Christopher L. Sherman, D.O. (t) 858-346-7171 (f) 888-760-5936
Orthopaedic Trauma/Adult Reconstruction

Sorrento Valley
4910 Directors Pl Ste 350
San Diego, CA 92121

Orange County
26730 Crown Valley Pkwy Ste 200
Mission Viejo, CA 92691

South Bay
655 S. Euclid Ave Ste 301
National City, CA 91950

NEW PATIENT INFORMATION:

Thank you for calling our office. We hope to be able to help you with your musculoskeletal problems.

Please take the time to fill out the enclosed papers and mail them to us before you're your scheduled visit. You can also bring them with you at the time of your visit.

Please bring any medical records, X-rays, MRI, or CT scans pertaining to the chief complaint. We will also need you to bring a list of all of the medication you are currently taking.

In order to prepare for your first visit, our assistant may ask you questions about your current medical problems, past medical history, and medical insurance billing information. Having this information in advance will help us to attend to your problem. Despite this preparation, we will have additional paperwork—required by the state—to be completed before your examination.

BILLING AND PAYMENT:
Office visits are payable at the time of the visit, along with co-payments and deductibles. This helps keep our overall expenses down—a savings that is passed down to the patient. Please be aware that your insurance plan may have some benefits that can be considered "non-covered" and even "not reasonable and necessary". In that case, you will be responsible for all services at the time of the visit.

We look forward to helping you with your musculoskeletal problem. Please be assured that we will do our best to assist you.

Your appointment with Dr. Christopher L. Sherman D.O. is confirmed for:

Sincerely,

Christopher L. Sherman, D.O.

PLEASE USE THE SPACE BELOW TO WRITE DOWN ALL MEDICATIONS

MEDICATION/Rx	DATE

PATIENT'S INFORMATION—PLEASE PRINT

Date:_____/_____/_____

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

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

Home Phone:_____ Cell Phone:_____

Occupation:_____ Work Phone:_____

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

Email:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Referring Provider:_____

PRIMARY INSURANCE (PLEASE CIRCLE ALL THAT APPLY)

Date of Injury: _____/_____/_____ Work Related: YES / NO Auto Related: YES / NO

Insurance Name:_____ Insurance Phone:_____

Billing Address:_____

Insured Subscriber's Name:_____ DOB: _____/_____/_____

SS#:_____/_____/_____ ID#:_____ Group #:_____

Effective Date:_____/_____/_____ Employer:_____

Employer's Address:_____ Phone:_____

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

SECONDARY INSURANCE

Insurance Name and Billing Address:_____

ID#:_____ Group #:_____ Effective Date:_____/_____/_____

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize CHRISTOPHER L. SHERMAN, D.O. to perform such medical services, which in his medical judgment is necessary for the welfare of the patient identified above. I authorize him to furnish information to insurance carriers concerning this illness or injury. I hereby irrevocably assign all benefits, including major medical benefits, for all medical services rendered to be paid directly to the doctor in accordance with California Insurance Code 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:_____/_____/_____

PAYMENT AND CREDIT POLICY

Thank you for selecting Christopher L. Sherman, D.O. for your health care needs. We have listed below our payment and credit policy for your convenience and understanding

PATIENT RESPONSIBILITY

Patients are responsible for all charges resulting from care with the provider. As a service to you we are contracted with most insurance companies and bill those carriers directly. Should insurance companies delay payment, you will need to participate in expediting payment, If certain procedures are not a covered benefit or considered not medically necessary by your insurance company, you will be required to sign an insurance waiver/disclaimer stating you understand the payment for such services is your responsibility. Patients need to understand that there are many insurance companies and different programs within those companies, that our staff cannot be expected to be "experts" on what is covered and what is not covered. The expectation of understanding one's plan falls on the shoulders of the patients. When in doubt a patient may call their insurance company's customer service number on the back of their card prior to an anticipated visit. This may not, however, eliminate the need to sign a waiver at the time of service. Patients who are unable to provide proof of insurance will be required to pay in full at the time of service. The undersigned will agree to be responsible for payment of any balances for care rendered to a minor. By signing this form you are certifying that you are eligible for benefits under your Health Plan. You understand if this is not correct or if you are not eligible under the terms of your Health Plan Agreement, you will assume responsibility for all charges for services rendered. In addition, if the above is not correct, you agree to pay in full for all services received within 30 days of receiving a bill from Christopher L. Sherman, D.O..

PROOF OF INSURANCE

All patients must complete our Patient Information form before seeing the doctor. We must obtain a copy of your driver's license/photo ID and current valid insurance card(s) to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Christopher L. Sherman, D.O. participates with Medicare and most PPO insurance plans. Please check with the staff to be sure your PPO or HMO is one we accept. We will bill any secondary insurance upon receipt of payment from the primary insurance. The patient will be required to sign a waiver agreeing to pay for any services not covered by their insurance.

INSURANCE AND PATIENT BILLING

New Patients —If you want Christopher L. Sherman, D.O. to bill your insurance, you are required to provide your insurance card for any primary and secondary plans at the time of your services. If you have no insurance, or do not want Christopher L. Sherman, D.O. to bill your insurance, you will be required to pay in full at time of service.

Established Patients —You will need to bring your current insurance card(s) to each visit so that Christopher L. Sherman, D.O. can verify current insurance information for billing the services you receive. Established patients are also required to complete an updated registration form and confirm billing information on an annual basis or at any time there is a change in the billing information. If you have no insurance, or do not want Christopher L. Sherman, D.O. to bill your insurance, you will be required to pay in full at time of service.

CO-PAYS AND DEDUCTIBLES

All co-pays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If co-pays that are not paid at time of service, resulting in a bill to the patient, a $15 billing charge will be assessed in addition to the co-pay. All charges not covered by insurance are due and payable within 30 days of the first billing you receive unless you have arranged a budget payment plan with our Billing Department.

