Patient Information

PATIENT INFORMATION

Date _____

SSN/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

_____
City State Zip Code

Cell ( ) _____

Best time/place to contact you? _____

E-mail _____

Sex ☐ M ☐ F Age _____

Date of Birth _____

☐ Married ☐ Widowed ☐ Single

☐ Separated ☐ Divorced ☐ Minor

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____
City State Zip Code

Employer/School Phone ( ) _____

Spouse's Name _____

DOB _____ SSN _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Y ☐ N

Subscriber's Name _____

Date of Birth _____

Social Security # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Memorial Orthopaedic Surgical Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed on page 8 of these forms.

TO BE COMPLETED BY PARENT/GUARDIAN

Name _____

Relationship _____ SSN _____

Address _____

_____

Cell ( ) _____

Home ( ) _____

Work ( ) _____

E-mail _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of Accident

☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your incident?

☐ Auto Ins ☐ Employer ☐ Worker's Comp ☐ Other

Attorney's Name (if applicable) _____

Name:_____ MRN _____

Patient Information

EMERGENCY CONTACT

Name _____ Relationship _____

Home ( ) _____ Cell ( ) _____ Work ( ) _____

In order to effectively communicate with you about your medical information, we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information, or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine/voicemail.**

Please check all boxes that you give Memorial Orthopaedic Surgical Group permission to use for your communications:

☐ You may contact me by telephone.	Phone Number ( ) _____
☐ You may leave a message/voicemail.	Phone Number ( ) _____
☐ You may contact me by mail.	
☐ You may contact me through email (Mychart).	

If you give permission for us to communicate with anyone else, please complete the list below:

Name/Phone Number	Relationship	Options
1.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
2.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

Only upon request, your organization will provide a copy of Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at **2760 Atlantic Avenue, Long Beach, CA 90806** to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are required to agree to my request, and by agreeing to such request, you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

PATIENT NAME _____ DATE _____

SIGNATURE _____ RELATIONSHIP TO PATIENT _____

Financial Interest Consent

I, _____ (patient), acknowledge and accept that my physician may have a financial interest in Hospital, Surgery Centers, Imaging Centers, and Physical Therapy and/or Surgical Devices that he/she chooses to utilize. I hereby recognize my right to choose another Physician or request the services of another facility or device to be used.

Patient Assent

BY MY SIGNATURE, OR BY THAT OF A PARENT OR OTHER RESPONSIBLE PARTY, I HEREBY ACKNOWLEDGE THAT I HAVE:

- ☐ COMPLETED THE "PATIENT INFORMATION" SHEET (PAGES 1 AND 2)
- ☐ COMPLETED THE "PERSONAL AND FAMILY HEALTH HISTORY" (PAGES 3 AND 4)
- ☐ READ THE "NOTICE OF MEDICAL PRIVACY PRACTICES" (PAGES 5 AND 6)
- ☐ READ THE "PATIENT CONSENT FORM" (PAGE 7)
- ☐ READ THE "FINANCIAL INTEREST CONSENT" (PAGE 8)

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

_____ _____

PRINT NAME RELATIONSHIP TO PATIENT

NOTICE OF MEDICAL PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, or health care operations.

- **Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.**

- **Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.**

- **Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.**

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

NOTICE OF MEDICAL PRIVACY PRACTICES

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.**
- **The right to inspect and copy your protected health information.**
- **The right to amend your protected health information.**
- **The right to receive an accounting of disclosures of protected health information.**
- **The right to obtain a paper copy of this notice from us upon request.**

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2014 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provision of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information at: **Memorial Orthopaedic Surgical Group** **2760 Atlantic Avenue** **Long Beach, CA 90806** **Office #: (562) 424-6666 x259**	**For more information about HIPAA or to file a complaint:** **The U.S. Department of Health & Human Services** **Office of Civil Rights** **200 Independence Avenue, S.W.** **Washington, DC 20201** **202.619.0257** **Toll Free: 1.877.696.6775**

MEMORIAL ORTHOPAEDIC SURGICAL GROUP

A MEDICAL CORPORATION

OFFICE FINANCIAL POLICY

Thank you for choosing Memorial Orthopaedic Surgical Group. We are committed to the success of your treatment. We hope you understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by the doctors and physical therapists.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any copay amount due, at the time services are rendered. For patients with dual insurance coverage we will bill both the primary and secondary insurance if you have provided us with the necessary information.

Patients insured with plans which we are NOT contracted with will be required to pay for the first visit in full. For any follow up visits you will need to pay 30% at the time services are rendered. There may be a 30% down-payment prior to any surgery needed.

