DOCS Spine + Orthopedics

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last name: First: Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐			
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Birth date:	Age:	Social Security Number:	Sex: ☐ M ☐ F
Preferred Language:	Race:	Ethnicity:			
Street address:	Cell phone: ( )	Home phone: ( )			
City:	State:	ZIP Code:	Driver's License:	Email address:	
Occupation:	Employer & Employer Address:	Employer phone: ( )			
Who referred you to this office? (Please check one box):	☐ Referred by Doctor - Dr.'s Name:				
☐ Family – Name:	☐ Friend - Name:	☐ Internet ☐ Hospital – Name:			
How would you like us to contact you for appointment reminder: ☐ Home Phone ☐ Cell Phone					
PHARMACY: Name, address, and phone number of pharmacy you would like medications called in to:					

INSURANCE INFORMATION

(Please give your insurance card to the front desk.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone: ( )		
Is this person a patient here? ☐ Yes ☐ No	Is this injury: ☐ Work Related ☐ Auto ☐ Personal Injury				
Is this patient covered by insurance? ☐ Yes ☐ No					
Please indicate primary insurance	☐ Blue Cross	☐ Blue Shield	☐ Aetna	☐ Cigna	☐ HealthNet
☐ SAG	☐ PacifiCare	☐ Medicare	☐ Medicare / Medi-Cal	☐ Other	
Subscriber's name:	Subscriber's S.S. number:	Birth date:	Group number:	Policy number:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Birth Date :	Policy number:		
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

Name of friend or relative :	Relationship to patient:	Home phone: ( )	Mobile phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Beverly Hills Orthopedic Group or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Patient History Form

Name:_____ **Nickname:** _____ **Today's Date:** _____

Date of Birth:_____ **Age:**_____ **Height/Weight:**_____/_____

Referred By: _____

History of Injury

Is this related to a: ☐ Work injury? ☐ Motor vehicle accident? If so, what state?_____ or ☐ Sport accident?

Which body part is injured?_____ ☐Right / ☐Left **Hand dominance:** ☐Right / ☐Left

Please list the injury/accident date:_____ **If chronic list how long:**_____

Please describe in your own words: (How the initial injury occurred and how it limits your activity)

_____

_____

_____

_____

Please rate your pain below on a scale of 1 to 10: (10 being the most painful)

Rest: 0-1-2-3-4-5-6-7-8-9-10 **At its worst:** 0-1-2-3-4-5-6-7-8-9-10

Is the pain: ☐Constant or ☐Occasional **Has it been:** ☐Worsening ☐Stable ☐Improving

Describe the pain: ☐Sharp ☐Dull ☐Aching ☐Stabbing ☐Throbbing ☐Sensitive to Touch

Do you have pain at night? ☐Yes / ☐No **Does the pain keep or wake you from sleep?** ☐Yes / ☐No (☐Keep I☐Wake)

What symptoms are you experiencing?

☐Locking ☐Catching ☐Giving Way/Instability ☐Popping ☐Grinding ☐Bruising ☐Numbness ☐Tingling

☐Aching ☐Weakness ☐Swelling Other (Please describe):_____

What, if anything, makes your symptoms worse?

☐Inactivity ☐Exercise (Describe):_____ Other (Please describe):_____

What, if anything, makes your symptoms better?

☐Rest ☐Activity ☐Cold Therapy ☐Heat Therapy ☐Medication ☐Other (Please describe):_____

What treatment have you tried for this injury?

☐ Nothing ☐Exercise ☐Ice ☐Decreased Activity ☐Bracing ☐ Injections (i.e. Synvisc/Hyalgan/Cortisone) (Date Started):_____

☐Physical Therapy (Number of Visits?): _____ ☐Acupuncture (Number of Visits?): _____ ☐Other: _____

☐Chiropractics (Number of Visits?): _____ ☐Medications (List): _____

_____

Have you seen another physician for this injury? ☐Yes / ☐No **Were you referred?** ☐Yes / ☐No

If yes, who/where? _____

MEDICATIONS (Please list all prescription, over the counter medications and supplements)

Medication	Dosage	Frequency

PAST MEDICAL HISTORY Please check if you currently suffer or have previously suffered from:

High Blood Pressure	_____	Osteoporosis	_____
Deep Vein Thrombosis (Blood Clot)	_____	Kidney Disease/Problem	_____
Liver Disease	_____	Seizures	_____
Heart Disease/Attack	_____	Arthritis	_____
Stroke	_____	Thyroid ☐Hyper ☐Hypo	_____
Cancer (Where?)	_____	Tuberculosis	_____
Elevated Cholesterol	_____	Pulmonary Embolism	_____
Ulcer Disease	_____	Polio	_____
Gastritis	_____	Rheumatic Fever	_____
Reflux Disease (GERD)	_____	Gout	_____
Asthma	_____	Depression	_____
Diabetes	_____	Psoriasis	_____
History of MRSA	_____	COPD	_____
Other:	_____	Sleep Apnea	_____

Do you have a pacemaker? ☐Yes / ☐No **Have you ever had heart, brain or artery surgery?** ☐Yes / ☐No

Do you have any chance of implants or metal shavings in your skin? ☐Yes / ☐No

SURGICAL HISTORY

Please list all surgeries to the area you are being seen for today:

Type of Surgery	Date	Surgeon

Please list all other surgeries you have had in the past:

Type of Surgery	Date	Surgeon

Have you ever had a reaction to anesthesia? ☐Yes / ☐No If yes explain:_____

ALLERGIES

Are you allergic to: Penicillin? ☐Yes / ☐No **Latex?** ☐Yes / ☐No **Steroids?** ☐Yes / ☐No **Sulfa?** ☐Yes / ☐No

Please list any environmental allergies:

Other Medication Allergies	What Happened?

