Joseph A. Longo III, M.D., P.C.
PATIENT INFORMATION FORM
Please Print

Name: _____, _____ _____ **Sex:** □ M □ F
(Last) (First) (Middle)

Local Address: _____ **Apt/Unit/Space:** _____

City: _____ **State:** _____ **ZIP:** _____ **Phone:** _____

Alternate Address: _____

E-mail Address:_____ May we email you regarding appointments/test results? □ Yes □ No

Cell Phone:_____ **Work Phone:**_____

Date of Birth:_____ **Age:**_____ **Social Security #:**_____

Emergency Contact:_____**Relationship:**_____**Phone:**_____

Employer: _____ **Occupation:** _____

Primary Care Physician: _____ **Phone:** _____

Who may receive information regarding your Protected Health Information? Check all that apply:
Name/Relationship: _____ Name/Relationship: _____

Name/Relationship: _____ Name/Relationship: _____

May we leave messages regarding test results and appointment on your answering machine? □ Yes □ No

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Date: _____ **Signature:** _____

History & Intake Form

Patient Name: _____

Past Medical History

☐ **None**

Select any of the following medical conditions that you currently have:

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Cardio: Hyperlipidemia/ High Cholesterol
- ☐ Cardio: Ischemic Heart Disease
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Deep Venous Thrombosis (blood clot)
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ Heart Attack
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Therapy
- ☐ Rheum: Fibromyalgia
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ Other:

_____

_____

Past Medical Surgeries

☐ **None**

Have you had any surgeries on the following organs? **Please list dates and surgeon if applicable.**

- ☐ Appendix (Appendectomy)
- ☐ Breast : Lumpectomy (Both Breasts)
- ☐ Breast : Lumpectomy (Left Breast)
- ☐ Breast : Lumpectomy (Right Breast)
- ☐ Breast : Mastectomy (Both Breasts)
- ☐ Breast : Mastectomy (Left Breast)
- ☐ Breast : Mastectomy (Right Breast)
- ☐ Colon (Colectomy) : Colon Cancer Resection
- ☐ Colon (Colectomy) : Diverticulitis
- ☐ Colon (Colectomy) : Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Gastric Bypass
- ☐ Heart : Biological Valve Replacement
- ☐ Heart : Coronary Artery Bypass Surgery
- ☐ Heart : Heart Transplant
- ☐ Heart : Mechanical Valve Replacement
- ☐ Heart : PTCA
- ☐ Heart : Pacemaker
- ☐ Kidney : Kidney Stone Removal
- ☐ Kidney : Kidney Transplant
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy) : Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy) : Prostate Cancer
- ☐ Prostate (Prostatectomy) : TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin : Basal Cell Carcinoma
- ☐ Skin : Melanoma
- ☐ Skin : Skin Biopsy
- ☐ Skin : Squamous Cell Carcinoma
- ☐ Tonsillectomy
- ☐ Uterus: Hysterectomy
- ☐ Uterus (Hysterectomy): Cesearean Section
- ☐ Uterus (Hysterectomy) : Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ Other:_____

_____

_____

_____

Orthopedic History

- ☐ **None**
- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture:_____
  - o **Right**
  - o **Left**
- ☐ Gout
- ☐ Handedness **Ambidextrous**
- ☐ Handedness - **Right**
- ☐ Handedness - **Left**
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Rickets
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ Other:_____
  _____
  _____
  _____

Orthopedic Surgery: Please list dates and surgeons if applicable.

