LOS AL Ortho | Los Alamitos Orthopaedic Medical & Surgical Group

3851 Katella Avenue Suite 150
Los Alamitos, CA 90720
(562) 314 1400 - Phone
(562) 431 0564 - FAX

Andrew Hanflik MD
Grietje van Dyk, MD, FAAOS
Justin Millard MD
Perry Secor, MD, FAAOS, FACS
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


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: _____

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## FINANCIAL POLICY

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 (e.g. insurance, address).

## Co-pays

The patient is **required** to provide an eligible insurance card and identification at each visit. **All co-payments, co-insurance, deductible amounts, and past due balances are due at time of check-in**. **We accept cash, credit cards, or debit cards. Checks are not accepted.**

## Insurance Claims

Health Insurance is a contract between you and your insurance company. 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 with 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 will provide a list of in-network insurance plans upon request.

***Our office does not accept Medi-Cal insurance, either as a primary or secondary 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.***

***Our office is not currently accepting any new Worker's Compensation or Personal Injury patients.***

## Referrals and Pre-authorizations

Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from your 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.

If the patient has an open deductible prior to elective surgery, the lesser of 50% of the estimated costs will be collected or the remainder of the deductible. If there is a credit balance after receipt of the EOB from the insurance provider, a refund will be provided to the patient. Patient acknowledges that our surgeon's professional fees are separate from both the facility and anesthesiology fees. Some surgical procedures require an assistant surgeon, who may also bill the patient for services rendered.

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## 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. 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.

## 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 statements over the course of 75 days. If payment is not received, the account may be sent to a collection agency or an attorney. Patients with delinquent accounts may be discharged from the practice.

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: _____**

## 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:

Carol Olivarez: 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

***Pain Medication Agreement***

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

To avoid any duplication, I am currently prescribed the following pain medication(s) or opioids:

**Please PRINT clearly**

| Medicine | Dose | How I Take It | Amount Per Month |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

I am currently taking these medicines to treat:_____

1. I will take my medicine as prescribed by my doctor.
2. I will talk with my doctor before changing my dose.
3. I will take care of my medicines. My doctor will not replace lost or stolen prescriptions.
4. I will ***not*** engage in illegal activities such as selling or trading my prescriptions.
5. My doctor will not approve early refills.
6. My doctor will not approve refills when the doctor's office is closed.
7. I request all refills by calling my doctor during their business hours.
8. I will get all refills for these medicines at this pharmacy: _____.
9. I know that my doctor may change or stop my medicine if it does not relieve my pain.
10. I agree that my doctor may share this form with doctors who are taking care of me, including emergency room doctors.
11. I understand that my doctor may take urine samples to check for medication compliance.
12. I understand that my doctor receives regular reports from the CURES program for the purpose of medication and treatment compliance.
13. I understand if I suddenly stop using these pain medications, I may have withdrawals.
14. I understand if I misuse my prescription, it can result in health problems or fatal consequences.

***My signature bellow means that I agree to follow the above rules. I understand that if I break the rules of this contract, the doctor may stop prescribing these medicines.***

Patient Name:_____ DOB:_____

Signed: _____ Date: _____

Provider: (PRINT) _____ Date: _____

Provider (signature) _____ Date: _____