

# 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	Live alone or with others		General stress level	Low Medium High
Tobacco-years of use		Single or multi-level home		Exercise level	None Occasional Moderate Heavy
Deaf or serious difficulty hearing	Yes No	Education level		Sporting activities	
Blind or serious difficulty seeing	Yes No	Are you currently employed?	Yes No	Caffeine intake	None Occasional Moderate Heavy
Difficulty concentrating/ remembering	Yes No	Employer		Alcohol Intake	None Occasional Moderate Heavy
Difficulty walking or climbing stairs	Yes No	Occupation		Alcoholic Drinks Per Day	
Difficulty dressing or bathing	Yes No	Occupational health risks		Has smoked since age	
Difficulty doing errands alone	Yes No	Work related injury?	Yes No	Smoking-how much?	
Marital Status		Auto related injury?	Yes No	Chewing Tobacco	
Number of Children		If injured, is litigation ongoing?	Yes No	Illicit drugs	
		Hand dominance		Advanced directive	

## Surgical History

<u>Surgery</u>	<u>Y/N</u>	<u>Details</u>	<u>Surgery</u>	<u>Y/N</u>	<u>Details</u>
Appendectomy			Oncology Surgery		
C-Section			Orthopedic Surgery		
Cardiac Catheterization			Pacemaker		
Gallbladder			Plastic Surgery		
Gastrointestinal Surgery			Renal Surgery		
Genitourinary Surgery			Thoracic Surgery		
Heart Surgery			Thyroid Surgery		
HEENT Surgery			Tonsillectomy		
Hernia			Vascular Surgery		
Hysterectomy			Other		
Neurosurgery			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 3<sup>rd</sup> 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

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**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



