CALIFORNIA ORTHOPEDICS & SPINE

Spine Center New Patient Form

Last Name	First Name	Middle Name
DOB: _____	✓ Hand Dominance ❑Right ❑Left	✓ Gender ❑Male ❑Female

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

Carefully read the following definitions	*Definitions*	
	Pain Levels	The level of pain you have had <u>on average</u> since your problem began
	Neck Pain	"Neck" includes middle of neck, upper shoulders, between shoulder blades
	Arm Pain	"Arm" includes shoulder, arm, or hand
	Back Pain	"Back" includes pain <u>above</u> the belt line across the lower back
	Leg Pain	"Leg" includes areas <u>below</u> the belt line including the buttock, legs, or feet

<u>Describe your condition:</u> In your own words, note the following: 1) What happened to you?; 2) What you feel?; 3) What caused it?; 4) How it changed over time?

_____
_____
_____
_____
_____
_____
_____
_____
_____

What was the approximate date your problem started?	

✓ **Have you had any of these diagnostic studies**	No	Yes	Date
Xrays of injured area			
MRI (magnetic resonance imaging)			
CT (computed tomography) scan			
Myelogram (x-ray with dye injection)			
Electromyogram (EMG)			
Discogram			
Arthrogram of sonogram			

Did your problem begin with a car accident?		No		Yes
If yes:	Were you the driver? ❑No ❑Yes	Were you wearing a seatbelt? ❑No ❑Yes	Did you pass out? ❑No ❑Yes	

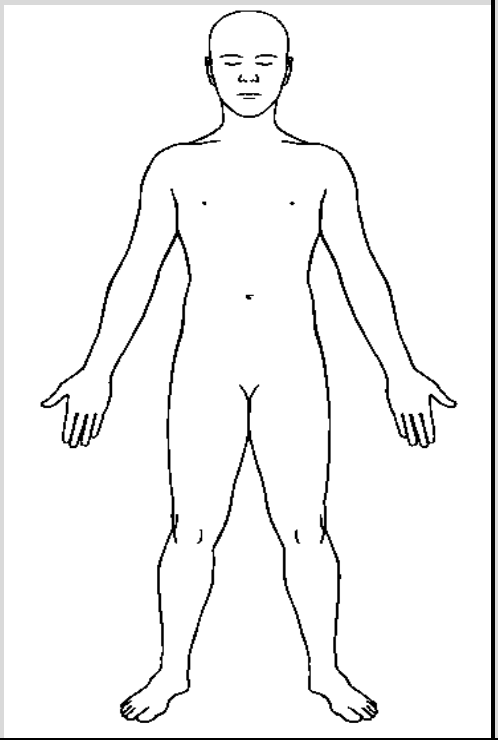
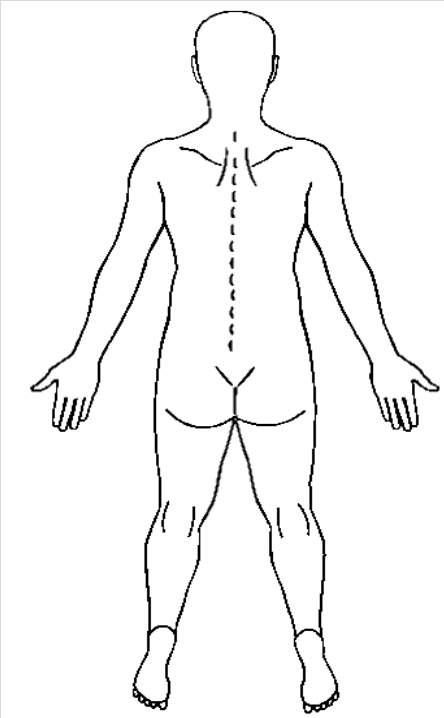
✓ To be sure all paperwork is filled out correctly, please check appropriate	Yes		Yes
On Workman's Compensation		Report should be sent to Referring Physician or Family Physician	
Receiving Disability Income		Report should be sent to another party: Name and Address:_____	
Legal Proceeding Pending		_____	

