ALL SPORTS ORTHOPEDICS

19255 SW 65th Ave Suite 110

Tualatin, OR 97062

P: 503-506-8384 F: 503-506-8364

Thomas McWeeney, MD

Sarah Jean Baptiste, PA-C

Patient Information:

First Name: _____ Last Name: _____

Address: _____ City: _____State: _____Zip Code: _____

Phone #: _____ Alternate Phone #: _____

Ok to leave a detailed message: Yes _____ No _____ Email Address: _____

Date Of Birth: _____ SSN:_____ Marital Status: Single_____ Married_____

Your Employer: _____ Employer #: _____

Spouse Name: _____Spouse Phone #: _____

Emergency Contact name: _____ Phone #: _____

Ethnicity: _____ Race: _____ Declined: _____ Height: _____ Weight: _____

Right Handed: _____ Left Handed: _____

Primary DR: _____ Clinic Name: _____ Phone #: _____

Referring Doctor: _____ Clinic Name: _____ Phone #: _____

Pharmacy: _____ Located: _____Phone #: _____

Was this a work injury: _____ When: _____ Where: _____

Insurance Information:

Insurance Name: _____ Subscriber name: _____

ID#: _____ Group #: _____

Insurance Phone #: _____ Secondary Insurance Name: _____

ID#:_____Group #: _____

Insurance phone #: _____

Workman Comp Case? Yes _____ No _____ Insurance Name: _____

Claim #: _____Adjuster Name: _____ Adjuster Phone #: _____

History of Present Illness:

Problem with which extremity? _____ Right _____ Left _____

Chief Complaint/Why are you here today? _____

Location of pain: _____Pain: Dull _____ throbbing _____ Sharp _____

Severity: Mild_____ Moderate _____ Severe _____ Duration: How long: _____

When does the pain occur? _____How often: _____

What Caused the Pain: _____ Injury: _____

Have you previously experienced any injury of symptoms regarding this body part? Yes _____ No_____

If so please provide details: _____

Please list any hobbies or sports you enjoy: _____

Which of the above activities are you unable to perform due to pain: _____

Past Medical History:

Have you had any of the following? Please check all pertinent boxes:

☐ MRSA	☐ A-Fib	☐ Anemia
☐ Angina	☐ Anxiety	☐ Arthritis
☐ Asthma	☐ Back Trouble	☐ Bi-Polar
☐ Bleeding Disorder	☐ Blood Clot –DVT-PE	☐ Bronchitis
☐ Cancer : Type _____	☐ Chest Pain	☐ CHF
☐ Depression	☐ Diabetes	☐ Dialysis
☐ Diverticulitis	☐ Emphysema	☐ Epilepsy/Seizures
☐ GI-Bleed- Reflux	☐ Glaucoma	☐ Heart Attack
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ High Cholesterol	☐ HIV	☐ Irregular Heart Beat
☐ Liver Problems	☐ Migraines/Headaches	☐ Neurological Disorders
☐ Numbness/Tingling	☐ Pace Maker	☐ Pneumonia
☐ Rheumatoid Arthritis	☐ Sleep Apnea	☐ Stroke
☐ Thyroid hyper/hypo	☐ Tuberculosis	☐ Ulcer
☐ Other	☐	☐

Past Surgical History:

☐ Abdominal Surgery	☐ ACL Repair	☐ Adenoidectomy
☐ Amputation	☐ Appendectomy	☐ Aortic Valve Replacement
☐ Arthroscopic Hip Surgery	☐ Arthroscopic Knee Surgery	☐ Arthroscopic Shoulder Sur.
☐ Back Surgery	☐ Carpal Tunnel Surgery	☐ Colon Resection
☐ Foot Surgery	☐ Gastric Bypass	☐ Heart Bypass Surgery
☐ Heart Valve Replacement	☐ Hip Fracture & Surgery	☐ Hysterectomy
☐ Joint Fusion	☐ Leg Circulation Surgery	☐ Meniscus Repair
☐ Pacemaker	☐ Rotator Cuff Repair	☐ Sinus Surgery
☐ Shoulder Surgery	☐ Thyroid	☐ Tonsillectomy
☐ Total Ankle Replacement	☐ Total Hip Replacement	☐ Total Knee Replacement
☐ Total Shoulder Replacement	☐ Weight Loss Surgery	☐ Other

Medication List:

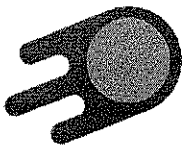
Name of Medication:	Dose:

Allergies:

Allergy:	Reaction:

I attest that the information I have given here is correct and true to the best of my knowledge. I also hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my injury to my insurance carrier. I understand that I am responsible for any amount not paid for by my insurance.

Patient/Guardian signature Date



ALL SPORTS ORTHOPEDICS

Financial Policy

Welcome to All Sports Orthopedics. We are committed to providing the best care possible and we appreciate your trust. Please take your time to review the following information and sign and date below.

All Sports Orthopedics will gladly submit claims to your insurance carrier. We also offer secondary and tertiary billing. Please remember that co-pays are due at the time of service. In the event of a motor vehicle accident, we will submit your claim(s) to the motor vehicle carrier.

