

# REGISTRATION

(PLEASE PRINT)

## STEVEN L. PORTER, M.D.

Mesa, Arizona 85206

Telephone: (480) 659-4811

Fax: (480) 659-4629

Date \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

### PATIENT INFORMATION

Name _____ Last Name First Name Middle Initial	SS/HIC/Patient ID # _____
Address _____	E-mail _____
City _____	State _____ Zip _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____ <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years	
Patient Employer/School _____	Occupation _____
Employer/School Address _____	Employer/School Phone (_____) _____
Whom may we thank for referring you? _____	
In case of emergency who should be notified? _____	Phone (_____) _____

### PRIMARY INSURANCE

Person Responsible for Account _____ Last Name First Name Middle Initial	
Relation to Patient _____ Birthdate _____	Soc. Sec. # _____
Address (If different from patient's) _____	Phone (_____) _____
City _____	State _____ Zip _____
Person Responsible Employed by _____	Occupation _____
Business Address _____	Business Phone (_____) _____
Insurance Company _____	
Contract # _____ Group # _____	Subscriber # _____
Names of other dependents covered under this plan _____	

### ADDITIONAL INSURANCE

Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber Name _____ Birthdate _____	Relation to Patient _____
Address (If different from patient's) _____	Phone (_____) _____
City _____	State _____ Zip _____
Subscriber Employed by _____	Business Phone (_____) _____
Insurance Company _____	Soc. Sec. # _____
Contract # _____ Group # _____	Subscriber # _____
Names of other dependents covered under this plan _____	

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Reason for today's visit (brief description of onset):  
\_\_\_\_\_  
\_\_\_\_\_

Date of Injury or onset of problem: \_\_\_\_\_ Was this related to an auto accident? Yes No

Work Related: Yes No

Affected side: Left Right Dominant hand: Left Right

What is your occupation \_\_\_\_\_

Have you had X-rays taken? Yes No Have you had an MRI? Yes NO If yes, where? \_\_\_\_\_

Drug Allergies: Yes No Please list drug and reaction \_\_\_\_\_

Daily Medications: (please include pain meds, herbs vitamins & OTC)  
Name Dose/Strength Times per Day

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

Past Surgical History: (list type and date)

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

Past Medical/Hospital History: (illnesses/conditions)

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

Do you now have or have you ever had

Anemia.....	Yes	No
Diabetes.....	Yes	No
Cancer/Type.....	Yes	No
Kidney/Bladder Trouble.....	Yes	No
High Blood Pressure.....	Yes	No
Heart Trouble. Type.....	Yes	No
Bleeding Disorder.....	Yes	No
Asthma.....	Yes	No
Neurological Disorders/Seizures.....	Yes	No
Depression.....	Yes	No
Stroke.....	Yes	No
Thyroid Disorder.....	Yes	No
Ulcer/Stomach Problems.....	Yes	No
Hepatitis: Type.....	Yes	No
Arthritis/Gout.....	Yes	No
Phlebitis/Blood Clots.....	Yes	No

Do you exercise? Yes No (running, biking, walking, cardio, weights etc) How often? \_\_\_\_\_

What type: \_\_\_\_\_

Do you smoke? Yes No Packs per day? \_\_\_\_\_

For how many years? \_\_\_\_\_

Do you drink alcohol? Yes No If yes, average consumption per week \_\_\_\_\_

Are you now or could possibly be pregnant? Yes No

Has any blood relative younger than 50 ever had unusual bleeding tendencies? Yes No If yes, who and what is their age:  
\_\_\_\_\_

Have you or any blood relative younger than 50 ever had a serious reaction to anesthesia? Yes No

If yes, who and what is their age?  
\_\_\_\_\_

**The above information is to the best of my knowledge a true statement of my current condition.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Steven L. Porter, M.D.

### Optional Administrative Services Fee Policy Overview

Each day we strive to exceed the expectations of you, our valued patients, through excellent medical care and exceptional service. To assist us in achieving our goal of exceptional service, we have adopted an Administrative Services Fee Policy.

Our Administrative Services Fee is an optional, annual flat fee of \$60.00. The fee covers all expenses related to Administrative Services, as listed below for a period of one year. The fee is per patient and must be paid at the time of service. This is not billable to your insurance carrier.

Patients who opt not to pay the optional annual Administrative Services Fee will be charged for services as requested. Fees for services requested must be paid in advance and are not billed to your insurance carrier.

### Administrative Services Listing

- |  |                      |
|--|----------------------|
| 1. Employee Completed Forms (Allow 48 hours for completion)  | \$35.00 per form     |
| * FMLA Forms   |                      |
| * Disability Forms   |                      |
| * Foreign Travel Forms   |                      |
| * Other Forms Requiring Manual Completion  |                      |
| 2. Computer Generated Forms  | \$15.00 per form     |
| * Flexible Spending Account Statements/Claim Forms   |                      |
| * Patient Account Print-Outs   |                      |
| * Payment Histories  |                      |
| * Paid-in-full Statements  |                      |
| * Insurance Appeal Letters   |                      |
| 3. Copying or Faxing of Medical Records<br>(Except to treating physicians and health insurance carriers)<br>(Please allow 72 hours for completion) | \$35.00 per copy/fax |

\_\_\_\_\_ I elect to participate in the Administrative Services Fee program.

