ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Patient Registration

Patient Information

First Name	Middle Initial	Last Name

Date of Birth	Social Security Number	Gender
		Male Female

Street Address	City	State	Zip Code

Marital Status (circle one)	Primary Care Physician
Married Single Divorced Widowed	

Phone number: Home	Cell	Work

verified by:

Email address	Driver's License #	Employer

Emergency Contact Name	Relationship	Phone

Date of injury/onset of symptoms	Was this an injury?	If yes, Where did your injury occur?
	NO YES	**WORK AUTO HOME SCHOOL OTHER:**

Insurance Information

Name of Primary Insurance:	Name of Secondary Insurance:
Insured's Name:	Insured's Name:
Insured's Date of Birth:	Insured's Date of Birth:
Insured's Social Security number	Insured's Social Security number
ID #	ID #
Group #	Group #
Claims Address:	Claims Address:
Phone:	Phone:

Guarantor Responsible Party ☐ **Patient** ☐ **Other (if other please fill in information below)**

verified by:

Name:	Date of Birth	Relationship to patient:

Street Address	City	State	Zip Code

Phone number	Social Security Number	Employer

I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original.

Photo identification and insurance cards must be presented at the time of service to enable OSI to submit claims to your insurance carrier. Should identification and insurance cards not be presented, you will become a <u>cash patient</u> with payment in full due at the time of service.

This agreement will remain valid from this day forward to include all future services relating to the above patient.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

ORTHOPAEDIC SPECIALITY INSTITUTE
280 S. MAIN STREET SUITE 200
ORANGE, CA 92868
(714) 634-4567

JONATHAN KAPLAN, MD

PATIENT HEALTH QUESTIONNAIRE

NAME: _____ **AGE:** _____ **DOB:** _____ **DATE:** _____

HEIGHT: _____ feet _____ inches **WEIGHT:** _____ pounds

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____
(First Name) (Last Name)

REFFERING PHYSICIAN/THERAPIST: _____ **PHONE:** _____
(First Name) (Last Name)

CHIEF COMPLAINT (what brings you in today):

BODY PART: _____ ☐ **Right** ☐ **Left** ☐ **Both**

WHEN DID THIS BEGIN / DATE OF INJURY? _____

HOW DID THIS HAPPEN?

SEVERITY OF PAIN (0 for no pain - 10 for most severe) with activity: _____ at rest: _____

WHAT MAKES IT BETTER (rest, ice, removing shoes, special shoes, massage, etc)?

WHAT MAKES IT WORSE (walking barefoot, getting up in the morning, stairs, at rest/night, weather)?

PREVIOUS TREATMENTS (physical therapy, orthotics, anti-inflammatory, cast/boot/brace)

WHAT IS YOUR GOAL FOR THIS EVALUATION (Relief of pain, correction of deformity or instability, etc)

PREVIOUS ORTHOPEDIC SURGERIES (what type and date)

YEAR	SURGERY	HOPSITAL/DOCTOR

ORTHOPAEDIC SPECIALITY INSTITUTE
280 S. MAIN STREET SUITE 200
ORANGE, CA 92868
(714) 634-4567

PAST MEDICAL HISTORY/ILLNESS (check all that apply) **none:**_____

High Blood Pressure	_____	Neuropathy	_____	Hepatitis: type	_____
Heart Disease/Heart Attack	_____	Psoriasis	_____	Liver Disease	_____
Poor Circulation in feet	_____	Cancer (type)	_____	Lung Disease	_____
Rheumatoid Arthritis	_____	Stroke	_____	Blood Clots	_____
Degenerative Arthritis	_____	Gout	_____	Thyroid Disease	_____
Anemia/Bleeding Disorders	_____	Osteoporosis	_____	Kidney Disease	_____
Diabetes	_____	HIV/AIDS	_____	Lupus (SLE)	_____
– HgA1c: _____ Date:	_____				

Other:_____

CURRENT MEDICATIONS (please list currently taking medication, use back for more space):

Name of medication	Dose	Times a day	Duration of use (months or years)