We accept cash, debit cards, visa, MasterCard and American Express.

If you have health insurance, please understand that this is an agreement between you and your insurance company. You are responsible for knowing your benefits. We will be happy to assist you in any way we can, but you are ultimately responsible for timely payment of your account.

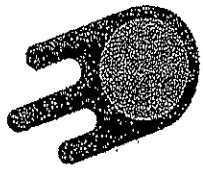
If you present a check to All Sports Orthopedics that is not honored by your bank, a $30.00 NSF (Non-Sufficient Funds) charge will be added to your account per occurrence.

Your signature on this policy authorizes All Sports Orthopedics to release health information to insurance carriers when necessary for payment and directs them to remit payment directly to All Sports Orthopedics. (Assignment of Benefits)

_____

Signature of patient Date

All Sports Orthopedics



Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge and agree that I have received a copy of All Sports Orthopedics notice of Privacy Practices.

Patient Name:_____

Patient Signature:_____

Patient Legal Representative:_____

I authorize the people named below to have access to my medical information from All Sports Orthopedics.

_____

_____

ALL SPORTS ORTHOPEDICS

Notice of Privacy Practices

The new privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) require that medical groups provide patients with a notice that describes how protected health information may be used and disclosed, and that explains patients' rights and the medical group's duties.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: We are permitted to use your health care information as necessary to provide you with medical treatment and services. We may disclose information about you to physicians, nurses, technicians, medical students or others who are involved in taking care of you. For example, our physicians may share information about your diabetes with an orthopedic specialist they are referring you to so that they will be aware that your healing process may take a bit longer.

Payment: We are permitted to use and disclose your health care information in order to bill and receive payment from you, or your insurance company for the services you receive from us. As an example, we will share information about your office visit with your insurance company so that they will reimburse us for the care you received. We will also share information with your insurance company about your condition and the treatment you are going to receive in order to determine if it will be pre-approved for payment by your insurance company.

Health Care Operations: We are permitted to use your health care information for our business operations. For example, our physicians may use your information to determine the quality of care you have received, and whether any improvements are needed in our systems. We may also disclose your information to another health care provider or health plan if they have a relationship with you and require the information for their own business operations.

Our practice is permitted or required to use or disclose confidential information without your written authorization in the following cases:

a) Uses and disclosures for public health activities; such as reporting disease, injury and vital events such as births and deaths, reporting about victims of abuse, neglect or domestic violence; and reporting reactions to medications and problem products.

b) Disclosures for health oversight activities for activities authorized by law including audits, investigations, inspections and licensure.

c) Disclosures for judicial and administrative proceedings where required by the court or an administrative order if you are involved in a lawsuit or a dispute.

d) Disclosures for law enforcement purposes where required by court order, warrant, criminal subpoena or other lawful purposes.

e) Uses and disclosures about decedents where required by state and federal law.

f) Uses and disclosures for cadaveric organ, eye or tissue donation purposes, where required by law, or your personal preferences that you have recorded in your chart.

g) Disclosures to avert a serious threat to health or safety, where required by state or federal regulations.

h) Uses and disclosures for specialized government functions, including monitoring US health care system, government programs and compliance with civil rights laws.

Other uses and disclosures will be made only with your written authorization and that you may revoke such authorization at any time.

Separate Statements for Certain Uses or Disclosures

The practice may contact you to provide appointment reminders or information about treatment alternatives or other heath-related benefits and services that may be of interest to you.

The practice may contact you to request your participation in marketing or fundraising activities for the practice.

Individual Rights

As a part of the new regulations, you have several individual rights with respect to protected health information:

1. You have the right to request restrictions on certain uses and disclosures, although the practice is not required to agree to a requested restriction;
2. You have the right to receive confidential communications;
3. You have the right to inspect and copy protected health information, provided your physician has not deemed that inspection to be a danger to your health or the health of others;
4. You have the right to request that we amend protected health information, should you find it to be incomplete or in error;
5. You have the right to receive an accounting of disclosures of protected health information; and
6. You have the right to obtain a paper copy of this notice from the practice upon request, even if you have previously agreed to receive this notice electronically.

Medical Practice's Duties

1. Our practice is required by law to maintain the privacy of confidential information and to provide individuals with notice of its legal duties and privacy practices with respect to such information;
2. Our practice is required to abide by the terms of the notice currently in effect; and
3. Our practice reserves the right to change the terms of this notice and to make the new notice provisions effective for all confidential information that we maintain. Should we decide to change the terms of our notice, we will send the revised notice to you either in electronic format, or via paper, depending upon your previously stated preference.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the practice (see contact information below) and/or to the Secretary of the DHHS by writing to:

Secretary of the US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Please note that we will not retaliate against you in any way for filing complaints.

Contact

Should you have any questions or complaints, please direct them by mail to:

Thomas McWeeney, MD
Privacy Officer
All Sports Orthopedics
Suite #110, at 19255 SW 65th Ave
Tualatin, Oregon, 97062
Or by phone at 503-506-8384

Effective Date

These regulations became effective on April 14, 2003.