Name:
DOB:
Chart:
Age:
Date:

Hofmann Arthritis Institute
24 South 1100 East Suite 101
Salt Lake City, UT 84102

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F
Mailing Address: _____
City: _____ State: _____ Zip: -( )
Home Phone: _____ Cell Phone: _____
Social Security Number: _____ Referring Physician: _____
Primary Care Physician: _____ E-mail: _____
Race: _____ Language: _____ Ethnicity: _____
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced
Spouse Name: _____ Spouse Date of Birth: _____
Spouse Social Security #: _____
Are you over the age of 18? ☐ Yes ☐ No

EMERGENCY CONTACT:

1 _____ Phone #: _____ Relation: _____
2 _____ Phone #: _____ Relation: _____

PRIVACY INFORMATION:

	Yes	No
Hofman Arthritis Institute staff and physicians may leave information with my spouse or: _____ .	☐	☐
Hofman Arthritis Institute staff and physicians may leave information on my voicemail concerning appointments and personal health information.	☐	☐

EMPLOYER INFORMATION:

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired
Employer Name: _____ Employer Phone #: _____

INSURANCE INFORMATION:

Primary Insurance: _____ ID #: _____ Group #: _____
Policy Holder: _____ Relationship to Patient: _____
Policy Holder DOB: _____ SS #: _____ Phone #: _____
Secondary Insurance: _____ ID #: _____ Group #: _____
Policy Holder: _____ Relationship to Patient: _____
Policy Holder DOB: _____ SS #: _____ Phone #: _____
Workers Comp ☐ Yes ☐ No Date of Injury: _____ Claim #: _____
Case Worker Name: _____ Number: _____

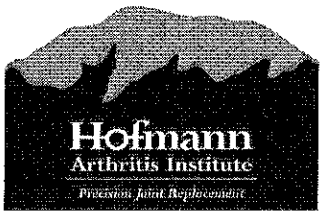
Consent to Treat: I authorize the physician or physicians in charge of the care of the above named patient to administer anesthetics and/or medications and to perform such operations and/or diagnostic procedures as may be deemed necessary by the physician for the diagnosis and treatment of this patient.

Financial Responsibility: I agree to be personally and fully responsible for payment for services rendered in accordance with any insurance benefits where applicable. I understand that I am financially responsible for charges not covered by my plan or for claims denied because of my failure to comply with conditions set by my insurance carrier. These conditions may include but are not limited to: failure to make co-payment or obtain a written referral for services provided by someone other than my primary care physician. A finance charge of 1.5% per month of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees court costs.

Assignment of Benefits: I request insurance benefits for services provided by paid directly to the medical clinic. I verify the accuracy of the above information and I authorize the release of any medical information on necessary to process payment for services provided.

Signature: _____ Date: _____

Name:
DOB:
Chart:
Age:
Date:



ePrescribing

Name: _____

Hofmann Arthritis Institute has implemented ePrescribing in each of our offices.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescriptions filled

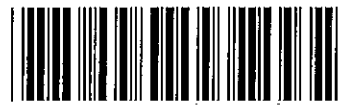
Patient Consent

I agree that Hofmann Arthritis Institute may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____
Patient Signature Date

Please give us your pharmacy information below:

Name:
DOB:
Chart:
Age:
Date:



Hofmann Arthritis Institute
24 South 1100 East Suite, Suite 105
Salt Lake City, UT 84102

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your health care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider. The content of this document may not be changed.

1. Each patient is responsible for his or her own bill.
2. Payment of all insurance co-payments and deductibles is required at the time medical services are rendered. A billing fee of $15 will be charged if you are unable to pay required co-payments on the day of service.
3. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is impossible you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. We accept cash, checks and major credit cards.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any services provided, but not covered by your insurance company, will be your responsibility to pay.
6. If your insurance company has not paid your full account within 60 days, you must pay the outstanding balance without further delay.
7. By signing below, you agree to pay all outstanding balances within net 30 days from date of invoice unless otherwise indicated above. (If applicable, HAI will not invoice patients until payment from insurances are received). A monthly finance charge of 1.5% per month (18% annual rate) will be charged to the amount not paid after 60 days, with a minimum charge of $.50 per month. The undersigned specifically agrees to pay all reasonable attorney fees and court cost in the even legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the amount is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.
8. Patients will be held liable for any damage done to the office.
9. A $25.00 fee will be charged on all returned checks.

USUAL AND CUSTOMARY RATES
Our rates for medical service reflect the usual and customary rates in the community. Unless we have accepted an alternative fee schedule from your insurance, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any).