OTHER SURGERIES

YEAR SURGERY HOSPITAL/DOCTOR

_____
_____
_____

ALLERGIES: **none:**_____ (medicine, adhesive tape, iodine products, x-ray dyes, etc)

_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY (blood relatives):

Cancer	_____	Relationship	_____
Heart Disease	_____	Relationship	_____
Diabetes	_____	Relationship	_____
Arthritis/Bone Disease	_____	Relationship	_____
Sickle Cell trait/Anemia	_____	Relationship	_____
Other_____		Relationship	_____

ORTHOPAEDIC SPECIALITY INSTITUTE
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PATIENT HABITS: Tobacco use : Y / N Packs per day____ How many years_____

Previous tobacco use:

Alcohol use: **Never / rarely / moderate / daily**

SOCIAL HISTORY:

Present occupation_____ Duration_____
Are you working? YES_____ NO _____ Last day worked _/_____/_____
Home members _____Live alone
_____Live with family members (relationship)_____
_____ Other_____

RECREATIONAL ACTIVITIES / HOBBIES (pick-up sports, crossfit, cycling groups)

ANY OTHER INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT YOU OR YOUR CONDITION?

REVIEW OF SYSTEMS

Constitutional:	Weight loss_____ Weight gain_____ Fatigue_____
Skin:	Rashes_____ Sores_____
Eyes:	Visual Difficulty_____ Eye irritation_____
Ears, nose, throat:	Sore Throat_____ Difficulty Swallowing _____ Ear Ache_____
Gastrointestinal:	Abdominal Pain_____ Nausea_____Vomiting_____ Jaundice_____
Genitourinary:	Painful urination_ Bloody Urine_____ Urinating at night_____
Respiratory:	Chronic cough_____ Shortness of Breath_____
Cardiovascular:	Chest pain_____ Palpitations_____
Musculoskeletal:	Joint Pain_____ Swollen Joints_____ Sore Muscles_____
Neurologic:	Numbness_____ Weakness_____
Psychiatric:	Depression_____bipolar_____ Anxiety_____ drug/alcohol tendency_____

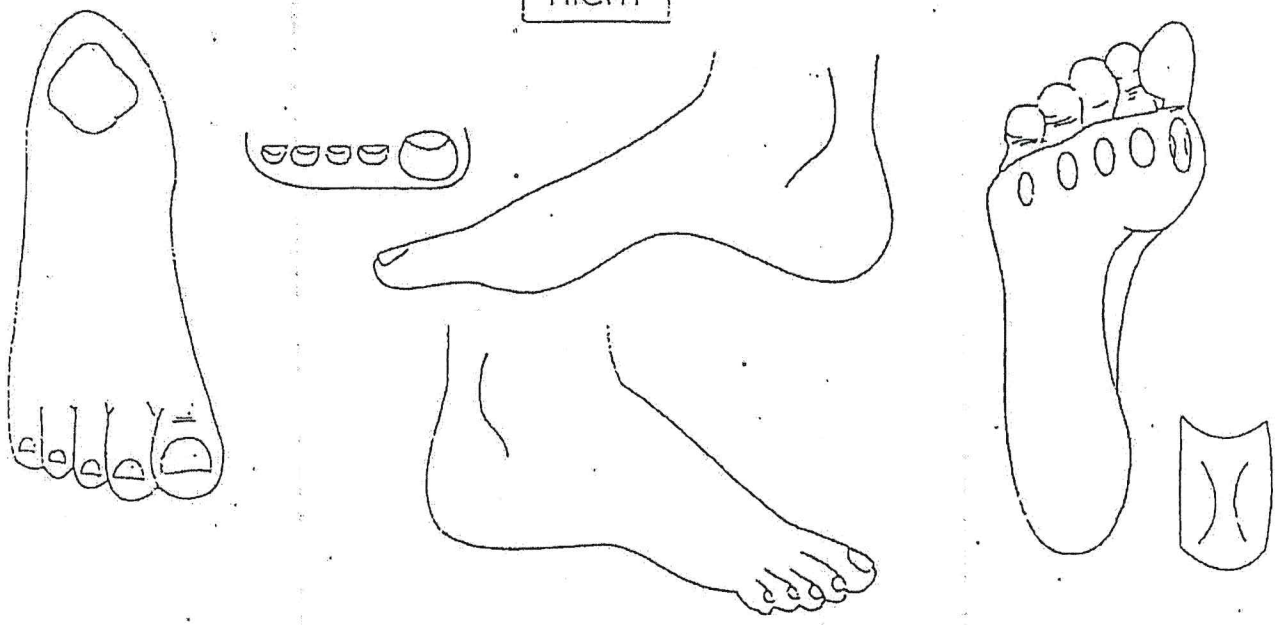
_____ _____
Signature of patient **Signature of person completing form, if other than patient**

