

PATIENT REGISTRATION FORM

PATI	ENT INFORMA	TION: (Plea	ase use full lega	l name	, no nicknar	nes)				
Last N	ame:			First Na	ame:					Middle Initial:
Date o	f Birth:			Age:		Sex:		Social Secur	ity #:	
Addre	SS:			ı						
City:						State:		Zip:		
Home	Phone #:					Cell Pho	one #:	L		
E-mail	Address:					I		Driver's Lice	nse #:	
Was th	nis an injury?	s No I	f yes, where did you	ur injury	occur? Wo	ork	uto Home	School	Date	of injury:
Emplo	yer Name:					Occupa	tion/Title/Position	1:		
Emplo	yer Address and Pho	ne #:				•				
Emerg	ency Contact Name:					Relatio	nship:		Phone	#:
GUA	RANTOR INFO	RMATION:	(List person or	insure	d name resp	oonsible	e for bill – use f	full legal na	me, no	nicknames)
Relatio	onship to Patient:	Self	Spouse	Paren	t 🔲 Oth	ner				
Last N	ame:			First Na	ame:					Middle Initial:
Date o	f Birth:			Age:		Sex:		Social Secur	ity #:	
Addre	ss:									
City:						State:		Zip:		
Home	Phone #:					Cell Pho	one #:			
Emplo	yer Name:					Occupa	tion/Title/Position	1:		
Emplo	yer Address and Pho	ne #:								
INSU	IRANCE INFOR	MATION: (Please allow red	ceptior	nist to photo	осору у	our insurance I	D cards)		
IF SOI	MEONE OTHER TH	AN PATIENT	IS THE INSURED	PARTY,	PLEASE INCL	.UDE DA	TE OF BIRTH FO	R CLAIMS		
S	Insurance Company	y :					Copay:	Пнмо	PPC	POS
<u>\</u>	Policy/ID #:						Group #:			
RIMARY INS	Claims Address & P	hone #:						ı		_
PRIL	Insured's Name:				Relationship:		T	Insured's Da	ite of Bir	th:
	Insured's Employer	:					Insured's Social	Security #:		
NS	Insurance Company	y:					Copay:	Пнмо	☐ PPC	POS
RY	Policy/ID #:						Group #:			
IDA	Claims Address & P	hone #:								
SECONDARY INS	Insured's Name:				Relationship:			Insured's Da	ite of Bir	th:
SE	Insured's Employer	:					Insured's Social	Security #:		
am fina nforma authori nsurar	ancially responsiblation regarding moty ty as original. Pho	e for all char edical history oto identifica identificatio	rges regardless on that is requested tion and insurance on and insurance on the regarders.	of insurated by the cord cards not cords on the cords of	ance verificat ne insurance Is must be pi ot be present	tion, ber compan resented ted, you	nefits and eligibi y. A photocopy d at the time of will become a <u>c</u>	ility. I author of this author service to e ash patient v	rize rele orization nable O with pay	al group. I understand that I hase of medical records and in is accepted with the same Is submit claims to your ment in full due at the time ient.

Patient History From

Patient	Date	DOB Age Se:	x Height Weight
Why are you here today?			Extremity: Right Left
Was this an accident? 🗌 Yes 🔲 N	o If so was it work relate	d? Yes No Date of Injui	ry:
How and where dif the accident ha	appen?		
Check as many as needed to expla	in symptoms associate with yo	ur injury/illness:	
Location:	Severity:	Aggravating Factors:	Relieving Factors:
Front	Mild	Weight bearing	Pain Medicine
Back	Moderate	Squatting	Anti-Inflammatory
Inside	Severe	Lifting	lce
Outside	No Pain	Sitting	Physical Therapy
	Improving	Standing	Chiropractor
Onset:	Worsening	Walking	
Sudden	Constant	Running	
Chronic		Overhead Motion	
Date:			
Cause:	Prior Treatments:	Prior Tests:	
Auto Accident	None	X-Ray	
Fall	Medicine	MRI	
Repetitive Use	Splint	CT	
Sports Injury	Surgery	EMG/NCS	
Other	Physical Therapy		
	Chiropractor		
PAST MEDICAL HISTORY			
	Past Surgeries:	Family History	:
Diabetes	Appendectomy	Diabetes	
Stroke	Tonsillectomy	Heart Di	
Hernia	Other	Cancer (type)
Hypertension			
Heart Disease	-	Social History:	
Seizures		Smoke: No	Yes Packs per Day hol: Mild Moderate Heavy
Blood Clot			
Ulcer		Recreati	ional Drugs
Cancer (type)			
Review of Systems: Please fill out 0	CURRENT symptoms only. Chec	ck if None or Normal	
General:	Mouth:	Cardiac:	Genitourinary:
Fever	Sore Throat	Chest Pain	Pain urinating
Chills		Palpitation	Increased frequency
	Neck:	Syncope	Urgency/Hesitancy
Skin:	Pain		
Rash	Swelling	Gastrointestinal:	Neurological:
New skin lesions		Abdominal Pain	Numbness
	Respiratory:	Nausea	Tingling
Eyes:	Shortness of breath		Location:
Blurry vision/difficulty	Cough	Diarrhea	
	Wheezing		Endocrine:
Ears:		Musculoskeletal:	Cold Intolerance
Ear Pain/difficulty sleeping		Back Pain	Weight loss/gain
		Neck Pain	Increased Thirst
Hematological:	Psychiatric:		
Fasy hruising or bleeding	Anxiety/Denression		