If you are insured with a plan which we ARE contracted with (including Medicare), you will need to pay for any non-covered services any outstanding deductible and your copay amount, at the time of each visit.

Patients with no insurance coverage are expected to pay for services at the time services are rendered.

Failure to make payment arrangements, or pay outstanding balances within 60 days of notification of amount due, may result in termination of care from Memorial Orthopaedic Surgical Group.

Our accepted methods of payment are cash, Visa, Mastercard, Discover Card & American Express. If requested, a short payment schedule may be arranged for those patients who have special financial conditions.

It is the patient's responsibility to verify their benefits for their particular plan and to make sure all the proper authorizations have been obtained. Some insurance plans will reduce benefits if the insured is treating with doctors outside of the designated network or if the proper authorization have not been obtained.

Again, thank you for trusting us with your care. If you have any questions regarding financial responsibilities or payment options, please contact our insurance department.

" I have read, understand and agree to the provisions of this policy."

_____ _____

(Signature patient/guarantor) (Date)

_____

(Print name)

NAME:_____ **DATE:**_____

Age:_____ Gender: ☐Male ☐Female Hand Dominance: ☐ Right ☐ Left
Who referred you for evaluation? _____
Who is your primary doctor?_____ Address:_____
What is being examined today?_____ Which side? (Right/Left)_____
DATE of accident, or How long have you had illness / problem / symptoms?_____
Please describe your injury: _____
_____

SYMPTOMS:

Where is your pain? How long has it been there?

Location	Duration (wks / yrs)
☐ Head	_____
☐ Neck	_____
☐ Shoulder L / R	_____
☐ Arm L / R	_____
☐ Hand L / R	_____
☐ Mid Back	_____
☐ Low Back	_____
☐ Buttocks L / R	_____
☐ Hip L / R	_____
☐ Leg L / R	_____
☐ Foot L / R	_____

When having pain is it generally…
☐ Mild discomfort
☐ Dull, achy pain
☐ Hard, aching pain, frequently worse
☐ Severe pain, sharp/shooting at times
☐ Burning pain
☐ Very severe, sharp, stabbing
☐ Extremely disabling

How often are you having pain?
☐ Rarely, if ever
☐ Occasional (If so, how often? _____)
☐ Recurrent (few days every month)
☐ Frequent (more than half the time)
☐ Very frequent (nearly every day)
☐ Constantly

How much of your pain is in your neck/back and how much is in your arm/leg? (must total 100%)

_____% neck/back + _____% arm/leg = 100%

Rate your pain at is worst and at its best:
(0 = No pain, 10 = Worst imaginable pain)

0 1 2 3 4 5 6 7 8 9 10 at is worst

0 1 2 3 4 5 6 7 8 9 10 at is best

Have you experienced any of the following:
☐ Numbness / Tingling in arms; (L), (R)
☐ Numbness / Tingling in hands; (L), (R)
☐ Numbness / Tingling in legs; (L), (R)
☐ Numbness / Tingling in feet; (L), (R)
☐ Weakness in legs; (L), (R)
☐ Weakness in arms; (L), (R)
☐ Clumsiness of hands; (L), (R), (both)
☐ Balance problems
☐ Bladder problems: _____
☐ Bowel problems:_____
☐ Pain that wakes you from sleep (night pain)

What makes your pain better?

☐ Lying down	☐ Looking up/down
☐ Sitting	☐ Looking L / R
☐ Standing	☐ Bending Forward
☐ Walking	☐ Bending Backwards
☐ Lifting	☐ Sneeze / Cough
☐ Sleeping	☐ Twisting
☐ Ice	☐ Heat

☐ Other (please describe):_____

What makes your pain worse?

☐ Lying down	☐ Looking up/down
☐ Sitting	☐ Looking L / R
☐ Standing	☐ Bending Forward
☐ Walking	☐ Bending Backwards
☐ Lifting	☐ Sneeze / Cough
☐ Sleeping	☐ Twisting
☐ Ice	☐ Heat

☐ Other (please describe):_____

What time of day is your pain usually worst?

☐ Morning	☐ Same all day
☐ Mid-day	☐ At night
☐ Evening	

Describe the course of your condition as:

☐ Rapidly worse	☐ Rapidly better
☐ Slowly worse	☐ Slowly better
☐ Unchanged	

What treatment have you received?

☐ None
☐ Physical Therapy
☐ Chiropractic
☐ Traction
☐ Acupuncture
☐ Anti-inflammatory med
☐ Muscle relaxants
☐ Narcotic medications
☐ Epidural injections
☐ Other: _____

What studies have been done on your spine?

