LOS AL Ortho | Los Alamitos Orthopaedic Medical & Surgical Group

3851 Katella Avenue Suite 150
Los Alamitos, CA 90720
(562) 314 1400 - Phone
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Andrew Hanflik MD
Grietje van Dyk, MD, FAAOS
Justin Millard MD
Perry Secor, MD, FAAOS, FACS
Richard Blanks, MD, FAAOS
Diana Lau, MD, FAAOS

Patient Name: Middle Initial:

Sex: Male Female SSN#:

DOB:

Home Address:

City: Zip Code:

State:

E-mail: Opt in for Patient Portal? YES NO

Occupation:

Primary Care Physician: City:

Pharmacy Address:

Primary Insurance: Group Number:

Plan ID Number: Guarantor Name:

Secondary Insurance: Group Number:

Plan ID Number: Guarantor Name:

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished to me by any of the physicians at Los Alamitos Orthopedic Medical and Surgical Group. I authorize any holder of medical information about me to release to my insurance any information needed to determine these benefits. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, and I accept financial responibility for non-covered services.

Signature Date

PERMISSION TO LEAVE PHONE MESSAGES

Dear Patient,
HIPPA privacy guidelines prevent us from leaving messages for you regarding appointments or any other medical matter. In order to efficiently communicate with you regarding appointment confirmations, changes or availability please sign below, thereby giving us permission to leave a message on your answering machine, service or with an emergeny contact. This waiver will apply only to messages regarding your appointment(s) or the need for the Doctors or their staff to speak with you regarding procedures or results. No other medical information will be communicated.

I give permission for the Doctors or their staff to leave phone messages with:

Consent to Call: YES NO Consent to Text: YES NO Answering Machine: YES NO

Home Phone: Mobile Phone:

Emergency Contact: YES NO

Contact Name: Phone #:

Patient's Name (Print)

Patient Signature Date

Hand Dominance: LEFT RIGHT

Main Problem and body part you are coming in for today

Were you recently injured or experienced any trauma; Is your complaint the result of recent trauma?

On a scale of 1 to 10 (10 being the worst) What is your CURRENT pain level

1 2 3 4 5 6 7 8 9 10

Where is your pain located

What is the quality of your pain Sharp Dull Achy Other:

How long have you had this problem

What is the timing of your problem Constant Occasional Morning Evening Other:

Do you have any mechanical symptoms Popping Clicking Grinding Other

Is there anything that makes it worse Activity Non-Activity Other

Have you had any of the following diagnostic studies within the last 6 months pertaining to this body part

X-Ray	Date	Location
CT Scan	Date	Location
Myelogram	Date	Location
EMG/Nerve Conduction	Date	Location
MRI	Date	Location
Arthrogram	Date	Location

Please list ALL medications you are currently taking:

Are you allergic to any medications or anything else? If YES, please explain:

List ALL surgeries you have had:

____

____

____

____

Social History

(Please circle all that apply to you)

Marital Status:	Single	Married	Widowed	Divorced	Separated	Registered Partnership
Caffeine:	NO	YES	How Much:			
Smoke:	NEVER	YES	FORMER	When did you quit		
Alcohol:	NO	YES	Type/Frequency:			
Recreational Drugs	NO	YES	Type/Frequency:			
Education:	High School	College	Post Graduate			
Are you currently working?	NO	YES	DISABLED	RETIRED	(If NO) Last day worked:	

Past Medical History

(Please circle all that apply to you)

Have you previously or currently been diagnosed with any of the following?

			If "Yes", please include the onset date:
AIDS/HIV	NO	YES	____________
Anxiety/Depression	NO	YES	____________
Asthma	NO	YES	____________
Bleeding Disorder	NO	YES	____________
Blood Clot	NO	YES	____________
Cancer	NO	YES	____________
COPD	NO	YES	____________
Coronary Artery Disease	NO	YES	____________
Diabetes	NO	YES	____________
Heart Attack (Myocardiac Infarction)	NO	YES	____________
Heart Problems	NO	YES	____________
Hepatitis	NO	YES	____________
High Cholesterol	NO	YES	____________
Hypertension	NO	YES	____________
Kidney Disease	NO	YES	____________
Liver Disease	NO	YES	____________
Seizures/Epilepsy	NO	YES	____________
Stroke	NO	YES	____________
Thyroid Problems	NO	YES	____________
Other:____________			____________

Comprehensive Review of Systems

(Please circle all that apply to you)