Medication List

Patient Name:	Date of Birth	:
Medications: Please clearly list all curre	ent medication names	
1.	9.	17.
2.	10.	18.
3.	11.	19.
4.	12.	20.
5.	13.	21.
6.	14.	22.
7.	15.	23.
8.	16.	24.
Allergies: No Known Allergies	Other (List all Medication All	lergies)

PLEASE READ

Gerald J. Alexander, M.D.

Mediation Rx Protocols and Patient Responsibility Form

Narcotic medications will not be dispensed to any patients without approval from Dr. Gerald Alexander or his Physician Assistant.

NSAIDS (i.e. Motrin, Naprosyn) or COX-2 (Celebrex) medications may be dispensed to preoperative and to post-operative patients 3 months after surgery. Stop any anti-inflammatory and aspirin containing products ten days prior to surgery.

Requests for medication refills will only be honored by pharmacy requests via fax within 72 hours advance notice. NO refills will be granted by patient requests!! Pharmacy requests via fax will be presented to the Physician Assistant on Mondays, Wednesdays, and Thursdays for authorizations.

Medication refills will not be available after office hours, weekends or holidays.

Medication refills will not be granted by walk-in patients without prior written authorization by Dr. Gerald Alexander or his Physician Assistant.

All medication dispensed to the patient is the responsibility of the patient, and is to be taken as directed by Dr. Gerald Alexander or his Physician Assistant. No refills will be granted for patients who missed their last scheduled appointment.

l,	understand and agree with the instructions
(Print name) given to me by Dr. Gerald Alexander or.	
6	
Patient Signature	Date



Accident/Injury Information Form

Name:	Doctor:
To help us process your insurance claim quid with your accident/injury details:	ckly and efficiently please provide us
When did your accident/injury occur?	
Where did your accident/injury occur?	
How did your accident/injury occur?	
Signature:	Date:



Medical Information Release Form (HIPAA Release Form)

Patient Name:	Date of Birth:/_	/ MR #:
If minor, Parent/Guardian Name:		
Release of Information		
I authorize the release of information including of changes and billing/collection/claims information. This information may be released to:		mination results, medication dose
[] Spouse/Name:		
[] Child(ren)/Name(s):		[] Information is not to be released to anyone other than me.
[] Other:		,
Messages		
Please call: [] my home phone # If unable to reach me:	[] my cell	phone #
[] you may leave a detailed message. OR		[] Do not leave messages on my voicemail.
[] please leave a message asking me to r	eturn your call.	, 10.00
The best time to reach me is (day of week)	bet	ween (time)
E-mail Messages/Portal		
[] Use my e-mail or portal contact to send mess OR [] Use my e-mail or portal contact to leave detain [] Attach lab results to e-mail/portal mess My e-mail address is:	iled messages and inforssage.	rmation.
This Release of Information will remain in effect excludes any psychiatry and psychology evaluate		
Signature:	D	ate:
Witness:	Da	nte:



Acknowledgement of Receipt of Notice of Privacy Practices and Notices to Consumers

Orthopaedic Specialty Institute

I hereby acknowledge that I received a copy of the medical practice's Notice of Privacy Practices as well as Consumers Notices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices and/or Consumer updates at each appointment.

NOTICE TO CONSUMERS

PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY

THE PHYSICIAN ASSISTANT COMMITTEE (916) 561-8780 WWW.PAC.CA.GOV **NOTICE TO CONSUMERS**

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA

> (800) 633-2322 WWW.MBC.CA.GOV

Signature:	Date:	_
Print Name:	Telephone:	-
If not signed by the patient, please indicate		
Relationship:		
Parent or guardian of minor patient		
Guardian or conservator of an incompe	etent patient	
Beneficiary or personal representative	of deceased patient	
Name of Patient:		

GENERAL ORTHOPAEDICS · SPORTS MEDICINE · ARTHROSCOPY · RECONSTRUCTIVE KNEE AND SHOULDER SURGERY · JOINT REPLACEMENT AND ARTHRITIS SURGERY PHYSICAL MEDICINE AND REHABILITATION · ADULT AND PEDIATRIC SPINE SURGERY · HAND AND UPPER EXTREMITY SURGERY · FOOT AND ANKLE SURGERY