☐ None
☐ MRI
☐ Myelogram
☐ DEXA Scan
☐ X-rays
☐ CT scan
☐ Bone Scan
☐ EMG

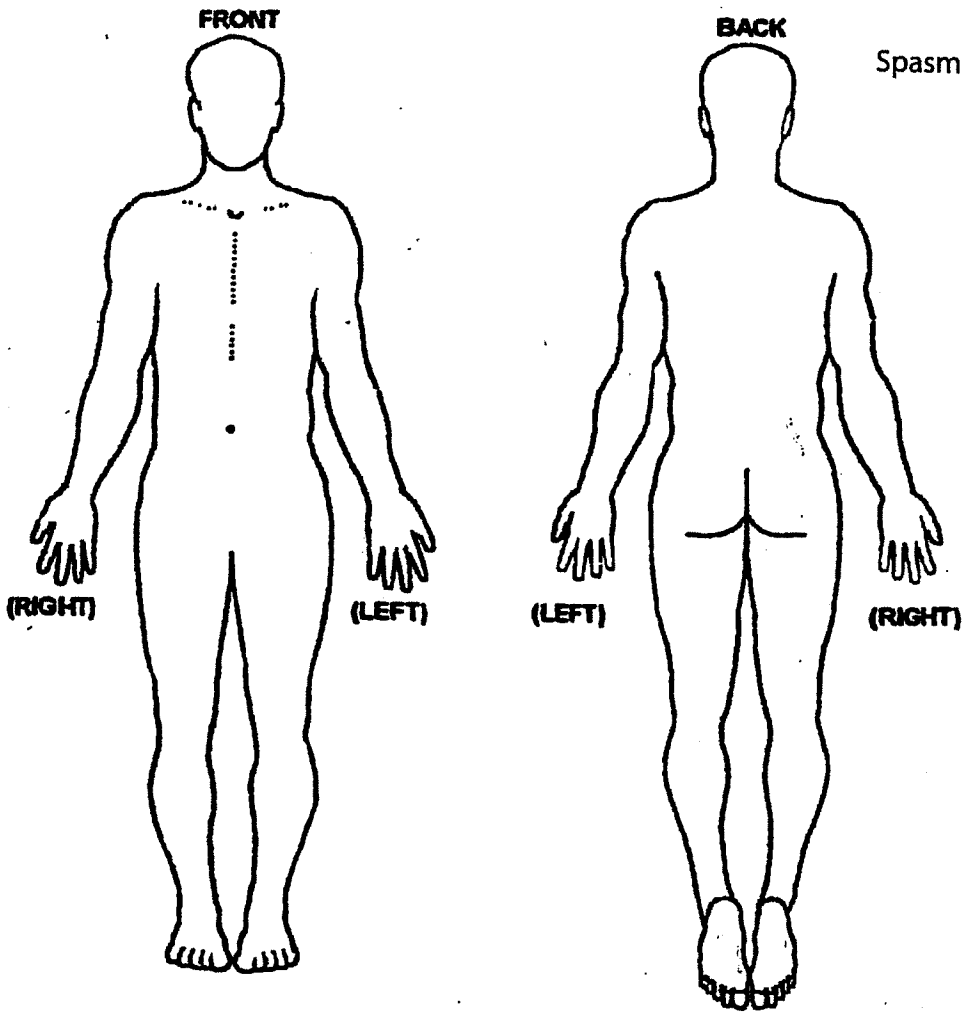
Have you had previous spinal surgery? ☐ No ☐ Yes Did it help you? ☐ No ☐ Yes
If yes, what type of surgery, who was the surgeon and when was it done? _____

_____

PAIN DRAWING:

Indicate where you are having symptoms by using the proper **symbols** and **arrows** to show where the pain goes or shoots. Be sure to show **ALL areas involved** and to indicate where the **PAIN IS WORST.**

Aching / Pain (X X X)
Numbness / Tingling (0 0 0)
Pins / Needle (::::::)
Burning (/////)
Spasm / Cramp (ΔΔΔ)



Please indicate that you have completed this form truthfully and as accurately as possible by signing below:

_____ _____
Signature ***Date***

PAST MEDICAL HISTORY:
Please rate your general health
☐ Excellent ☐ Fair
☐ Good ☐ Poor

What medical problems do you have?
☐ None
☐ Cancer (what type?) _____
☐ Heart Disease
☐ Lung Disease (i.e. pneumonia, asthma, COPD)
☐ Liver Disease (i.e. jaundice, hepatitis)
☐ Diabetes
☐ High Blood pressure (hypertension)
☐ Rheumatic Fever
☐ High cholesterol
☐ Anemia or bleeding problems
☐ Thyroid Disease
☐ Kidney Disease
☐ Urinary tract infections
☐ Other serious Health problems: _____
_____

