CALIFORNIA
ORTHOPEDICS & SPINE

Medical History Form
Orthopedics

Patient Name:______________________________ Appointment Date:________________ with Dr. ____________________________

DOB:_______________ Sex: ☐ F ☐ M Height:________ Weight:_________ Dominant hand: ☐ R ☐ L

Have you ever been treated by this Physician? ☐ Y ☐ N

Referring doctor name:

How did you hear about us? (ie. doctor referral, friend, etc.) If social media, please specify site: ______________________________

Please explain the reason for your visit:

How long has this body part been a problem? Days_____ Weeks_____ Months______ Years______

In this section, check the **ONE BOX** which best describes how your problem started. Then answer the question below the box you Checked. Use as much space to the right as needed.

☐ NO INJURY (or onset was: ☐ Gradual or ☐ Sudden
Please indicate why you think it started?

☐ INJURY ☐ Accident ☐ Sport (NOT Auto or Work)
Date: __________Please specify where and how it happened.
What Sport?_______________ School?________________

☐ INJURY AT WORK
Date:__________

☐ WORK RELATED (BUT NO INJURY)
Date: __________ How did your job cause the problem?

☐ AUTO ACCIDENT Date: ____________
If so, is there a legal case pending? ☐ Y ☐ N

On a scale of 0 – 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes and goes (intermittent)

Does your pain wake you from your sleep? ☐ Y ☐ N

Do you have: ☐ Swelling ☐ Bruises ☐ Numbness ☐ Tingling ☐ Weakness ☐ Locking/Catching ☐ Buckling/Giving Way

Since my problem started, it is: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

What makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed
☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Coughing ☐ Sneezing

Which makes your symptoms better: ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other:__________________

Have you had any of these treatments? Injection: ☐ Y ☐ N Brace: ☐ Y ☐ N Physical Therapy: ☐ Y ☐ N Cane/Crutch: ☐ Y ☐ N

What tests/scans have you had for this problem:

☐ X-Rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV) Where?______________________

Please list any surgical procedures you have had on this body part?

Procedure #1______________________ Surgeon_____________________ City___________________ Date__________

Procedure #2______________________ Surgeon_____________________ City___________________ Date__________

Please complete reverse side of this form

General Medical and Social History

Have you ever had problems with general anesthesia? ☐ Yes ☐ No

Present **Medications** taken regularly: ______________________________

____

Allergies to Medications: ______________________________

Prior and current illnesses and injuries: ______________________________

____

List all surgeries and hospitalizations: ______________________________

____

____

Alcohol: Don't Drink:____________ Quantity Socially:__________ Quantity Daily:__________

Tobacco: Don't Smoke:___________ Smoker:________ # of Years:______ # of Packs:______

Are you currently having or have you ever had a problem with the following:

	Yes	No	Describe all "Yes" responses
Heart Disease	☐	☐	______________
High Blood Pressure	☐	☐	______________
Lung/Breathing Problem	☐	☐	______________
Cancer	☐	☐	______________
Diabetes	☐	☐	______________
Ulcer or Stomach Problem	☐	☐	______________
GI Bleed	☐	☐	______________
Kidney Problem	☐	☐	______________
Hepatitis	☐	☐	______________
Anemia or other Blood Disorder	☐	☐	______________
Epilepsy or Seizures	☐	☐	______________
Anxiety/Depression	☐	☐	______________
Arthritis/Rheumatoid Arthritis	☐	☐	______________
Thyroid Problem	☐	☐	______________
Other Medical Condition	☐	☐	______________
Blood Clots/DVT/PE	☐	☐	______________

Family History

Does your immediate family have a history of any of the following medical conditions?

	Yes	**No**	**Relationship**
Heart Disease	☐	☐	______________
High Blood Pressure	☐	☐	______________
Stroke	☐	☐	______________
Diabetes	☐	☐	______________
Cancer	☐	☐	______________

I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

______________________________ ______________________________

Patient Signature (Date) Physician Signature (Date)

Do not write in this box/For official use only/Chief Complaint

CALIFORNIA
ORTHOPEDICS & SPINE

Patient Demographic

Patient Information

Name:______ Date Today:______ Date of Injury:______
Address:______ Date of Birth:______ Age:______
City:______ State:______ Zip:______ Home Phone #______
Email:______ Cell Phone #______
Social Security:______ Pharmacy & City Location:______
❑ Male ❑ Female Marital Status:______ Occupation:______
Employer:______ City:______ Zip:______
Employer Address:______ Work Phone #______
Spouse/Parent Name:______
In Case of Emergency Notify:______ Emergency Contact Phone #______

Primary Care Physician (PCP):______ Injured Body Part:______
Sports/Hobbies/Activities:______
Special Needs:______

IT IS A FEDERAL REQUIREMENT THAT CALIFORNIA ORTHOPEDICS & SPINE REPORTS THE FOLLOWING:

*Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to State

*Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Decline to State

*Preferred Language: ______

* This information will be held confidential and only a limited number of people will have access to the data

Insurance Information

How are you planning on paying for your visit today with the doctor (check ***ONE*** only)

Medical Insurance: ______ Workman Compensation Insurance/Claim: ______
Privately Paying/Cash: ______ Motor Vehicle Insurance/Claim: ______

Subscriber or Policy Holder:______ Subscriber Birth date:______
Name as it appears on insurance card:______
Relationship to subscriber/insured:______ Subscriber Social Security #______
Insurance Carrier:______ Phone #______
Claim Address:______ City:______ State:______ Zip:______
Insurance I.D.#______ Group/Plan #______
Secondary Insurance:______

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to my physician (California Orthopedics & Spine). I understand I am financially responsible for non-covered services and also authorize my physician to release any information required.

