SOUTH ORANGE COUNTY ORTHOPAEDICS, INC

26730 Crown Valley Parkway, Suite 200
Mission Viejo, CA 92691

Appointment with Dr.

☐ Herbert Eidt, MD ☐ Michael Fitzpatrick, MD ☐ Mark Elzik, MD

☐ Samuel Park, MD ☐ Steve Rhyan, PAC ☐ William Wang, MD

PATIENT'S INFORMATION – PLEASE PRINT

Date: ____/_____/_____

Legal Last Name: _____ Patient First Name: _____ MI _____

Address: _____ City: _____ State: _____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

DOB: _____/_____/_____ M / F (circle one) SS#: _____ - _____ - _____

Emergency Contact: _____ Relationship: _____ Phone: _____

REFERING PHYSICIAN _____ PRIMARY CARE PHYSICIAN: _____

How did you hear about us? ☐ Google ☐ Friend ☐ Yelp ☐ Referring ☐ High School ☐ Other: _____

PRIMARY INSURANCE (Please circle all that apply)

MEDICARE PPO/PRIVATE MEDI-CAL HMO SELF-PAY Work Related: **(Filing for Workers Comp)** Yes / No Auto: Yes / No

Co-Pay: $_____ **(CO PAYMENTS ARE DUE AT THE TIME OF SERVICE)**

Insurance Name: _____ Insurance Phone: _____

ID# _____ Group #: _____ Eff. Date: _____

Insured Subscriber's/Primary's Name: _____ DOB: _____ SS#: _____-_____-_____

Relationship of Patient to Insured/Subscriber: Self Father Mother Child Spouse Other: _____

SECONDARY INSURANCE

Insurance Name & Billing Address: _____

ID# _____ Group #: _____ Eff. Date: _____

Insured Subscriber's Name: _____ DOB: _____

Relationship of Patient to Insured/Subscriber: Self Father Mother Child Spouse Other: _____

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize SOUTH ORANGE COUNTY ORTHOPAEDICS, to perform such medical services, which in their medical judgment are necessary for the welfare of the patient identified above. I authorize them to furnish information to insurance carriers concerning this illness and /or injury. I hereby irrevocably assign all benefits, including major medical benefits, for medical services rendered to be paid directly to the doctor in accordance with California Insurance Code, Section 10133. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

SUBSCRIBER/INSURED SIGNATURE: _____ DATE: _____

South Orange County Orthopaedics, Inc.

Herbert C. Eidt, MD ● Michael J. Fitzpatrick, MD ● Samuel W. Park, MD ● William Wang, MD ● Mark E. Elzik, MD

Dear Patient,

Legislation has recently been enacted that requires healthcare facilities to adopt an Electronic Medical Records system and utilize the system to report specific data. The following questions are to fulfill this requirement.

South Orange County Orthopaedics/Newport Orthopedic Institute would like to assure you that your answers to these questions will have absolutely no impact on your care. You may opt to not answer any question by checking or writing "Decline to Answer."

RACE

- ☐ African American
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic
- ☐ Pacific Islander
- ☐ White
- ☐ Other
- ☐ Decline to Answer

ETHNICITY

- ☐ Hispanic Origin
- ☐ Not Hispanic Origin
- ☐ Decline to Answer

Primary Language _____

Thank You,

South Orange County Orthopaedics/Newport Orthopedic Institute

26730 Crown Valley Parkway, Suite 200
Mission Viejo, CA 92691
Phone: 949-364-2154 ● Fax: 364-2110

PATIENT HEALTH HISTORY

Your Health History is IMPORTANT. Please answer all questions thoroughly

Name: _____ Today's Date: _____

Age: _____ DOB: _____ Height: _____ Weight: _____

Hand Dominance: ☐ Right ☐ Left ☐ Ambidextrous

Chief Complaint

Why are you seeing the doctor today? _____

Date of Injury: _____ Date of Surgery: _____

Current pain Level of injury (0-10 where 0 = none, 10 = extreme): _____

Current problem is the result of a(n): Check all that apply

☐ Car accident ☐ Work accident ☐ Other: Explain:_____

Past Medical History

☐ Diabetes 1 or 2	☐ High Blood Pressure	☐ Heart Disease	☐ Lung Disorders
☐ High Cholesterol	☐ Kidney Problems	☐ Prostate Problems	☐ Thyroid
☐ Anemia	☐ Arthritis Type_____	☐ Gout	☐ Liver Disease
☐ Psychiatric	☐ Stroke	☐ TB	☐ Hepatitis (A, B or C)
☐ Seizure	☐ Bleeding Disorders	☐ Polio	☐ Multiple Sclerosis
☐ Eating Disorder	☐ STD's	☐ AIDS/HIV	☐ Low Blood Pressure

