Welcome to Huntington Orthopedics

Thank you for selecting our office to care for your orthopedic needs! Our goal is to provide you with the highest quality orthopedic care in a gentle, efficient and pleasant manner.

In order to improve our services, it is important that you tell us how you heard about Huntington Orthopedics?

_____

Please complete all sides of the enclosed forms and return them to the front desk.

New Patient Registration Form

Patient Name: _____, _____ **Date of Birth:** __/__/__ **Sex: (M/F)** __

New Patient ____ **Former Patient** ____ **SSN:** __ __ __ - __ __ - __ __ __ __ **Marital Status:**(Circle) **S M D W**

Home Phone #: (__ __ __) __ __ __ - __ __ __ __ **Cell Phone #:** (__ __ __) __ __ __ - __ __ __ __

Address: _____ **Email:** _____

City: _____ **State:** _____ **Zip:** _____

Employer: _____ **Work #:**(__ __ __) __ __ __ - __ __ __ __

Person to Notify in Case of Emergency:_____

Emergency Contact Relationship:_____ **Phone #:** (__ __ __) __ __ __ - __ __ __ __

Referring Physician: (Physician who sent you to us) _____

Primary Care Physician: _____ **Address:**_____

Insurance Information

Primary Insurance Carrier: _____

ID #: _____ **SS#:** __ __ __ - __ __ - __ __ __ __ **Group Name/#:**_____

Name of Policyholder:_____ **Date of Birth:** __/__/__ **Sex: (M/F)** __

Employer:_____

Relationship to Policyholder: Self____ **Husband**____ **Wife**____ **Child**____ **Other**_____

Secondary Insurance Carrier: (Billed for Medicare Only) _____

ID #:_____ **SS#:** __ __ __ - __ __ - __ __ __ __ **Group Name/#:**_____

Name of Policyholder:_____ **Date of Birth:** __/__/__ **Sex: (M/F)** __

Relationship to Policyholder: Self____ **Husband**____ **Wife**____ **Child**____ **Other**_____

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private insurance and any other health plan to Huntington Orthopedics. This assignment will remain in effect until revoke by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

Notice of Privacy Practices for Protected Health Information and Acknowledgement of Notice Receipt

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices implemented by this practice and understand that my protected health information may be used by the practice in the notice.

Furthermore, for the purpose of continuity of care, I specifically authorize Huntington Orthopedics to communicate my protected health care information with my primary care physician and/or referring physician(s) noted above. I understand that this authorization may be revoked in writing anytime, except to the extent that action had been taken in reliance on this authorization.

Signature of Patient or Responsible Party _____ **Date** __/__/__

Patient History Form

Patient Name:_____ **Age:**_____ **M/F:**_____ **DOB:**_____

Is this work related: Yes___ No___ **Was it reported: Yes__ No__**

History of Present Illness:

What is the current problem you are having:_____

_____

How did the pain start: _____

What date did the pain start: _____

Are the symptoms: Worsening ___ Same ___ Improving ___

Is the pain: (check all that apply)

___ sharp ___ dull ___ burning ___ numb ___ clicking/ popping ___ throbbing

__ cramping ___ constant ___ intermittent ___ radiates to: _____

__ associated with activities ___ unrelated to activity

Level of pain: ____ out of 10

What treatment have you received?

__ Medication:_____ **___ Physical Therapy ___ X-rays ___ MRI**

___ Injection ___ Surgery:_____ **___ Acupuncture ___ Other:**_____

Have you seen any other physician prior to coming to our office: ____Yes ____No

If yes, please list: _____ **Date:** _____

_____ **Date:** _____

New Patients: please proceed to the Medical History Form

Returning Patients:

Have there been any changes in your medical history since your last visit?

- **Any new issues or symptoms beside the current injury?**
- **Newly diagnosed medical problems?**
- **New Medications?**
- **Surgical Procedures?**
- **Changes to your family medical history?**

If so, please request a Medical History Form and update accordingly.

Medical History Form

History of Past Illness:

Have you ever had any of the following? Please check all pertinent spaces:

___ Aids or HIV	___ Cellulitis	___ Joint Replacement
___ Alzheimer's	___ Depression	___ Kidney Disease
___ Anemia	___ Diabetes	___ Liver Disease
___ Anxiety	___ Epilepsy/Seizures	___ Migraine Headaches
___ Arthritis	___ Glaucoma	___ Parkinson's
___ Back Trouble	___GI Disease	___ Skin Disease
___Bladder Infections	___ Heart Disease	___ Sleep Apnea
___ Blood Transfusions	___ Hemorrhoids	___ Sports Injury
___ Blood Clots	___ Hepatitis	___ Stroke
___ Broken Bones	___ High Blood Pressure	___ Thyroid Disease
___ Cancer	___ High Cholesterol	___ Ulcer

Past Surgical History:

Please list previous Hospitalizations/Surgeries/ Serious Illnesses and when?

_____

_____

Allergies:

Please list any known drug allergies and the allergic to them.

