Richard L. Shindell, M.D.
Pediatric Orthopaedics and Scoliosis
Board Certified

PLEASE PROVIDE SOCIAL SECURITY NUMBERS IF YOU WOULD LIKE FOR US TO FILE A CLAIM WITH YOUR INSURANCE

PATIENT REGISTRATION FORM

Please read carefully and fill out this form completely in black ink only

Patient last name | First | MI | Date of Birth | Sex

SSN# | School Name | Grade

Home Address | City | State | Zip Code | Home Phone

Pediatrician/Family physician name | Office address | Phone number

Father's Information

Last Name | First | MI | Date of birth | SSN#

Home address | City | State | Zip Code | Home Phone

Employer name | Occupation | Employer address | City | State | Zip | Work Phone

Mother's Information

Last Name | First | MI | Date of birth | SSN#

Home address | City | State | Zip Code | Home Phone

Employer name | Occupation | Employer address | City | State | Zip | Work Phone

PRIMARY INSURANCE NAME_____

Member number | Group number | Phone number

Claims address | City | State | Zip Code

Policy holder (full name) | Date of birth | SSN# | Relationship to patient

PARENT/GUARDIAN SIGNATURE **DATE**

PATIENT HISTORY
PLEASE PRINT IN BLACK INK ONLY
PLEASE COMPLETE ENTIRE FORM

PATIENT INFORMATION

Name_____ Age_____
Last First MI
Date of Birth_____ Male _____ Female _____

Reason for visit: (If a fracture please give date and how injury occurred) _____
_____
_____
_____

When did the problem begin? _____
Has your child been seen by a physician for **this** problem? Yes ◯ No ◯
Referring Hospital _____
Referring Physician: _____Phone(____)_____
_____
Address: _____City_____State:_____Zip: _____
Has your child received treatment for this problem? (x-rays, ultrasound, MRI) Yes ◯ No ◯
If so, did you bring the films/disc with you today? Yes ◯ No ◯
Does your child have any other medical conditions? Yes ◯ No ◯ If yes, please explain:_____
_____
Is there family history of this condition? Yes ◯ No ◯

Previous Surgeries? Yes ◯ No ◯ If yes, please list procedure and date:_____
_____
_____
_____

Medication or Food Allergies: Yes ◯ No ◯ If yes, please list: _____
_____
_____
_____

List Current Medications (including vitamins, herbal supplements, over the counter medications) _____
_____
_____
_____

Has Your Child Gone Through A Recent Growth Spurt? Yes ◯ No ◯
If female, is it possible that your child may be pregnant? Yes ◯ No ◯ Unsure ◯ N/A ◯
Date of First Menstrual Cycle: _____

Has your child had any problems in anyway related to the following? If so, please check and **GIVE DETAILS BELOW.**

Unexpected weight loss _____ Yes ◯ No ◯
Shortness of breath_____ Yes ◯ No ◯
Weight gain_____ Yes ◯ No ◯
Wheezing _____ Yes ◯ No ◯

Fever _____ Yes ◯ No ◯
Cough _____ Yes ◯ No ◯
Chills _____ Yes ◯ No ◯
Fainting Spells _____ Yes ◯ No ◯
Fatigue _____ Yes ◯ No ◯
Bruising _____ Yes ◯ No ◯
Heart Murmur _____ Yes ◯ No ◯
Numbness _____ Yes ◯ No ◯
Tingling _____ Yes ◯ No ◯
Unsteady gait _____ Yes ◯ No ◯
Dizziness _____ Yes ◯ No ◯
Tremors _____ Yes ◯ No ◯
Joint Pain _____ Yes ◯ No ◯
Swelling _____ Yes ◯ No ◯
Instability _____ Yes ◯ No ◯
Joint Stiffness _____ Yes ◯ No ◯
Redness/warmth of Extremity _____ Yes ◯ No ◯
Rash _____ Yes ◯ No ◯
Muscle Pain _____ Yes ◯ No ◯
Nausea _____ Yes ◯ No ◯
Poor Healing _____ Yes ◯ No ◯
Diarrhea _____ Yes ◯ No ◯
Itching _____ Yes ◯ No ◯
Vomiting _____ Yes ◯ No ◯

