TOSMG PATIENT INFORMATION FORM

Referred by: _____

Today's Date: ____/ ____/ ____

Last Name: _____ **First Name:** _____ **MI:** ____

Address: _____ **Social Security #** _____-_____-_____ **Gender:** M / F

City: _____ State: _____ Zip: _____ **Date of Birth:** ____/____/____ **Age:** _____

Home Telephone: (_____) _____-_____ **Marital Status:** Single / Married / Divorced / Widowed

Work Phone: (_____) _____-_____ **Ethnicity:** _____

Cell Phone: (_____) _____-_____ **Language: ENGLISH Other:** _____

E-Mail address: _____ Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ **Tel:** (_____)_____ **Relationship** :_____

Primary Care Physician: _____ **Date Last Seen by PCP:** _____

IS YOUR COMPLAINT TODAY RELATED TO A WORK INJURY? YES / NO

INSURANCE INFORMATION

Is your insurance plan an **HMO / PPO / EPO / Medicare / Workers' Compensation / Other:** _____

PRIMARY INSURANCE

Insurance Company Name: _____
Insured's Name: _____
Relationship to patient: Self/Spouse/Dependent
Insured's SS# _____-____-_____
Insured's D.O.B ____/____/____
Insured's Employer Name: _____
Group and ID# _____

SECONDARY INSURANCE

Insurance Company Name: _____
Insured's Name: _____
Relationship to patient: Self/Spouse/Dependent
Insured's SS# _____-____-_____
Insured's D.O.B ____/____/____
Insured's Employer Name: _____
Group and ID# _____

********************CONSENT FOR MEDICAL TREATMENT & ASSIGNMENT OF BENEFITS********************

PATIENT'S or INSURED'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature of patient (parent if minor): X _____ **Date:** ____/ ____/ ____

************************************PRESENT COMPLAINT************************************

Part of body: _____ **Left/ Right/ Both Specific areas:** _____

Onset: ___/___/___ gradual/ sudden **Duration:** ____ days/ weeks/ months/ years **Pain scale** (1-10):_____

Status: improving/ worse/ stable/ resolved/ fluctuating **Frequency:** intermittent/ constant/ occasional/ rare

Does your pain radiate? Y /N Where? _____ **Quality:** aching/ burning/ dull/ sharp/ throbbing _____

Context: no injury/ injury/ sports injury/ motor vehicle accident/Other: _____

***Describe:** _____

Trauma: Type: fall/ running/ direct blow/ twisting/ lifting/ crush History of injury to area? Y/N Year: _____

Where: _____ Date: ___/___/___ or around: _____

Aggravated by: **Nothing**

bending/ lifting/ movement/ walking/ sitting/ standing/ pushing/ pulling/ stairs Other:_____

Relieved by: **Nothing**

splint/ ice/ heat/ massage/ therapy/ elevation/ exercise/ stretching / OTC medicines: _____

Associated symptoms: **Nothing**

bruising/ instability/ tenderness/ weakness/ numbness/ tingling/ swelling/ limping/ locking/ decreased mobility

TOSMG MEDICAL HISTORY FORM NAME:_____ DATE:_____

YOUR DOCTORS: Please list your current doctors and their specialties:

DOCTOR	SPECIALTY	DOCTOR	SPECIALTY
1.		3.	
2.		4.	

MEDICAL CONDITIONS: Please list your medical conditions:

Height: _____ Weight:_____

1.	4.	7.
2.	5.	8.
3.	6.	9.

SURGERIES: Please list any surgeries you've had, including the left or right side and year:

SURGERY	YEAR	SURGERY	YEAR
1.		4.	
2.		5.	
3.		6.	

FAMILY MEDICAL HISTORY: Please list the status of your family members with medical conditions

RELATIVE	STATUS	AGE	MEDICAL CONDITIONS
Father	Alive___Deceased___		
Mother	Alive___Deceased___		
Sibling #1 Bro/Sis	Alive___Deceased___		
Sibling #2 Bro/Sis	Alive___Deceased___		
Child #1 M/F	Alive___Deceased___		
Child #2 M/F	Alive___Deceased___		

SOCIAL HISTORY: Occupation:_____Hand dominance: R__ L__ Ambidextrous___

Tobacco use: No__Yes__ Former: Quit Date:_____Type: Cigarettes/ Chew/ Pipe/ Cigar

Amount/ packs per day_____# of years_____

Alcohol consumption: No___Yes__ Type: Beer/ Wine/ Hard liquor:_____ # per day/ week/ month____

History of alcohol abuse: No__Yes__

Recreational drug use: No__ Yes__ Type:_____Have you ever used needles? No__Yes__ Year: _____

ALLERGIES: Please list any medication allergies or reactions to medications/ other agents:

ALLERGY:	REACTION:

CURRENT MEDICATIONS: Please list prescription and non prescription meds including herbal supplements

