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ORTHOPAEDIC SURGERY
and SPORTS MEDICINE

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. Lie. #_____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: _____

Primary insurance: _____ Phone: _____

Address: _____

Group: _____ ID: _____

Subscriber: _____Employer: _____

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Secondary insurance: _____Phone: _____

Address: _____

Group: _____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.

Patient Signature: _____ Date: _____

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Name: _____ Date: _____ Chart #: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Race: _____

PROBLEM (Chief Complaint): _____

Who Referred you to our office? _____

Primary Doctor: _____ City: _____ State: _____

Past Medical History:
List all surgeries and hospitalizations including dates

1	5
2	6
3	7
4	8
Do you smoke? Yes No	Do you drink alcohol? Yes No
# Of years smoked? If quit, when?	Amount per day? Amount per week?

Allergies (list below) ☐ No known allergies

1	3
2	4

Have you ever had the following: Circle or check if yes

Aids	Emphysema	Heart Failure	Seizures
Asthma	Epilepsy	Hepatitis	Stroke
Cancer	Diabetes Mellitus	HIV	Tuberculosis
coronary artery disease	Heart Attack	Hypertension	Peptic Ulcers

CURRENT MEDICATIONS:
Lis all current prescriptions medications

Medication	Dosage	Taken how often	Medication	Dosage	Taken how often

List all current over the counter medications, herbals, vitamin, mineral dietary (nutritional supplements)

Medication	Dosage	Taken how often	Medication	Dosage	Taken how often

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CONSTITUTIONAL SYMPTOMS
___ Good general health lately
___ Recent weight change
___ Fever
___ Fatigue
___ Headaches
___ Chills

EYES
___ Eye disease or injury
___ Wear glasses/ contact lenses
___ Blurred or double vision
___ Glaucoma
___ Temporary blindness

RESPIRATORY
___ Chronic or frequent coughs
___ Spitting up blood
___ Shortness of breath
___ Asthma or wheezing

PSYCHIATRIC
___ Memory loss or confusion
___ Nervousness
___ Depression
___ Insomnia

ENDOCRINE
___ Glandular or hormone problem
___ Thyroid Disease
___ Diabetes
___ Excessive thirst or urination
___ Heat or cold intolerance
___ Skin becoming dryer
___ Change in hat or glove size

CARDIOVASCULAR
___ Heart trouble
___Chest pain or angina pectoris
___ Palpitation
___ Shortness of breath with walking, or lying flat
___ Swelling of feet, ankles, or hands

GASTROINTESTINAL
___Loss of appetite
___ Change in bowel movements
___ Nausea or Vomiting
___ Frequent diarrhea
___ Painful bowel movements or constipation
___ Rectal bleeding or blood in stool
___ Abdominal pain or heartburn
___ Peptic ulcer (stomach or duodenal)

INTEGUMENTARY (SKIN/BREAST)
___ Rash or itching
___ Change in skin color
___ Change in hair or nails
___ Varicose veins
___ Breast pain
___ Breast lump
___ Breast discharge

NEUROLOGICAL
___ Frequent or recurring headaches
___ Light headed or dizzy
___ Convulsions or seizures
___ Tremors
___ Paralysis
___ Stroke
___ Head Injury

HEMATOLOGICAL/ LYMPHATIC
___ Slow to heal after cuts
___ Bleeding or bruising tendency
___ Anemia
___ Phlebitis
___ Past transfusion
___ Enlarged glands
___ Sickle cell anemia
___ Free bleeding

MUSCULOSKELETAL
___ Joint pain
___ Joint stiffness or swelling
___ Weakness of muscles or joints
___ Muscle pain or cramps
___ Back pain
___ Cold extremities
___ Difficulty in walking

EAR/NOSE/MOUTH/THROAT
___ Hearing loss or ringing in ears
___ Chronic sinus problem or rhinitis
___ Nose bleeds
___ Mouth sores
___ Bleeding gums
___ Bad breath or bad taste
___ Sore throat or voice change
___ Swollen glands in neck

