THE SHOULDER CLINIC

Patient Information

Patient's Last Name_____ First_____ Middle_____ M____ F____

Home Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Age_____ Date of Birth_____ Single _____ Married_____ Divorced_____ Widowed_____

Patient's Employer_____ Years with Firm_____ Occupation_____

Spouse's Name_____ Employer/Occupation_____ Phone_____

Family Physician_____ Referred by _____

Whom may we contact in case of emergency? _____ Phone_____

Father's/Mother's Name (If a Minor) _____ Employer_____ Phone_____

Occupation_____

HIPAA

_____ (Initial) "I acknowledge that I have received The Shoulder Clinic of Idaho's Notice of Privacy Practices on this or a prior occasion

Insurance Information

Date on accident/injury or onset of symptoms_____

Brief Descriptions _____

PRIMARY INSURANCE COMPANY NAME_____

Patient Relationship to Subscriber please circle one (Self, Spouse, child) Date of Birth_____

I.D. No._____ Group No. _____

SECONDARY INSURANCE COMPANY NAME _____

Patient Relationship to Subscriber please circle one (Self, Spouse, child) Date of Birth_____

I.D. No._____ Group No. _____

Please Read & Sign Below

Recognizing the inherent risks of transmission of contagious diseases. especially during surgery, I voluntarily agree to be tested for such diseases as hepatitis, syphilis, HIV/AIDS, herpes, etc., when deemed necessary by physician. Questions should be discussed with your physician. I hereby authorize the doctors of THE SHOULDER CLINIC OF IDAHO to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expense relating to the services performed from time to time, but not to exceed my indebtedness to said physicians and surgeons. It is understood that any money received from the above-named insurance company over and above my indebtedness will be refunded to me or, in the proper case, to my employer or other provider of insurance, when my bill is paid in full. I understand I am financially responsible to said doctors for charges not covered by this assignment. I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original copy in the doctor's files, and authorize the insurance company to accept the photocopy, I release you from all legal responsibility or liability that may arise from this authorization. This authorization shall continue and be in force and effect until revoked in writing by me.

Affiliation with Treasure Valley Hospital

Please be advised that Dr. Goodwin, Dr. Chopp, and Dr. Lynch have limited partnership-ownership in Treasure Valley Hospital in Boise. We feel proud of the high quality of care this facility provides our patients

There are several medical facilities that are available for your radiographic imaging needs (i.e. MRI scans), and surgical procedures including Treasure Valley Hospital.

Please feel free to discuss this at any time with Dr. Goodwin, Dr. Chopp, or Dr. Lynch.

_____ Date _____

Responsible Party's Signature