ORTHOPAEDIC PATIENT HISTORY

PATIENT'S NAME: _____

AGE:___ _____SEX:_ _____OCCUPATION:_____

HEIGHT:_____ WEIGHT:_____

WHY ARE YOU HERE TODAY?_____

HOW DID THE INJURY HAPPEN?_____

_____

DATE OF INJURY OR ONSET OF CONDITION:_____

IS THIS RELATED TO WORK?_____

HAVE YOU BEEN OFF WORK DUE TO THIS INJURY?_____YES _____NO

IF SO, WHAT DAYS HAVE YOU MISSED?_____

ARE YOU CURRENTLY BACK TO WORK?_____YES _____NO

LENGTH OF TIME WITH CURRENT EMPLOYER:_____

HAVE X-RAYS BEEN TAKEN RECENTLY?_____YES _____NO

WHERE?_____

HAVE YOU EVER HAD ANY PREVIOUS OR SIMILAR INJURIES TO ANY BONES OR JOINTS?

_____

_____

IF YOU ANSWER "YES" OR "?" TO ANY OF THE NEXT SIX QUESTIONS, PLEASE EXPLAIN ON THE BACK OF THIS FORM: HAVE YOU EVER HAD:

	YES	NO
1. HEART DISEASE	_____	_____
2. LUNG DISEASE	_____	_____
3. STOMACH/BOWEL DISEASE	_____	_____
4. CIRCULATION PROBLEMS	_____	_____
5. DIABETES	_____	_____
6. HYPERTENSION	_____	_____

PREVIOUS WORK RELATED INJURIES:_____

TIME LOST FROM WORK DUE TO THIS:_____

PAST SURGERIES: (BE SPECIFIC)_____

_____

CURRENT MEDICATION: (DOSAGE & FREQUENCY)_____

_____

ALLERGIES OR SENSITIVITIES TO MEDICATIONS:_____

_____

DO YOU SMOKE?_____YES _____NO HOW MUCH?_____

ALCOHOLIC BEVERAGE USE?_____YES _____NO HOW MUCH?_____

GYNECOLOGICAL: FREQUENCY OF PERIODS_____

DATE OF LAST MENSTRUAL PERIOD_____

_____ _____

SIGNATURE OF PATIENT DATE SIGNED

JOHN G. ELLIS, M.D. ORTHOPAEDICS & SPORTS MEDICINE Michael H. French, D.O

Matthew D.Robinson, D.O Steven T. Kelley, M.D.

40949 Winchester Road
Temecula, California 92591
Phone: (951) 296-6676
Fax: (951) 296-6675

REGISTRATION INFORMATION

(please print)

Patient Name_____
Last Name First Middle Initial

Address_____
Street City State Zip Code

Home Phone ( )_____ Cell( )_____ Wk ( )_____

Birthdate_____ Age_____ Sex: Male____ Female_____

Patient's Social Security Number: ____ ___ _____ Dr. Lic. #_____ State____

Email address: _____

Marital Status Married___ Single___ Widowed___ Divorced___ Separated_____

Employer_____ Phone_____

Employer Address_____

Occupation_____

Responsible Party Name (IF NOT PATIENT)_____

Social Security Number _____ Date of Birth:_____

Address if different from above:_____

Phone number (_ _)_____ Cell ( )_____

Employer_____ Phone_____

Name of **spouse** (If married)_____

Date of Birth:_____ Social security #_____

Employer:_____ Phone_____

PrimaryInsurance _____ Phone_____

Address_____

Group_____ ID_____

Subscriber_____ Employer:_____

Secondary Insurance_____Phone_____

Address_____

Group_____ID_____

Subscriber_____Employer_____

Date of injury or onset of problem_____

Was injury the result of an automobile accident? Yes_____ No_____

Injured while at work? Yes _____ No_____ Not Sure _____

Referred by_____

Primary Care/Family Physician_____

Address_____Phone_____

In case of emergency, notify_____

Address_____ Phone_____

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF INSURANCE BENEFITS:

The undersigned hereby authorizes treatment by providers at this facility. I also authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes the physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I,_____hereby authorize
(Name of insured)

my insurance company of record to pay and assign directly to the treating physician at this facility all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to the provider will be credited to my account, in accordance with the above said assignment.

Signed_____Date_____

ORTHOPAEDIC SURGERY AND SPORTS MEDICINE

40949 Winchester Road, Temecula, CA 92591

Phone: (951) 296-6676 • FAX: (951) 296-6675

X-Ray Patient Consent Form

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examinations which may be considered necessary or advisable in the course of my evaluation and treatment in this office.

Signed _____ Date _____

If Patient is a Minor

I am the parent or legal representative of _____ who is a minor. I authorize the performance of diagnostic x-ray of this minor as deemed necessary for evaluation or treatment.

Signed _____ Date _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed _____ Date _____

Authorization to Release Medical Records

Medical records from this office will not be released to any individual or facility without your written authorization. Please note below all authorized recipients, including other physicians and medical offices:

_____

Name/Facility Name

_____

Address

_____

_____

_____

Name/Facility Name

_____

Address

_____

_____

_____

Name/ Facility Name

_____

Address

_____

_____

_____ Date: _____

Patient Signature (parent/guardian signature if patient is a minor)

OFFICE POLICIES

PLEASE INITIAL THAT YOU HAVE READ AND UNDERSTAND EACH STATEMENT BELOW.