Cancer Type & current Status: _____

Other (please describe): _____

Medication & Dosage	Reason for Medication	Medication & Dosage	Reason for Medication

ALLERGIES (including what happens):

Past Surgical History

Surgeries	Year	Complications/Outcome

Have you ever had any problems with anesthesia? ☐ No ☐ Yes ☐ Never had anesthesia

If yes, please describe:

_____

Do you have sleep apnea? ☐ No ☐ Yes

Social History

Occupation: _____

☐ Work in Home ☐ Employed ☐ Student ☐ Retired

Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children? ☐ No ☐ Yes # _____

Do you live alone? ☐ No ☐ Yes

Do you have a history of substance abuse? ☐ No ☐ Yes What? _____

Drink Alcohol? ☐ No ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ 1-2 x/year

Drink Caffeine? ☐ No ☐ Yes What type? _____

Currently Smoking? ☐ No ☐ Yes _____ Packs per day for _____ years

Quit Smoking? ☐ This year? ☐ > 1 year ☐ > 5 years ☐ >10 years

Previously smoked _____ packs per day for _____ years.

Have you used other tobacco products? ☐ No ☐ Yes What? _____

Family History

Relation	Age	State of health	Age of Death	Medical Conditions or Cause of Death
Father				
Mother				

Review of Systems

Are you currently having or have had problems with your:

	Circle		Describe all YES Responses:
Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Irregular Heart Beat	No	Yes	_____
Digestion	No	Yes	_____
Bowel Movement	No	Yes	_____
Bladder Problems	No	Yes	_____
Bleeding Problems	No	Yes	_____
Balance Problems	No	Yes	_____
Numbness/Tingling	No	Yes	_____
Blackout/Fainting	No	Yes	_____
Headaches	No	Yes	_____
Breast Mass	No	Yes	_____
Psych Problems	No	Yes	_____
Fever/Chills	No	Yes	_____
Chest Pain	No	Yes	_____
Difficulty Breathing	No	Yes	_____
Skin Issues	No	Yes	_____
Pregnant	No	Yes	_____

Are all immunizations up to date? ☐ Yes ☐ No, immunization due for _____

I certify that the above information is correct to the best of my knowledge; I will not hold my Doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature: _____ Date: _____

South Orange County Orthopaedics, Inc.

Herbert C. Eidt, MD ● Michael J. Fitzpatrick, MD ● Samuel W. Park, MD ● William Wang, MD ● Mark E. Elzik, MD

This agreement between the patient _____ (**print Patient's Name**) and Prescribing Physician (Doctor) is for the purpose of establishing agreement between Doctor and patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient agree this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor -patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor to the Patient:

- I understand the reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.
- I realize that all of the medications have potential side effects, and will have any recommended laboratory studies required to keep the regimen as safe as possible.
- I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used any medication for at least four days.
- I will not use any illegal controlled substances, including marijuana, cocaine, etc.
- I will not share, sell, or trade any medication for money, goods or services.
- **I will not fill a prescription for pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Doctor,** I understand it is against the law to do so. If another physician (including dentists) prescribes pain medication for me, **the Doctor must approve arrangements prior to filling the prescription for pain medication to verify no duplication.**
- I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.
- I agree to use _____ pharmacy, located at _____, Telephone number _____, for all my pain medication. **If I change pharmacies for any reason, I agree to notify the Doctor at the time I receive a prescription,** and advise my new pharmacy of any prior pharmacy's address and telephone number.
- I agree to waive any applicable privilege or right of privacy of confidentiality with respect to the prescribing of my pain medication. I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the California Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize the Doctor to provide a copy of this agreement to the pharmacy.
- I agree that I will use my medication at a rate no greater than the prescribed rate, and that use of my medication at a greater rate will result in being without medication for a period of time.
- I understand that this medication regiment will be continued for the period of time seen beneficial by my Doctor. My case will be reviewed at the end of that period. If there is no evidence that I am improving or that progress is being made to improve my function or my quality of life, the regiment will be tapered to my pre-trial medications and my care will be referred back to my primary care physician.
- Doctor and Patient agree this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively, and failure of the patient to abide by the terms of this agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This agreement is entered into on _____ day of _____, _____

_____

Patient's Signature

26730 Crown Valley Parkway, Suite 200
Mission Viejo, CA 92691
Phone: 949-364-2154 ● Fax: 364-2110
www.SOCORTHO.com

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By signing below you are acknowledging that you have received, read, and agree to SOCO's:

Financial Policy

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

Notice of Privacy Practices

_____ I hereby acknowledge the receipt of the Notice of privacy Practices.
Initials A copy of the Privacy Practices will be available per my request.

