

Last Name	First Name	Middle Name
Age: _____	<input checked="" type="checkbox"/> Hand Dominance <input type="checkbox"/> Right <input type="checkbox"/> Left	<input checked="" type="checkbox"/> Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

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

Describe your condition: 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?	
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<input checked="" type="checkbox"/> 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			

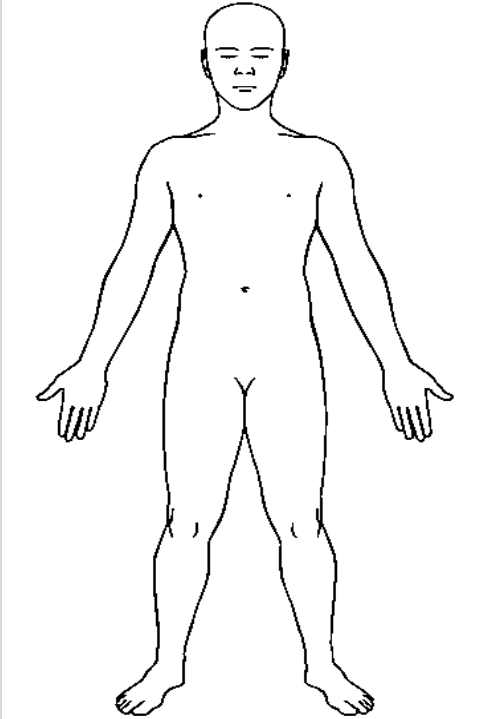
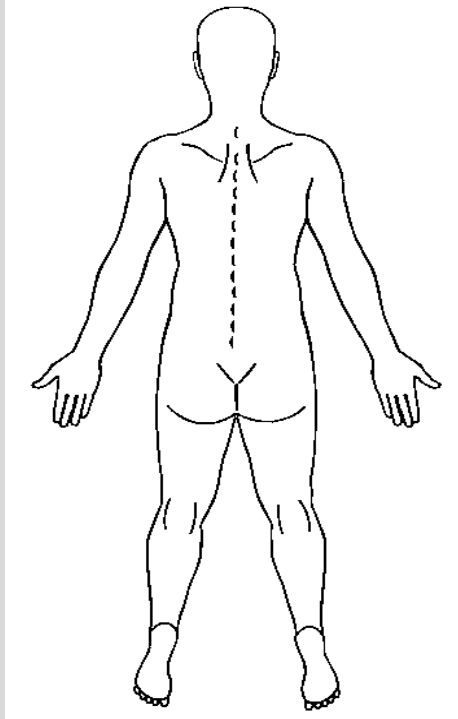
Did your problem begin with a car accident?	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
If yes:	Were you the driver?	Were you wearing a seatbelt?	Did you pass out?	
	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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

For a total of 100%, what % is back pain and what % is leg? (i.e. 30% low back pain with 70% leg pain)	% Low Back Pain	% Leg Pain	
		+	=100%
For a total of 100%, what % is neck pain and what % is arm? (i.e. 20% neck pain with 80% arm pain)	% Neck Pain	% Arm Pain	
		+	=100%

<input checked="" type="checkbox"/> 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											
<input checked="" type="checkbox"/> Your level of pain right now											

<input checked="" type="checkbox"/> Describe the quality and severity of your pain?		
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Gnawing	<input type="checkbox"/> Splitting
<input type="checkbox"/> Shooting	<input type="checkbox"/> Hot-Burning	<input type="checkbox"/> Tiring/Exhausting
<input type="checkbox"/> Stabbing	<input type="checkbox"/> Aching	<input type="checkbox"/> Sickening
<input type="checkbox"/> Sharp	<input type="checkbox"/> Heavy	<input type="checkbox"/> Fearful
<input type="checkbox"/> Cramping	<input type="checkbox"/> Tender	<input type="checkbox"/> Punishing-Cruel

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

✓ 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:			
Opioids (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)	<input type="checkbox"/> I have no medical problems

✓Do you have history of cancer?	No	Yes	Details (If Yes)

Surgical history (i.e.:Tonsillectomy, hip replacement, heart surgery, etc)	<input type="checkbox"/> I have not had surgery in the past
Date of Surgery	Surgery (Specify Right or Left side if relevant)

Mental Health History		<input type="checkbox"/> 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)			<input type="checkbox"/> I currently take no medications	

Allergic reactions including medicines, iodine, intravenous dye, latex, shellfish, etc.		<input type="checkbox"/> I have no allergies		
Medication/Substance		Allergic Reaction		

Occupational/Social history				<input type="checkbox"/> 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				<input type="checkbox"/> I have no family history of disease	
Relationship		Disease		Relationship	

Review of systems															
✓	<i>General</i>			✓	<i>Eye, Ear, Nose, Throat</i>			✓	<i>Musculoskeletal</i>			✓	<i>Psychiatric</i>		
	Fever or Chills				Difficulty swallowing				Joint pains				Anxiety		
	Dizziness				Hearing loss				Muscle aches				Depression		
	Fainting spells				Hoarseness				Ankylosing spondylitis				Psychiatric hospitalization		
	Fatigue				Nose bleeds				Weak bones				Panic attacks		
	Frequent headaches				Ringing in ears				Rheumatoid arthritis				Suicidal thoughts		
	Insomnia				Sinus problems				Osteoarthritis				Psychiatric drugs		
	Sweats				Blurry vision				Bone cancer				Memory loss		
	Weight changes				Poor vision				Bone infections			Other:			
Other:				Other:				Other:				✓	<i>MEN only</i>		
✓	<i>Cardiovascular</i>			✓	<i>Gastrointestinal</i>			✓	<i>Genitourinary</i>				Breast lumps		
	Ankle swelling				Poor appetite				Bladder control				Enlarged prostate		
	Chest pains				Bowel changes				Blood in urine				Erectile dysfunction		
	Enlarged heart				Constipation				Frequent urination				Penis discharge		
	Heart attack				Diarrhea				Kidney stones				Prostate cancer		
	Heart murmur				Excessive thirst				Painful urination			Other:			
	Heart palpitations				Heartburn				Urgent urination			✓	<i>WOMEN only</i>		
	High blood pressure				Nausea				Weak stream				Abnormal pap smear		
	Shortness of breath				Rectal bleeding			Other:				Breast lumps			
	Irregular heartbeat				Stomach pain			✓	<i>Neurological</i>				Vaginal discharge		
	Prolonged bleeding				Ulcers				Loss of motor control				Severe menstrual pain		
	History of blood clots				Vomiting				Weakness				Hot flashes		
Other:				Other:				Paralysis				Other:			
✓	<i>Endocrine</i>			✓	<i>Skin</i>				Poor balance			Date of last period:			
	Blood sugar problem				Bruise easily				Seizures			Age periods began:			
	Use of steroids				Foot ulcers				Speech difficulties			Age of menopause:			
	Over active thyroid				Rashes				Tremors			Are you pregnant?			
	Under active thyroid				Sores that won't heal				Muscle wasting			# of pregnancies?			
Other:				Other:				Other:				# of live births?			

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
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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 *Race: American Indian or Alaska Native White
 Not Hispanic or Latino Asian Decline to State
 Decline to State Native Hawaiian or other Pacific Islander
 Black or African American

*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

**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.

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:

Name

Relationship

Name

Relationship

Patient Name

Date

Signature



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: _____