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 | ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss | Sex ☐ M ☐ F ☐ Sgl ☐ Mar ☐ Div ☐ Sep ☐ Wid

Street Address | City | State | ZIP Code | Birth Date | Age

Social Security #	Home Phone No. (can we leave test results on your answering machine ☐ Yes ☐ No	Cellular Phone #	E-Mail Address
	( )	( )	

Occupation | Employer | School or College attending and Grade level

Who REFERRED you: ☐ Dr. ______ ☐ Hospital ER ☐ Insurance Co. ☐ St Joseph Hosp Referral

☐ Family/Friend: who? ☐ Web/Internet Site: Which One?(Google; Yelp; Facebook)

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.

Were 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?	☐ Yes ☐ 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 ☐ Self ☐ Spouse ☐ Child ☐ Other ______

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

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?
		( )	( )	☐ Yes ☐ No
		( )	( )	☐ Yes ☐ 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, (PPO) Preferred Provider Organizations, and (WC) Workers 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 services is due at the time service 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 Orange 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 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 were 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 for service. You will need to submit the receipts to your insurance for reimbursement.

Medicare: Medicare pays 80% of their allowed amount. You are responsible 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 check.

Motor Vehicle and 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.

Health History Questionnaire

Name: ____________________ Today's Date: ____________

Date of Birth: ____________ Height: ____________ Weight: ____________

Primary Care Physician: ____________________ Referred by: ____________________

Reason for today's visit: ____________________ Date and Duration of Injury: ____________

How did it happen?: ____

Medical History

Please list all PAST and Current medical problems/diseases being treated and WHO treated them

(Including disease of the heart, lung, stomach, intestines, kidney, liver, arthritis, diabetes, cancer, high blood pressure)

Medical Problem(s) ☐ **NONE:**	Year Diagnosed	Treating Doctor

Past Surgical History

Please list all surgeries include the year and the surgeon

Surgeon ☐ **NONE:**	Year	Surgeon

Medications

Please list all medications, dose and frequency

Medication ☐ **NONE:**	Dose	Frequency

Allergies ☐ **NONE:**

(TURNOVER PLEASE)

Orthopaedic Injuries

☐ **NONE:**

Please list previous fractures, sprains or other significant injury to you neck, back, arms or legs

Injury	Year	Injury	Year

Review of Systems

Are you currently having OR have you had problems with:	Circle		Describe all YES responses
Eyes, Ear, Nose or Throat	NO	YES	
Rheumatoid, Lupus, Inflammatory	NO	YES	
Lungs, Breathing, Asthma	NO	YES	
Chest Pain, Heart, CHF	NO	YES	
Stomach, Bowels, Gastritis, Ulcers	NO	YES	
Bladder, Urine	NO	YES	
Nervous system, Neuropathy	NO	YES	
Seizures, Fainting	NO	YES	
Psychological Problem	NO	YES	
High Blood Pressure	NO	YES	
Cancer	NO	YES	
Diabetes	NO	YES	
Easy Bleeding, Anemia	NO	YES	
Deep Vein Thrombosis	NO	YES	
Anesthesia problems	NO	YES	

Family History

Please list immediate family's medical problems or cause of death

Family Member	Age	Health Status or Cause of Death
Mother		
Father		
Sibling		
Sibling		
Child		
Child		

Social History

Occupation	Retired ? Yes or No
What is your Hobby/Main Sport?:	
Alcohol Intake: Never Rarely Moderately Daily	
☐ Current Smoker: How many packs per day _______, for How many years ______	Never Smoked ☐
☐ Previous Smoker Number of packs per day _______, for How many years ______?	Year Quit Smoking
Marital Status Single Married Separated Divorced Widowed	

Patient Signature: ______________________________ **Today's Date:** ________________

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: ____

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