______ ______
Patient Signature Date

California Orthopedics & Spine
18 Bon Air Road, Larkspur, CA 94939
(415) 927-5300

HIPAA Notice of Privacy Practices

Effective as of April/14/2003
Revised March/26/2013

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

HIPAA

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

HIPAA COMPLIANCE OFFICER Phone email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

CALIFORNIA
ORTHOPEDICS & SPINE

Acknowledgement of our Notice of Privacy Practices and Consent to Obtain Prescription History

I agree that California Orthopedics and Spine may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of California Orthopedics & Spine Notice of Privacy Practices. (A laminated copy is available at the front desk. Additionally, I may request a hard copy at any time.) By signing below, I am giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices. I am also authorizing you to release and or discuss my Health Care Information with the following persons:

Patient Name ______________________ Date ______________

Signature ______________________

Authorized persons:

Name ______________________ Relationship ______________

Name ______________________ Relationship ______________

CALIFORNIA ORTHOPEDICS & SPINE

Patient Information and Treatment Contract

At California Orthopedics & Spine, we strive to provide the most up-to-date treatment options that will benefit you. The following document helps prevent confusion about your responsibilities in treating your medical condition. Please read the following information carefully.

FINANCIAL RESPONSIBILITY

You are responsible for all costs of your treatment. Your insurance may or may not cover all of the costs associated with the plan of care pursued by you and your physician. All copays are due at the time of service. As a courtesy to you, we will bill and collect the amount allowed by your insurance contract for your treatment. We are not responsible for insurer's inadequate payment, unreasonable payment delays, or claim denials. We do our best to make sure planned treatments are preauthorized for payments, but we advise that you verify your insurance benefits before undergoing treatments, procedures, or surgical intervention. Please be aware that certain services are not typically covered under the scope of a routine office visit by your insurance and, as such, are billed as follows:

Forms and Letters	$25.00 per page
Pharmacy Medication Authorizations/Appeals	$50.00 per medication
Office Visit/Imaging No-Show	$150.00
Procedure/Surgery No-show	$250.00
Return Check Fee	$25.00

LATE ARRIVAL POLICY

Please be aware that if you are late to your appointment, you may be asked to reschedule your visit, or you may have to wait until we can fit you in after on-time arrivals have been seen.

PHONE CALL POLICY

Our office receives a tremendous number of phone calls each day. In order to devote the appropriate care and attention to each patient in the office, our physicians and/or office staff typically return phone calls during the lunch hour or after regular business hours. The Medical Board of California discourages physicians from providing treatment information over the phone; therefore, if you are experiencing a new problem, please reschedule a return visit to discuss the issue in person. If you are having a life-threatening emergency, please dial 9-1-1. In general, we are not available to discuss issues over the phone with multiple family members. If you believe you will have difficulty remembering the treatment recommendations discussed during your office visit, please bring a family member to the visit to assist with note taking for your recollection.

INSURANCE RELEASE POLICY

Please note that for MRIs, you will receive two bills: one from California Orthopedics & Spine (for the “technical” portion; the MRI itself) and one from California Advanced Imaging Medical Associates (for the “professional” portion; the radiologist’s interpretation of the MRI images). I hereby authorize the release of any medical information necessary to process an insurance claim. I request payment for the technical services performed by the provider to be made to California Orthopedics & Spine. I understand that I will be responsible for all non-covered services, including out of network charges, and any denial not covered by my medical insurance program.

MEDICATION REFILL POLICY

You are responsible for keeping track of your own medications. No prescription refills for lost medications will be issued. No routine-controlled substance prescription refills will be authorized after hours or on the weekends. Please allow 72 hours’ notice for routine medication refill requests. Refill requests are most easily made by calling your pharmacy or sending a request through the Patient Portal located on our website. By signing below, you are giving California Orthopedics & Spine providers authorization to communicate verbally, electronically, or in writing to your pharmacy or other providers regarding your current medications.

PAIN MEDICATION POLICY

In addition to the above Medication Refill Policy, these further guidelines apply to controlled substances: all controlled substance prescriptions must be picked up in person with a photo ID. All prescriptions for controlled substances must be filled by one medical office at one pharmacy. Evidence of obtaining a controlled substance by more than one medical office or using multiple pharmacies without prior disclosure is grounds for discontinuation of controlled substance refills. By accepting a prescription for a controlled substance, you are agreeing to random urine drug screens and any possible associated costs of these screens so that we may confirm appropriate use of the prescribed medication(s). The presence of unauthorized substances or the absence of your prescribed medications in a urine drug screen are grounds for discontinuation of medication refills. By accepting a controlled substance prescription from our offices, you grant our physicians and staff, permission to discuss aspects of your care and medications with all involved physicians, hospitals, and pharmacies as medically necessary.

By signing this document, I acknowledge that I have read, understand, and accept the policies noted above.

Print Name: ____ Date: _______________

Patient Signature: _____________________________________