DETAILED DESCRIPTION _____

_____

_____

_____

_____

DEVELOPMENTAL SECTION

Normal Pregnancy? Yes ◯ No ◯
Was Child Premature? Yes ◯ No ◯ If yes, How Many Weeks? _____
Normal Delivery? Yes ◯ No ◯
Presentation? Vertex (head first) ☐ Breech ☐ Vaginal ☐ C-Section ☐
Pre/Postnatal Problems? Yes ◯ No ◯ If yes, please explain _____

_____

_____

Birth Weight _____ Length _____
At what age did your child Sit? _____ Crawl _____ Walk _____ Talk _____

DO NOT WRITE BELOW THIS LINE FOR OFFICE USE ONLY

Current Wt. _____ ***Ht.*** _____

Provider Signature _____ Date _____

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Richard L. Shindell, M.D., P.C.
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F: 602-604-0499
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Consent for Treatment of a Minor

I hereby certify that I am the parent/legal guardian of: _____
Date of Birth: _____ who is a minor, give authorization to Richard L. Shindell M.D. and all persons acting as his agents to provide medical care to my child.

Authorization and Release of Medical Information

I authorize Richard L. Shindell M. D. to release any and all information including records of diagnosis and/or treatment of my child to third party payers and/or other healthcare practitioners.
I agree to assign insurance benefits to Richard L. Shindell M.D. provider of medical care whenever requested and whenever necessary to facilitate payment of a claim.
I acknowledge that I have received a copy of the Notice of Privacy Standards (HIPAA), which describes the uses and disclosures of health information.

I understand that I may revoke this consent at any time by notifying Richard L. Shindell in writing.
A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

My Signature below acknowledges that I have been given the opportunity to read or have had the above information explained to me, that I fully understand the statements in this document and consent to each of them. I certify that I as the parent/guardian of said patient that I am authorized to act on the patient's behalf to execute the above and accept the terms herein.

Patient Name_____ Date of Birth _____

_____

Parent/Legal Guardian (Signature) Parent/Legal Guardian (Print) Date

Patient's Name: _____ DOB:_____

The provider and staff at Richard Shindell, M.D. are here to take care of children. Our focus is on the medical care and health of your child(ren) – NOT legal issues involving divorce, separation, or custody agreements. That is why we ask you to read and agree to the following:

1. Please make decisions regarding future appointments, surgery scheduling, physical therapy, etc. for your child(ren) prior to visiting our practice.

2. Either a parent or a legal guardian can schedule an appointment for their child, be present for the visit, and/or obtain a copy of the visit summary. ***Unless there is a court order in progress in the child's record that restricts a parent's rights, please do not ask us to limit the other parent's involvement in your child's care.***

3. Payment (co-pays, deductibles, etc.) are due at the time of service regardless of which parent is responsible for medical coverage. We are not a party to your divorce agreement, ***We will collect payment due from the parent who brings the child to the visit***. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

4. Both parents/legal guardians can sign a "Consent to Treat" form. This means other persons (like grandparents, nannies, etc.) are authorized to bring your child to our practice, and can consent for treatment during that visit. ***We will NOT be involved in any disputes regarding named individuals on your child(ren)'s*** Consent to Treat ***form.*** Both parents/legal guardians can see who is named on each other's forms; however, we will not comply with requests to eliminate names on the other's form, unless instructed by the court. Please refer these requests to your attorney.

5. Additionally, we will **not:**

    - Call the other parent for consent prior to treatment or inform the other parent whenever visits are scheduled.
    - Restrict either parent's/legal guardian's involvement in your child(ren)'s care, unless authorized by law.
    - Tolerate appointment scheduling/cancelling patterns of behavior between parents.

