

LA VETA ORTHOPAEDIC ASSOCIATES REGISTRATION FORM

The information on this form is kept confidential and will be part of your medical record.

TODAY'S DATE: _____ **YOUR PRIMARY CARE PHYSICIAN:** _____

PATIENT INFORMATION (Please fill out completely. This information is used to assist us in processing your claim.)

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms. <input type="checkbox"/> Miss	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married
Street Address		City	State	ZIP Code	Birth Date	Age	
Social Security #	Home Phone No. (can we leave test results on your answering machine <input type="checkbox"/> Yes <input type="checkbox"/> No)			Cellular Phone #		Office Phone #	
Occupation		Employer	School or College attending and Grade level				

Who REFERRED you: Dr. _____ Insurance Co. St Joseph Hosp Referral Svc.
 Family or Friend: who? Hospital ER Web/Internet site Yellow Pages Other: _____

Other FAMILY MEMBERS Seen in our Office:

Is the problem you are here for part of a Third Party Case (car accident)? No Yes Third Party: In the case of a litigated personal injury or any car accident injury your medical insurance cannot be billed and your charges today will have to be paid in full. Ask for the Third Party Policy form.

Where you injured on the job (Work Comp)? Yes No What was the date of your injury? (used for insurance billing) _____ or No Specific Injury Date

What specific body part(s) are you being seen for today? _____

HEALTH INSURANCE (PLEASE GIVE YOUR INS. CARD AND ID TO THE RECEPTIONIST TO COPY)

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No. ()
Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation	Employer	Employer Address	Employer Phone No. ()

Please indicate your primary insurance:

Subscriber's Name	Subscriber's Social Security #	Birth Date	Group #	Policy #	Co-Pay \$
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance (if applicable)		Subscriber's Name	Group #	Policy #	
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

IMPORTANT: IN CASE OF EMERGENCY WHO CAN WE CONTACT FOR YOU (Please list 2 contacts)

Name of Friend or Relative	Relationship to Patient	Home Phone No.	Work/Cell Phone No.	Is it OK for us to discuss your medical information with them?
		()	()	<input type="checkbox"/> Yes <input type="checkbox"/> No
		()	()	<input type="checkbox"/> Yes <input type="checkbox"/> No

FINANCIAL AGREEMENT/ASSIGNMENT AND RELEASE

I hereby authorize and consent to the examination and treatment as deemed necessary by my physician at "La Veta Orthopaedic Associates". I have read the Financial Agreement on the other side of this form and I agree to be bound by its terms. I understand and agree that I am ultimately responsible for the balance on my account for any professional services or equipment rendered. I understand and agree that payment by the responsible party will not be delayed or withheld because of any dispute between the responsible party, insurance company, Third Party payer, or because of pending legal claims. I certify that the above information is true to the best of my knowledge.

I hereby authorize my insurance company, including Medicare, Private Insurance or other health plans to pay directly to my physician at "La Veta Orthopaedic Associates" all benefits I am entitled to accruing under my policy. I authorize my physician or insurance company to release any information required to process my claim and secure payment.

X _____
 PATIENT OR GUARDIAN SIGNATURE DATE

(TURN OVER FOR OUR FINANCIAL POLICY)

LA VETA ORTHOPAEDIC ASSOCIATES FINANCIAL POLICY

Thank you for choosing us as your health care provider. Our practice is committed to providing the best treatment for our patients. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

General: We accept Visa, Mastercard, Cash, and checks. We accept many employer group plans, Medicare, preferred provider organizations (PPO's), and Worker's Compensation Insurance. We do not accept HMO insurance. You should be aware of any out-of-pocket expenses which you may incur when seeking medical care. Payment for service is due at the time services are rendered unless payment arrangements have been arranged in advance.

Usual, Customary and Reasonable Fees: The "UCR" is defined as usual, customary, and reasonable fees for this region. Our fees fall within the acceptable range as determined by the Oranges County Medical Association and by most companies and therefore are covered up to the maximum allowance determined by each carrier. Thus, our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees that they will pass as UCR and does not reflect current cost of care in this area.

Insurance Billing and Payments: Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Filing of insurance claims is a courtesy service that we extend to our patients. Not all services and medical equipment will be covered. In the event your insurance company has not paid your account in full within a reasonable period, the balance will be transferred to you. You are ultimately responsible for your bill.

In-Network and Out-of-Network Providers: For those plans that we are in-network "providers", we have agreed to provide a discount on our UCR fees. If we are not "providers" or if your insurance plan changes to one for which we are not "providers" all charges for your care will be due at the time of service. You will need to submit the receipts to your insurance for reimbursement.

Medicare: Medicare pays 80% of their allowed amount. You are responsible for 20% of Medicare's allowed amount and your yearly deductible. It is illegal for us not to charge the 20%. You will be billed in full for those services and supplies that Medicare does not cover. We will bill your secondary insurance as a courtesy. Patients, who switch from the traditional Medicare coverage to a Medicare HMO, must inform us prior to receiving medical care and will be responsible for all charges. Should Medicare deny medical claims due to a patient's enrollment in an HMO, the patient will be responsible for full payment of services rendered.

Returned checks: A \$25.00 fee plus any bank charges will be charged for any returned checks.

Motor Vehicle & Personal Injuries (Third party claims): We do not file Third Party Liability Claims for motor vehicle injuries or injuries sustained through fault of another party. Patients are expected to pay for services rendered at the time of service. They will be provided billing documents which can be presented to their attorney or Third Party liability carrier. We do not accept liens.