Constitutional	Normal	No Weight Gain	No Weight Loss		
	Fever	Night-Sweats	Malaise		
Eyes	Normal	Eye Disease/injury	Wears Glasses/Contact Lenses		
Ears	Normal	Difficulty Hearing	Ear Pain		
Nose	Normal	Frequent Nosebleeds	Nose Problems	Sinus Problems	
Mouth/Throat	Normal	Mouth Ulcer	Bleeding gums	Snoring	
	Oral Abnormalities	Dry Mouth	Sore Throat	Sinusitis	
	Teeth Abnormalities	Mouth Breathing	Ringing in the ears		
Cardiovascular	Normal	Shortness of Breath when: Walking or Lying down			
	Known Heart Murmur	Light-headed on standing	Ankle Swelling		
	Chest Pain on exertion	Palpitations			
Respiratory	Normal	Wheezing	Shortness of Breath		
	Cough	Coughing up Blood	Sleep Apnea		
Musculoskeletal	Normal	Muscle aches	Muscle weakness		
	Back pain	Swelling in the extremities	Arthralgias/joint pain		
	Cramps	Difficulty walking	Osteoporosis		
	Neck pain	Fractures			
Gastrointestinal	Normal	Normal Appetite	Vomiting	Nausea	
	Constipation	Abdominal Pain	GERD	Vomit w/ Blood	
	Change in Appetite	Black or Tarry Stools		Frequent Diarrhea	
Genitourinary	Normal	Urinary Loss of Control	Hematuria	Difficulty Urinating	
	Increased Urinary Frequency		Incomplete Emptying		
Integumentary	Normal	Change in skin color	Dry Skin	Itching	Rash
	Abnormal Mole	Growths/lesions	Jaundice	Psoriasis	
	Breast Lump	Changes in hair/nails	Laceration	Non-healing area	
Neurologic	Normal	Loss of consciousness	Weakness	Paralysis	
	Migraines	Numbness	Seizures	Frequent/Severe Headaches	
	Restless Legs	Gait Dysfunction	Dizziness	Tremor	
Psychiatric	Normal	Depression	Delirium	Dementia	Agitation
	Sleep Disturbances	Memory Loss	Hallucinations	Anxiety	Restless Sleep
	Feeling unsafe in a Relationship		Alcohol Abuse	Mood Swings	Suicidal Thoughts
Diabetes/Thyroid	Normal	Fatigue	Increased thirst		
	Increased Hair growth	Hair Loss	Cold Intolerance		
Hematologic/Lymphatic	Normal	Swollen Glands	Excessive Bleeding		
	Anemia	Easy Bruising	Phlebitis	Blood Clotting Problems	
Allergic/Immunologic	Normal	Runny Nose	Sinus Pressure		
	Itching	Hives	Frequent Sneezing		

HIPAA – MEDICAL AUTHORIZATION FOR RELEASE OF INFORMATION FORM

Los Alamitos Orthopaedic Medical & Surgical Group

3851 Katella Ave Ste 150

Los Alamitos California 90720

Phone: 562-314-1400 Fax: 562-431-0564

Patient Name: ________________________________ **DOB:** ________________________

1. **Authorization**
   I, ____________________________, authorize _____________________________________ (healthcare provider) to use and disclose the protected health information described below to:
   _____________________________________ (individual/group seeking information)
1. **Effective Period**
   This authorization for release of information covers the period of healthcare from:
   - __________________ to ____________________ (date)
     -OR-
   - all past, present and future healthcare dates
2. **Extent of Authorization**
   - I authorize the release of my complete health record (including records relating to mental health, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse)
     -OR-
   - I authorize the release of my complete health record with the exception of the following information:
     Mental Health Records ______
     Communicable Diseases ______
     HIV and AIDS diagnosis/testing ______
     Alcohol/Drug abuse treatment ______
     Other (please specify) _____________________________________
3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I direct.
4. This authorization will remain in force and effect until ____________ (date), at which time this authorization expires.
5. I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Representative: ____
Printed Name: ____
Date: ____

FINANCIAL POLICY 2018

Thank you for choosing **Los Alamitos Orthopaedic Medical & Surgical Group** as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments, co-insurance, deductible amounts and past due balances are due at time of check-in. We accept cash, check or credit cards. No post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. To properly bill your insurance, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Our office does not accept Medi-Cal insurance. If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. Our office will notify you by mail if we no longer accept your insurance. You have the option at that time to continue treatment with our physicians by accepting all financial responsibility for treatment or you may have your care and medical records transferred to the physician of your choice.

