

# **ORTHOPAEDIC INSTITUTE OF HENDERSON OFFICE POLICIES**

**10001 South Eastern Avenue, Suite 102, Henderson, NV 89052  
100 N. Green Valley Parkway, Suite 310, Henderson, NV 89074  
Phone 702.565.6565  
Fax 702.990.5275/702.565.8898**

**Steven R. Hoer, MD  
Craig D. Clark, MD**

**Robert J. Tait, MD  
William D Kelley PA-C**

**R. Jeff Grondel, MD**

## **To All Patients:**

We ask you read the following policy regarding communications with our office. If you are unclear about any of the information, please ask a member of our staff for an explanation.

1. When calling in for a prescription renewal, please refill your medications 24-48 hours before the medication runs out. The pharmacy will contact our office regarding refilling your medication. This process will take approximately 24 hours.
2. When calling in a problem you are having over the phone, please give our office all pertinent information regarding your current health status. The triage personnel will relay this information to the physician. The calls are usually returned after 5:30 p.m. the day the call is received. If the situation is life threatening, go directly to the emergency room and ask them to call us.
3. Referrals commonly require 5-7 business days to complete the cycle. This includes referrals for physicians, diagnostic imaging, therapy, etc. Please allow the office at least 72 hours before calling back unless the referral was an urgent request by your physician.
4. If you need to cancel your appointment please contact us at least 24 hours in advance.
5. Office hours are 9:00 a.m. to 5:00 p.m., Monday through Friday. We are closed on Saturday and Sunday. A physician from our office is on call during non-office hours.

**ORTHOPAEDIC INSTITUTE OF HENDERSON  
AGREEMENT TO TREAT**

Steven R. Hoer, MD    Robert J. Tait, MD    R. Jeff Grondel, MD  
Craig D. Clark, MD    William D Kelley PA-C

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Phone \_\_\_\_\_

Sex  Male     Female    Date of Birth \_\_\_\_\_ (mm/dd/yyyy)    SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Retired:        Y        N        Marital Status:        Married        Single        Divorced        Widowed

Employer Name: \_\_\_\_\_ Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Orthopedist you are seeing today \_\_\_\_\_

Chief Complaint (reason for visit) \_\_\_\_\_

Pharmacy Preference (name, address, and phone number) \_\_\_\_\_

Name of Primary Care (Family) Physician \_\_\_\_\_ Name of referring physician \_\_\_\_\_

Workman's Comp Carrier Name \_\_\_\_\_ Claim # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # \_\_\_\_\_ Case Adjuster's Name \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_ DOB \_\_\_\_\_ S.S. # \_\_\_\_\_

Responsible Party's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Maiden Name \_\_\_\_\_

Is Injury Related to an Auto Accident?    YES    NO        Is this a Liability Injury?        YES    NO

If YES, Attorney Name \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

**Authorization for Release of Medical Records:** My physician is authorized to provide to my referring physician, insurance company or their representatives, workman's comp carrier, or my attorney information they may require regarding my condition while under their treatment or observation, including but not limited to history obtained, medical history, physical findings, diagnosis, prognosis, and treatment recommended.

**Financial Agreement:** I authorize my insurance company to pay my physician for services rendered, in consideration of the services rendered by my physician at my request and direction. I understand I am responsible for, and agree to pay in full, all charges incurred for services rendered. I further understand that in the event that special arrangements have been made to have payment made through my insurance company, and the carrier elects not to cover any or all of the claim, I am responsible for the balance in full. I further agree to pay lawful and reasonable interest charges after (30) days from date if billing in any unpaid balance.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date**

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### CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (narcotics, tranquilizers, and barbiturates) are very useful, but have high potential for misuse and abuse. Therefore, they are clearly controlled by the local, state, and federal government. They are intended to relieve pain, to improve function, and/or ability to work, not simply to feel good. Due to the fact my doctor is now or may be prescribing such medication for me in the future to help manage pain, I agree to the following conditions:

1. **I am responsible for my controlled substance medication.** If the prescription is lost, misplaced, stolen, or if I use it up sooner than prescribed, I understand **it will not be replaced.**
2. **I will not request nor accept** controlled substance medication from any other physician or individual while I am receiving such medication from my doctor at the Orthopaedic Institute of Henderson without informing my doctor immediately. Besides being illegal to do so under NRS 453.391, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.
3. **Refills** of controlled substance medications:
  - a. **Will be made only during the hours of 9:00 a. m. to 3:30 p.m.** Refills **will not be made** at night, on holidays, or on weekends.
  - b. **Will not be made** if I "run out early." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount left.
  - c. **Will not be made** as an "emergency," such as on Friday afternoon because I suddenly realize I will run out "today." I must keep track of my medication and plan ahead. I will call **at least 24 hours ahead if I need assistance** with a controlled substance medication prescription.
4. I understand **if I violate any of the above conditions**, my controlled substance prescription and/or treatment at the Orthopaedic Institute of Henderson may be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to local medical facilities and other authorities.

I understand the **main treatment goal is to improve my ability to function and/or work.** In consideration of this goal and that I have been or may be given potent medication to help me reach that goal, **I agree to help myself by following better health habits,** specifically involving exercise, weight control, and the use of tobacco or alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature of Patient (Parent or Guardian if minor)

\_\_\_\_\_  
Date

**ORTHOPAEDIC INSTITUTE OF HENDERSON  
ACCIDENT FORM**

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Please complete the following:

Today's Date \_\_\_\_\_

Nature of Illness or Injury \_\_\_\_\_  
\_\_\_\_\_

Are you:      Right-handed \_\_\_\_\_      Left-handed \_\_\_\_\_

Date Illness/Injury Occurred \_\_\_\_\_

Date First Treated \_\_\_\_\_

How Did Illness/Injury Occur? \_\_\_\_\_  
\_\_\_\_\_

Where Did Illness/Injury Occur? \_\_\_\_\_  
\_\_\_\_\_

Did Illness/Injury Occur in the Course of Employment? \_\_\_\_\_  
\_\_\_\_\_

Is There Any Other Party Responsible for this Bill? \_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Insurance Identification Number \_\_\_\_\_

Patient Signature (Parent or Guardian if minor) \_\_\_\_\_

# ORTHOPAEDIC INSTITUTE OF HENDERSON HEALTH HISTORY

## MEDICATION HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form.

Are you taking ANY kind of prescription medication now?  No  Yes (If yes, please list below. If you run out of room, use the back of this sheet for additional information).

### PLEASE PRINT NEATLY

Name, dose and how often	Problem being treated	Date of Prescription	Prescribing Doctor

Are you allergic to ANY medication?  No  Yes If yes, please list below.

Name of Medication	Type of Reaction

## SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)?  No  Yes  
 high fever  trouble with intubation (placement of breathing tube), other \_\_\_\_\_

Have you ever had surgery?  No  Yes (If yes, please list below)

### WHAT TYPE OF SURGERY

### DATE OF SURGERY

### PHYSICIAN

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PATIENT NAME:** \_\_\_\_\_