GENITOURINARY
___ Frequent urination
___ Burning or painful urination
___ Blood in Urine
___ Change in force of stream when urinating
___ Incontinence or dribbling
___ Male-testicle pain
___ Female-pain with periods
___ Female- irregular periods
Female- # of pregnancies _____
Female- # of miscarriages _____
Female- Date of last pap smear _____

Patient Signature: _____ Date: _____

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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 25% 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____

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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	$25.00	
(Continuing forms on the same claim will be $10 each)		
ONLINE EDD EXTENSION	$10.00	
PAPER EDD EXTENSION		$25.00
PRIVATE EDD EXTENSION	$25.00	
(Aflac, FMLA, etc.-each form)		

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 REFIUED BEFORE THE WEEKEND.

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

Signature: _____ Date: _____

Print Name: _____

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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.

Signature: _____ 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.

Signature: _____ 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.

Signature: _____ Date: _____

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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

_____

_____

_____

Signature: _____ Date: _____
(parent/guardian signature if patient is a minor)

ORTHOPAEDIC SURGERY and SPORTS MEDICINE

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.*

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 fund-raising 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.

Ill. 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, 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

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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.

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

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

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Health Information Exchange Consent

This practice participates in an electronic Health Information Exchange (HIE) with other health care providers and local hospitals. With your permission, our participation in the HIE provides the electronic method for us to disclose our confidential health information about you to other participants who are treating you and request your information. Your participation in the HIE is voluntary and your receipt of treatment or payment for treatment will not be conditioned on whether or not you sign this form.

The purpose of this consent is to obtain your permission for sharing a limited summary of your health record. The limited summary of your health record will include (as applicable) the following components:

- Your name
- Demographic information (preferred language, sex, race, ethnicity, and date of birth)
- Guarantor details
- Insurance Details
- Provider's name and office contact information
- Date and location of your visit
- Diagnoses
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, and BMI)
- Smoking status
- Functional, cognitive, and disability status
- Care plan goals and instructions
- Reason for referral
- Current problem list
- Current medication list
- Current medication allergy list
- Chief complaint/reason for visit
- Future appointments
- Encounters
- Procedures
- Care team members

The health information that will be shared through the HIE will include information from both before and after today's date.

Health care providers who receive health information about you through the HIE may copy or include that information into their own medical records when caring for you. If you cancel this consent, such cancellation will have on effect on the health information already accessed and copied.

Your health information is private and confidential and is protected by state and federal law. These laws are commonly referred to as HIPAA and 42 CFR Part 2. All HIE Participants have signed agreements promising to protect your information as required by these laws.

You have a right to ask for a copy of this form after you sign it.

I DO NOT give my permission to allow my healthcare provider to share my health information with other providers and the local hospitals

I give my permission to allow my healthcare provider to share my health information with other providers and the local hospitals

Patient Signature: _____ Date: _____

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Patient Account: _____

Online Patient Portal Registration Instructions

www.osasm.com

This will provide you step by step instructions on how to access the online portal for the first time. The online portal can be used to access our new patient paperwork, access your medical records, request appointments, and edit your contact or insurance information.

You will soon receive an email inviting you to join our patient portal. There will be a link in the email for you to click on. That link will take you to the login page.

Click "Create New Account".
Select user type- "as patient", click "continue".
Enter the email address you provided our office, and then enter your patient account# as listed above. - Complete the basic information asked. Click "Continue".
Create password and accept "Terms and Conditions", click "submit".

Congratulations, you are now a member of our online patient portal! Please remember to bookmark the website listed above for easy access. You will only need your email address and password for all future logins. If you have any questions, please do not hesitate to call the office and speak to one of our staff.

Sincerely,

Orthopaedic Surgery and Sports Medicine staff