

Patient Registration



Last Name: _____

First Name: _____

Middle Initial _____ Preferred Name _____

Sex: _____ Date of Birth: _____

SSN: _____

Address: _____

City: _____ State _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Consent to call: YES or NO

(would you like to receive automated messages/text and alerts from our practice via your mobile number?)

Work Phone: _____

E-Mail: _____

Contact Preference: Hm Wk Cell Email Mail

Marital Status: _____

Language: _____

Race: _____ Ethnicity _____

How did you hear about us? _____

Referring Physician: _____

Primary Care Physician: _____

IS THIS ACCIDENT RELATED? Yes or No (Auto, Work, Other)

Emergency Contact Information:

Name: _____

Relation: _____

Phone: _____ Mobile: _____

Next of Kin: _____

Relation: _____

Phone: _____

Guarantor (name to whom statements are sent)

Guarantor Name: _____

Guarantor's relation to patient: _____

Guarantor's Address _____

Primary Insurance Information:

Type of Insurance: _____

Policy holder Name: _____

Relation to Patient: _____

Sex: _____ Date of Birth: _____

Social Security Number: _____

Policy ID Number: _____

Policy Group Number: _____

Employer Name: _____

Employer Phone: _____

Secondary Insurance Information:

Type of Insurance: _____

Policy holder Name: _____

Relation to Patient: _____

Sex: _____ Date of Birth: _____

Social Security Number: _____

Policy ID Number: _____

Policy Group Number: _____

Employer Name: _____

Employer Phone: _____

Signature: _____

Date: _____

ORTHOPEDIC ASSOCIATES OF NORTHERN CALIFORNIA

P (530) 897-4500

F (530) 897-4544

131 Raley Blvd., Chico CA

6127 Clark Rd., Ste 200 Paradise, CA

All Fees whether they are covered by insurance or not, are due/payable within 30 days unless other arrangements have been made. A service charge is applicable after this period, regardless of insurance status. It could be either 1 1/2 % per month (18% annual percentage rate, or a minimum charge of \$50 cents. I hereby authorize my insurance benefits to be paid to the physician. I am financially responsible for all non-covered charges. I authorize the physician to release any information required by other physicians/agencies for the purpose of reimbursement to my account or pending treatment deemed necessary by my physician.

Health Information

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Name: _____ DOB: _____ Date: _____

Primary MD: _____ Referring MD: _____ Scheduled to see today: _____

Briefly explain the reason for today's visit: _____

Pharmacies that you have Medications filled at

Have you had any prior imaging for this problem (X-Rays, MRI, CT, EMG)? YES NO

1. Type of Exam: _____ Where: _____ Approx When: _____

2. Type of Exam: _____ Where: _____ Approx When: _____

IS THIS INJURY WORK RELATED: YES NO

IS THIS INJURY AUTO RELATED: YES NO

IS THIS INJURY IN LITIGATION: YES NO ATTORNEY: _____

Treating Physicians

Please List all physicians you are currently treating with, and why

Medication Allergies & Reaction YES OR NO

METAL ALLERGY YES OR NO

LATEX ALLERGY YES OR NO

Irritation with any type of Jewelry: Yes No Type of Jewelry: _____

Current Medications (Prescription and Over the Counter) Include Dosage, Directions and Prescribing Doctor

Patient Name _____ Date _____

Family History

Please indicate if Paternal/Maternal
(ie mother, father, sibling, grandmother, grandfather)

<u>Condition</u>	<u>Relation</u>
Arthritis	
Asthma	
Back Problems	
Bleeding Disorders	
Cancer	
Diabetes	
Heart Attack (MI)	
Heart Problem	

<u>Condition</u>	<u>Relation</u>
High Cholesterol	
Hypertension	
Orthopedic Problems	
Osteoarthritis	
Osteoporosis	
Pulmonary Embolism	
Rheumatoid Arthritis	
Other	

Other Conditions not listed above: _____

Social History

Smoking Status	Never	Former	Current
Tobacco-years of use			
Deaf or serious difficulty hearing	Yes	No	
Blind or serious difficulty seeing	Yes	No	
Difficulty concentrating/ remembering	Yes	No	
Difficulty walking or climbing stairs	Yes	No	
Difficulty dressing or bathing	Yes	No	
Difficulty doing errands alone	Yes	No	
Marital Status			
Number of Children			

Live alone or with others	
Single or multi-level home	
Education level	
Are you currently employed?	Yes No
Employer	
Occupation	
Occupational health risks	
Work related injury?	Yes No
Auto related injury?	Yes No
If injured, is litigation ongoing?	Yes No
Hand dominance	

General stress level	Low Medium High
Exercise level	None Occasional Moderate Heavy
Sporting activities	
Caffeine intake	None Occasional Moderate Heavy
Alcohol Intake	None Occasional Moderate Heavy
Alcoholic Drinks Per Day	
Has smoked since age	
Smoking-how much?	
Chewing Tobacco	
Illicit drugs	
Advanced directive	