_____

_____

Medications:

(Please include non-prescription)

Drug Name	Dose	Frequency

Drug Name	Dose	Frequency

Family Medical History:

	Age	Conditions or Diseases	If Deceased, Cause of death
Father			
Mother			
Sibling(s)			

Family History of:

___ Blood clots ___ Bleeding Disorders ___ Stroke ___Problems with anesthesia

Patient Social History:

Marital Status: ___ Single ___ Married ___Divorced ___ Widowed ___ Separated

Use of Alcohol: ___Never ___ Rarely ___ Moderate ___ Daily

Use of Tobacco: ___ Never ___ Previously (years____), quit date_____

___ Currently____ packs per day x _____years

Recreational Drug Use: ____No ____Yes, please describe_____

Dominant Hand: ___ Right Handed ___ Left Handed

Occupation: _____

Sports/ Hobbies: _____

Please continue onto next page.

Review of Systems:

Have you recently had any of these symptoms? (please check all that apply)

Constitutional:

___ Fatigue ___ Fever ___ Weight Change

___ Headaches

Eyes:

___ Vision changes ___ Blurry vision

Ears, Nose, Throat:

___ Ringing in ears ___ Nosebleeds

___ Sinus problems ___ Hoarseness

Cardiovascular:

___ Chest Pain ___ Palpitation

___ Shortness of Breath

___ Swelling of hands/feet

Respiratory:

___ Cough ___Wheezing ___Sneezing

Gastrointestinal:

___ Nausea ___ Vomiting ___ Heartburn

___ Diarrhea ___Constipation

___ Black or bloody stools

Gynecologic/ Urologic:

___ Difficulty urinating ___ Burning ___ Itching

___ Erectile dysfunction

___ Changes in Menstrual Cycle

Hematologic:

___ Bleeding Problems ___ Blood Clots

___ Easy Bruising

Skin:

___ Rash ___ Changes in moles

Psych:

___ Depression ___ Anxiety

___Suicidal thoughts

Neurological:

___ Numbness/Tingling ___Balance/Dizziness

___ Tremors ___ Frequent falls

___Clumsiness with hands

Musculoskeletal:

___ Joint Pain ___ Back/ Neck Pain

___ Joint Stiffness/ Swelling

___ Weakness of Muscles or Joint

To the best of my knowledge, the questions on this form have been answered accurately. I understand that proving incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Signature: _____ **Date:** _____

Please do not write in this area (OFFICE USE ONLY)

I have reviewed the medical history form (and there have been no interval change).

Date:									
Initials:									

HIPPA Medical Information Release Form

Patient Information:

Patient Name:_____, _____ **Date of Birth:**__/__/__

Address:_____ **Cell Phone #:** (__ __ __) __ __ __ - __ __ __ __

City: _____ **State:** _____ **Zip:** _____

Authorizes:

Name of Health Care Provider/Plan/ Other: _____

Address: _____

To Disclose:

___ **Self, Delivery options:** ___ **Pick up** ___ **Mail to address above**

___ **To be picked up by, hereby authorize** _____ **to pick up my records.**

___ **Send to: Name of Health Care Provider/ Plan/ Other** _____

Address: _____

Information to be Disclosed: **From** ___/_____ **to** ___/_____

___ **All medical records related to (specify condition, treatment, etc.):** _____

___**All billing records related to (specify condition, treatment, etc.):**_____

___ **Radiology films/ images (specify test):** _____

___ **Specific Records/ Information as follows:** _____

_____

_____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

___**Alcohol/Drug Abuse** ___ **HIV Test Results** ___ **Mental Health/Developmental Disabilities**

Purpose: (Check all that apply- copy fees may apply) ___ **Further Medical Care**

___ **Legal Investigation/Action** ___ **Insurance Eligibility/ Benefits** ___**Personal (at my request)**

___ **Other:** _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosers: 1) already made in reliance upon this Authorization; or 2) needed for an insurer to contest a claim/ policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

Signature of Patient/ Legal Rep: _____ **Date:** _____

If signed by a person other than the patient, complete the following:

1) Patient is: ___ a minor ___ legally incompetent or incapacitated ___deceased
2) Legal authority: ___ parent* ___ legal guardian ___ next to kin/executor of deceased ___ activated POA for Health Care * By signing the above, I hereby declare that I have not been denied physical placement of this child.

Alexandre Arkader, M.D
T. Thomas Ackerson, M.D.
Walter H. Burnham, M.D.
Mark Jo, M.D.
Vahe R. Panossian, M.D.
Mort Rizvi, M.D.
George Tang, M.D.

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipated and everyone hopes to avoid. We believe that the method of resolving disputes by disputed by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing that place where your claim will be presented. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. This is because the time it takes to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

HIPAA Short Form Notice of Privacy Practices

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

Your rights regarding Health Information about you:

- Right to Inspect and copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice (full Notice is available upon request)

Changes to this Notice:

We reserve the right to change this Notice. We will post a copy of the current Notice in our facility with the current effective date on the first page.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgement of Receipt of this Notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records. This acknowledgment provides that you have declined to accept the Compete Notice and instead requested this Short Form. We post a copy of the current complete Notice of Privacy Practices in our facility, on our web site at address: http://www.huntingtonorthopedics.com and you may also ask for a copy.

Effective date: July 15, 2013