** For **foot and ankle** patients, please draw and/or indicate where you are feeling pain, numbness, tingling, etc on diagram **

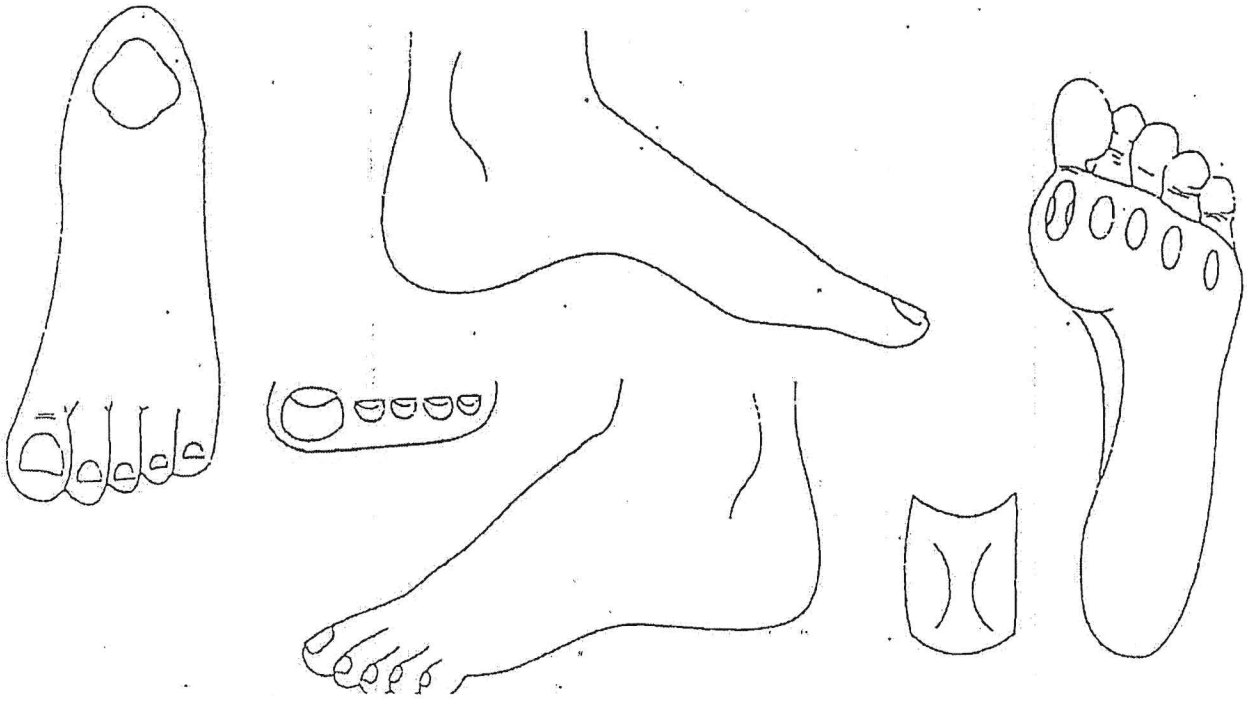
PLEASE MARK LOCATION OF PAIN IN FOOT
USING THIS SCALE: MILD 1
MODERATE 2
SEVERE 3

ALSO: INDICATE ANY
BURNING OR TINGLING
ON THE PICTURES BELOW

RIGHT



LEFT



ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

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 diagnosis, records, examination results, medication dose changes and billing/collection/claims information.
This information may be released to:

[ ] Spouse/Name: _____

[ ] Child(ren)/Name(s): _____

[ ] Other: _____

[ ] Information is not to be released to anyone other than me.