Referrals and Pre-authorizations

Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Surgical Fees

The insurance company will be billed following surgery; however, the patient responsibility portion will be due and payable at your first post-operative office visit. At your request, an estimate of those fees will be made for you prior to your surgery. This will only be an estimate based on the expected procedures and services performed. If the insurance company does not pay for the service provided, it is the patient's responsibility to pay the balance within 30 days from the date of surgery.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to bring a credit card for authorization in the amount of **$300** at the initial appointment if not being seen for surgery and will be asked to make payment arrangements for the balance. Imaging patients must present a credit card for authorization in the amount of **$75** at the initial appointment and will be asked to make payment arrangements for any balance. Extended payment arrangements are occasionally available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. *It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.*

Missed Appointments

Los Alamitos Orthopaedic Medical & Surgical Group requires 24-hour notice of appointment cancellation. Appointments missed and not previously canceled may be charged a fee of **$25** per occurrence.

Returned Checks

The charge for a returned check is **$25** payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

I, ________________________________, have read the above financial policy and understand and accept my financial responsibility.

Patient/Guardian Signature: _____________________________________ **Date:** _____________________

Witness: _____________________________________ **Date:** _____________________

PRIVACY PRACTICES AND POLICY

You have the right to:

1. Revoke or modify your authorization by writing to our business office
   Please note, we will respond in writing whether we approve or deny your request
   Please note, you may submit an addendum no longer than 250 words in length for each item you believe is erroneous and request that this document be included in your PHI and you may request to review such records
2. Review your PHI in person by writing to our business office and letting us know when and where you are able to view it within our normal business hours
   Please note, if the request is denied, we will explain the reason in writing
3. Request a copy of your PHI by writing to our business office
   Please note, if the request is denied, we will explain the reason in writing
4. Request an accounting of certain disclosures that are made of your PHI by writing to our business office.
   Please note that we will respond to your request in a reasonable amount of time but not later than 60 days after we receive your written request.
5. Receive a copy of this Notice of Privacy Practices
6. Restrict restrictions on how we use and disclose your PHI for our treatment, payment and healthcare operations by writing to our business office.
   Please note that we are not required to accept your request for restriction
7. Request that we provide your PHI to you in a confidential manner by writing to our business office.

PHI is critical to providing you with quality healthcare. We will accommodate any reasonable request, unless they are administratively burdensome, or prohibited by law. We must follow the privacy practices set forth in this notice while in effect. If you have any questions about this notice, wish to exercise your rights, or file a complaint, please direct your inquiries to:

Stacey Ulrich: Privacy Officer

Los Alamitos Orthopaedic Medical & Surgical Group

3851 Katella Avenue, Suite 150

Los Alamitos, California 90720

You may contact your Health Plan or the California Department of Managed Care with your concerns as well. You also have the right to directly complain to the Secretary of the United States Dept. of Health and Human Services. We will not retaliate against you for filing a complaint against us. We will use and disclose your PHI to the fullest extent authorized by law. We reserve the rights as expressed in this notice. We reserve the right to revise our Privacy Practices consistent with the law and make them applicable to your entire PHI that we possess, regardless of when it was received or created. If we make material changes to our Privacy Practices, we will promptly revise this Notice. Unless law requires the changes, we will not implement material changes to our Privacy Practices before we revise this Notice.

I acknowledge that I have read and agree to the above PRIVACY PRACTICES AND POLICY:

____ ________________________

PATIENT'S SIGNATURE DATE

Medication Agreement

I, ______________________________, agree to the following rules about my medicine(s).

I am taking these medicines to treat:____

The medication(s) covered by this agreement include: **Please PRINT clearly**

Medicine	Dose	How I Take It	Amount Per Month
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________

1. I will take my medicine as prescribed by my doctor. I will talk with my doctor before changing my dose.
2. I will take care of my medicines. My doctor will not replace lost or stolen prescriptions.
3. My doctor will not approve early refills.
4. My doctor will not approve refills when the doctor's office is closed.
5. I request all refills by calling my doctor during these hours: ____________________.
   Doctor's phone number: ____________________.
6. I will get all refills for these medicines at this pharmacy: ______________________.
7. I know that my doctor may change or stop my medicine if it does not relieve my pain.
8. I agree that my doctor may share this form with doctors who are taking care of me, including emergency room doctors.
9. I will see my doctor every ____.
10. I agree to follow the above rules. I understand that if I do not follow these rules, the doctor may stop prescribing these medicines and may ask me to go elsewhere for care.
11. I also understand that my doctor may take urine samples to check for medication compliance.
12. My physician receives regular reports from the CURES program for the purpose of medication and treatment compliance.

Signed: ____________________________________ Date: __________________

Provider: (PRINT) ____________________________ Date: __________________

Provider (signature) ___________________________ Date: __________________

Patient Name:____________________________ DOB:_________________