



# Rodney D. Henderson, M.D. PC

Board Certified Orthopaedic Surgeon  
2851 S. Avenue B, Suite 2403 Yuma, AZ 85364  
Phone (928) 726-2990\*Fax (928) 726-0786 email: [rhendersonmd@yahoo.com](mailto:rhendersonmd@yahoo.com)  
[www.rodhendersonmd.com](http://www.rodhendersonmd.com)

## WORKER'S COMPENSATION PATIENT REGISTRATION FORM

Today's Date: \_\_\_\_\_

Referred by:  Family  Friend \_\_\_\_\_  Dr. \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
Last Name, First Name, MI

Gender:  Male  Female Marital Status: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Permanent Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Local Address: \_\_\_\_\_

City: \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ EMAIL: \_\_\_\_\_

Current Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

**Name of Primary Care Physician:** \_\_\_\_\_

### WORKER'S COMPENSATION INSURANCE INFORMATION

Worker's Comp INSURANCE Carrier: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_

Adjuster's phone number: \_\_\_\_\_ Employer at time of injury: \_\_\_\_\_

Claim #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Attorney's Name (if any): \_\_\_\_\_ Phone: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rodney D. Henderson, M.D. PC or insurance company to release any information required to process my claims.

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## HEALTH HISTORY QUESTIONNAIRE & WORKER'S COMPENSATION SUPPLEMENTAL HISTORY

*Please fill out the entire questionnaire so we may have the most accurate information concerning your injury*

**Patient's Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

Reason for Visit/Which Body Part is affected? \_\_\_\_\_

Job title/Occupation: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Type of business \_\_\_\_\_ How long have you worked for this employer: \_\_\_\_\_

Date of injury: \_\_\_\_\_ Date employer notified: \_\_\_\_\_

If you are on light duty? \_\_\_\_\_ what date did you start? \_\_\_\_\_ If not working Date last worked? \_\_\_\_\_

Describe your work duties/Check any activities required in the course of your work:

Lifting  \_\_\_\_\_ Lbs.      Bending       Stooping       Squatting       Sitting   
Carrying  \_\_\_\_\_ Lbs.      Pushing       Pulling       Walking       Standing

Are you still working for the same employer? \_\_\_\_\_ If No, date you separated from employer \_\_\_\_\_

Did injury occur at employer's place of business? Yes \_\_\_\_\_ No \_\_\_\_\_

Exact place at where you were injured (ex: break room, parking lot, etc.) \_\_\_\_\_

Describe in your own words how the injury/accident happened: \_\_\_\_\_

Have you had any prior or previous injury to this area? \_\_\_\_\_ If so how long ago? \_\_\_\_\_



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## NEW PATIENT MEDICAL HISTORY FORM

**Patient Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Race:**  Caucasian  African American  Hispanic  Asian  Other \_\_\_\_\_

**Ethnicity:**  Hispanic  Non-Hispanic  Other \_\_\_\_\_

**Preferred Language:**  English  Spanish  Chinese  Other \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referral Source:** Doctor (name) \_\_\_\_\_ Other (ex. Google search): \_\_\_\_\_

### CHIEF COMPLAINT

**Dominant Hand:**  Right  Left  Ambidextrous

**Description of Symptoms:** (select only ONE primary symptom and ONE affected area)

Pain  Numbness/Tingling  Fracture  Stiffness  Other: \_\_\_\_\_

Shoulder	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Pelvis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Neck	<input type="checkbox"/>
Upper Arm	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Hip	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Upper Back	<input type="checkbox"/>
Elbow	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Thigh	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Mid Back	<input type="checkbox"/>
Forearm	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Knee	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Low Back	<input type="checkbox"/>
Wrist	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Lower Leg	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Buttocks	<input type="checkbox"/>
Hand	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Ankle	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Tail Bone	<input type="checkbox"/>
Thumb	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Foot	<input type="checkbox"/> Right	<input type="checkbox"/> Left		
Index	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Great Toe	<input type="checkbox"/> Right	<input type="checkbox"/> Left		
Middle	<input type="checkbox"/> Right	<input type="checkbox"/> Left	2 <sup>nd</sup> Digit	<input type="checkbox"/> Right	<input type="checkbox"/> Left		
Third	<input type="checkbox"/> Right	<input type="checkbox"/> Left	3 <sup>rd</sup> Digit	<input type="checkbox"/> Right	<input type="checkbox"/> Left		
Little	<input type="checkbox"/> Right	<input type="checkbox"/> Left	4 <sup>th</sup> Digit	<input type="checkbox"/> Right	<input type="checkbox"/> Left		
			5 <sup>th</sup> Digit	<input type="checkbox"/> Right	<input type="checkbox"/> Left		

**Pain radiates from/to:** (ex. from low back to right leg) \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

**1. Is your problem the result of an injury or accident?**

- No Injury     Injury     Injury at Work     Auto Accident     Sport Injury     Prior Surgery

