Welcome to our Practice

We have found it much easier for our patients to complete the enclosed forms in the comfort of their own home. Please complete the entire packet and return to our office no later than 7 days prior to your scheduled appointment, unless prior arrangements have been made.

You can email your completed forms to info@umpquaortho.com

Our Providers

- Michael J. Krnacik M.D.
- Sandesh Pandit M.D.

Items to bring to your appointment:

- Your current health insurance cards and photo Identification

Directions:
277 Medical Loop, Roseburg, Oregon 97471-1644
From Stewart Parkway
Turn at the light signal into the main entrance of the hospital (Mercy Drive)
Immediately turn left onto Medical Loop, follow Medical Loop, our building is on the left.

If you are unable to keep this appointment for any reason, please contact our office as soon as possible at 541-677-2131

Umpqua Orthopedics Patient Registration Form

Last Name:_____ First Name:_____ MI:_____

Preferred Name: _____

DOB:_____ Age:___ Sex: ☐ M ☐ F Social Security Number:_____

Gender Identity Check One: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female

☐ Other ☐ Decline to disclose

Mailing Address:_____ City:_____ State:___ Zip: _____

Physical Address (If Different from Mailing Address):

_____ City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone:_____ Voicemail? ☐ Yes ☐ No

Email address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Spouse Name:_____ Spouse Phone Number: _____

Are you employed ☐ Yes ☐ No Patient Occupation:_____

Patient Employer:_____ Employer Phone: _____

Retired ☐ Yes ☐ No Disabled ☐ Yes ☐ No

Primary Care Physician: _____

Preferred Pharmacy: _____

Responsible Party for the patient:

☐ Self ☐ Spouse ☐ Parent ☐ Step-parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other

Name:_____ Phone: _____

Mailing Address:_____ City:_____ State:___ Zip: _____

Employer:_____ Employer Phone Number: _____

Primary Insurance for the patient:

Insured / Employee Name:_____ Insured Date of Birth: _____

Insured Social Security:_____ Relationship to Patient:_____

Insurance Company Name:_____ Employer Name: _____

Policy ID:_____ Group Number:_____ Effective Date:_____

Secondary Insurance for the patient:

Insured / Employee Name:_____ Insured Date of Birth: _____

Insured Social Security:_____ Relationship to Patient:_____

Insurance Company Name:_____ Employer Name: _____

Policy ID:_____ Group Number:_____ Effective Date:_____

Please provide a list of all the parties we may speak with or leave a message with regarding the patients' medical care, appointment scheduling, payment information or contact in case of an emergency.

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

Race and Ethnicity

Race: ☐ White ☐ Hispanic ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African ☐ Decline

American ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to respond

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to respond

Preferred Language: _____

Language Services

Do you need a language Interpreter? ☐ Yes ☐ No If yes what language: _____

Do you need an ASL Interpreter? ☐ Yes ☐ No

By Signing below, I certify that the information provided is true and complete to the best of my knowledge.

By providing my email above, I consent to receive marketing emails from Umpqua Orthopedics for updates, health information, marketing, and special offers. I understand these emails may contain Protected Health Information (PHI) and acknowledge the risk of electronic communication (e.g., potential interception), accepting these risks for convenience. I know this consent is voluntary and I can unsubscribe at any time by asking the office to remove my email address from my account.

Signature:_____ Date:_____

Printed Name:_____ Date:_____

UMPQUA ORTHOPEDICS
ACCIDENT/INJURY/INFORMATION FORM

Please answer all questions and sign the bottom of the form.