___ **YOUR COPAY IS DUE AT THE TIME OF SERVICE. Charges not covered under your insurance are your responsibility.**

___ **If you have a deductible that has not yet been met we will collect 50% of your owed charges on the day of service and bill you for the balance after your claim has been processed by your insurance.**

___ **It is your responsibility to notify the receptionist of any changes to your insurance coverage, employer, address, phone numbers or other information that may affect your visit to this office.**

___ **If your insurance coverage requires a referral or authorization, you must have this with you at the time of your appointment.**

___ **This office accepts CASH, VISA, and MASTERCARD. We do not accept checks.**

___ **X-Rays should be returned to you after the doctor has viewed the film or CD. All x-rays left at this office will be destroyed if left here for more than 30 days.**

___ **Due to the nature of Orthopedics, our doctors may be called to surgery or have emergency patients that need additional time. The doctor may be unable to see you at your scheduled appointment time.**
. If so, we appreciate your understanding and patience. We value the importance of your time as well, and in the event that your doctor is delayed, we will reschedule your appointment if you are unable to wait.

___ **If you are unable to keep your scheduled appointment, please contact our office 24 hours in advance to cancel or reschedule.**

___ **I understand that telemedicine is the use of electronic information and videoconferencing technology by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Orthopaedic Surgery and Sports Medicine providers providing health care services to me via telemedicine.**

I authorize Orthopaedic Surgery and Sports Medicine Associates employees and physicians to take photographs, videos, create electronic files, or other types of media productions that capture my name, voice and/or image to be used by Orthopaedic Surgery and Sports Medicine Associates for the purpose of websites and social media.

YES___ NO___

PLEASE INITIAL THAT YOU HAVE BEEN INFORMED OF THE OFFICE POLICIES BELOW.

___ As mandated by law, we provide our patients access to their electronic medical records through the office portal software - Prime clinical systems. While this platform is HIPAA compliant, our office is not liable for any breach of confidentiality.

___ Due to cost increases, you will be charged as follows for completion of forms:

INITIAL DISABILITY FORM (Continuing forms on the same claim will be $10 each)	$ 25.00
ON- LINE EDD EXTENSION	$10.00
PAPER EDD EXTENSION	$25.00
PRIVATE DISABILITY FORM (Aflac, FMLA, etc. – each form)	$25.00
COPY RECORDS:	
1 – 10 PAGES	$ 10.00
11 – 25 PAGES	$ 15.00
26 PLUS PAGES	$ 25.00
COPY X-RAYS (per disc)	$ 25.00

___ Please allow a minimum of FIVE BUSINESS DAYS for completion and the doctor's signature on disability forms, copying records and copying x-ray films.

___ PRESCRIPTION REFILLS:

PLEASE CALL YOUR PHARMACY AT LEAST 48 HOURS IN ADVANCE FOR REFILLS; REQUESTS CALLED IN ON A FRIDAY WILL NOT BE REFILLED BEFORE THE WEEKEND.

Prescriptions that must be refilled through this office also need a minimum of 48 hours advance notice.

Signed_____Dated____/_____/____

Print Name_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name:_____

Date of Birth: _____Social Security #:_____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we will try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

[ ] I have received the Notice of Privacy Practices (effective date _____).

_____ _____

Patient's (or Legal Representative's) Signature) Date

_____

Relationship of Legal Representative

For office use only

To be completed only if Acknowledgement is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?
[ ] Yes [ ] No

2) Please explain why the patient was unable to sign this Acknowledgement and our efforts to try to obtain the patient's signature:

_____
_____
_____
_____
_____
_____

_____ _____

Name/Title Date

Orthopaedic Surgery and Sports Medicine
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for one medical condition and need to contact another of your doctors to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or attorney for audit purposes.

In addition, unless you object, we may use your health information to send you appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder to help you remember the appointment. Or, we

may look at your medical information and decide that another treatment or a new service we offer may interest you.

Furthermore, we may want to use information found in your medical record, such as your name, address, and phone number, to contact you for our fundraising purposes. For example, in order to provide more charity care or otherwise improve the health of your community, we may want to raise additional money and therefore may contact you for a donation. You have the right to opt out of these communications at any time.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents

- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about you to those people We may also share medical information with these people to notify them about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice (such as for marketing purposes) or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Privacy Officer. Specifically, you have the following rights:

- You have the right to ask that we limit how we use or disclose your medical information. For example, for services you request no insurance claim be filed and for which you pay privately,

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you have the right to restrict disclosures for these services for which you paid out of pocket. You have the right to ask that we send you information at an alternative address or by an alternative means. We will consider your request, but are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so. To request confidential communications, you must make your request in writing to Orthopaedic Surgery and Sports Medicine, Attn: Office Administrator. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

- With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.
- In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

- You have a right to receive a paper copy of this Notice and/or an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request.

IV. Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights' Region IV office. We will provide the mailing address at your request.

We will take no retaliatory action against you if you make any complaints, whether to us or to the Department of Health and Human Services. We support your right to the privacy of your health information.

If you have questions about this Notice or any complaints about our privacy practices, please contact our Privacy Officer, either by phone or in writing at:

Jennifer Nelson
40949 Winchester Rd. Temecula, CA. 92591
951-296-6676

V. Effective Date: This Notice was effective on **04-01-2014**