Messages

Please call: [ ] my home phone # _____ [ ] my cell phone # _____.
If unable to reach me:

[ ] you may leave a detailed message.
OR
[ ] please leave a message asking me to return your call.

[ ] Do not leave messages on my voicemail.

The best time to reach me is (day of week) _____ between (time) _____.

E-mail Messages/Portal

[ ] Use my e-mail or portal contact to send messages for me to contact the nurse for information.
OR
[ ] Use my e-mail or portal contact to leave detailed messages and information.
[ ] Attach lab results to e-mail/portal message.
My e-mail address is: _____.

This Release of Information will remain in effect until termination by me in writing. This release specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Signature: _____ Date: _____

Witness: _____ Date: _____

Orthopaedic Specialty Institute
Medical Group of Orange County

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 Consumer 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	NOTICE TO CONSUMERS
PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY THE PHYSICIAN ASSISTANT COMMITTEE (916) 561-8780 WWW.PAC.CA.GOV	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 incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

280 S. Main Street · Suite 200 · Orange, CA 92868 · Tel. (714) 634-4567 · Fax (714) 634-4569

ORTHOPAEDIC SPECIALTY INSTITUTE

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:**

  - **Medicare** – 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.

Initials _____

- **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.
- **Surgery Deposits** – 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.
- **Medical Records** – 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).
- **Divorce Related** – 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.
- **Bad Debt** - 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.
- **Usual and Customary Rates** - 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.

- **Financial Responsibility** – 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 re-schedule 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 Name)	(Date)
(If signed Above by Representative, Relationship of Signer to Patient)	(Name of Patient if Different from Above)	

Initials _____

Orthopaedic Specialty Institute
Medical Group of Orange County

Patient Registration

Patient Information

First Name	Middle Initial	Last Name

Date of Birth	Social Security Number	Gender
		Male Female

Street Address	City	State	Zip Code

Marital Status (circle one)	Primary Care Physician
Married Single Divorced Widowed	

Phone number : Home	Cell	Work

verified by:

Email address	Driver's License #	Employer

Emergency Contact Name	Relationship	Phone

Date of injury/onset of symptoms	Was this an injury?	If yes, Where did your injury occur?
	NO YES	WORK AUTO HOME SCHOOL OTHER:

Insurance Information

Primary Insurance Carrier	**Secondary Insurance Carrier**
Insured's Name:	Insured's Name:
Insured's Date of Birth:	Insured's Date of Birth:
Insured's Social Security number	Insured's Social Security number
ID #	ID #
Group #	Group #
Claims Address:	Claims Address:
Phone:	Phone:

Guarantor Responsible Party ☐ **Patient** ☐ **Other (if other please fill in information below)**

verified by:

Name:	Date of Birth	Relationship to patient:

Street Address	City	State	Zip Code

Phone number	Social Security Number	Employer

I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original.

Photo identification and insurance cards must be presented at the time of service to enable OSI to submit claims to your insurance carrier. Should identification and insurance cards not be presented, you will become a cash patient with payment in full due at the time of service.

This agreement will remain valid from this day forward to include all future services relating to the above patient.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

ORTHOPAEDIC SPECIALITY INSTITUTE
280 S. MAIN STREET SUITE 200
ORANGE, CA 92868
(714) 634-4567

JONATHAN KAPLAN, MD

PATIENT HEALTH QUESTIONNAIRE - Pediatric

NAME: _____ **AGE:** _____ **DOB:** _____ **DATE:** _____

HEIGHT: _____ feet _____ inches **WEIGHT:** _____ pounds

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____
(First Name) (Last Name)

REFFERING PHYSICIAN/THERAPIST: _____ **PHONE:** _____
(First Name) (Last Name)

CHIEF COMPLAINT (what brings you in today):

BODY PART: _____ ☐ **Right** ☐ **Left** ☐ **Both**

WHEN DID THIS BEGIN / DATE OF INJURY? _____

HOW DID THIS HAPPEN?

