Orthocare Health

18035 Brookhurst St Suite 1200 | Fountain Valley. CA 92708
31920 Del Obispo St., Suite 170, San Juan Capistrano, CA 92975
Ph: 949-691-3131 Fax: 949-940-8311

Name:_____Date of Birth:_____
First / Middle Initial / Last

Sex:_____ Marital Status: Single / Married / Divorced / Widow SSN (Optional):_____

Address: _____City/State: _____ Zip: _____

Home Phone: ( ) _____Cell: ( ) _____ Work: ( )_____

Email Address: _____Preferred Language: _____

Occupation: _____Employer: _____

Emergency Contact: _____Relationship: _____ Phone: _____

If Minor, Legal Guardian Name: _____Phone: _____

Primary Care Doctor: _____Phone: _____

Please fill out insurance information, unless insurance card given to reception:

Primary Insurance Name: _____Subscriber ID: _____

Secondary Insurance Name: _____Subscriber ID: _____

Preferred Pharmacy: _____ Phone : _____ City: _____

How did you hear about us? Family, Friend, Physician, Online Search, Insurance Website, Other:_____

All physicians provide care under their License and Tax ID. I hereby authorize my insurance company to make payments directly to the physician/provider for all medical expense benefits otherwise payable to me for professional services rendered. I authorize the physician/provider to furnish to the insured's insurance company all information which said insurance may request concerning my claim including chart notes. I understand that I am financially responsible for all charges not covered by my insurance benefits. If I do not have health insurance, I agree to pay in full for services rendered on the day I receive them, unless a payment plan has been previously agreed upon.

Patient/Guardian Signature:_____Date: _____

Health History

What are your current health conditions/issues/concerns?

Drug Allergies – List all medications you are allergic to as well as your reactions when you take them

Medications – List all medications you are currently taking and the doses

Are you on any Blood thinners? YES NO **If YES, which one(s)?**

List any prior surgeries as well as the year surgery was done:

Family History – Are there any conditions that run in your family? If so, what are they?

Social History – Please answer the following questions

Do you **Smoke**? Yes No If Yes, How many packs per day? _____

Do you have a **prior** smoking history? Yes No

On Average, how many **alcoholic** beverages do you consume per **WEEK**? Zero 1-2 3-4 5-6 7 or more

On Average, how many **caffeinated** beverages do you consume per **DAY**? Zero 1-2 3-4 5-6 7 or more

On Average, how many days per **WEEK** do you **exercise**? None 1-2 days, 3-4 days, 5-6 days, 7 days

For Females, Last Menstrual Period:

Do you have any **implantable devices**? (ex: pacemaker):

Current Height:_____ Current Weight:_____

Review Of Systems (Please circle any current problems)

General Fatigue, fever, night sweats, chills, weight gain/loss, other: _____
Musculoskeletal Joint or muscle pain, swelling, stiffness, weakness, instability, other: _____
Eyes Loss of vision, double vision, eye redness, blurred vision
Head Hearing loss, ringing in ears, dizziness, sinus infections, frequent bloody nose, mouth sores, sore throat, other: _____
Cardiovascular Chest pain irregular heartbeat palpitations leg swelling other: _____
Respiratory Shortness of breath difficulty breathing chronic cough coughing up blood
Genitourinary Painful urination blood in urine increased frequency loss of bladder control Heavy or irregular periods other: _____
Skin Rash color change abnormal moles nail changes other: _____
Neurologic Headache dizziness numbness tingling weakness seizure fainting
Psychiatric Anxiety depression insomnia memory loss other: _____
Endocrine Appetite change increased thirst increased urination heat or cold intolerance other: _____
Hematologic Easy bruising prolonged bleeding enlarged lymph nodes Hepatitis C other: _____
Allergic and Immunologic Hives seasonal or environmental allergies exposure to HIV other: _____

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at a reasonable cost. Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, Visa, MasterCard, American Express or Discover. Insurance co-payments are due at the time of service. If you are unable to pay your copayment at your visit, your appointment may need to be rescheduled. Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover therefore we can't guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility.

We need the following every time you come in for a visit:
1. Insurance card
2. Present current picture ID
3. Payment of any outstanding balance (if applicable)
4. Payment of today's visit

Returned check charge – Non-sufficient funds checks are subject to a $25 fee (in addition to fees from your bank)

Collections charge – Accounts that are not paid within 60 days from the due date may be sent to an external collection agency. In addition to your outstanding balance, a $10 collection fee will be added to cover our cost. We reserve the right to discontinue services for patients with delinquent accounts.

Patient Name:_____ Patient Signature: _____ Date: _____

Other Office Policies

We expect you to take a proactive role in your health. Your physician will make recommendations during your visit appropriate for your condition. You are responsible for your health and following the recommendations of your doctor in order to achieve the best outcome possible.