State the reason for your visit today and the body part(s) affected:

_____

Is your problem related to: Car/Motorcycle Accident Yes/No Date_____
Slip or fall accident Yes/No Date_____
Job Injury Yes/No Date_____

Briefly describe how the injury occurred:

_____

_____

IF YOUR REASON FOR YOUR VISIT IS NOT RELATED TO A WORKMAN'S COMPENSATION INJURY OR A MOTOR VEHICLE ACCIDENT PLEASE SIGN BELOW THEN PROCEED TO THE NEXT PAGE. IF RELATED PROCEED TO #2

By signing below, I certify that the information on this form is true and complete to the best of my knowledge and the treatment I am requesting is NOT RELATED to a Motor Vehicle Accident, Work related accident or Third-Party Liability.

Patient Name:_____ Patient Signature:_____ Date:_____

IF YOUR REASON FOR YOUR VISIT IS RELATED TO A WORKMANS COMPENSATION INJURY OR A MOTOR VEHICLE ACCIDENT, PLEASE COMPLETE 2 THRU 4 AND SIGN BELOW

2. Please provide claims information if injury is related to a Workers Compensation Claim or Motor Vehicle.

Claim number: _____

If related to a Workman's Compensation Carrier Claim:
Employer at time of injury: _____
Work Comp. Insurance Carrier:_____

Phone: ( ) _____

Date of injury: _____

If related to a Motor Vehicle Claim:
Auto Insurance Carrier: _____
Agent Name: _____

Phone: ( ) _____

Date of injury: _____

3. Do you have an attorney in regard to this injury? Yes No (If no proceed to sign below)

4. Attorney Name:_____

Phone: ( ) _____

By signing below, I certify that the information on this form is true and complete to the best of my knowledge and the treatment I am requesting IS RELATED to a one of the following and information on the claim has been provided above:
Check one below.
Motor Vehicle Accident ☐
Work Related Accident ☐
Third Party Liability ☐

Patient Name:_____ Patient Signature:_____ Date:_____

OFFICE PAYMENT & FINANCIAL POLICY UMPQUA ORTHOPEDICS

CO-PAYMENTS, DEDUCTIBLES AND ESTIMATED CO-INSURANCE: Due at each visit prior to seeing the doctor.

INSURANCE: We will bill your insurance as a courtesy. Deductibles, co-pay's and estimated co-insurance are due at the time. of service. Any remaining patient balance responsibility is due prior to the next appointment or within 30 days of receiving treatment. The following forms of payment are acceptable: Cash, Master Card, Visa, Discover or American Express. We will do our best to help you but ultimately it is the patient's responsibility to determine whether their insurance provider is contracted with our physicians; or considers our physicians to be "in network". Your deductibles or co-pays may be higher as a result if we are not.

SERVICES: You MAY receive a separate bill from our office if you received additional services during your visits. This may be but not limited to: Imaging, injections, casting, or durable medical equipment. These services may be applied to additional co-pays or your deductible.

SELF PAY (NO INSURANCE): A $200 deposit is required at time of check in for each appointment. The deposit will be applied to the services provided that day, any remaining balance is due prior to the next appointment or within 30 days of receiving the treatment, whichever comes first.

WORKERS COMPENSATION CLAIMS / MVA CLAIMS : Provide all billing information including mailing address, telephone number, claim number and any other pertinent information. You must have an attending physician assigned to your claim and we must be able to verify that the condition you are requesting treatment for is an accepted condition on your claim. Regular health insurance information will be required, as well, regardless of claim status.

RETURN CHECKS: If a check is returned by your bank, you will be charged a $25.00 return check fee, plus the original amount of the check. The total of these amounts will be due within 5 business days of the bank declining your check and must be paid by cash, cashier's check or money order. Once a patient has a check returned, no further checks will be accepted.

FORMS/SPECIAL REPORTS: (i.e. FMLA, Oregon Paid Leave, Disability Forms, Attending Physician Statements etc.):
The physicians charge a fee of $25.00 per page for any form that needs to be completed or signed; the fee must be paid prior to the physician completing the forms. A minimum of three business days is required to complete the forms. (Friday, Saturday, Sunday, holidays and any office closures are excluded)

MEDICAL RECORDS: We will be happy to provide you with a copy of your medical records or transfer your records to another provider/facility. We require you to sign a medical records release and there is a fee of $23.00 for the first 10 pages and $.25 per page for any additional pages, x-ray images can be sent via secure email.