SEVERITY OF PAIN (0 for no pain – 10 for most severe) with activity: _____ at rest: _____

WHAT MAKES IT BETTER (rest, ice, removing shoes, special shoes, massage, etc)?

WHAT MAKES IT WORSE (walking barefoot, getting up in the morning, stairs, at rest/night, weather)?

PREVIOUS TREATMENTS (physical therapy, orthotics, anti-inflammatory, cast/boot/brace)

WHAT IS YOUR GOAL FOR THIS EVALUATION (Relief of pain, correction of deformity or instability, etc)

PREVIOUS ORTHOPEDIC SURGERIES (what type and date)

YEAR	SURGERY	HOPSITAL/DOCTOR

ORTHOPAEDIC SPECIALITY INSTITUTE
280 S. MAIN STREET SUITE 200
ORANGE, CA 92868
(714) 634-4567

PAST MEDICAL HISTORY/ILLNESS (check all that apply) **none:**_____

High Blood Pressure	_____	Neuropathy	_____	Hepatitis: type	_____
Heart Disease/Heart Attack	_____	Psoriasis	_____	Liver Disease	_____
Poor Circulation in feet	_____	Cancer (type)	_____	Lung Disease	_____
Rheumatoid Arthritis	_____	Stroke	_____	Blood Clots	_____
Degenerative Arthritis	_____	Gout	_____	Thyroid Disease	_____
Anemia/Bleeding Disorders	_____	Osteoporosis	_____	Kidney Disease	_____
Diabetes	_____	HIV/AIDS	_____	Lupus (SLE)	_____
- HgA1c: _____ Date:	_____				

Other:_____

CURRENT MEDICATIONS (please list currently taking medication, use back for more space):

Name of medication	Dose	Times a day	Duration of use (months or years)

OTHER SURGERIES

YEAR	SURGERY	HOSPITAL/DOCTOR

ALLERGIES: **none:**_____ (medicine, adhesive tape, iodine products, x-ray dyes, etc)

_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY (blood relatives):

Cancer	_____	Relationship_____
Heart Disease	_____	Relationship_____
Diabetes	_____	Relationship_____
Arthritis/Bone Disease	_____	Relationship_____
Sickle Cell trait/Anemia	_____	Relationship_____
Other_____		Relationship_____

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ORANGE, CA 92868
(714) 634-4567

SOCIAL HISTORY:

Year In School _____ Duration_____

TEAM SPORTS (If Applicable)	**LEVEL (FR/SO/JV/VARSITY)**	**POSITION**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER RECREATIONAL ACTIVITIES / HOBBIES (pick-up sports, crossfit, cycling groups)

ANY OTHER INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT YOU OR YOUR CONDITION?

REVIEW OF SYSTEMS

Constitutional:	Weight loss_____ Weight gain_____ Fatigue_____
Skin:	Rashes_____ Sores_____
Eyes:	Visual Difficulty_____ Eye irritation_____
Ears, nose, throat:	Sore Throat_____ Difficulty Swallowing _____ Ear Ache_____
Gastrointestinal:	Abdominal Pain_____ Nausea_____Vomiting_____ Jaundice_____
Genitourinary:	Painful urination__ Bloody Urine_____ Urinating at night_____
Respiratory:	Chronic cough_____ Shortness of Breath_____
Cardiovascular:	Chest pain_____ Palpitations_____
Musculoskeletal:	Joint Pain_____ Swollen Joints_____ Sore Muscles_____
Neurologic:	Numbness_____ Weakness_____
Psychiatric:	Depression_____bipolar_____ Anxiety_____ drug/alcohol tendency_____

_____ _____

Signature of patient **Signature of person completing form, if other than patient**