Medication Refills: We require that you inform our office at least 2 business days prior to needing a medication refill. Our surgeons may not be immediately available to refill your medication due to their other responsibilities. Therefore, we require time to coordinate medication refills.

Disability Form Policy: We receive many requests to fill out paperwork for work, FMLA, disability, etc. Please help us by filling in all personal information PRIOR to submitting the form.
Our staff strives to fill out forms in a timely manner; turnaround time will usually be 5 business days. - A fee of $20 will be charged for the completion of disability forms.

Dictated Letters: Letters prepared for third parties will be charged $30. Turnaround time for letters is five business days.

Privacy Preferences
As your health partner, we often have to communicate sensitive, personal health information. This information is protected by federal privacy laws and serves as:
- A basis for planning my care and treatment
- A means of communication between health professionals on my team
- A tool for routine health care operations such as assessing quality and outcomes
- A source of information for creating my bill for health service

Please indicate your privacy preferences below:
1. List the individuals whom may share your personal health information with:_____

2. List the physical address that we can send your personal health information: Same as Home Address

Different Address _____

3. May we leave personal health information on a voicemail? ___yes ____no

If “yes” what is the preferred phone number? Home Cell Other _____

4. May we send you text messages with personal health information? ___yes ____no

In addition, I acknowledge by my signature below that I have been provided a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. This policy will remain in effect until I revoke it in writing.

_____ _____ _____
Print Name Signature Date

NOTICE OF PRIVACY PRACTICES ORTHOCARE HEALTH
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed below.
A. How this Medical Practice May Use or Disclose Health Information: This medical practice collects medical and related identifiable patient information (such as billing information, claims information, referral and health plan information) and stores it in a chart, in administrative or billing files, and on a computer. The medical record is the property of this medical practice, but the information in the medical record is accessible to the patient. This information is considered "protected health information" (PHI) under the HIPAA Privacy Rule. The law permits us to use or disclose health information for the following purposes without the patient's written authorization: **1. Treatment**. We use medical information to provide medical care. We disclose medical information to our employees and others who are involved in providing the care our patients need. For example, we may share medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription, or a laboratory that performs a test. We may also disclose medical information to members of patients' families or others who can help them-when they are sick or injured or following the patient's death. **2. Payment.** We use and disclose PHI to obtain payment for the services we provide. For example, we give health plans the information they require for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to our patients. **3. Health Care Operations**. We may use and disclose PHI to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get health plans to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs, and business planning and management. We may also share PHI with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of this PHI. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, health care clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. **a.** We may also share PHI with other health care providers, health care clearinghouses, or health plans that have a relationship with our patients when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. **b.** We may also share PHI with other health care providers, health care clearinghouses, and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities that collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official. **4.**

Appointment Reminders. We may use and disclose medical information to contact and remind our patients about appointments. If the patient is not a home, we may leave this information on the patient's answering machine or in a message left with the person answering the phone. **5. Sign-in Sheet.** We may use and disclose medical information about our patients by having them sign in when they arrive at our office. We may also call out their names when we are ready to see them. **6. Notification and Communication with Family.** We may disclose our patients' health information to notify or assist in notifying a family member, personal representative or another person responsible for their care about their location or general condition in the event of their death, unless a patient had instructed us otherwise. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with our patient's care or helps pay for care. If our patient is able and available to agree or object, we will give the patient the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over the patient's objection if we believe it is necessary to respond to the emergency circumstances. If our patient is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient's family and others. **7. Marketing**. Provided we do not receive any payment for making these communications, we may contact our patients to encourage them to purchase or use products or services related to their treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to them. We may similarly describe products or services provided by this practice and tell our patients which health plans we participate in. We may contact our patients to request feedback about their experience for quality assurance purposes or to request online reviews.

We may receive financial compensation to talk with our patients face-to-face, to provide them with small promotional gifts, or to cover our cost of reminding them to take and refill medication or otherwise communicate about a drug or biologic that is currently prescribed for the patient, but only if the patient either;