**How long have the symptoms been present?** (ex. 2 days, 4 months) \_\_\_\_\_

**Describe the onset:** Acute (sudden)    Chronic condition (>3 months)    **Onset Date:** \_\_\_\_\_

**2. Are you represented by an attorney?** Yes    No    **Attorney Name:** \_\_\_\_\_

**Will there be any legal actions with respect to this problem?** Yes    No

**3. Have you had a problem like this before?** Yes    No

**Describe:** \_\_\_\_\_

**4. Have you been seen in an ER?** Yes    No

**Treating ER:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**5. Rate the pain (10 being the most pain):**  0  1  2  3  4  5  6  7  8  9  10

**6. Do the symptoms wake you from sleep?**  Yes  No

**7. Please describe the symptoms:**     Sharp  Dull  Stabbing  Throbbing  Aching  Burning  Shooting

**8. What is the timing of the symptoms?**     Constant     Intermittent (comes and goes)

**9. Is the problem getting better or worse?**     Getting better     Getting worse     Unchanged

**10. What makes the symptoms worse?**

- Squatting     Kneeling     Sitting     Bending     Stairs     Twisting     Moving     Lying in bed  
 Running     Walking     Athletics     Standing     Gripping     Lifting     Reaching Overhead

**11. Are there any other symptoms associated with this problem?**

- Redness     Bruising     Swelling     Numbness     Stiffness     Limping     Clicking     Locking  
 Popping     Tingling     Weakness     Giving way

**PRIOR TESTING / TREATMENT**

**Have you had any prior tests?**  None  X-rays  MRI  CT Scan  Nerve Test (EMG/NCV)  Bone Scan

**Have you had any prior treatment for this problem?**  Yes  No

**Type of treatment Status of symptoms after treatment (select only those that apply) Date of treatment**

- |                  |  |                       |  |
|------------------|--|-----------------------|--|
| Ice              | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged | Heat                  | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged |
| Rest             | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged | NSAIDs                | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged |
| Muscle Relaxers  | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged | Chiropractor          | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged |
| Physical Therapy | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged | Home Exercise Program | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged |
| Surgery          | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged | Injections            | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged |
| Bracing          | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged | TENS unit             | <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged |

**Other/Comments:** \_\_\_\_\_

**Do you have a personal history of any of the following?**  None

<input type="checkbox"/> Aneurysm Where: _____	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Arthritis Type: _____	<input type="checkbox"/> Angina (Chest Pain)	<input type="checkbox"/> Stroke / TIA	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Bone or Joint Infections	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Phlebitis (Blood Clots)	<input type="checkbox"/> Hyperthyroidism	
<input type="checkbox"/> MRSA Infection	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	<input type="checkbox"/> Seizures
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Pulmonary Embolism	
<input type="checkbox"/> Hepatitis Type: _____	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Reaction to Anesthesia Type: _____		
<input type="checkbox"/> Cancer Type: _____	<input type="checkbox"/> Diabetes Type: _____	Last A1C: _____		
<input type="checkbox"/> Chemotherapy / Radiation	<input type="checkbox"/> Hypertension	<b>Please list any other conditions not listed:</b> _____		

\_\_\_\_\_

**MEDICAL QUESTIONS**  
**Mark all that currently apply:**

Metal in body    Claustrophobic    Pregnant    Sleep Apnea    Uses a CPAP    Snores

**Are you taking blood thinners?**  Yes  No

**Select all previous hospitalizations/surgeries:**  None

<input type="checkbox"/> Aneurysm (Brain) Surgery	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Mastectomy
<input type="checkbox"/> LAP Band / Gastric Bypass Surgery	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Stents	<input type="checkbox"/> Appendectomy
<input type="checkbox"/> Aortic Bypass / Vascular Surgery	<input type="checkbox"/> Cataract (Eye) Surgery	<input type="checkbox"/> Lumpectomy	
<input type="checkbox"/> Cholecystectomy (Gallbladder)	<input type="checkbox"/> Malignancy/Cancer	<b>Other Surgery</b> _____	

**Orthopedic on side:**

Arthroscopy: Knee  **Right**  **Left**       Arthroscopy: Shoulder  **Right**  **Left**       Carpal Tunnel Release  **Right**  **Left**

Rotator Cuff Repair  **Right**  **Left**       Total Hip Replacement  **Right**  **Left**       Total Knee Replacement  **Right**  **Left**

Total Shoulder Replacement  **Right**  **Left**       Spinal Surgery - Indicate Level: \_\_\_\_\_

**Other Orthopedic Surgery** \_\_\_\_\_

**Please list all medications you take on a regular basis:**  None

Medication	(Please provide list) "SEE LIST"	Dosage and Frequency (e.g. 20 mg, once/day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Do you have any allergies?**  Yes  No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	Reaction
_____	_____
_____	_____
_____	_____