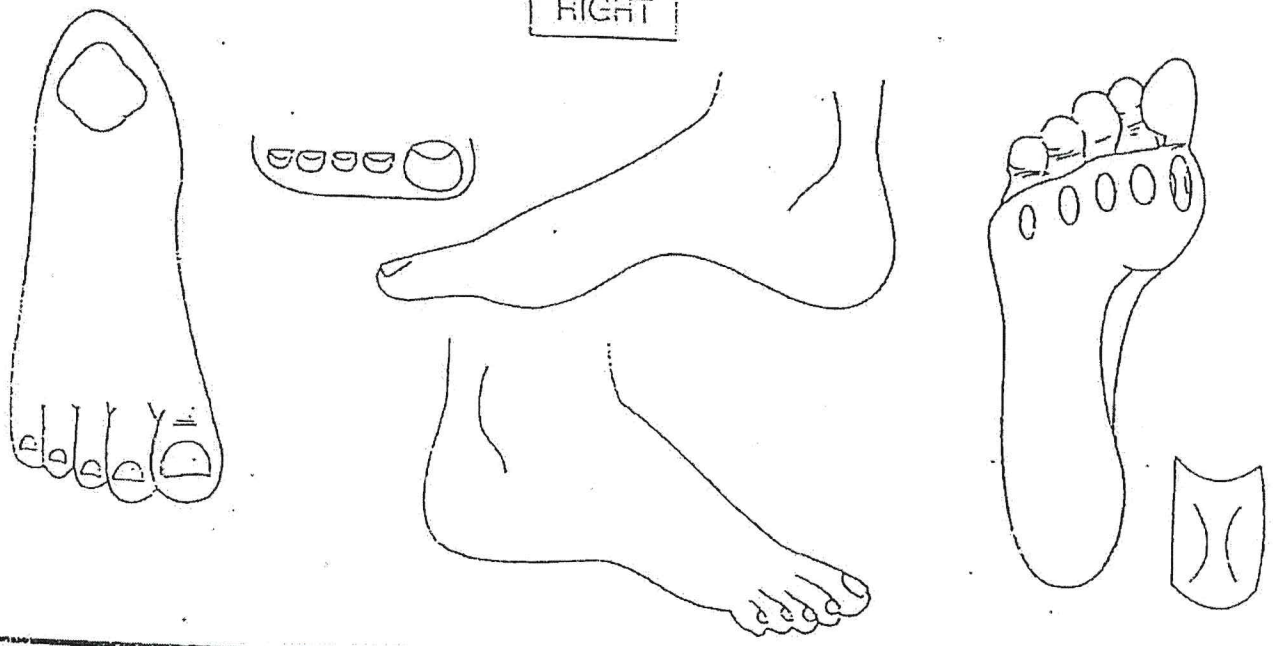
** For **foot and ankle** patients, please draw and/or indicate where you are feeling pain, numbness, tingling, etc on diagram **

PLEASE MARK LOCATION OF PAIN IN FOOT
USING THIS SCALE:

