

Appointment Doctor \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT INFORMATION (CHILDS name if applicable):**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

\*SSN \_\_\_\_\_ Age \_\_\_\_\_ Male  Female

DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Employer \_\_\_\_\_ Work Status \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**RESPONSIBLE PARTY / PARENT PRESENT WITH CHILD**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

\*SSN \_\_\_\_\_ Age \_\_\_\_\_ Male  Female

DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Employer \_\_\_\_\_ Work Status \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**SPOUSE / OTHER RESPONSIBLE PARTY**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

\*SSN \_\_\_\_\_ Age \_\_\_\_\_ Male  Female

DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Employer \_\_\_\_\_ Work Status \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**INSURANCE 1**

Ins. Co. Name \_\_\_\_\_

Insured Policy Holder \_\_\_\_\_

Insured DOB \_\_\_\_\_ SSN \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group ID # \_\_\_\_\_

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

Claims Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Pre Certification Phone # \_\_\_\_\_

**INSURANCE 2**

Ins. Co. Name \_\_\_\_\_

Insured Policy Holder \_\_\_\_\_

Insured DOB \_\_\_\_\_ SSN \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group ID # \_\_\_\_\_

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

Claims Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Pre Certification Phone # \_\_\_\_\_

**CURRENT INJURY INFORMATION**

Type: Accident Work Auto Date \_\_\_\_\_

Place \_\_\_\_\_ Time \_\_\_\_\_

Body Part: \_\_\_\_\_ Right Left Bilateral

Description of Accident \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**RELATIVE / FRIEND NOT LIVING IN HOME**

Last \_\_\_\_\_ First \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

**\*Disclosure of this information is voluntary. However, failure to provide this information will result in no credit being extended and all services must be paid for at the time they are rendered.\***

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. Charges shown by statements are agreed to be correct and reasonable, unless protested in writing within thirty days of the billing date. If in the event legal action should become necessary to collect an unpaid balance due for medical services rendered, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper. I authorize Casper Orthopaedic Associates, P.C. to obtain credit/employment information required for collection purposes.

X-rays taken at Casper Orthopaedic Associates, P.C. will remain the property of Casper Orthopaedic Associates, P.C. Copies of x-rays can be provided for a small fee.

It may be necessary for additional tests to be ordered and performed outside of Casper Orthopaedics Associates, P.C. I authorize transfer of medical information, patient information and insurance information to the following outside sources: Wyoming Medical Center, Casper Surgical Center, Wyoming Surgical Center, Wyoming Imaging Center, Casper Medical Imaging, Diagnostic Lab, and Medical Testing Lab and/or other medical facilities if indicated. I have the right to amend, revoke and to obtain a written report annually of all disclosures of health information.

Casper Orthopaedics will routinely call the patient to remind them of an upcoming appointment. A message will be left on your voice mail or answering machine regarding the date and the time of that appointment.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

I have received the Patient Information Brochure \_\_\_\_\_ / \_\_\_\_\_  
Patient Signature Date

### PRIVACY NOTIFICATION

By signing below, you acknowledge that you have been informed of the Notice of Information Privacy Practices ("Notice") from Casper Orthopaedic Associates, P.C. You have the right to review our Notice prior to signing this acknowledgment. The terms of the Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting Casper Orthopaedic, P.C. at (307) 265-7205 and request a revised Notice. We will also post any revised Notice at 4140 Centennial Hills Boulevard. You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to those restrictions.

Acknowledgment \_\_\_\_\_ Date \_\_\_\_\_

### INSURANCE OPTION

I hereby authorize and request payment to be made directly to Casper Orthopaedic Associates, P.C. for medical treatment provided to myself or any member of my family covered by my medical insurance program. If necessary, I authorize release of medical information relative to any claims submitted to my insurance company. I understand that any part of my bill not paid by my insurance company is my responsibility. Further, should my insurance company not honor this assignment of benefits, I will immediately forward any payment made directly to me by my insurance carrier. This authorization shall remain in effect for twelve (12) months from the date signed. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it will not have any affect on any actions they took before they received the revocation.

Insurance 1 \_\_\_\_\_ Insurance 2 \_\_\_\_\_

Insured Policy Holder Name \_\_\_\_\_ Insured Policy Holder Name \_\_\_\_\_  
(Signature) (Signature)

Date \_\_\_\_\_ Date \_\_\_\_\_

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

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

Are you experiencing pain associated with the condition for which you are being seen? \_\_\_\_\_

Please rate your pain from 0-10 Pain Rating Scale \_\_\_\_\_ (0 = no pain, 10 = severe pain)

Do you have a living will or durable Power of Attorney? Copy in chart?  yes  no

Allergies	Reactions	Past Medical History Have you had a history of:
Latex <input type="checkbox"/> No <input type="checkbox"/> Yes		Please check appropriate answer
		Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes
		Lung Disease <input type="checkbox"/> No <input type="checkbox"/> Yes (Asthma, emphysema, chronic bronchitis)
		High Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes
		Vascular Disease <input type="checkbox"/> No <input type="checkbox"/> Yes
Current Medications / Herbs	Dose	Heart Attack <input type="checkbox"/> No <input type="checkbox"/> Yes
		Congestive Heart Failure <input type="checkbox"/> No <input type="checkbox"/> Yes
		Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes
		Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes
		Insulin <input type="checkbox"/> No <input type="checkbox"/> Yes
		Rheumatoid Arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes
		Lupus <input type="checkbox"/> No <input type="checkbox"/> Yes
		Gout <input type="checkbox"/> No <input type="checkbox"/> Yes
		Chronic Urinary Infection <input type="checkbox"/> No <input type="checkbox"/> Yes
		MRSA
		Do you take pain meds <input type="checkbox"/> No <input type="checkbox"/> Yes
		Pain Contract? <input type="checkbox"/> No <input type="checkbox"/> Yes
Previous Surgeries		Date