COLLECTION POLICY: Any unpaid services over 120 days will be turned over to collections. If your account is turned over to "in office" collections, you will be allowed to schedule only if you pay the full amount prior to scheduling. Accounts turned to a collection agency will not be rescheduled. Patients who arrive for their appointment that are not prepared to pay their estimated portion will be rescheduled. If you have questions you can call our office at 541-677-2131

I have read the above office policy and as a patient, legal guardian of a minor or impaired patient, I understand that I am financially responsible for payment of my account. I understand deductibles, co-pay's and estimated co-insurance are due at the time of service. Any remaining patient balance responsibility is due prior to the next appointment or within 30 days of receiving treatment. I am also aware that **delinquent accounts are subject to other collection means at my own expense including legal fees.**

I have read, understand and agree to the above policy in accordance with the terms and conditions set forth in the policy of this office. I also hereby attest I that have given payment information to the best of my knowledge for complete and timely payment.

_____ _____

Signature Date

Printed Name: _____

UMPQUA ORTHOPEDICS

Patient Cancellation, Tardiness and No-Show Agreement

Umpqua Orthopedics strives to provide each patient with quality personalized attention and the best care possible. Patients who cannot make an appointment should call and cancel at least 24 hours in advance. This opens appointments for other patients needing prompt medical care. Whenever one patient "no shows", another patient could have been seen in his/her place.

As a courtesy, Umpqua Orthopedics attempts to confirm each appointment by calling the patient prior to their appointment. ***However, it is the patient's responsibility to make or cancel appointments and to ensure current insurance information, mailing addresses and phone numbers are provided.***

Umpqua Orthopedics follows the guidelines below:

No Show: A patient appointment that has not been cancelled at least 24 hours in advance of the scheduled appointment time.

When a no-show occurs, the patient will receive a phone call or letter advising they missed their appointment without giving the office 24 hours' notice.

Late Arrival: A patient arrives past the scheduled appointment time.

If the patient arrives late and the provider is unable to work them into the schedule, they will reschedule for the next available appointment time.

No-Show Patient Discharge: After the fourth patient no-show, the provider may choose to discharge the patient.

My signature below represents that I have read, understand, and agree to the terms of the Patient Cancellation and Tardiness and No-Show Policy.

_____

Patient's Printed Name

_____ _____

Patients, Parent, or Guardian Signature Date

Umpqua Orthopedics Patient Rights & Responsibilities

The Patient Rights and Responsibilities shall be given to every new patient and shall be permanently posted at Umpqua Orthopedics.

WHEN YOU ARE SEEN BY AN EMPLOYEE OF UMPQUA ORTHOPEDICS, YOU HAVE THE RESPONSIBILITY TO:

- Treat the staff with consideration, respect and dignity.
- Understand that your life-style does affect your health.
- Take an active part in your health care.
- Follow the agreed upon treatment plan. If you choose or are unable to follow the treatment plan, it is your responsibility to inform the Medical Provider.
- Observe facility rules and regulations that are for the safety and consideration of all patients and staff.
- Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, durable power of attorney, and other matters relating to your healthcare.
- Report whether you understand a contemplated course of action and what is expected of you.

WHEN YOU ARE SEEN BY AN EMPLOYEE OF UMPQUA ORTHOPEDICS YOU HAVE THE RIGHT TO:

- Be treated with consideration, respect and dignity;
- Have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand;
- Have privacy during case discussion, counseling & treatment;
- Review your records in the presence of a healthcare professional;
- Know the name and qualifications of staff providing your care;
- Know your diagnosis, health problems, test results, the potential advantages and risks of treatment or procedures in language you can understand;
- Expect that all services, treatment and counseling techniques will take place with your informed consent;
- Participate in referral planning;
- Have access to the patient comment procedure;
- Have another individual present in the exam room with you, if you so desire.

