ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

JONATHAN KAPLAN, M.D.

PATIENT HEALTH QUESTIONNAIRE

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

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

PRIMARY CARE PHYSICIAN: _____ **PHONE**:_____

REFERRING PHYSICIAN/THERAPIST: _____ **PHONE**:_____

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	HOSPITAL/DOCTOR

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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 train/Anemia	_____	Relationship_____
Other	_____	Relationship_____

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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**

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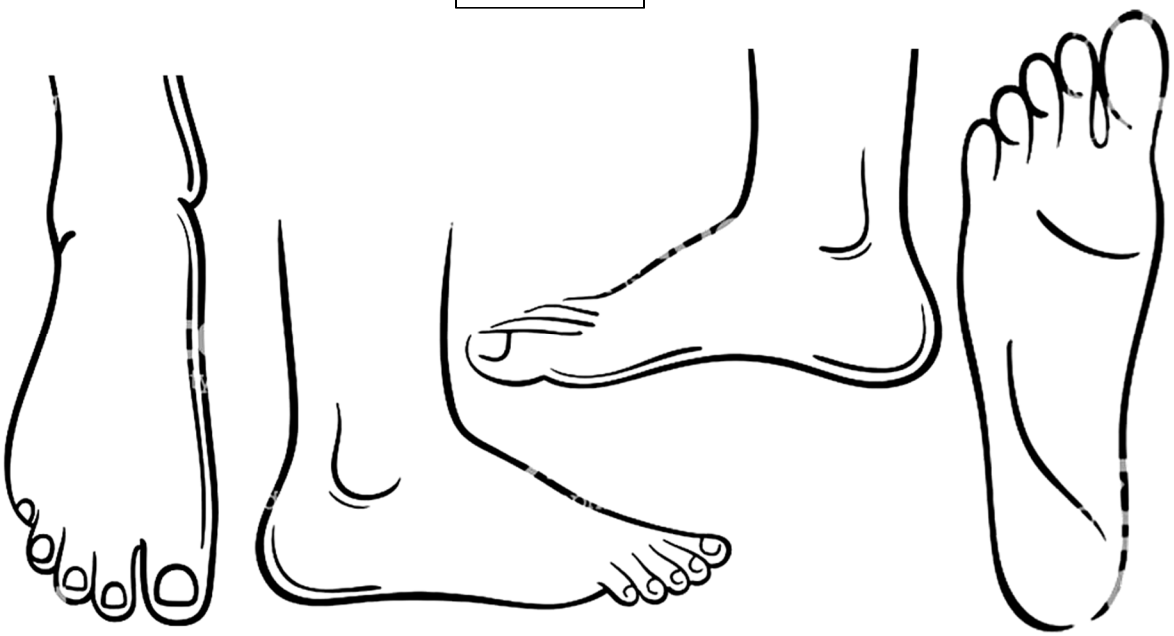
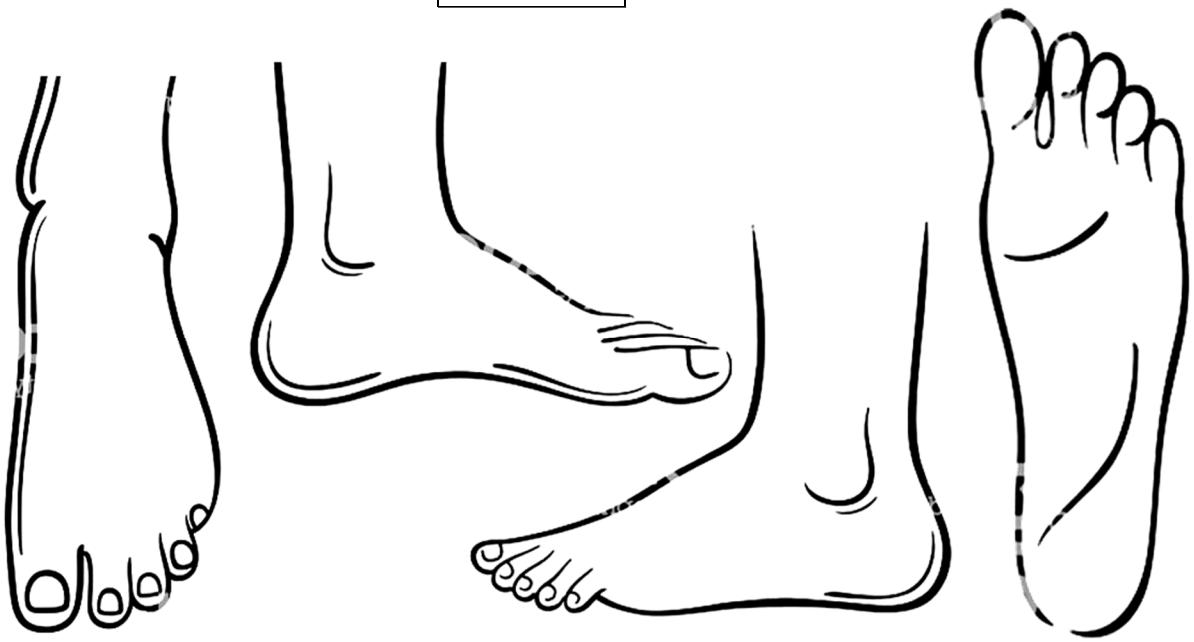
PLEASE MARK LOCATION OF PAIN IN FOOT
USING THIS SCALE: MILD 1
MODERATE 2
SEVERE 3

ALSO: INDICATE ANY
BURNING OR TINGLING
ON THE PICTURES BELOW

RIGHT



LEFT



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PATIENT REGISTRATION FORM

PATIENT INFORMATION: (Please use full legal name, no nicknames)			
Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Sex:	Social Security #:
Address:			
City:		State:	Zip:
Home Phone #:		Cell Phone #:	
E-mail Address:			Driver's License #:
Was this an injury? ☐ Yes ☐ No	If yes, where did your injury occur? ☐ Work ☐ Auto ☐ Home ☐ School		Date of injury:
Employer Name:		Occupation/Title/Position:	
Employer Address and Phone #:			
Emergency Contact Name:		Relationship:	Phone #:

GUARANTOR INFORMATION: (List person or insured name responsible for bill – use full legal name, no nicknames)			
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other			
Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Sex:	Social Security #:
Address:			
City:		State:	Zip:
Home Phone #:		Cell Phone #:	
Employer Name:		Occupation/Title/Position:	
Employer Address and Phone #:			

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)
IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INS	Insurance Company:		Copay:	☐ HMO ☐ PPO ☐ POS
	Policy/ID #:		Group #:	
	Claims Address & Phone #:			
	Insured's Name:	Relationship:		Insured's Date of Birth:
	Insured's Employer:		Insured's Social Security #:	
SECONDARY INS	Insurance Company:		Copay:	☐ HMO ☐ PPO ☐ POS
	Policy/ID #:		Group #:	
	Claims Address & Phone #:			
	Insured's Name:	Relationship:		Insured's Date of Birth:
	Insured's Employer:		Insured's Social Security #:	

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 SPECIALTY INSTITUTE

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: _____

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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 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
16300 Sand Canyon Ave · Suite 511 · Irvine, CA 92618 · Tel. (949) 255-9890 · Fax (949) 255-9776

ORTHOPAEDIC SPECIALTY INSTITUTE

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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_____