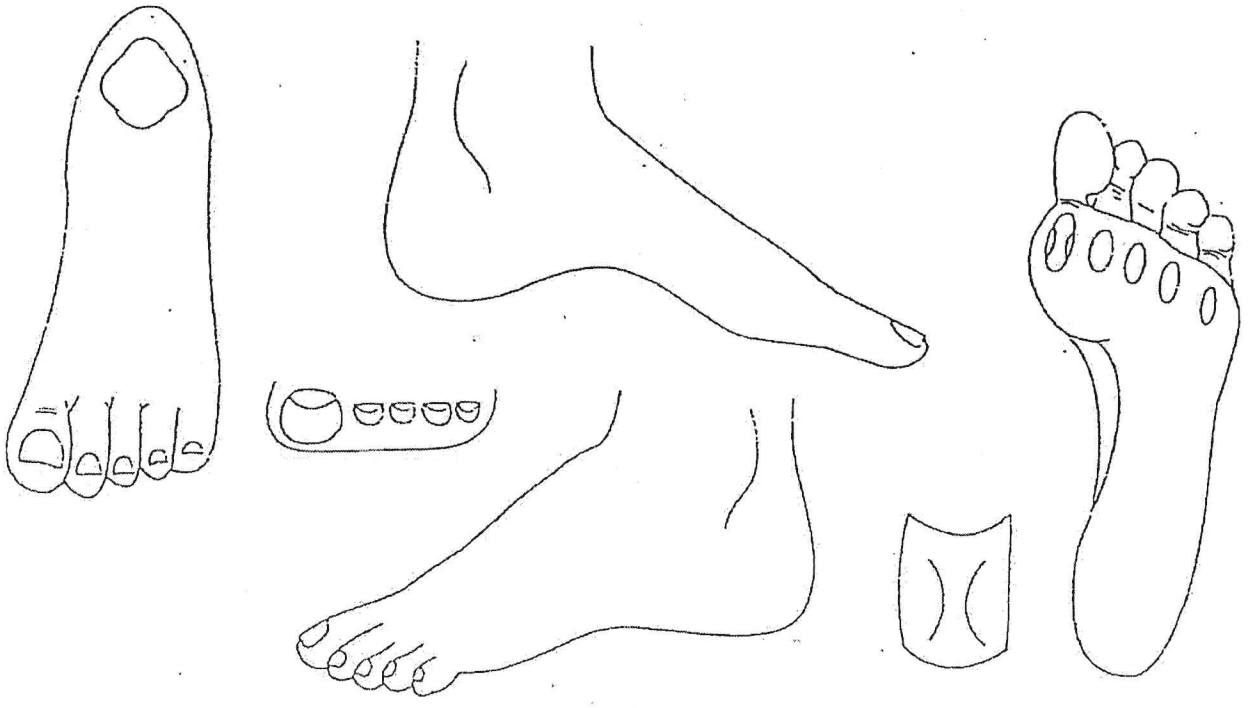
MILD	1
MODERATE	2
SEVERE	3

ALSO: INDICATE ANY BURNING OR TINGLING ON THE PICTURES BELOW

RIGHT



LEFT



ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

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 diagnosis, records, examination results, medication dose changes and billing/collection/claims information.
This information may be released to:

[ ] Spouse/Name: _____

[ ] Child(ren)/Name(s): _____

[ ] Other: _____

[ ] Information is not to be released to anyone other than me.

Messages

Please call: [ ] my home phone # _____ [ ] my cell phone # _____.
If unable to reach me:

[ ] you may leave a detailed message.
OR
[ ] please leave a message asking me to return your call.

[ ] Do not leave messages on my voicemail.

The best time to reach me is (day of week) _____ between (time) _____.

E-mail Messages/Portal

[ ] Use my e-mail or portal contact to send messages for me to contact the nurse for information.
OR
[ ] Use my e-mail or portal contact to leave detailed messages and information.
[ ] Attach lab results to e-mail/portal message.
My e-mail address is: _____.

This Release of Information will remain in effect until termination by me in writing. This release specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Signature: _____ Date: _____

Witness: _____ Date: _____

Orthopaedic Specialty Institute
Medical Group of Orange County

Accident/Injury Information Form

Name: _____ Doctor: _____

To help us process your insurance claim quickly and efficiently please provide us with your accident/injury details:

When did your accident/injury occur? _____
_____
_____

Where did your accident/injury occur? _____
_____
_____

How did your accident/injury occur? _____
_____
_____

Signature: _____ Date: _____

Thank you for your assistance.

280 S. Main Street - Suite 200 - Orange, CA 92868 – Tel. (714) 634-4567

Orthopaedic Specialty Institute
Medical Group of Orange County

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

Orthopaedic Specialty Institute

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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 incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

280 S. Main Street • Suite 200 • Orange, CA 92868 • Tel. (714) 634-4567 • Fax (714) 634-4569

ORTHOPAEDIC
SPECIALTY INSTITUTE

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.

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  - **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.

Initials_____

- **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.
- **Surgery Deposits** – 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.
- **Medical Records** – 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).
- **Divorce Related** – 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.
- **Bad Debt** - 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.
- **Usual and Customary Rates** - 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.

- **Financial Responsibility** – 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 re-schedule 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 Name) (Date)

_____

(If signed Above by Representative, Relationship of Signer to Patient) (Name of Patient if Different from Above)

Initials_____