Umpqua Orthopedics Patient Registration Form

I understand that Umpqua Orthopedics, referred to below as ("This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

1. Make decisions about and plan for my care and treatment.
2. Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
3. Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
4. I authorize payment of medical benefits to Umpqua Orthopedics for services rendered.
5. I understand that I am responsible for all charges incurred through Umpqua Orthopedics.
6. Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By (Patient):	Date:
Patients Printed Name:	

-OR-

By (Patient):	Date:
Description of Representative's Authority:	

PATIENT NAME:____DOB:____________________DATE:______________

IS THIS DUE TO AN INJURY? ☐ YES ☐ NO

IF YES, HOW DID INJURY OCCUR?____

WHEN DID YOUR SYMPTOMS BEGIN/ DATE OF INJURY? ____

ALLERGY HISTORY ☐ NO KNOWN ALLERGIES

LIST ANY MEDICATIONS AND NON-MEDICATION ALLERGIES (IODINE, LATEX, ADHESIVE, DYES, ETC..)

MEDICATION OR ALLERGY NAME	REACTION

MEDICATIONS: ☐ NO CURRENT MEDICATIONS

PLEASE LIST PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION	STRENGTH/ DOSE	HOW OFTEN TAKEN

PATIENT HEALTH HISTORY ☐ NO DISEASES OR MEDICAL CONDITIONS LISTED

CHECK IF YOU HAVE ANY OF THE FOLLOWING DISEASES OR MEDICAL CONDITIONS:

☐ DIABETES	☐ KIDNEY DISEASE	☐ RHEUMATOID ARTHRITIS
☐ HIGH BLOOD PRESSURE	☐ KIDNEY FAILURE	☐ FIBROMYALGIA
☐ CANCER	☐ ANEMIA	☐ PSORIASIS
☐ CHF	☐ PERIPHERAL VASCULAR DISEASE	☐ HEPATITIS
☐ HEART DISEASE	☐ HISTORY OF BLOOD CLOTS	☐ ANXIETY
☐ ASTHMA	☐ HIGH CHOLESTEROL	☐ DEPRESSION
☐ COPD	☐ STROKE	☐ DEVELOPMENT DISORDER
☐ MIGRAINES	☐ HEART ATTACK	☐ BI-POLAR
☐ SEIZURES	☐ ATRIAL FIBRILLATION	☐ PSYCHIATRIC ILLNESS
☐ DIVERTICULITIS	☐ CATARACTS	☐ HIV/AIDS
☐ GERD	☐ EYE DISEASE	☐ _____
☐ LIVER DISEASE	☐ HYPOTHYROID	☐ _____
☐ ULCERATIVE COLITIS	☐ THYROID DISEASE	☐ _____

SURGICAL HISTORY ☐ NO SURGICAL HISTORY

ENTER THE NAME OF ANY SURGICAL PROCEDURES YOU HAVE HAD AND THE YEAR THEY WERE PREFORMED

NAME OF SURGIAL PROCEDURE	YEAR OF SURGERY

FAMILY HISTORY ☐ HISTORY UNKNOWN ☐ NO SIGNIFICANT FAMILY HISTORY

IF ANY RELATIVES HAVE HAD THE FOLLOWING, PLEASE INDICATE RELATIONSHIP:

CANCER: _____ HEART DISEASE:_____

KIDNEY DISEASE: _____ DIABETES: _____

PSYCH/SOCIAL:_____ BLOOD CLOTS/BLEEDING DISORDER:_____

SOCIAL HISTORY

OCCUPATION: ☐ RETIRED ☐ DISABLED ☐ SELF EMPLOYED ☐ STUDENT ☐ CHILD

☐ UNEMPLOYED ☐ EMPLOYED, WHERE EMPLOYED: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