PHARMACY: CVS/ Walgreens/ Rite·aid/ Costco/ Pavilions/ Sav·on/ Other: _____

Address:_____Ph: (_____)_____

MEDICATION	STRENGTH	DIRECTIONS	MEDICATION	STRENGTH	DIRCETIONS

SYSTEM REVIEW: Please check all that apply:

Constitutional: Fever Weight loss __ Night sweats

HEENT: Headaches Hearing loss __Vision loss

Respiratory: Cough __ Difficulty breathing

Integumentary: Contact allergy __ Rash

Cardiovascular: Chest pain Leg swelling __Irregular heartbeat

Gastrointestinal: Abdominal pain __Black tarry/bloody stools __Diarrhea __Nausea/Vomiting

Neurological: Memory loss Numbness __Seizures __Tremors

Psychiatric: Anxiety __Depression __Insomnia

Hematologic: Bleeding Clotting __Bruising

Immunologic: __Environmental allergies __Food allergies

Other_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check/circle all that apply):

Voice Communication

Home #_____ Work#_____ Cell#_____ Other#_____

□ OK to leave message with detailed information: HOME / WORK / CELL / OTHER
□ Leave message with call back number only: HOME / WORK / CELL / OTHER

□ The following people are authorized to receive my medical information:

Name: _____ Phone: (___) _____ Relationship:_____

Name: _____ Phone: (___) _____ Relationship:_____

Name: _____ Phone: (___) _____ Relationship:_____

Written Communication

□ OK to mail to home address
□ OK to mail to work/office address
□ OK to mail to a different address: _____
□ Home fax: (___)_____
□ Work fax: (___)_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

I have received *Torrance Orthopaedic and Sports Medicine Group Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that it may become necessary to disclose my protected health information to another entity as part of my medical treatment, payment of my account, or other health care operations as defined in the *Notice of Privacy Polices*. I consent to such disclosures for these permitted uses to include electronic interchange, telephone, facsimile and mail.

I understand that I may request restrictions regarding the use of my health information or revoke this consent by following the procedures outlined in the *Notice of Privacy Policies*. However, Torrance Orthopaedic is not required to agree with any restrictions I request and may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

Note: Uses and disclosure for treatment, payment, operations (TPO) information may be permitted without prior consent in an emergency.

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Print Name Name of Patient (if different)

TORRANCE ORTHOPAEDIC & SPORTS MEDICINE GROUP

Financial Policy

We would like to thank you for choosing us to provide your orthopaedic care. We are committed to providing you with excellent and affordable healthcare. Because you may have questions regarding personal and insurance responsibility for services rendered, we have developed this payment and financial policy. Please read it, ask for clarification if needed, and sign in the space provided. A copy of this policy will be given to you.

All patients must complete the Patient Information and Insurance Form before seeing the doctor.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS

Regarding Insurance Billing

You must provide proof of insurance. If you are not able to provide proof of insurance coverage, you will be considered uninsured and you will be responsible for full payment at time of service. We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor listed on the Patient Information form.

- **PPO Plans (with which we are contracted):** We have agreed to take a discount from your insurance company. Your co-insurance and/or unmet deductible is your responsibility and is due at time of treatment. In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or coinsurance amounts. All co-pays will be collected at the time of service. **If your co-payment is not made at time of service, a $20.00 administrative fee will be added to your account due and payable by you, not your insurance company.** If you are scheduled to have a surgical procedure you may be required to pay a $250 deposit for outpatient surgery or $500 deposit for in-patient surgery. This is a deposit which will secure your time on the doctor's surgery schedule. It will be applied toward any out-of-pocket expenses deemed patient responsibility by your insurance company. You *may* forfeit all or part of this deposit if you do not cancel your surgery in a timely fashion. Please ask the doctor's secretary for further details regarding this deposit.

- **Medicare:** We accept assignment with Medicare. Medicare pays 80% of their allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed amount as a courtesy; however, you are responsible for the balance regardless of payment from a secondary insurance. **We do not accept MediCal.**

Self-Pay Patients:
Please be prepared to pay for services as they are rendered. We will be collecting a $250 fee upon check-in for new patients and $125 upon check-in for established patients. If surgery is needed, an estimate of your charges will be provided and a 50% payment deposit is required prior to the procedure. The deposit is for our services only. We cannot estimate the charges you may incur by other providers involved with your treatment. *Any overpayments will be credited to the account and refunded to the payer after the full course of treatment has been completed.*

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Forms fee – There is a fee of $20.00 per form for completing disability and/or insurance forms. Payment for these is due when the form is dropped off. Please allow 5 business days to complete the form(s). For a full list of fees, please see receptionist

Medical Imaging Request– There will be a fee for all requests on disk or film for MRI or X-Ray copies. Fees vary depending on request. Please see receptionist for a full list of these fees.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Print Patient Name	Signature Patient/Parent/Guardian	Date