- ☐ **None**
- ☐ Achilles Tendon Repair
- ☐ ACL Reconstruction
- ☐ Ankle Fracture ORIF: Bilateral
- ☐ Ankle Fracture ORIF: **Left**
- ☐ Ankle Fracture ORIF: **Right**
- ☐ Bunion Correction
- ☐ Carpal Tunnel Decompression: **Bilateral**
- ☐ Carpal Tunnel Decompression: **Left**
- ☐ Carpal Tunnel Decompression: **Right**
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ CMC Arthroplasty
- ☐ Distal Radius ORIF: **Bilateral**
- ☐ Distal Radius ORIF: **Left**
- ☐ Distal Radius ORIF: **Right**
- ☐ Ganglion Cyst Excision
- ☐ IMN Femur: **Bilateral**
- ☐ IMN Femur: **Left**
- ☐ IMN Femur: **Right**
- ☐ IMN Tibia: **Bilateral**
- ☐ IMN Tibia: **Left**
- ☐ IMN Tibia: Right
- ☐ Joint Replacement: Hip **(Both)**
- ☐ Joint Replacement: Hip **(Left)**
- ☐ Joint Replacement: Hip **(Right)**
- ☐ Joint Replacement: Knee **(Both)**
- ☐ Joint Replacement: Knee **(Left)**
- ☐ Joint Replacement: Knee **(Right)**
- ☐ Joint Replacement: Shoulder **(Bilateral)**
- ☐ Joint Replacement: Shoulder **(Left)**
- ☐ Joint Replacement: Shoulder **(Right)**
- ☐ Knee Arthroscopy: Bilateral
- ☐ Knee Arthroscopy: **Left**
- ☐ Knee Arthroscopy: **Right**
- ☐ Kyphoplasty/ Vertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression and Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Meniscus Repair
- ☐ Reverse Total Shoulder Replacement
- ☐ Revision of Total Hip Arthroplasty
- ☐ Revision of Total Knee Arthroplasty
- ☐ Revision of Total Shoulder Arthroplasty
- ☐ Rotator Cuff Repair: **Bilateral**
- ☐ Rotator Cuff Repair: **Left**
- ☐ Rotator Cuff Repair: **Right**
- ☐ Shoulder Arthroscopy
- ☐ Trigger Finger Release
- ☐ Other:_____
  _____
  _____

Medications (please list all current medications or check option which applies)

- ☐ I brought a copy of my medication list (**please provide the list to the front desk receptionist**)
- ☐ Not currently taking any medications

Medication Name	Dosage	Reason

Supplements (please list all current supplements or check an option which applies)

- ☐ I brought a copy of my medication list **(please provide the list to the front desk receptionist)**
- ☐ Not currently taking any supplements

Supplement Name	Dosage

Allergies (please list all know **drug** allergies or check options which applies)

- ☐ I brought a copy of my **drug** allergy list (**please provide the list to the front desk receptionist**)
- ☐ No Known **Drug** Allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Family History

	Mother	Father	Sister	Brother	Daughter	Son	Other:_____
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes							
Other: _____							

Have you received a pneumonia vaccination?

☐ YES ☐ NO

Did you have your flu vaccine for this year?

☐ YES ☐ NO

Do you have a living will?

☐ YES ☐ NO

Do you have a health care proxy in the event you are unable to make your own medical decisions?

☐ No

☐ Yes Designee's name:_____ Phone Number: (_____) _____-_____

Social History

Smoking:

☐ Never Smoker

☐ Former Smoker Quit Date: __/__/__

☐ Current Smoker

- o Smokes less than daily
- o Smokes Daily #packs per day: __

Alcohol Use:

☐ Do not drink alcohol

☐ Less than 1 drink a day

☐ 1-2 drinks a day

☐ 3 or more drinks a day

Exercise Frequency:

☐ Several times a day

☐ Once a day

☐ Few times a week

☐ Few times a month

☐ Never

☐ Other:_____

Patient Information

Insurance Company: _____ Primary Care Physician: _____

Preferred Pharmacy Name: _____ Occupation: _____

Pharmacy Zip code: _____ Cross Roads: _____ Phone Number: (___) ___-_____

Medical Alerts

☐ **None**

☐ Blood thinners

☐ Pacemaker

☐ Defibrillator

☐ Premedication prior to procedures

☐ Rheumatoid arthritis

☐ RSD

☐ Allergy to shellfish/iodine

☐ Allergy to latex

☐ Allergy to adhesive

☐ Under pain management

☐ Pregnancy or planning a pregnancy

☐ Hemorrhage

☐ Allergy to antibiotics

☐ History of Post-op N&V

☐ Other:

_____

Joseph A. Longo III, M.D. 3300 N 75th St. Scottsdale, AZ 85251

Phone: 480-941-5656 **Fax: 480-990-2015**

PATIENT DISCLOSURE: CONSULTING AGREEMENTS WITH ORTHOPEDIC/PHARMACEUTICAL COMPANIES

Dear Patient:

Welcome to our practice. During the course of your treatment Dr. Longo may recommend various medications and/or surgical interventions with or without implants, and other medical therapies. This is to provide you with information regarding the relationships between Dr. Longo and orthopedic, pharmaceutical and hospitals or organizations.