1. **TOBACCO USE:**

HAVE YOU EVER SMOKED?_____ **IF NEVER SMOKER PLEASE GO TO #2**

CURRENT SMOKER? YEAR STARTED?_____ HOW MANY CIGARETTES PER DAY DO YOU SMOKE?_____

HOW SOON AFTER YOU WAKE UP DO YOU HAVE YOUR FIRST CIGARETTE? _____

ARE YOU INTERESTED IN QUITTING? _____

FORMER SMOKER? _____ YEAR STARTED? _____ YEAR STOPPED?_____

DO YOU USE ANY OF THE FOLLOWING:

E-CIGARETTE OR VAPING DEVICE _____ SMOKELESS (CHEW) _____ CIGARS_____

2. **ALCOHOL USE:**

HAVE YOU HAD A DRINK CONTAINING ALCOHOL IN THE LAST YEAR ? _____

IF NO ALCOHOL USED PLEASE GO TO #3

IF YOU ANSWERED YES PLEASE ANSWER THE ADDITIONAL QUESTIONS BELOW:

HOW OFTEN DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR? _____

HOW MANY DRINKS DID YOU HAVE ON A TYPICAL DAY WHEN YOU WERE DRINKING IN THE PAST YEAR?

_____

HOW OFTEN DID YOU HAVE SIX OR MORE DRINKS ON ONE OCCASION IN THE PAST YEAR? _____

3. **FALL RISK:**

HOW MANY TIMES HAVE YOU FALLEN IN THE LAST YEAR?_____

HOW MANY TIMES DID YOUR FALL RESULT IN INJURY? _____

HAND DOMINANCE: ☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

REVIEW OF SYSTEMS ☐ NO CURRENT SYMPTOMS

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS IN THE LAST 30 DAYS:

GENERAL

☐ WEIGHT LOSS ☐ WEIGHT GAIN ☐ FEVER ☐ CHILLS ☐ NIGHT SWEATS ☐ FATIGUE

HEENT

☐ BLURRY VISION ☐ VISION LOSS ☐ HEARING LOSS ☐ NOSE BLEEDS ☐ SINUS CONGESTION ☐ SORE THROAT

CARDIAC

☐ CHEST PAIN ☐ PALPITATIONS ☐ MURMUR ☐ FAINTING ☐ SWELLING FEET/ ANKLES

RESPIRATORY

☐ SHORTNESS OF BREATH ☐ WHEEZING ☐ COUGH ☐ SNORING

GI/GU

☐ HEARTBURN ☐ NAUSEA ☐ VOMITING ☐ CONSTIPATION ☐ DIARRHEA ☐ INCONTINENCE

MUSCULOSKELETAL

☐ JOINT PAIN ☐ JOINT WEAKNESS/ STIFFNESS ☐ BACK PAIN ☐ NECK PAIN ☐ DIFFICULTY WALKING

SKIN

☐ RASH ☐ VARICOSE VEINS ☐ ITCHING ☐ REDNESS ☐ WOUNDS

NEUROLOGICAL

☐ HEADACHES ☐ NUMBNESS/ TINGLING ☐ SEIZURES

PSYCH

☐ MEMORY LOSS ☐ DEPRESSION ☐ INSOMNIA

HEME

☐ EASY BLEEDING / BRUISING ☐ BLOOD CLOTS ☐ TRANSFUSION

ENDO

☐ EXCESSIVE THIRST / URINATION ☐ HEAT / COLD INTOLERANCE ☐ HAIR LOSS

HAVE YOU TRIED ANY OF THESE CONSERVATIVE TREATMENTS	WAS THE TREATMENT BENEFICIAL YES OR NO		DATE OF TREATMENT
PHYSICAL THERAPY	☐ YES	☐ NO	
INJECTIONS	☐ YES	☐ NO	
MEDICATIONS	☐ YES	☐ NO	
OTHER:_____	☐ YES	☐ NO	
OTHER: _____	☐ YES	☐ NO	