Prescription Refill Policy

_____ I have read the Prescription Refill Policy. I understand and agree to this Policy.
Initials

Medication Acknowledgement of Driving Impairment

_____ I have read and understand the Medication Acknowledgement of Driving Impairment.
Initials (Not applicable for patients under 16 years of age)

DME Acknowledgment of Driving Impairment

_____ I have read and understand the DME Acknowledgement of Driving Impairment.
Initials (Not applicable for patients under 16 years of age)

Acknowledgment of Diagnostic Testing Results

_____ I have read and understand the Diagnostic Results.
Initials

_____

Signature of Patient or Responsible Party Print Name Date

Use or Disclosure of Personal health Information Authorization

I authorize the release of my patient health information to the following personal contacts (Spouse, Child, Assistant, etc).
I understand it is my responsibility to notify SOCO of any changes in the information below.

_____

Name Relationship

☐ Appointment Information
☐ Treatment Information
☐ Billing Information

_____

Name Relationship

☐ Appointment Information
☐ Treatment Information
☐ Billing Information

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to SOCO's Privacy Officer.

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FINANCIAL POLICY

South Orange County Orthopaedics (SOCO) is committed to providing you the best medical care. In order to achieve this goal, you must have a clear understanding of our financial policy which is important in order to sustain a professional relationship.

As a patient entering our practice, we will require identifying information, including a current Driver's License or State ID Card, and insurance ID cards.

Payment Methods: SOCO Accepts Cash, Checks, Visa, MasterCard, and American Express and Discover through HealthiPASS.

Uninsured or Self-Pay Patients: Payment is due in full at the time of service.

Insurance Billing: It is your responsibility to know your benefits both in and out of network and how they will apply to your treatment by the doctor. SOCO will follow the insurance contract guidelines for billing and collections. Please verify if SOCO is a preferred provider with your insurance plan prior to receiving services. HMO & EPO Patients: You are responsible for obtaining authorization and approval for treatment with your Medical Group or PCP prior to treatment.

Eligibility: HealthiPASS is a new system SOCO has adopted to verify real-time eligibility with your insurance **and its use is required at each visit**. In addition to eligibility, the system is designed to improve transparency around costs of care. It does so by providing SOCO patients estimates of patient responsibility based on information received through integration (gateway) with your insurance company and the day's charges.

Co-Pay, Deductible and Share of Cost: HealthiPASS will also be used to **collect patient responsibility** co-pays at the time of visit, as well as, share of cost and deductibles at the time of claim processing. In the latter case, the system will notify you of any balance associated with your claim 5 days before your credit card, ACH, deposit or HSA account is debited. You will have up to 5 business days from delivery of your email to change your method of payment, if desired.

If you have questions regarding a pending transaction, we have a dedicated team at SOCO to answer your questions and they can be reached during regular business hours at 949-248-7327.

Insurance Information:

Narrow Networks: Blue Cross and Others: The insurance industry is changing and there are many narrow networks being developed. SOCO/NOI has a long history of being an in-Newtork provider, but recent developments with BLUE CROSS Individual and Family Plans have restricted our participation with this insurance. Group Blue Cross PPO is still in network but others may not be! If you are concerned about our network status, we can verify that with you. Prior to your appointment please call 949-364-2154. If there is uncertainty around our participation we may ask you to sign a waiver and an ABN (Advance Beneficiary Notice). Upon execution we will submit the claim to your insurance and be an advocate on your behalf for claims payment. HealthiPASS is required for check in and if it is determined we are out of network, we will convert the claim to patient responsibility using the same discounts we provide for cash patients.

Covered California: SOCO is participating in Covered California through Blue Shield, Health Net, United Healthcare & OSCAR.

Surgery Deposits: Deposits are due in full prior to the scheduled procedure. Deposit amounts vary based on your share of costs and include any unpaid deductible or co-insurance. SOCO charges only for professional services provided by your physician. You will receive separate billing from the facility where your procedure is performed, the anesthesiologists, and other assistants that your surgeon may require.

Durable Medical Equipment (DME): DME is provided as ordered by your physician. Your insurance will be billed in accordance to your insurance coverage guidelines; however, you will be responsible for any unmet deductible and co-insurance rates. Some DME products are not covered by insurance, in which case, you will be notified of the item and its cost. DME is intended for single patient use only and is not subject to returns.

Medical Records: All Medical Record requests are subject to a clinical preparation fee of $20.00. For diagnostic films, such as an X-ray, MRI, and CT scan, you will be charged the actual cost of films printed or a CD for $15.00. The actual cost of shipping and handling will be added if applicable.

Forms: There is a $35.00 fee for any from that requires a doctor's signature. This includes non-government disability forms, travel cancellation, employer forms, and any other miscellaneous requests or forms. This is not payable by insurance and must be paid upon request.