\_\_\_\_\_ I elect not to participate in the Administrative Services Fee program. I will pay for Administrative Services on an as needed basis at the fees listed above.

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_\_  
Date

# DR. STEVEN PORTER

ORTHOPEDIC SURGEON

## NOTICE TO PATIENTS

State law A.R.S. & 32-1401 (25) (ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, whether these are available elsewhere on a competitive basis. (I/We) support this law, because it helps patients make reasonable financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that (I/We) have a direct financial interest in the diagnostic or treatment agency, or in the non-routine goods or services named below. Further, as indicated below, goods or services that (I/We) prescribed are available on a competitive basis.

### **DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:**

- Surgery Center of Scottsdale (SCOA)
- The Orthopedic Surgery Center of Arizona (TOSCA)
- Arizona Orthopedic Surgical Hospital

THESE SERVICES ARE AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS:

- ❖ Scottsdale Healthcare (Osborn)
- ❖ Banner Canyon Springs
- ❖ Greenbaum
- ❖ Arizona Spine and Joint Hospital
- ❖ Banner Gateway
- ❖ Mercy Gilbert

The law provides for the acknowledgement of you having read and understood these disclosures by dating and signing this form in the spaces provided below.

### **ACKNOWLEDGEMENT**

**(I/WE) HAVE READ THIS NOTICE TO PATIENTS, AND (I/WE) UNDERSTAND THE DISCLOSURES THAT IT CONTAINS**

**Dated this \_\_\_\_\_ Day of \_\_\_\_\_, 20\_\_\_\_\_**

\_\_\_\_\_  
Signature of patient or Guardian

**Steven L. Porter, M.D.**  
Patient Financial Policy

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Thank you for choosing Dr. Porter. Dr. Porter and staff are committed to providing quality, affordable medical care without regard to financial status. We sincerely hope that by sharing our financial expectations we will strengthen the practice-patient relationship and keep the lines of communications open. This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the policies, please feel free to contact our Patient Accounts Specialist.

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**Proof of Insurance**

- Please bring your insurance card(s) with you to each appointment.
- It is your responsibility to inform the practice of changes in your health insurance.
- We will bill your health insurance carrier as a courtesy to you for all services provided by Dr. Porter.
- We perform insurance benefit verifications on all new patients, patients with changes to their insurance, and all patients whose last visit was greater than 1 year from their last visit.
- Please remember: an insurance contract is made between the patient and the insurance carrier, not the Physician. The ultimate obligation for payment rests with you. This office does not accept responsibility for collecting your insurance claim or for negotiating a disputed claim. You are responsible for payment of your account.

**Payment is due At the Time of Service**

- We accept cash, checks, debit and credit cards (MasterCard, Visa). There will be a \$25.00 charge for any and all returned checks.
- All co-payments, deductibles and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.
- Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule.
- Patient responsible balances are due when you check in for your appointment in addition to any co-payments, deductibles and non covered services.
- An estimated payment for surgery will be collected prior to your procedure as the doctor cannot collect payment at the time of service at the hospital.

**Self Pay Accounts**

- We designate accounts, Self-Pay, under the following circumstances: (1) patient is covered by an insurance plan that our providers do not participate in, (2) patient does not have a current, valid insurance card on file, (3) patient does not have a valid insurance referral on file, or (4) patient does not have health insurance coverage.

**Referrals**

- If your insurance plan has a designated primary care physician (PCP) and you are required to obtain a written referral from that doctor, you must provide the office with that referral at the time of check-in. If you do not have a current, valid referral, we may ask you to either reschedule your appointment or pay for the visit at the time of service.

**Billing, Payments and Refunds**

- All balances are due in full within 14 days of the statement date.
- If you cannot pay the balance in full within 14 days, please contact our Patient Accounts Specialist to see if you qualify for payment options.
- It is your responsibility to notify the office of any changes in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on the other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this practice.
- If your account is over 120 days past due and you have not made a reasonable attempt to pay, a collection agency will be retained to collect payment for all monies due with an additional (35%) fee added to cover the cost of the collection agency and administrative costs. A (50%) fee will be added if legal costs are necessary.

**Cancellation Policy**

- Dr. Porter requires a 24 hour notice prior to the appointment schedule time for cancellations. A fee of \$35.00 will be billed to the patient in the event the office does not receive notification of cancellation.
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I have read the Patient Financial Policy and I agree to abide its terms.

\_\_\_\_\_  
Patient Name (please print)

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

\_\_\_\_\_  
Signature, Patient or Legal Guardian

\_\_\_\_\_  
Date