Surgical History

<u>Surgery</u>	<u>Y/N</u>	<u>Details</u>
Appendectomy		
C-Section		
Cardiac Catheterization		
Gallbladder		
Gastrointestinal Surgery		
Genitourinary Surgery		
Heart Surgery		
HEENT Surgery		
Hernia		
Hysterectomy		
Neurosurgery		

<u>Surgery</u>	<u>Y/N</u>	<u>Details</u>
Oncology Surgery		
Orthopedic Surgery		
Pacemaker		
Plastic Surgery		
Renal Surgery		
Thoracic Surgery		
Thyroid Surgery		
Tonsillectomy		
Vascular Surgery		
Other		
Other		

Patient Name _____ Date _____

Past Medical History

<u>Condition</u>	<u>Y/N</u>	<u>Notes</u>	<u>Condition</u>	<u>Y/N</u>	<u>Notes</u>	<u>Condition</u>	<u>Y/N</u>	<u>Notes</u>
Anemia			Heart Attack (MI)			Osteoporosis		
Anxiety Disorder			Heart Disease			Pacemaker		
Arthritis			Heart Problems			Peripheral Vascular Disease		
Asthma			Hepatitis			Pulmonary Embolism		
Bleeding Disorder			Hernia			Rheumatoid Arthritis		
Blood Clots			Hypercholesterolemia			Seasonal Allergies		
Cancer			Hypertension			Seizures/Epilepsy		
Coronary Artery Disease			Kidney Disease			Stroke		
Depression			Leg or Foot Ulcers			Thyroid Problems		
Diabetes			Liver Disease			Tuberculosis		
GERD/Reflux			Lung Disease			Ulcers		
Gout			Menopause		Age Started:	Urinary Tract Infections		
HIV or AIDS			Migraines					

Review of Systems (Please check all that Apply)

Constitutional: Fever Night Sweats Significant Weight Gain (lbs Gained _____) Significant Weight Loss
Other

Please explain any check marks above: _____

Eyes: Dry Eyes Irritation Vision Change Other

Please explain any check marks above: _____

ENMT: Ears: Difficulty Hearing Pain Other

Nose: Frequent Nosebleeds Nose/Sinus Problems Other

Mouth/Throat: Sore throat Bleeding Gums Snoring Dry Mouth Mouth Ulcers
Oral Abnormalities Teeth Problems Other

Please explain any check marks above: _____

Cardiovascular: Chest Pain Arm Pain on exertion Shortness of breath when walking
Shortness of breath when lying down Palpitations Heart Murmur Chest pain on exertion
Light-Headed upon Standing Other

Please explain any check marks above: _____

Respiratory: Cough Wheezing Sortness of breath Coughing up blood Sleep Apnea Other

Please explain any check marks above: _____

Gastrointestinal: Abdominal Pain Vomiting Change in appetite Frequent Diarrhea
Vomiting blood Black or tarry stools Other

Please explain any check marks above: _____

Genitourinary: Incontinence Difficulty urinating Hematuria Increased urinary frequency
Incomplete emptying Other

Please explain any check marks above: _____

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Patient Name _____ Date _____

Review of Systems-Continued

Musculoskeletal: Muscle Aches Muscle weakness Joint Pain Back pain Swelling in the Extremities
Other

Please explain any check marks above: _____

Integumentary: Abnormal mole Jaundice Rashes Itching Dry Skin Growth/Lesions Other

Please explain any check marks above: _____

Neurologic: Loss of consciousness Weakness Numbness Seizures Dizziness
Frequent or severe headaches Migraines Restless Leg Other

Please explain any check marks above: _____

Psychiatric: Depression Sleep Disturbances Feeling unsafe in Relationship Alcohol abuse Restless Sleep
Other

Please explain any check marks above: _____

Endocrine: Fatigue Increased Thirst Hair Loss Increased Hair Growth Other

Please explain any check marks above: _____

Hematologic/Lymphatic: Swollen Glands Bruising Excessive Bleeding Other

Please explain any check marks above: _____

Allergy/Immunologic: Runny Nose Sinus Pressure Itching Hives Frequent Sneezing
Reaction to Metals Other

Please explain any check marks above: _____



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HIPAA Disclosure Form

PRINT PATIENT NAME: _____

I. Please list the family members or the other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name _____ Relationship _____ DOB _____

Name _____ Relationship _____ DOB _____

Name _____ Relationship _____ DOB _____

Name _____ Relationship _____ DOB _____

II. Please list your primary care physician and any other physician's that you give us permission to release information to. This can include but is not limited to chart notes, op reports and diagnostic reports.

Physician _____ Specialty _____ Phone #: _____

Physician _____ Specialty _____ Phone#: _____

III. Medication History Authorization – Please indicate whether you (the patient or patient's representative) will grant us permission to download the patient's medication history automatically from our pharmacy benefit managers.