For a total of 100%, what % is back pain and what % is leg?	% Low Back Pain		% Leg Pain	
(i.e. 30% low back pain with 70% leg pain)		+		=100%

For a total of 100%, what % is neck pain and what % is arm?	% Neck Pain		% Arm Pain	
(i.e. 20% neck pain with 80% arm pain)		+		=100%

✓ **Your <u>average</u> level of pain**	0	1	2	3	4	5	6	7	8	9	10
	←Less Pain							Worse Pain →			
Neck Pain											
Right Arm Pain											
Left Arm Pain											
Low Back Pain											
Right Leg Pain											
Left Leg Pain											
✓ **Your level of pain right now**											

✓ **Describe the quality and severity of your pain?**					
	Throbbing		Gnawing		Splitting
	Shooting		Hot-Burning		Tiring/Exhausting
	Stabbing		Aching		Sickening
	Sharp		Heavy		Fearful
	Cramping		Tender		Punishing-Cruel

Using the symbols, mark the location and type of pain on the diagrams If you have pain into the lower leg, feet, or hands, make sure you note it	RIGHT LEFT FRONT 	LEFT RIGHT BACK 
<u>Type of Sensation:</u> Stabbing/Burning: ^ Aching: X Pins and Needles: – Numbness: O		

✓ **Do you have:**	No	Yes	Explain where
Numbness in the arms/hands or legs/feet?			
Weakness in the arms/hands or legs/feet?			

✓	Morning	Afternoon	Evening	Night	Lying flat	Sitting	Standing	Walking	Bending Back	Coughing/ Sneezing
Pain worse with										
Pain better with										

List the daily activities, sports, or hobbies you are having difficulty performing due to your pain

_____

_____

✓ **Do you have:**	No	Yes
Loss of bowel control? (difficulty controlling/initiating bowel movements or incontinence)		
Loss of bladder control? (difficulty controlling/initiating urination or incontinence)		
Night pain for which you change position or get out of bed?		
Balance problems from leg weakness?		
Balance problems not from weakness but from lack of coordination?		
Problems handling small objects such as coins or problems buttoning your shirts?		

✓**Treatment history**	No	Yes	Details (If Yes)	✓ Made my pain:		
				Better	No Change	Worse
Acetaminophen (Tylenol)			Medication:			
Non Steroidal Anti-inflammatory Drugs (NSAIDS) or COX-inhibitors (e.g. Advil)			Medication:			
Opiods (ie Vicodin, Percocet, Morphine)			Medication:			
Neuropathic pain meds (Gabapentin, Lyrica)			Medication:			
Interventional pain procedures (Epidurals, nerve or joint injections, implants)			How many: Date of last injection:			
Physical Therapy			How long:			
Acupuncture			Name:			
Chiropractor			Name:			
Physiatrist or Pain Specialist			Name:			
Pain Psychologist			Name:			
Other Pain Physician			Name:			

Medical history (ie: High blood pressure, asthma, high cholesterol, heart problems, diabetes, etc)	❑ I have no medical problems	

✓Do you have history of cancer?	No	Yes	Details (If Yes)
			Type: Prior treatment:

Surgical history (i.e.:Tonsillectomy, hip replacement, heart surgery, etc)	❑ I have not had surgery in the past
Date of Surgery	Surgery (Specify Right or Left side if relevant)

Mental Health History		❑ I have not seen a mental health expert in the past		
	No	Yes	Name	Practice Location
Psychiatrist				
Psychologist				

List ALL medications, vitamins, and supplements you are currently taking. (May attach list of medications)			❑ I currently take no medications

Allergic reactions including medicines, iodine, intravenous dye, latex, shellfish, etc.	❑ I have no allergies
Medication/Substance	Allergic Reaction