(1) has a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise the patient about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) the patient is a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while the patient has a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type; (1) the fact and source of the remuneration; and (2) the patient's right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose PHI for marketing purposes or accept any payment for other marketing communications without the patient's prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity our patients authorize, and we will stop any future marketing activity to the extent the patient revokes that authorization. **8. Sale of Health Information.** We will not sell our patients' health information without their prior written authorization. The authorization will disclose that we will receive compensation for PHI if the patient authorizes us to sell it, and we will stop any future sales of information to the extent that the patient revokes that authorization. **9. Required by Law.** As required by law, we will use and disclose our patients' health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. **10. Public Health.** We may, and are sometimes required by law, to disclose our patients' health information to public health authorities for purposes related to; preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform our patients or their personal representative promptly unless in our best professional judgment, we believe the notification would place a patient at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm. **11. Health Oversight Activities.** We may, and are sometimes required by law, to disclose our patients' health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law. **12. Judicial and Administrative Proceedings.** We may, and are sometimes required by law, to disclose our patients' health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about our patients in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify them of the request and they have not objected, or if their objections have been resolved by a court or administrative order. **13. Law Enforcement** We may, and are sometimes required by law, to disclose out patients' health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes. **14. Coroners.** We may, and are often required by law, to disclose our patients' health information to coroners in connection with their investigations of deaths. **15. Organ or Tissue Donation.** We may disclose our patients' health information to organizations involved in procuring, banking or transplanting organs and tissues. **16. Public Safety.** We may, and are sometimes required by law, to disclose our patients' health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public. **17. Proof of Immunization.** We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if the patient has agreed to the disclosure on behalf of themselves or their dependent. **18.** Specialized Government Functions. We may disclose our patients' health information for military or national security purposes or to correctional institutions or law enforcement officers that have the patient in their lawful custody. **19. Workers' Compensation.** We may disclose our patients' health information as necessary to comply with workers' compensation laws. For example, to the extent our patients' care is covered by workers' compensation, we will make periodic reports to their employer about their conditions. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer. **20. Change of Ownership.** In the event that this medical practice is sold or merged with another organization, our patients' health information/record will become the property of the new owner, although our patients will maintain the right to request that copies of their health information be transferred to another physician or medical group. **21. Breach Notification.** In the case of a breach of unsecured protected health information, we will notify our patients as required by law. If they have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. **22. Other disclosures specified in our Notice of Privacy Practices.** We may disclose our patients' health information as otherwise described in our Notice of Privacy Practices. **B**. When this Medical Practice May Not Use or Disclose Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies individual patients without their written authorization. If a patient authorizes this medical practice to use or disclose health information for another purpose, the patient may revoke the authorization in writing at any time. **C.** Our Patients' Health Information Rights

1. Right to Request Special Privacy Protections. Our patients have the right to request restrictions on certain uses and disclosures of their health information by a written request specifying what information they want to limit, and what limitations on our use or disclosure of that information they wish to have imposed. If our patients tell us not to disclose information to their commercial health plan concerning health care items or services for which they paid for in full out-of - pocket, we will abide by their request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other requests and will notify our patients of our decision. **2. Right to Request Confidential Communications**. Our patients have the right to request that they receive their health information in a specific way or at a specific location. For example, they may ask that we send information to a particular email account or to their work address. We will comply with all reasonable requests submitted in writing which specify how or where our patients wish to receive these communications. **3. Right to Inspect and Copy.** Our patients have the right to inspect and copy their health information, with limited exceptions. To access their medical information, our patients must submit a written request detailing what information they want access to, whether they want to inspect it or get a copy of it, and if they want a copy, their preferred form and format. We will provide copies in the requested form and format if it is readily producible, or we will provide our patients with an alternative format they find acceptable, or if we can't agree and we maintain the record in an electronic format, their choice of a readable electronic or hardcopy format. We will also send a copy to any other person our patients designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny our patients' request, under limited circumstances. If we deny a request to access a child's records or the records of an incapacitated adult because we believe allowing access would be reasonably likely to cause substantial harm to the patient, the guardian or legal representative will have a right to appeal our decision. If we deny a patient's request to access their psychotherapy notes, our patients will have the right to have them transferred to another mental health professional. **4. Right to Amend or Supplement** Our patients have a right to request that we amend their health information if they believe it is incorrect or incomplete. Our patients must make a request to amend in writing and include the reasons they believe the information is inaccurate or incomplete. We are not required to change our patients' health information and will provide them with information about this medical practice's denial and how they can disagree with the denial. We may deny their request if we do not have the information, if we did not create the information (unless the person or entity that created the information Is no longer available to make the amendment}, if they would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny a request, our patients may submit a written statement of their disagreement with that decision, and we may, in turn, prepare a written rebuttal. Our patients also have the right to request that we add to their record a statement of up to 250 words concerning anything in the record they believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information. **5. Right to an Accounting of Disclosures.** Our patients have a right to receive an accounting of disclosures of their health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to them or pursuant to their written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to Impede their activities. **6. Right to a Paper Copy of Notice of Privacy Practices.** Our patients have a right to notice of our legal duties and privacy practices with respect to their health information, including a right to a paper copy of this Notice of Privacy Practices, even if they have previously requested its receipt by email. If we have a website, we must post our current Notice of Privacy Practices on our website.

Changes to this Notice of Privacy Practices We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. Complaints about this Notice of Privacy Practices or how this medical practice handles our patients' health information should be directed to our Privacy Officer listed below:

ATTN: Privacy Officer Orthocare Health 31920 Del Obispo St., Suite 170, San Juan Capistrano, CA 92975, TEL 949-691-3131, FAX 949-940-8311

If our patients are not satisfied with the manner in which this office handles a complaint, they may submit a formal complaint to: Office for Civil Rights U.S. Department of Health & Human Services 907th Street, Suite 4-100 San Francisco, CA 94103