Dr. Longo has actively participated in research and development of new implants and improved surgical instruments and techniques. During his participation in these areas, Dr. Longo has worked under contract with orthopedic and pharmaceutical companies as a consultant and research and development. In addition, Dr. Longo has been instrumental by presenting instructional lectures relating to treatments, implants and surgical techniques to physicians and medical personnel, for which he received monetary compensation for his services.

Currently, Dr. Longo is a paid consultant to DJ Orthopedics, as well as holding investments in a number of orthopedic and pharmaceutical companies. Dr. Longo acts as co-director of the Total Joint Center at Scottsdale Healthcare Osborn.

Our office uses products from Encore Medical Corporation and other companies in the care of our patients as well as similar products from other manufacturers. The specific needs of each patient will determine which product will be used in your care and the manufacturer is never considered in the treatment of our patients.

Dr. Longo is a member of The American Academy of Orthopedic Surgeons (AAOS), which holds its members to extremely high ethical standards to insure that even the appearance of a conflict of interest does not jeopardize the trust that patients place in its doctors.

AAOS has adopted standards of professionalism that require orthopedic surgeon members to identify and disclose potential conflicts of interest to their patients, the public and colleagues. These standards also clearly explain procedures and circumstances under which AAOS members may work and be compensated by industry, as well as penalties for noncompliance.

You can learn more about these standards of professionalism at the AAOS website: http://www.aaos.org/industryrelationships.

It is important that you are aware of the relationships between Dr. Longo and the orthopedic/pharmaceutical industries. Please do not hesitate to inquire with our staff if you have questions or concerns.

_____ _____

Patient signature Date

Joseph A. Longo, III M.D., P.C.
Orthopedic Surgeon
3300 North 75th Street
Scottsdale, Arizona 85251-6411
Phone: 480-941-5656
Fax: 480-990-2015

SURGERY CANCELLATION POLICY

In the event that you undergo surgery with Dr. Longo, we request that you please read and sign this policy waiver.

In order to maintain respect and efficiency for our collaborating facilities in regard to hospital staff, anesthesia staff, and scheduling, Longo Orthopedics will be implementing a surgery cancellation policy effective March 1st, 2015.

If your circumstances change and you must cancel your surgery, we ask that you do so in a timely manner. Otherwise:

- Cancellations within **one (1) week** of scheduled surgery date will be charged a $150.00 fee.
- Cancellations within **seventy-two (72) hours** of scheduled surgery date will be charged a $300.00 fee.

We understand that sometimes it may be necessary to reschedule a surgical procedure due to illness and emergencies; therefore we will allow for a one-time reschedule and forgo the cancellation fee if requested in a timely manner. Any additional reschedules will be charged $150.00, plus the original cancellation fee.

We thank you in advance for your cooperation in this matter.

Sincerely,
Joseph A. Longo, III, M.D., P.C.

_____
Patient Signature

_____
Printed patient name

_____
Today's date

Joseph A Longo III, M.D., P.C.
FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. It is our goal to provide the highest quality medical care and reduce the potential for confusion or misunderstanding in the course of your patient experience. We have adopted the following FINANCIAL POLICY to be read and signed by our patient s prior to commencement of treatment.

INSURANCE: As a courtesy to our patients, we will file your medical claim with insurance plans with which we have an agreement as long as valid insurance information is provided to us. It is the responsibility of the patient to make accurate and detailed insurance information available to us to enable processing of your insurance claim. The patient is to be considered self-pay until this information is provided to us. The patient is to notify our office with any insurance changes prior to scheduled appointments. Your insurance policy is an agreement between you and your insurance company. All account balances are the responsibility of the patient and it is not the responsibility of this office to dispute decisions made by your insurance carrier. Payment is due from the patient upon receipt of the first statement from our office. The patient is expected to know their insurance benefits to include deductibles and co-payments. Co-payments are to be paid at the time of service. If we are not participating providers with your insurance carrier, or if you do not have medic al insurance, all charges incurred during your treatment are due and payable at the time of service.

ALL CHECKS RETURNED FOR NSF (NON SUFFICIENT FUNDS) WILL BE ASSESSED A $25.00 CHARGE

REFERRALS/AUTHORIZATIONS: If a referral or authorization is required by your insurance carrier to obtain services by a specialty provider, it is the responsibility of the patient to notify their primary care physician to request referrals and authorizations to be provided to our office prior to your scheduled visit.