Personal balances over $200.00 will be required to make minimum payments of $50.00 per month. Patients with personal balances over 90 days who do have a payment plan with the Billing Department may be referred to collection agency.

APPOINTMENTS

A scheduled time has been reserved for you. Please give 24 hours notice if you are unable to keep this appointment. There may be a charge of $25.00 for NO SHOW office visit appointments or if office visit appointments are not cancelled a day in advance.

Scheduled in-office procedures that are not cancelled a day in advance may be subject to a charge of $50.00.

Scheduled surgical procedures that are not cancelled a day in advance may be subject to a charge of $100.00.

RECORDS/FORMS

If you request our staff or physicians to complete disability or FMLA forms there will be a fee of $25.00.

If you request a copy of your medical records there will be a fee of $25.00

TO ALL OF OUR PATIENTS

Christopher L. Sherman, D.O. is committed to providing quality services to his patients. We have developed this payment/credit policy in an attempt to provide fair service to all of our patients while trying to keep health care costs down. We appreciate your assistance and understanding of our policy. Please remember, while we are billing your insurance for you, it is still your responsibility to follow-up with the insurance company and to make sure that there is timely payment of your account. If you have any questions, regarding your bill, please contact our office at: 619-267-3020.

P a t i e n t s N a m e

_____

Signature of Responsible Party

_____

Relationship to Patient

_____

Date

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly of indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physical certifications

I have received, read and understand the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I can contact this organization at any time at any of the offices listed above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

Office Use Only

I attempted to obtain the patient's signature on acknowledgement of this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date: Initials: Reason:

NOTICE OF PRIVACY PRACTICES

PLEASE TAKE THIS COPY WITH YOU

Effective Date: February 1, 2012
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 above.

A. How this Medical Practice May Use Or Disclose Your Health Information
This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medial record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you 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 your health plan 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 your medical information 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 to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.
4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your 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 you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we my 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 your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will us their best judgment in communication with your family and others.
7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization.
8. Required By Law. As required by law, we will use and disclose your 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.
9. Public Health. We may, and are sometimes required by law to disclose your health information to public 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 you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
10. Health Oversight Activities. We may, and are sometimes required by law to disclose your 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.
11. Judicial and Administrative Proceedings. We may, and are sometimes required by law to disclose your 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 you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
13. Coroners. We may, and are often required by law, to disclose your health Information to coroners in connection with their investigations of deaths.
14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public Safety. We may, and are sometimes required by law, to disclose your 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.
16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
17. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred t another physician or medical group.

B. When This Medical Practice May Not Use or Disclose Your Health Information.

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information either mailed to a specific location or you or someone you have authorized in writing may pick up the information in person.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your 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 you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provide to you or pursuant to your written authorization, or as described in paragraphs 1(treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (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. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices.

We reserve the right to amend 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 will offer you a copy. We will also post the current notice on our website.

E. Complaints.

If you believe your privacy right have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Jeff Craven, Privacy Officer, at 858-346-7171. You will not be penalized for filing a complaint.

PATIENT HEALTH HISTORY

Your Health History Is IMPORTANT. **Please answer all questions thoroughly.**

Name_____ Today's Date:_____

Past Medical History:

☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Lung Disorders
☐ High Cholesterol	☐ Kidney Problems	☐ Prostate Problems	☐ Thyroid
☐ Anemia	☐ Arthritis	☐ Gout	☐ Liver Disease
☐ Psychiatric	☐ Stroke	☐ TB	☐ Hepatitis
☐ Seizure	☐ Bleeding Disorder	☐ Polio	☐ Multiple Sclerosis
☐ Eating Disorder	☐ STD's	☐ AIDS/HIV	☐ Low Blood Pressure

Cancer Type and Current Status:_____

Other (please describe):_____

Past Surgical History:

Surgery/Hospitalization	Year	Complications/Outcome

Have you ever had general anesthesia? ☐ Yes ☐ No

Have you ever had any problems with anesthesia? ☐ Yes ☐ No

If yes, please describe:_____

Do you have sleep apnea? ☐ Yes ☐ No

ALLERGIES: Please List

Are all immunizations up to date? ☐ Yes ☐ No

If no, which immunizations are due?:_____

Review of Systems:

Are you currently having or have you had problems with your:

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

Social History:

Occupation:_____ ☐ Work at Home ☐ Employed ☐ Student ☐ Retired

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children?: ☐ No ☐ Yes #_____ Do you live alone? ☐ No ☐ Yes

Habits:

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

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

Quit Smoking? ☐ This Year ☐ > 1 Year ☐ > 5 Years ☐ > 10 Years

Previously Smoked_____ packs a day for _____years

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

Are you exposed to tobacco in your household? ☐ No ☐ Yes

Family History:

Relation		Age	State of Health	Age of Death	Medical Conditions
Father					
Mother					
Brother					
Sister					
Grandfather (Mom's)					
Grandmother (Mom's)					
Grandfather (Dad's)					
Grandmother (Dad's)					

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

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

Dr. Sherman is honored to participate in your care. In doing so, we, as a practice desire the following to optimize your results and enhance our relationship:

1. Follow all weight bearing restrictions
2. Make all scheduled appointments
3. Communicate any concerns, questions, and problems on phone or in person,
4. Attend all therapy sessions as well as referrals to see a specialist
5. Maintain all splints and casts

Failure to do so may result in complications as well as protracted recovery. In addition, repeated non-compliance will result in termination of care with Dr. Sherman

We will be as flexible as possible in order to accommodate you. That said, YOU are ultimately responsible to follow these requests.

I acknowledge that I have read and understand what Dr. Sherman requests of me.

Signed:_____Date:_____