**LATEX allergy?**  Yes  No      **IODINE allergy?**  Yes  No

**FAMILY HISTORY**

Have any direct relatives had any of the following disorders?  None for all

**Father**  None  Diabetes  Heart Disease  Hypertension  Bleeding Problems  Epilepsy  Connective Tissue  
 Muscular Dystrophy  Stroke  Osteoporosis  Rheumatoid Arthritis  Cancer

Comments (ex. cancer type) \_\_\_\_\_

**Mother**  None  Diabetes  Heart Disease  Hypertension  Bleeding Problems  Epilepsy  Connective Tissue  
 Muscular Dystrophy  Stroke  Osteoporosis  Rheumatoid Arthritis  Cancer

Comments (ex. cancer type) \_\_\_\_\_

**Sibling**  None  Diabetes  Heart Disease  Hypertension  Bleeding Problems  Epilepsy  Connective Tissue  
 Muscular Dystrophy  Stroke  Osteoporosis  Rheumatoid Arthritis  Cancer

Comments (ex. cancer type) \_\_\_\_\_

**SOCIAL HISTORY**

Do you use tobacco?  Daily  Occasionally  Former smoker  Never  Unknown

Do you drink alcohol?  Daily  Occasionally  Rarely  Never

Marital Status:  Married  Single  Divorced  Widowed  Domestic Partnership

Are you currently working?  Yes  No  Retired  Disabled If no, what date did you last work? \_\_\_\_\_

Please list work restrictions, if any: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  Student

**REVIEW OF SYSTEMS**

Please indicate if you have experienced any of the following symptoms in the last 6 months? \_\_\_\_\_

None for all

- |         |   |   |  |                               |
|---------|---|---|--|-------------------------------|
| 1) GI   | <input type="checkbox"/> Heartburn, Ulcers  | <input type="checkbox"/> Nausea, Vomiting                           | <input type="checkbox"/> Blood in Stool      | <input type="checkbox"/> NONE |
| 2) ENDO | <input type="checkbox"/> Fever              | <input type="checkbox"/> Heat or Cold Intolerance                   | <input type="checkbox"/> Night Sweats        | <input type="checkbox"/> NONE |
| 3) CON  | <input type="checkbox"/> Weight Loss        | <input type="checkbox"/> Loss of Appetite                           | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> NONE |
| 4) EYE  | <input type="checkbox"/> Blurred Vision     | <input type="checkbox"/> Double Vision                              | <input type="checkbox"/> Vision Loss         | <input type="checkbox"/> NONE |
| 5) ENT  | <input type="checkbox"/> Hearing Loss       | <input type="checkbox"/> Hoarseness                                 | <input type="checkbox"/> Trouble Swallowing  | <input type="checkbox"/> NONE |
| 6) CV   | <input type="checkbox"/> Chest Pain         | <input type="checkbox"/> Palpitations                               |  | <input type="checkbox"/> NONE |
| 7) RS   | <input type="checkbox"/> Chronic Cough      | <input type="checkbox"/> Pneumonia                                  | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> NONE |
| 8) GU   | <input type="checkbox"/> Painful Urination  | <input type="checkbox"/> Blood in Urine                             | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> NONE |
| 9) SK   | <input type="checkbox"/> Frequent Rashes    | <input type="checkbox"/> Skin Ulcers <input type="checkbox"/> Lumps | <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> NONE |
| 10) NEU | <input type="checkbox"/> Frequent Falls     | <input type="checkbox"/> Loss of Coordination                       | <input type="checkbox"/> Numbness            |                               |
|         | <input type="checkbox"/> Change in Bowel    | <input type="checkbox"/> Change in Bladder                          | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> NONE |
| 11) PSY | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Drug/Alcohol Addiction                     | <input type="checkbox"/> Sleep Disorder      | <input type="checkbox"/> NONE |
| 12) HEM | <input type="checkbox"/> Easy Bleeding      | <input type="checkbox"/> Easy Bruising                              | <input type="checkbox"/> Anemia              | <input type="checkbox"/> NONE |

Other/Comments: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



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## NOTICE OF PRIVACY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### **TYPES OF INFORMATION WE GATHER AND USE:**

In administering your health care, we gather and maintain information that may include non-public personal information. For example:

- You financial transactions with us (billing transactions).
- Your medical history, treatment notes, all test results and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- Information from health care providers, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

### **YOUR RIGHTS UNDER THE FEDERAL PRIVACY STANDARD:**

Although your health record is the physical property of Rodney D. Henderson, M.D. PC, you have certain rights with regard to the information contained therein. You have the right to:

- Request restrictions on the use and disclosure of your health information for treatment and payment.
- You may ask us to communicate with you by alternative means, and, if the method is reasonable, we must grant the request.
- You have the right to receive and keep a copy of this notice of information practices. If you do request a copy, the law requires us to ask you to acknowledge receipt of your copy.
- You have the right to inspect and copy your health information upon request. We reserve the right to charge a reasonable, cost-based fee for making copies.
- You have the right to obtain a correction of your health information unless we did not create the record or the information is accurate and complete.
- You have the right to obtain an accounting of non-routine uses or disclosures.
- You have the right to revoke authorization to use or disclose your health information at any time.