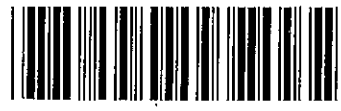
ASSIGNMENT OF INSURANCE BENEFITS
I further authorize and direct said agency, attorney or Insurance Company to pay from the proceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I understand that there are several types of advance directives; the two most common forms are living wills and a durable power of attorney designation. I understand that in the ambulatory care setting, if I suffer a cardiac or respiratory arrest or other life-threatening situation, signing this document grants consent for resuscitation and transfer to a higher level of care. Therefore in accordance with Federal law, HAI is notifying you that it will NOT HONOR previously singed advanced directives. If this is not acceptable to you, you must address this issue with your physician prior to performing the procedure.

HIPAA PRIVACY NOTICE: I acknowledge that I have received HAI's HIPAA PRIVACY notice and have had the opportunity to review its content.

Signature of Patient or Responsible Party _____ *Date* _____

Name:
DOB:
Chart:
Age:
Date:



ARBITRATION AGREEMENT

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 defined in the Utah Health Care Malpractice Act. (Utah Code 78-14-3(15)). Each party may use any legal process to resolve non-medical malpractice claims.
C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors, and estates.
D. The term "Patient" or "you" means:
    a. You and any person who makes a Claim for care give to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND
    b. Your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve and Claim by:
    a. working directly with each other to try and find a solution that resolves the Claim, OR
    b. using non-binding mediation (each of us will bear one-half of the costs); OR
    c. using binding arbitration as described in the 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 non-binding 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 the 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.
    a. Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
    b. 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 courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah 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 Utah 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 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 Utah Uniform Arbitration Act.

Name:
DOB:
Chart:
Age:
Date:

E. All Claims May be Jointed. 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"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of the Agreement.
A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of the 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 hearing will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the pre-litigation panel review requirements. 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 the Agreement within 10 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, the Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this agreement (see Article 4(E)).

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.

Name:
DOB:
Chart:
Age:
Date:

Article 9 Acknowledgement 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 this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care.

Article 10 Receipt of Copy I have received a copy of this document.

Provider: Hofmann Arthritis Institute
Name of Physician, Group or Clinic

By: _____
Signature of Physician or Authorized Agent

_____
Name of Patient (Print)

_____
Signature of Patient or Patient's Representative (Date)

BC18

Name:
DOB:
Chart:
Age:
Date:

HOFMANN ARTHRITIS INSTITUTE MA _____
New Patient HIP

☐ **Dr Hofmann** ☐ **Dr Magee** ☐ **Dr Schaeffer** ☐ **McQueen PA** ☐ **Allen PA**

Name: _____ Date of Birth: _____
How did you hear about us? _____ Primary Care Physician _____
Referring Physician _____

What problem can we help you with? _____ **Date of Injury:** ____ / ____ / ____

Hip Pain
- ☐ Side of body
- ☐ Buttock
- ☐ Groin

Posterior Leg Pain
- ☐ Associated with numbness
- ☐ Associated with weakness in muscles below knee

Groin Pain
- ☐ With clicking
- ☐ With catching

Type of Pain
- ☐ Throbbing
- ☐ Ache
- ☐ Stabbing
- ☐ Shooting
- ☐ Clicking or pop
- ☐ Dull

Duration of Pain
- ☐ Constant
- ☐ Occasional
- ☐ Only with Activity
- ☐ Pain at Rest
- ☐ Wakes at night

Hip Instability or Giving Way
- ☐ Going up or down stairs
- ☐ With quick changes of direction (pivoting)
- ☐ After noticing a sharp pain in the hip

Hip Catching and Locking
- ☐ Painless inability to move hip smoothly
- ☐ Painful inability to move hip smoothly
- ☐ When in certain positions only

Hip Swelling
- ☐ Constant
- ☐ Occasional
- ☐ Associated with pain
- ☐ Painless

Circle approximate pain level: 1 2 3 4 5 6 7 8 9 10 Intolerable

Duration of Pain: _____ Location of Pain: _____

Pain Aggravated By:
- ☐ Standing
- ☐ Working
- ☐ Walking
- ☐ Driving
- ☐ Lying

Tried:
- ☐ Ice / Heat
- ☐ Anti Inflammatory
  - ☐ can't take Anti-Inflammatory
- ☐ Injections
- ☐ Physical therapy
- ☐ Braces / Orthotics / Assistive Device

