THE SHOULDER CLINIC

Patient Information

Patient's Last Name: _____ First: _____ Middle: _____ M: ____ F: ____

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

Home Phone: (_____) _____ Cell: (_____) _____ Email: _____

Date of Birth: _____ Single: _____ Married: _____ Divorced: _____ Widowed: _____

Primary Care Physician Last Name: _____ First: _____ Referred by: _____

Local Pharmacy: _____ Pharmacy Location: _____

Emergency Contact: _____ Relation: _____ Phone: (_____) _____

Parent/Legal guardian Full Name: _____ Phone: (_____) _____

HIPAA

Initials: _____ I, the undersigned, do hereby acknowledge that The Shoulder Clinic of Idaho has publicly posted the clinic's Notice of Privacy Practice documentation, and I may receive a copy upon request.

Consent to Treat

I, the undersigned, do hereby agree and give my consent for The Shoulder Clinic of Idaho to furnish medical care and treatment to the patient identified above.

Responsible Party's Signature: _____

Date: _____

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

As a patient of The Shoulder Clinic of Idaho, your physician may order tests and studies, or may personally perform procedures at local hospitals. These could include (but are not limited to) laboratory tests, X-rays, CAT scans, MRIs, injections, and surgical procedures. Dr. Chopp, Dr. Lynch, and Dr. Johnson are limited partners of, and have a financial interest in, Treasure Valley Hospital, which is one of the local hospitals that provides these services. Dr. Chopp, Dr. Lynch, and Dr. Johnson also practice at St. Alphonsus and St Luke's hospitals where they do not have ownership nor a financial interest. This form is to confirm that you have the right to choose the hospital where you would like to receive your services.

Responsible Party's Signature: _____ **Date:** _____