280 S. Main Street · Suite 200 · Orange, CA 92868 · Tel. (714) 634-4567 · Fax (714) 634-4569 16300 Sand Canyon Ave · Suite 511 · Irvine, CA 92618 · Tel. (949) 255-9890 · Fax (949) 255-9776

CONSENT FOR TREATMENT - NOTICE OF POLICIES

I hereby consent and authorize Orthopaedic Specialty Institute Medical Group of Orange County (OSI) healthcare providers to perform medical care, diagnostic tests, surgical care and other therapeutic measures, as may be indicated for my health and well-being. If I will not comply with the medical program of care provided or recommended, I understand that thereupon I relieve my physician(s), healthcare provider(s), medical staff, and the company, of all responsibility resulting from my action.

I also authorize OSI, all associated physicians and all associated agencies, to gather, maintain and release any and all of my information that might be required for processing of any of all claims for third party payers (including but not exclusive of, private insurance, Medi-Cal, Medicare, Tricare, Work-Comp, etc.)

I acknowledge that I have been given the ability to review OSI's policies including Financial Policy.

FINANCIAL POLICY

- We will submit claims to your insurance company for all medical services rendered at OSI. Any other services related to your medical care not rendered at OSI (i.e. laboratory, pathology, hospital fees, outpatient surgery center fees, anesthesiologist, co-surgeon, etc.), will be billed by the entity providing those services. It is your responsibility to verify that OSI is part of your insurance plan. We will attempt to verify your eligibility and benefits with your insurance carrier; however, this does not guarantee that they will pay for the services provided, and you will remain financially responsible if they do not provide payment.
- OSI accepts the following insurance plans:
 - ➤ <u>Medicare</u> pays 80% after the deductible has been met. We will bill your coinsurance for the remaining 20% as a courtesy; however, you are responsible for the 20% coinsurance of the Medicare allowable amount.
 - Contracted PPOs and HMOs you are responsible for the payment of co-pay and deductible at the time of the service, as well as for any charges for which you failed to secure prior authorization (if necessary).
 - Non-Contracted PPOs you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
 - > Self-Pay (uninsured) you are expected to pay in full at the time of the service.
 - Worker's Compensation you are not responsible for any charges unless the case has been dismissed or denied.

- Personal Injury/Motor Vehicle Accidents you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
- <u>Surgery Deposits</u> once the decision for surgery is made, our surgery coordinator will contact your insurance carrier
 to confirm eligibility benefits and obtain authorization. The surgery coordinator will provide you with an estimated cost of
 your surgery. This amount will be collected as a deposit at or before the time of your pre-operative appointment.
- <u>Medical Records</u> all medical records requests are subject to a preparation fee. Any additional costs related to shipping and handling will be added to these costs (if applicable).
- <u>Divorce Related</u> the parent authorizing treatment for a child will be the parent responsible for the charges related to
 that care. If the divorce decree requires the other parent to pay all, or part of the treatment costs, it is the authorizing
 parent's responsibility to collect from the other parent.
- <u>Bad Debt</u> patients who do not pay bills within 90 (ninety) days of the statement date, will be referred to a collections agency, and *may be discharged from the practice for non-payment.*
- Failed Appointment Charge for MRI we reserve the right to charge \$25 (twenty-five) for each failed appointment not canceled at least 24 hours before the scheduled appointment time. This charge is not covered by your insurance.
- <u>Usual and Customary Rates</u> our practice is committed to the best treatment for our patients. Our charges are
 considered usual and customary for our area. You are responsible for payment, regardless of any insurance company's
 arbitrary determination of usual and customary charges.
- <u>Financial Responsibility</u> based on our contractual agreements with the insurance companies and our internal policies, we are informing you of the following:
 - Your health insurance deductibles and any expenses deemed not covered by your insurance company will be your financial responsibility.
 - All monies owed by you, such as office visits co-payments and non-covered services or supplies, are due at the time of the service.
 - If you are not prepared to pay any amounts due at the time of the visit, you will be asked to reschedule the appointment, unless the physician determines that your medical condition prohibits this.
- Method of Payment our office accepts the following forms of payment: credit cards, cash, money order, and checks.
 A \$25 (twenty-five dollar) service charge will be assessed to your account for any returned check by your bank. This charge is not covered by your insurance.

Thank you for understanding our policies. If you have any questions or concerns, please do not hesitate to contact our office at (714) 634-4567.

By signing in the box below indicates that you are acknowledging and are in agreement with all of the above. Further, you understand and agree that your consents/assignments remain in effect until you choose to revoke them in writing.

(Signature of Patient or Authorized Representative)	(Printed	l Name)	(Date)
signed Above by Representative, Relationship of Signer to Patient		(Name of Patier	nt if Different from Above)