete the following:

Today's Date_______________________________________

How did you hear about us? ☐ Physician: ___________________ ☐ Friend ☐ Internet ☐ Other: ______________

Nature of Illness or Injury____

____

Date Illness/Injury Occurred_____________________________

Date First Treated_____________________________________

How Did Illness/Injury Occur?____

____

Where Did Illness/Injury Occur?____

____

Did Illness/Injury Occur in the Course of Employment?_____________________________________

____

Is There Any Other Party Responsible for this Bill?_______________________________________

____

Email: ____ May we contact you via email? ☐ Yes ☐ No

Would you like to receive our FREE Newsletter via email? ☐ Yes ☐ No

Name____

Patient Signature (Parent or Guardian if minor) ___________________________________

ORTHOPAEDIC INSTITUTE OF HENDERSON
HEALTH HISTORY

MEDICATION HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form.

Are you taking ANY kind of prescription medication now? ☐ No ☐ Yes (If yes, please list below. If you run out of room, use the back of this sheet for additional information).

PLEASE PRINT NEATLY

Name, dose and how often	Problem being treated	Date of Prescription	Prescribing Doctor

Are you allergic to ANY medication? ☐ No ☐ Yes If yes, please list below.

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes
☐ high fever ☐trouble with intubation (placement of breathing tube), other ______________________________

Have you ever had surgery? ☐ No ☐ Yes (If yes, please list below)

WHAT TYPE OF SURGERY	DATE OF SURGERY	PHYSICIAN

PATIENT NAME:______________________________