ADDITIONAL SERVICES: There is a charge to the patient of $35.00 per occurrence, which will be collected prior to completion of forms and paperwork when our physician is requested to complete paperwork for you (i.e. Disability/FMLA forms).

There will be a $25.00 charge to the patient, due and payable prior to rescheduling the appointment in the event of cancellations without 24-hour notice or appointment "no shows".

RELEASE OF INFORMATION: I hereby authorize Joseph A Longo III M.D. P.C. to release information to my insurance company with regard to all treatment as is necessary to obtain payment for services provided and to review activity related to provider participation with my insurance plan. I assign all benefits to which the patient, or the insured, is entitled for my treatment and medical services provided to me to be paid directly to Joseph A Longo III M.D. P.C.. I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance.

I have read and understand this FINANCIAL POLICY, and by signing, am in agreement and accept all terms and conditions described above.

_____ _____

Signature of patient or responsible party Date

Joseph A. Longo III, M.D. 3300 N 75th St. Scottsdale, AZ 85251

Phone: 480-941-5656 **Fax: 480-990-2015**

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and your access to your Health Insurance and Portability and Accountability Act of 1996 (HIPAA)

OUR COMITTMENT TO YOUR PRIVACY:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following information: Use and disclosure of your health information.

The following circumstances may require us to use or disclose your health information:

1) To public health authorities and health oversight agencies that are authorized by law to collect information.
2) Lawsuits and similar legal proceedings in response to a court or administrative order.
3) If required to do so by a law enforcement official.
4) As necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another person or the general public. We will only make disclosures to a person or representative of an organization to facilitate prevention of the threat.
5) If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6) To federal officials for intelligence and national security activities authorized by law.
7) To correctional institutions or law enforcement officials if you are an inmate or in the custody of a law enforcement official.
8) For worker's compensation and similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1) Communications; you can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you can request that we contact you at home and not place of employment. We will accommodate reasonable requests.
2) You can request a restriction in our use and disclosure of your health information for the treatment, payment or health information to only certain individuals involved in your care or payment for your treatment, such as family members and friends. We are not required to agree with your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is needed to facilitate your medical care.

3) You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care, including patient medical record and billing records, but not including psychotherapy records. You must submit your request in writing to Joseph A. Longo III, M.D., P.C. 3300 N 75th St. Scottsdale, AZ 85251.
4) You may ask to amend your health information if you believe it is incorrect or incomplete as long as the information is maintained and kept by our office. To request an amendment, please submit your request to Joseph A. Longo III, M.D., P.C. 3300 N 75th St. Scottsdale, AZ 85251.
5) Right to a copy of this notice; you are entitled to receive a copy of this notice of privacy practices. You may request a copy of this notice at any time.
6) Right to file a complaint; if you believe ,your privacy rights have been violated, you may file a complaint with our practice or with The Secretary of the Department of Health and Human Services. To file a complaint, it must be received by Joseph A. Longo III, M.D., P.C. 3300 N 75th St. Scottsdale, AZ 85251 in writing. You will not be penalized in any way for filing a complaint.
7) Right to an authorization for the use and disclosures; Our practice will obtain written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If a disclosure of your protected health information was made for a reason other than treatment, payment or health care operations, you have the right to receive and accounting of the disclosure.
8) I consent to my medication history to be viewed by Longo Orthopedics and Joseph A. Longo III, M.D..

If you have any questions regarding this notice or our health information privacy policies, please contact the office of Joseph A. Longo III, M.D., P.C. at (480) 941-5656.

Your signature below acknowledges your receipt of a copy of Joseph A. Longo III, M.D., P.C. Notice of Privacy Practice.

_____ _____

Signature Date

_____

Printed name

MEDICARE PATIENTS ONLY

MEDICARE SIGNATURE ON FILE

I require that payment of authorized Medicare benefits be made on my behalf to:

Joseph A. Longo III, M.D., P.C.
3300 N. 75th St.
Scottsdale, AZ 85251-6411

For any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA)/ Centers for Medicare and Medicaid Services (CMMS) and its agents and any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature (#2 below) requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approval claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare-assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

1. PATIENT'S NAME (Please print): _____

2. PATIENT'S SIGNATURE: _____

3. PATIENT'S MEDICARE # _____