### **WITH THE REGULATORY CONSENT GRANTED BY THE HEALTH AND HUMAN SERVICES DEPARTMENT WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND OPERATIONS.**

#### **FOR EXAMPLE:**

- Rodney D. Henderson, M.D. PC can use your personal health information to diagnose, plan and implement the best course of treatment for you.
- Rodney D. Henderson, M.D. PC may use your health information to receive payment from a third party payer such as Workers Compensation, if applicable and appropriate.

### **OUR RESPONSIBILITY UNDER THE FEDERAL PRIVACY STANDARD:**

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you with this notice as to our legal duties and privacy practices with respect to individually identifiable health information about you that we collect and maintain.
- Abide by the terms of this notice.
- Train any personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/confidentiality policies.
- Lessen the harm of any breach of privacy or confidentiality.

**PLEASE KEEP THIS FOR YOUR RECORDS**



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## RECEIPT OF PRIVACY NOTICE

### Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use of disclosure of my identifiable health information by Rodney D. Henderson, M.D. PC for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at Rodney D. Henderson, M.D. PC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Rodney D. Henderson, M.D. PC is not required to agree to the restrictions that I may request. However, if Rodney D. Henderson, M.D. PC agrees to a restriction that I request, the restriction is binding upon Rodney D. Henderson, M.D. PC.

I have the right to revoke this consent, in writing, at any time except to the extent that Rodney D. Henderson, M.D. PC has taken action in reliance on this consent.

*My identifiable health information* means health information, including my demographic information, collected from me and created or received by practitioner, another health care provider, or my employer. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Rodney D. Henderson, M.D. PC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Rodney D. Henderson, M.D. PC. This Notice of Privacy Practices also describes my right and the duties of Rodney D. Henderson, M.D. PC with respect to my identifiable health information.

Rodney D. Henderson, M.D. PC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

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Signature of Patient or Legal Representative

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Date





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## CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, examination, and diagnoses, treatment plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routing healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a notice of Privacy Practices that provides a more complete description of information uses and disclosures regarding its content and meaning and fully understand its content and implication.

I understand that I have the right to:

- Review the notice prior to signing this consent.
- Object to the use of my health information for directory purposes.
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operation and that the organization is not required to agree to the restrictions.
- Revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that the organization reserves the right to change their notice and practices prior to implementation and will mail a copy of any revised notice to the address I've provided.

I Request the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date



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## FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. **By signing this document you agree to terms and conditions.** If you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card or workman's compensation information at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your behalf. **IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.**
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. If you have secondary insurance, we will be happy to submit the claim to your insurance for reimbursement. Once both insurance plans' explanation of benefits are received, **YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.**
4. We will be happy to verify your insurance benefits and obtain pre-authorizations for your scheduled treatment with RODNEY D. HENDERSON, M.D. PC. **However**, it is ultimately your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
5. If our physician does not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
6. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
7. Co-payments are due at time of service. A **\$10.00 processing fee (or service fee)** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the next business day.
8. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
9. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 30 days will be charged a \$10.00 re-bill fee. Any balances greater than 45 days will accrue interest at the rate of 10 percent for each 30 days that the bill remains unpaid. No prorating of interest will be applied. Any balances greater than 120 days will be forwarded to a collection agency.
10. If you participate with a high-deductible health plan, we require that a copy of the health savings account debit/credit card or a personal credit card remain on file.
11. We require **24-HOUR NOTICE** for canceling any appointments. There is a **\$30.00** charge for weekday appointments if 24-hour notice is not given. Calling the morning of your appointment or after hours the day before your appointment **DOES NOT** qualify as 24-hours' notice and the cancellation fee **WILL APPLY.**
12. A **\$25.00** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
13. We charge **\$25.00** to process medical records transfer requests. An additional fee may be charged via a separate entity for large files. Please speak with a member of our staff regarding the estimated charges to copy or transfer medical records.
14. If you require forms to be completed, **OTHER THAN STATE DISABILITY FORMS**, there is a **\$15.00** charge per form. Payment is due when the forms are delivered. We have a 3- to 5-day turnaround time for forms. If a form is needed sooner than 3 days, there is an additional **\$10.00** *rush* fee.
15. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
16. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

**I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.**

\_\_\_\_\_  
Print Patient Name(s)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date