Prior Treatments:
- ☐ Rest / Decrease Activity
- ☐ Wheelchair / Crutches / Cane
- ☐ Arthroscopic surgery (small incision surgery)
- ☐ Open surgery (large incision surgery)
- ☐ **Treated for over 3 months**

Past Medical History:
- ☐ Liver disease / Jaundice
- ☐ Seizures
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Chronic headache
- ☐ Infections: _____
- ☐ Lung disease
- ☐ Asthma
- ☐ Heart disease
- ☐ Depression
- ☐ High blood pressure
- ☐ Elevated cholesterol
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Stomach Ulcers
- ☐ Kidney disease
- ☐ Pulmonary Embolism
- ☐ DVT (deep venous thrombosis)
- ☐ Other: _____

Females: Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly Date of last menstrual period _____

Past Surgical History (Please list dates and names of surgeries starting with most recent) ☐ **No Previous Surgeries**

_____	____ / ____ / ____	_____	____ / ____ / ____
_____	____ / ____ / ____	_____	____ / ____ / ____
_____	____ / ____ / ____	_____	____ / ____ / ____
_____	____ / ____ / ____	_____	____ / ____ / ____
_____	____ / ____ / ____	_____	____ / ____ / ____

Name:
DOB:
Chart:
Age:
Date:

Medications: (please list any medication that you currently use, including over the counter medications) ☐ **NONE**

Medication	Dose	Medication	Dose

Allergies: ☐ **NONE KNOWN**

☐ Codeine ☐ Morphine ☐ Latex
☐ Jewelry/Metals ☐ Diagnostic Dyes ☐ Ibuprophen
☐ Penicillin ☐ Sulfa Drugs ☐ Tylenol (Acetaminophen)
☐ Aspirin ☐ Iodine ☐ Other _____

Known allergies to anesthesia? ☐ No ☐ Yes Describe: _____

Family History: (Does it run in your family?) (Please list family member(s) who have had health issues)

Diabetes	☐ Yes	☐ No	_____	Arthritis	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____	Hip Problems	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____	Cancer	☐ Yes	☐ No	_____
Blood Clots	☐ Yes	☐ No	_____				

Social History:

Married ☐ Single ☐ Divorced ☐ Seperated ☐ Widowed ☐ Other ☐

Occupation: Current _____ Past _____ ☐ Retired

☐ Disabled Reason for disability? _____

Do you live alone? ☐ Yes ☐ No With Whom? _____

Do you smoke? ☐ Yes ☐ No _____ Packs/Day Quit: ____ Months ago ____ Years ago

Do you drink alcohol? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly Infrequently

Any substance abuse (Illegal Drugs)? ☐ Yes ☐ No Please list: _____

General Health Review:

General: Weight loss, Weight gain, Fevers, Night Sweats, Decreased Appetite, Chills, Fatigue

Eyes: Blurred vision, Glaucoma, Pain, Glasses, Contacts, Sore eyes, Vision loss, Double vision

Ears/Nose/Mouth: Nosebleeds, Bronchitis, Ear pain, Hearing loss, Dentures, Gum bleeding, Cavities, Tooth abscess

Cardiovascular: High cholesterol, Heart attack, Chest pain, Aortic aneurysm, Palpitations, Shortness of breath, Leg Swelling, Heart murmur

Respiratory: Sleep apnea, Emphysema, Tuberculosis, Wheezing, Pneumonia, Sputum, Cough, COPD

Gastrointestinal: Poor appetite,Difficulty swallowing,Acid reflux,Nausea,Vomitting,Constipation,Diarrhea,Hemorrhoids,Abnormal stool,Pain

Urinary: Kidney stones, incontinence, UTI, Blood in urine, Burning during urination, Frequent urination, Urgent urination

Musculoskeletal: Pain, Joint swelling, Muscular weakness, Cramps, Fractures, Injury

Skin: Rash, Skin color changes, Easy bruising, Skin infections

Neurologic: Seizures, Poor coordination, Numbness, Poor memory, Tingling sensations, Dizziness, Fainting, Headaches, Stroke, Bad Balance

Hematologic: Leukemia,Edema,Bleeding disorder, Anemia, Leg swelling, Prior blood transfusion

Immunologic: AIDS, HIV, Hepatitis, STD

Psychological: Depression,Anxiety,Mania,Sleep disturbances, Personality disorders

Endocrine: Diabetes, Frequent drinking, Hormone therapy, Thyroid problems

What specific question can we help you answer today? _____

I certify that the above information is complete and accurate

_____ _____
Signature Date