Occupational/Social history			❑ I am currently retired
What is your occupation?			
✓	No	Yes	Details (If Yes)
Are you out of work due to your spinal condition?			How long have you been out of work?
Do you have a workman's compensation claim?			Date of work injury:
Do you smoke cigarettes?			How many packs per day? For how many years?
Do you smoke a pipe or cigars?			How often?
Do you dip snuff or chew tobacco?			How often?
Do drink caffeine?			How many cups per day?
Do drink alcohol?			How many drinks per week?
Do you use any street drugs?			Which drugs and how often?
Have you been diagnosed with a substance abuse problem			Which substance?
Who do you live with?			

Family history of disease		❑ I have no family history of disease	
Relationship	Disease	Relationship	Disease

Review of systems

✓	*General*
	Fever or Chills
	Dizziness
	Fainting spells
	Fatigue
	Frequent headaches
	Insomnia
	Sweats
	Weight changes
Other:	

✓	*Eye,Ear Nose,Throat*
	Difficulty swallowing
	Hearing loss
	Hoarseness
	Nose bleeds
	Ringing in ears
	Sinus problems
	Blurry vision
	Poor vision
Other:	

✓	*Musculoskeletal*
	Joint pains
	Muscle aches
	Ankylosing spondylitis
	Weak bones
	Rheumatoid arthritis
	Osteoarthritis
	Bone cancer
	Bone infections
Other:	

✓	*Psychiatric*
	Anxiety
	Depression
	Psychiatric hospitalization
	Panic attacks
	Suicidal thoughts
	Psychiatric drugs
	Memory loss
Other:	

✓	*Cardiovascular*
	Ankle swelling
	Chest pains
	Enlarged heart
	Heart attack
	Heart murmur
	Heart palpitations
	High blood pressure
	Shortness of breath
	Irregular heartbeat
	Prolonged bleeding
	History of blood clots
Other:	

✓	*Gastrointestinal*
	Poor appetite
	Bowel changes
	Constipation
	Diarrhea
	Excessive thirst
	Heartburn
	Nausea
	Rectal bleeding
	Stomach pain
	Ulcers
	Vomiting
Other:	

✓	*Genitourinary*
	Bladder control
	Blood in urine
	Frequent urination
	Kidney stones
	Painful urination
	Urgent urination
	Weak stream
Other:	

✓	*Neurological*
	Loss of motor control
	Weakness
	Paralysis
	Poor balance
	Seizures
	Speech difficulties
	Tremors
	Muscle wasting
Other:	

✓	*MEN only*
	Breast lumps
	Enlarged prostate
	Erectile dysfunction
	Penis discharge
	Prostate cancer
Other:	

✓	*WOMEN only*
	Abnormal pap smear
	Breast lumps
	Vaginal discharge
	Severe menstrual pain
	Hot flashes
Other:	
Date of last period:	
Age periods began:	
Age of menopause:	
Are you pregnant?	
# of pregnancies?	
# of live births?	

✓	*Endocrine*
	Blood sugar problem
	Use of steroids
	Over active thyroid
	Under active thyroid
Other:	

✓	*Skin*
	Bruise easily
	Foot ulcers
	Rashes
	Sores that won't heal
Other:	

This form is used to gather information so that my doctor can maximize the time used to examine me and answer my questions about my condition and treatment options. 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)

Office Use Only	Height		Weight		BP	/	Pulse	

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

HIPAA Notice of Privacy Practices

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

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.

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
Less than 24 hour/same-day cancellation	$150.00
Procedure/Surgery No-show	$250.00
Return Check Fee	$25.00

SAME-DAY CANCELLATION / LATE ARRIVAL POLICY

Please be aware that any cancellation less than 24 hours in advance will incur a fee of $150.

Additionally, 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.

OPEN PAYMENTS DATABASE NOTIFICATION

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

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

Print Name: _____ Date: _____

Patient Signature: _____