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
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 HSTORY

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	☐Right	☐ Left	Pelvis	☐Right	☐ Left	Neck	☐
Upper Arm	☐Right	☐ Left	Hip	☐Right	☐ Left	Upper Back	☐
Elbow	☐Right	☐ Left	Thigh	☐Right	☐ Left	Mid Back	☐
Forearm	☐Right	☐ Left	Knee	☐Right	☐ Left	Low Back	☐
Wrist	☐Right	☐ Left	Lower Leg	☐Right	☐ Left	Buttocks	☐
Hand	☐Right	☐ Left	Ankle	☐Right	☐ Left	Tail Bone	☐
Thumb	☐Right	☐ Left	Foot	☐Right	☐ Left		
Index	☐Right	☐ Left	Great Toe	☐Right	☐ Left		
Middle	☐Right	☐ Left	2nd Digit	☐Right	☐ Left		
Third	☐Right	☐ Left	3rd Digit	☐Right	☐ Left		
Little	☐Right	☐ Left	4th Digit	☐Right	☐ Left		
			5th Digit	☐Right	☐ 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 ☐ Improved ☐ Worsened ☐ Unchanged
Rest ☐ Improved ☐ Worsened ☐ Unchanged
Muscle Relaxers ☐ Improved ☐ Worsened ☐ Unchanged
Physical Therapy ☐ Improved ☐ Worsened ☐ Unchanged
Surgery ☐ Improved ☐ Worsened ☐ Unchanged
Bracing ☐ Improved ☐ Worsened ☐ Unchanged
Heat ☐ Improved ☐ Worsened ☐ Unchanged
NSAIDs ☐ Improved ☐ Worsened ☐ Unchanged
Chiropractor ☐ Improved ☐ Worsened ☐ Unchanged
Home Exercise Program ☐ Improved ☐ Worsened ☐ Unchanged
Injections ☐ Improved ☐ Worsened ☐ Unchanged
TENS unit ☐ Improved ☐ Worsened ☐ Unchanged

Other/Comments:_____

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

☐ Aneurysm Where:_____ ☐ Emphysema ☐ Kidney Disease ☐ Kidney Stones ☐ Epilepsy

☐ Arthritis Type:_____ ☐ Angina (Chest Pain) ☐ Stroke / TIA ☐ Heart Attack ☐ Pacemaker

☐ Bone or Joint Infections ☐ HIV / AIDS ☐ Phlebitis (Blood Clots) ☐ Hyperthyroidism

☐ MRSA Infection ☐ Tuberculosis ☐ Asthma ☐ COPD ☐ Seizures

☐ Congestive Heart Failure ☐ Hypothyroidism ☐ Stomach Ulcers ☐ Pulmonary Embolism

☐ Hepatitis Type: _____ ☐ High Cholesterol ☐ Reaction to Anesthesia Type:_____

☐ Cancer Type: _____ ☐ Diabetes Type: _____ Last A1C: _____

☐ Chemotherapy / Radiation ☐ Hypertension **Please list any other conditions not listed:**_____

_____

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**

☐ Aneurysm (Brain) Surgery ☐ Hysterectomy ☐ Hernia Repair ☐ Mastectomy

☐ LAP Band / Gastric Bypass Surgery ☐ Heart Surgery ☐ Stents ☐ Appendectomy

☐ Aortic Bypass / Vascular Surgery ☐ Cataract (Eye) Surgery ☐ Lumpectomy

☐ Cholecystectomy (Gallbladder) ☐ Malignancy/Cancer **Other Surgery**_____

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

Other/Comments:_____

_____ _____

Signature **Date**

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NOTICE OF PRIVACY

This notice describes how medical information about you may be use 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 PRICACY 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 HEATH AND HUMAN SERVICES DEPARTMENT WE MAY USE OR DISCLOSE YOU HEALTH INFORMATION FOR TREATMENT, PAYMENT AND OPERATIONS.
FOR EXMAPLE:

- 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 confidentially.
- 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 evidence 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 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 in a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Legal Representative 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