Have you or family members ever had problems with anesthesia? (i.e., high fever)  No  Yes

Have you had an EKG in the past 3 months?  No  Yes If so, where? \_\_\_\_\_

CONTINUED TO NEXT PAGE

Has anyone in your immediate family had:

Heart disease  No  Yes \_\_\_\_\_

Diabetes  No  Yes \_\_\_\_\_

Other: \_\_\_\_\_

**Social History**

Employed (Occupation) \_\_\_\_\_ Unemployed Student Homemaker

Marital Status \_\_\_\_\_

If appropriate – Are you pregnant at this time  No  Yes

Is there someone in the home that could assist if needed  No  Yes Name: \_\_\_\_\_

Exercise Daily Weekly Monthly Rarely Never

What type of exercise \_\_\_\_\_

Exercise Tolerance: How many flights of stairs can you climb before becoming short of breath? \_\_\_\_\_

Are you on a special diet  No  Yes Describe \_\_\_\_\_

History of substance abuse  No  Yes What \_\_\_\_\_

Smoke Currently  No  Yes \_\_\_\_\_ packs per day for \_\_\_\_\_ years

Quit smoking  No  Yes When \_\_\_\_\_

Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years

Drink alcohol None Daily 1-2 x/week 1-2 x/month 1-2 x/year \_\_\_\_\_

**Review of Systems**

Are you currently having, or have you had problems with your: Please describe all Yes responses

- Eyes/Vision  No  Yes \_\_\_\_\_
- Ears, Nose, Throat  No  Yes \_\_\_\_\_
- Shortness of breath  No  Yes \_\_\_\_\_
- Digestion/Reflux  No  Yes \_\_\_\_\_
- Bowel Movement  No  Yes \_\_\_\_\_
- Bladder Problem  No  Yes \_\_\_\_\_
- Chest Pain/Heart  No  Yes \_\_\_\_\_
- Bleeding Problems  No  Yes \_\_\_\_\_
- Blood Clots/DVT  No  Yes \_\_\_\_\_
- Balance Problems  No  Yes \_\_\_\_\_
- AIDS/HIV  No  Yes \_\_\_\_\_
- Immune System  No  Yes \_\_\_\_\_
- Arthritis/Joint Stiffness  No  Yes \_\_\_\_\_
- Skin  No  Yes \_\_\_\_\_
- TB/Infection  No  Yes \_\_\_\_\_
- Cancer  No  Yes \_\_\_\_\_
- Hepatitis/Jaundice  No  Yes \_\_\_\_\_
- Cold/Cough/Flu  No  Yes \_\_\_\_\_

Have you ever been diagnosed with sleep apnea?  No  Yes \_\_\_\_\_

Are you currently being treated with C-PAP?  No  Yes \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_, MD  
 REVIEWED BY: \_\_\_\_\_, MD  
 REVIEWED BY: \_\_\_\_\_, RN  
 REVIEWED BY: \_\_\_\_\_, RN  
 REVIEWED BY: \_\_\_\_\_, RN

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

POS: \_\_\_\_\_

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

**ARBITRATION AGREEMENT**  
**CASPER ORTHOPAEDIC ASSOCIATES, P.C.**

**ARTICLE 1 Dispute Resolution**

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

**ARTICLE 2 Definitions**

- A. The term "we," "parties," or "us" means you, (the Patient), and the provider.
- B. The term "Claim" means one or more Malpractice Actions as defined under Wyoming law.
- C. The term "Provider" means the physician, group or Casper Orthopaedics, and their employees, partners, associates, and agents.
- D. The term "Patient" or "you" means:
  - (1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents, or legal representatives.

**ARTICLE 3 Dispute Resolution Options**

- A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
  - (1) working directly with each other to try and find a solution that resolves the Claim, OR
  - (2) using non-binding mediation (each of us will bear one-half of the costs); OR
  - (3) using binding arbitration as described in this Agreement.

**YOU MAY CHOOSE TO USE ANY OR ALL OF THESE METHODS TO RESOLVE YOUR CLAIM**

- B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.
- C. Arbitration – Final Resolution. If working with the Provider or using nonbinding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

**ARTICLE 4 How to Arbitrate a Claim**

- A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
- B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
  - (1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

(2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal court of Wyoming. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Wyoming court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Wyoming Uniform Arbitration Act.

- C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.
- D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Wyoming Uniform Arbitration Act.
- E. All Claims May Be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). This includes consulting, assisting, or referral physicians utilized by Casper Orthopaedics, including, but not limited to anesthesiologists, pathologists, and other subspecialists. Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

#### **ARTICLE 5 Liability and Damages May Be Arbitrated Separately**

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

#### **ARTICLE 6 Venue / Governing Law**

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Casper, Wyoming. Arbitration proceedings are private and shall be kept confidential. The provisions of the Wyoming Uniform Arbitration govern this Agreement. We hereby waive the pre-litigation panel review requirements of Wyoming Statute. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

#### **ARTICLE 7 Term / Rescission / Termination**

- A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.
- B. Rescission. You may rescind this Agreement within 3 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing.

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

**ARTICLE 8 Severability**

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

**ARTICLE 9 Acknowledgment of Written Explanation of Arbitration**

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs I understand that I can rescind this Agreement within 3 (three) days of signing it.

I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE**

**BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL**

By: \_\_\_\_\_  
**Patient or Patient's Representative**

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

\_\_\_\_\_  
**Print Patient's Name**

\_\_\_\_\_  
**Date**

By: \_\_\_\_\_  
**Physician or Authorized Representative**

**CASPER ORTHOPAEDIC ASSOCIATES, P.C.**