By signing the form on the opposite side of this page you are acknowledging this financial agreement and also agree to be bound by its terms.

Please initial here _____ to indicate that you received this policy. Please bring in these forms so that your chart can be completed.

last revised Aug 05

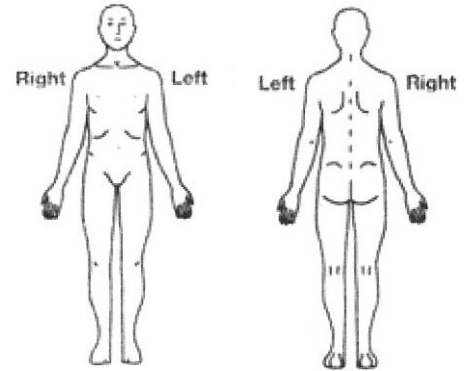
New Patient Information

Patient Name _____ AGE _____ DATE _____

Date of Injury: _____ or NO specific date

What is your complaint (mark areas of pain with X on the diagram)?

and Explain how it came about:



- Severity (How severe is the pain/problem? Mild Mod Severe)
- Associated signs/symptoms: Weakness Tingling Numbness Clicking Locking Swelling Stiffness
- Quality (Burning, tingling, numbness, swelling, etc.)
- Modifying Factors (What makes the pain/problem worse or better?)
- Are you able to work? Yes or No, Are you able to play sports? Yes or No

Other doctors or specialists who have seen you for this:

What tests or studies have you had: None or Xrays___ MRI___

What treatment have you had: None or Medications _____ Injections___ PT___ Chiro___ Rest___ Surgery: _____

Your Medical History

- | | | |
|-------------------------|-----------------------------|------------------------------|
| Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hypertension | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Stroke | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heart trouble | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Arthritis/gout | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Convulsions | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bleeding tendency | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| TB infection | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Liver disease/hepatitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Gastritis / Ulcers | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| HIV/AIDS | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hereditary defects | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Previous Surgeries/Serious Injuries or Fractures

Medications (list dose) (use bottom of page to list more)

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Other Condition: _____

SOCIAL History

- Marital status: Single Married Separated Divorced Widowed
- Use of alcohol: Never Rarely Moderate Daily
- Use of tobacco: Never Previously, but quit Current packs/day _____
- Use of drugs: Never Type/Frequency _____

Your Sport or Hobbie(s): _____

Allergies

- | | |
|--------------------|--|
| Anesthetic | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Penicillin | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Sulfa | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Codeine | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Novocaine | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Aspirin | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Iodine..... | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Latex/rubber | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Other drug allergies _____

Please read carefully and check Y or N for the following:

Family MEDICAL History

- Diabetes No Yes
 - Cardiac No Yes
 - Cancer No Yes
 - Rheumatoid Disease No Yes
 - Lupus No Yes
-

Musculoskeletal

- Multiple Joint pain No Yes
- Joint stiffness or swelling No Yes
- Weakness of muscles or joints No Yes
- Calf or Foot cramps No Yes
- Back pain No Yes
- Cold extremities No Yes
- Difficulty in walking No Yes
- Rheumatoid Disorders No Yes

General Symptoms

- Recent health changes? No Yes
- Recent weight change No Yes
- Fever No Yes
- Night sweats No Yes

Genitourinary

- Frequent urination No Yes
- Burning or painful urination No Yes
- Blood in urine No Yes

Cardiovascular

- Heart trouble No Yes
- Chest pain or angina pectoris No Yes
- Palpitation No Yes
- Shortness of breath with walking or lying flat No Yes
- Swelling of feet, ankles or hands No Yes
- High blood pressure No Yes

Neurological

- Frequent or recurring headaches No Yes
- Light headed or dizzy No Yes
- Convulsions or seizures No Yes
- Numbness or tingling sensations No Yes
- Tremors No Yes
- Paralysis No Yes
- Stroke No Yes
- Head injury No Yes

Respiratory

- Chronic or frequent coughs No Yes
- Spitting up blood No Yes
- Shortness of breath No Yes
- Asthma or wheezing No Yes

Psychiatric

- Depression No Yes
- Other No Yes

Gastrointestinal

- Frequent diarrhea No Yes
- Rectal bleeding or blood in stool, tarry stools No Yes
- Abdominal pain or heartburn No Yes
- Peptic ulcer (stomach or duodenal) No Yes

Endocrine

- Glandular or hormone problem No Yes
- Thyroid disease No Yes
- Diabetes No Yes

Hematological/Lymphatic

- Slow to heal after cuts No Yes
- Bleeding or bruising tendency No Yes

Name of your Primary Care Doctor:

Name of your Cardiologist:

Patient Name

Patient Signature

Date

Physician's Signature

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ (Date)
Physician's or Authorized Representative's
Signature

By: _____ (Date)
Patient's or Patient Representative's Signature

By: _____
Print Patient's Name

Print or Stamp Name of Physician,
Medical Group or Association Name

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

Acknowledgement of Receipt of Notice of Privacy Practices

LA VETA ORTHOPAEDIC SURGERY ASSOCIATES

725 W. La Veta Ave. Ste. 260 Orange, CA 92868

Privacy Officer – Paul A. Beck MD 714.639.3750

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices to review. I further acknowledge that a copy of the current notice will be posted in the reception area and on this practice's web site (www.MyOrthoDoc.com). I will be offered a copy of any amended Notice of Privacy Practices to review at each appointment.

Print Name: _____

Telephone: _____

Signed: _____

Date: _____

If not signed by the patient, please indicate:

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: _____