Referrals for Physician & Ancillary Services: When being referred to an outside organization as part of your care (i.e. Physical Therapy, MRI, DME Providers, Physicians, etc.), SOCO does not verify if these organizations are preferred providers with your insurance plan. Please verify this directly with your insurance company prior to obtaining services.

If you choose to seek care at a non-preferred/non-participating provider for ancillary services, you may be responsible for higher copayments and costs in excess of your insurance company's allowable amounts, up to the non-preferred provider's total billed charges. Patients accept the financial responsibility for any additional cost for service when obtaining services from a non-preferred/non-participating provider regardless of being referred by South Orange County Orthopaedics. For assistance locating a preferred provider for ancillary services, you may contact your insurance company directly.

Returned Checks: A $25.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter.

Outside Collections and Payment Plans: If unable to make payment in full, contact the billing department immediately to make payment arrangements. If the account is referred for collections, you will be responsible for the balance of your account plus a collection agency charge of 25% of the balance and reasonable attorney's fees. If your account becomes delinquent or is referred for collections, your provider and/or any collection agent of your provider has authorization to obtain your credit report to assist them in the collection of your bill.

NOTICE OF PRIVACY PRACTICES

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

The Notice of Privacy Practices explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. The policy in its entirety can be requested from the receptionist or found on our web-site. Please review it carefully. For your convenience the following is a summary of the information discussed in the notice.

- Our Pledge
- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information for:
    - Treatment
    - Payment
    - Health Care Operations
    - Notifications and Special Circumstance and the Law
    - Research and Marketing
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Your agreement only acknowledges that we have made available for your review a paper copy of our Notice of Privacy Practices and have retained a copy of this acknowledgement as required by law.

PRESCRIPTION REFILL POLICY

The patient is responsible for knowing when medication(s) will need to be refilled. The specific protocol is outlined below. All patients are requested to execute acknowledgement that they have read the protocol and agree with its requirements.

- It is the policy of South Orange County Orthopaedics/ Newport Orthopedic Institute that medications will only be refilled between 8:00am to 3:30pm, Monday – Friday.
- **No prescription refills will be given on Saturday, Sunday or holidays.**
- At least 48 - 72 business hours are needed to process a refill request.
- Early refills will not be authorized.
- Medications or prescriptions will not be replaced if lost or misplaced.
- If your physician is not in the office, or is unavailable, you may have to wait until he/she returns for medication refills to be authorized.
- Non-controlled/non-narcotic prescriptions require a follow up appointment every 3-6 months.
- Controlled-substances/narcotic prescriptions require a follow up appointment every 30-90 days.
- Prescriptions may be picked up between 8:30am – 12:00pm and 1pm – 5pm. Our office is closed for lunch from 12pm – 1pm.
- When picking up a prescription for a controlled substance, you may be asked to provide a valid form of picture identification.

The physicians of South Orange County Orthopaedics do not routinely prescribe narcotics on a long term basis, nor do we administer narcotics by injection at any of our office locations. Individuals who are seeking "pain killers" for chronic use will be advised to make an appointment with a pain management or primary care physician.

MEDICATION ACKNOWLEDGEMENT OF DRIVING IMPAIRMENT

(Not applicable for patients under 16 years of age)

While you are under the care of your Physician, you may be prescribed medication that could impair your ability to operate a motor vehicle, heavy machinery or equipment.

Please refrain from operating a motor vehicle under the influence of prescribed medications that impair judgment. Arrange for proper transportation and use the proper precautions when taking prescribed medications. If you have any questions, please ask your Physician or your pharmacist.

DME ACKNOWLEDGMENT OF DRIVING IMPAIRMENT

(Not applicable for patients under 16 years of age)

While under the care of your Physician, you may be fitted into Durable Medical Equipment, or DME (Cain, Walking Boots, Shoulder Slings, etc). While the DME is to be utilized to protect or support your condition, by wearing the DME, it may impair your ability to operate automotive vehicles.

You might not be able to operate a vehicle safely due to the use of your DME, please arrange for proper transportation and use the proper precautions. If you have any questions regarding this matter, please ask your Physician.

DIAGNOSTIC TESTING RESULTS

While under the care of a Physician/Provider with SOCO, you may be sent to have diagnostic testing performed (MRI, CT-scan, bone scan, lab work). ***It is the patient's responsibility to return to the office to receive the results of any diagnostic testing.*** Most testing is completed at an outside facility. It is the patient's responsibility to obtain the results of all tests in addition to ensuring all outside results are sent to the Physician's office prior to the follow up appointment. Reports may be faxed to (949) 364-2110. SOCO is able to directly access testing performed at Mission Imaging Facilities, OMEGA Imaging Center, and Crown Valley Imaging Center.