YES _____ NO _____

IV. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home. _____

V. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES _____ NO _____

VI. Please print the alternative daytime telephone number(s) where you would like to receive communications regarding your appointments, lab and x-ray results, and other health care information:

() _____ () _____

*** I am fully aware that a cellular phone is not a secure and private line ***

VII. Can confidential messages be left on your answering machine or voicemail? YES _____ NO _____

VIII. I am fully aware my health information will be transmitted by electronic transmission, fax transmittal, internet, or e-mail.

SIGNATURE: _____ DATE _____

(If Minor of 18 years Parent or Guardian Signature)

Patient Partnership & Financial Policy

(Version 1.3)

To Our Patients:

We are pleased you have chosen Orthopedic Associates of Northern California to provide your medical services. We are committed to providing you with the best possible medical care to meet your needs. Our practice firmly believes that to achieve our mission we must maintain a high level of understanding and good communication with our patients throughout the course of treatment. Just as we would communicate with you your treatment plan and importance to be compliant to ensure the best outcome, similarly we pride ourselves on communicating with you any anticipated out of pocket costs to create a better understanding and level of expectation. Our Patient Financial Partnership policy is designed to be completely transparent and together alleviate any surprises during your road to recovery and good health.

The following information is provided to clarify our policies concerning payment for professional services:

1. **Time of Collection:** Our front desk staff and/or kiosk system will be asking for copayments, out-of-pocket deductible or co-insurance, self-pay deposits, and outstanding balance payments when you check in for your appointment. Deductible and out-of-pocket costs will have been determined prior to your arrival by contacting your insurance company for these amounts and applying them to the estimated costs of your procedures & treatment. We accept many forms of payment, including cash, check, money orders, Visa, MasterCard, Discover, American Express, as well as Care Credit.
2. **Account Balances:** Financial estimates are not always exact; account balances reflect the final service(s) rendered and insurance benefits allowed under your plan. Unless other arrangements have been made, the following payment plans will be automatically set up. Account balances ranging from-
 - \$10-\$75 will be default to a Net 30-day payment plan
 - >\$75-\$200 will default to a Net 60-day payment plan
 - >\$200-\$350 will default to Net 90-day payment plan
 - Balances over \$350 will default to a Net 120-day payment planExtended plans will be considered on a case by case basis and must be secured with an ATM/Credit Card contract for the monthly payments. The automated payment date for the recurring payment will be a date in the month that best works for you.
3. **Care Credit Financing Option:** Our office proudly provides Care Credit as a way to finance your balance with interest rates as low as zero percent depending on the terms chosen.
4. **Uninsured or non-covered services:** Uninsured patients will be directed to the business office prior to scheduling services for financial counseling. A deposit towards treatment of \$450.00 (minimum) is required at the time of your appointment.
5. **Patient Credits:** Credits are refunded after treatment by any provider in the practice has been completed and all claims have been finalized by your insurance.
6. **Missed Appointments:** All appointments that are missed or not cancelled within 24 hours are subject to a no-show fee. This applies to same day cancelations. The fee for office visits is \$75 and \$100 for MRI appointments. Reminder calls are provided 48 hours in advance to help you meet the 24 hour window. Notifying us timely helps us- to help you- remain compliant with treatment and get you rescheduled ASAP to help ensure a great outcome. It also helps us to help other patients that need that appointment time to also ensure their best outcome.



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If you are consistently unable or unwilling to meet these new guidelines there is a possibility we may need to reschedule any future appointments or services until a time when you are able to do so. Additionally, any open account balance that reaches 90 days+ could be automatically transferred to our 3rd party collection partner. Please note a situation of this type would be considered on a case-by-case basis.

It is also *extremely important* that we be notified, *as soon as possible*, of any changes in your insurance status, or to your insurance carrier. This would include eligibility changes, becoming newly insured or uninsured, or acquiring additional, or new secondary coverage. Failure to do so will result in a direct balance billing to you under the direction of this policy since we will not be able to bill your insurance without this information.

Orthopedic Associates of Northern California understands that you may be facing stressful life events while you are acquiring our services. Our account specialist are here to help counsel our patients on our policies, and any insurance questions that arise. We hope to help you as much as possible through this process, and be an advocate for you as you navigate through the financial portion of your medical care.

If you have any questions about these policy changes we are happy to help you. Please contact your account specialist at (530) 897-4500 option 5 or (530)-897-4545.

Cordially,

Orthopedic Associates of Northern California

In order to properly bill your insurance, please provide the following information:

Subscriber's full name _____
Subscriber's Social Security Number ____-____-_____
Subscriber's Date of Birth ____/____/____
Patient's full name _____
Patient's Date of Birth ____-____-_____
Patient's Social Security Number (if adult) ____-____-_____

By signing below, you certify that you have received, read, and understand Orthopedic Associates Patient Financial Partnership Policy. Version 1.3

Patient Signature **or**
Guardians Signature
(if patient under the age of 18)

Relationship Name of Patient
(please print)

DATE