6. It is both parent's responsibility to communicate with each other about the patient's care, office dates/visits and any other pertinent information relevant to the care of the child. Please do not ask our providers to call the non-attending parent following visits.

7. Should the issues that come between parents become disruptive to our practice or impede the care of children, we reserve the right to discharge your family from further treatment.

_____ _____

Parent/Legal Guardian Date

_____ _____

Parent/Legal Guardian Date

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's name: _____ Date of Birth: _____

Previous name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address:_____

City: _____ State:_____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

333 E. Osborn Rd., Suite 255 Phoenix, Arizona 85012 P: 602.604.8941 F: 602.604.0499

Richard L. Shindell, M.D., P.C.
Pediatric Orthopaedics and Scoliosis
Patient Financial Policy

Thank you for choosing Richard L. Shindell, M.D. as your health care provider. We are committed to building successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fee, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.)

Parents/Guardians are required to provide insurance card and photo identification at every appointment.

Insurance Claims: Insurance is a contract between you and your insurance company. As a courtesy we will file the claim for you, however, we will not become involved in disputes between you and your insurance carrier; in the event that you are not satisfied with the processing of your claim we ask that you direct these questions to your insurance company.

Referrals and Pre-authorizations: If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain your referral or authorization may result in a lower or no payment from your insurance company and the balance will be your responsibility.

Co-pays/Deductibles: All co-pays and past due balances are due at time of check-in, unless previous arrangements have been made with our billing coordinator prior to your appointment. We accept cash or credit cards.

Divorce and Separated Couples: The parent bringing the child to our office will be responsible for payment at the time services are rendered. Our practice does not honor divorce specifics.

Cancelled and Missed Appointments: If you must cancel an appointment, we ask that you cancel at least 24 hours before the appointment so that we may offer the appointment time to another patient.

Forms Completed: We charge $25.00 for each form that you ask us to fill out. We require 7-10 business days to complete any form.

Medical Records Copied: We charge $50.00 to copy records for your attorney. X-rays or itemized statements are not included. We require 30 business days from the time we receive a signed request to process a request for medical records.

I hereby certify that I as the parent/guardian of

Patient Name_____ Date of Birth _____

I am authorized to act on the patient's behalf and that I have read and understand the policy and by signing agree to abide by these guidelines.

_____

Parent/Legal Guardian (Signature) Parent/Legal Guardian (Print) Date

Richard Shindell, M.D.
333 East Osborn Road, Suite 255
Phoenix, Arizona 85012

Consent for treatment in absence of natural parent or legal guardian

Date: _____

I, _____, am the parent/legal guardian of patient _____,

date of birth _____, I do hereby give permission to _____

to make any medical decision during my absence for date of service _____.

Dr. Richard Shindell may proceed with any necessary treatment.

_____
Parent's full name (Print)

_____ _____
Parent's Signature Date

_____
Appointed representative's full name (Print)

_____ _____
Appointed representative's signature Date

Verbal consent given to staff member:_____

by_____ the parent/legal guardian of patient named above.

On _____ for date of service _____.

Full printed name of staff member *Signature of staff member* *Date*

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Pediatric Orthopaedic and Scoliosis

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, surgeries, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorney in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above. I also assign and/or convey to the above named health care provider any legal or administrative claim or choose an action arising under any group health plan, employee benefits plan, health insurance or tort-feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, surgeries, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or close an action). This constitutes and express and knowing assignment or ERISA breach of fiduciary duty claims and other legal and/or administrative claims

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, surgeries, and/or medications provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare, Medicaid and applicable federal and state laws.

A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED VALID, THE SAME AS IF IT WAS THE ORIGINAL.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____	_____
Patient's Name (print)	Legal guardian signature
_____	_____
Legal guardian name (print)	Date