PAST SURGICAL HISTORY:
Have you had any previous surgery?
☐ None
☐ Tonsillectomy
☐ Appendectomy
☐ Cholecystectomy (Gallbladder)
☐ Heart (bypass)
☐ Thyroid surgery
☐ Hip replacement
☐ Knee replacement
☐ Knee Arthroscopy
☐ Pacemaker
☐ Cancer surgery (describe:)_____
☐ Other (list:)_____

MEDICATIONS: ☐ None
Please list all medications that you take and dose:
_____
_____
_____
_____
_____
_____

ALLERGIES: ☐ None
Please list all drug allergies and reactions:
_____
_____
_____

SOCIAL HISTORY:
What is you occupation? _____

Are you presently employed?
☐ Yes; where and for how long
_____
☐ No; how long since you were
_____

Are you married? ☐ Yes ☐ No

Who do you live with? _____

Do you smoke?
☐ No
☐ Yes; _____ packs per day
_____ years
☐ used to, but quit

Do you drink alcohol (beer, wine, liquor)?
☐ No
☐ Yes; how much/often?
_____

FAMILY HISTORY:

Do any of the following medical problems run in your family? If so, please list family member:
☐ None
☐ Heart disease
☐ Diabetes
☐ Hypertension
☐ High Cholesterol
☐ Thyroid disease
☐ Renal (kidney) disease
☐ Pulmonary (lung) disease
☐ Liver disease
☐ Cancer
☐ Spinal stenosis
☐ Scoliosis
☐ Osteoporosis
☐ Other serious health problems; list:
_____
_____

Females only: Are you pregnant?_____

What is your height? _____

How much do you weigh? _____

Review of Systems:

Please check and describe any signs or symptoms which you are currently experiencing from any of the following organ systems. If none, please write "NONE".
Please list any other problems you may be experiencing that you do not see listed.

Constitutional Symptoms:
☐ Fever ☐ Chills ☐ Night Sweats ☐ Weight Loss ☐ Fatigue ☐ Appetite loss

Eyes:
☐ Corrective lenses ☐ Cataracts ☐ Blurry Vision ☐ Double Vision

Ears, Nose, Mouth, Throat:
☐ Hearing loss ☐ Sinus Congestion ☐ Hoarse voice ☐ Painful/Difficulty swallowing

Cardiovascular (Heart, circulation):
☐ Chest pain ☐ Cool extremities (poor circulation) ☐ Cold sensitivity

Respiratory (Lungs):
☐ Shortness of breath ☐ Painful breathing ☐ Wheezing ☐ Cancer

Genitourinary (i.e. urinary tract infection, prostate):
☐ Urinary frequency ☐ Urinary incontinence ☐ Painful urination
☐ Sexual dysfunction ☐ Enlarged prostate ☐ Cancer

Gastrointestinal:
☐ Reflux ☐ Ulcers ☐ Cancer
☐ Diarrhea ☐ Constipation ☐ Bloody stool
☐ Nausea ☐ Vomiting

Musculoskeletal:
☐ Joint pain, where?_____
☐ Joint swelling
☐ Joint stiffness ☐ Fibromyalgia

Skin/Breast:
☐ Cancer, where?_____ what type?_____
☐ Lumps or masses, where? _____
☐ Rashes

Psychiatric:
☐ Depression ☐ Manic
☐ Eating Disorder

Neurological:
☐ Stroke ☐ Trouble speaking ☐ Peripheral nerve disorder, list?_____
☐ Balance problems ☐ Seizures ☐ Tremor ☐ Reflex Sympathetic Dystrophy

Endocrine:
☐ Diabetes ☐ Hypoglycemia ☐ Thyroid
☐ Parathyroid ☐ Adrenal ☐ Osteoporosis

Hematologic/Lymphatic:
☐ Anemia ☐ Clotting disorder
☐ Platelet disorder ☐ Sickle Cell
☐ Lymphedema
☐ Swollen lymph nodes, where?_____
☐ Tender lymph nodes, where?_____

Immunologic:
☐ Rheumatoid ☐ Lupus

_____
Doctor's Signature (documenting review of above)

Financial Interest Consent

I, _____ (print name), acknowledge and accept that my physician may have a financial interest in hospitals, surgery centers, imaging centers, physical therapy and/or surgical devices that he/she chooses to utilize. I hereby recognize my right to choose another physician or request the services of another facility or device be used.

_____ _____

Signature Date