SOCIAL HISTORY

Occupation:_____ Are you currently working? ☐Yes ☐No ☐Retired ☐Limited Duty

Recreational activities:_____ ☐College or ☐Pro?

Current activity level:_____

Tobacco product use: ☐Never ☐Smoke ☐Chew **Freq:** ☐Everyday ☐Occasionally ☐Former Year Quit _____

Alcohol use (Drinks per day): ☐6 or More ☐4-5 ☐2-3 ☐1 ☐Less than 1 ☐0 In last year ☐Don't drink

Recreational drugs: ☐Yes ☐No Type/Frequency: _____

FAMILY HISTORY (Please check family history conditions as well as who had the condition)

Blood Clots:_____ Osteoporosis:_____ Rheumatoid Arthritis:_____

Diabetes:_____ Heart Disease:_____ Hypertension:_____

Seizures:_____ Stroke:_____ Anesthetic Problems:_____

Cancer:_____ Other:_____

Signature:_____ Date:_____

Print Name:_____

DOCS Spine + Orthopedics

Cancellation Policy

Cancellation of an Appointment

Appointments are in high demand, and thus, in order to best serve the needs our patients, please promptly call our office if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. We would appreciate a minimum of 24 hours advanced notice for cancellations.

How to Cancel Your Appointment

Please call (310) 860-3048 or email us at appointments@snibbeorthopedics.com.

Late Cancellations

Late cancellations or failure to show up at scheduled time will be considered a "no show."

No Show Policy

A "no show" is when a patient misses an appointment without contacting the office to cancel in advance. No shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in our appointment system as a "no show." The first time there is a "no show," the patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment. If there is a second "no show" within 1 year, a fee of $25.00 will be billed to the patient. This fee is to be paid prior to scheduling the patient's next appointment. Three "no shows" in 1 year will result in the termination from our practice.

Thank you in advance for your cooperation. Please sign and date below to acknowledge that you read and understand this information.

_____ _____

Signature Date

8436 W. 3rd Street, Suite 800, Los Angeles, CA 90048
P: (310) 860-3048 F: (310) 550-7680

DOCS Spine + Orthopedics

Office Policy
Disability Form Processing

Due to the very high volume of patients who require disability paperwork to be completed and signed by the doctor, we have adopted the following guidelines to assist in rapid processing of those important and necessary forms.

Please note that any paperwork processed by this office will take 5 business days (from the date received) to complete and mail. If you would like us to fax it to your Employer/Insurance Company/Outside Agency, please provide their fax number.

Paper work cannot be processed unless you have completed all portions of the document that are to be filled out by the patient. NO EXCEPTIONS. This will not apply if the paperwork does not require signature.

A copy of your paperwork will be placed in your chart after the doctor signs it and will remain a part of your permanent record. This applies to ALL forms.

When we send the original document out to the employer/insurance company/other agency, a copy will be sent to you at your home. If another facility or office requires a copy of this, it is your responsibility to forward it to that party.

All Private Insurance Disability forms, Life Insurance forms and Worker's Compensation forms will require a $25.00 - $75.00 fee due at the time forms are submitted to our office. The fee determined based upon the length of the forms. You will be notified of the exact fee when you present the forms to us for completion. **Paperwork will not be processed without payment in advance.** We accept cash, checks and credit cards. Please make checks payable to Snibbe Orthopedics.

We appreciate your assistance in completing your portion of the forms. We feel that this will allow us to better serve you, the patient. Please sign and date below to acknowledge that you read and understand this information. If you have any questions or concerns feel free to contact our office.

_____ _____

Signature Date

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DOCS Spine + Orthopedics

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

8436 W. 3rd Street, Suite 800, Los Angeles, CA 90048
P: (310) 860-3048 F: (310) 550-7680

DOCS Spine + Orthopedics

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Office of Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza – Room 322
San Francisco, CA 94102

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

PLEASE SIGN THE ACCOMPANYING "ACKNOWLEDGMENT" FORM. PLEASE NOTE THAT BY SIGNING THE ACKNOWLEDGMENT FORM YOU ARE ONLY ACKNOWLEDGING THAT YOU HAVE RECEIVED OR BEEN GIVEN THE OPPORTUNITY TO RECEIVE A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

DOCS Spine + Orthopedics

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)

1. Authorization

I authorize ___Snibbe Orthopedics_____ (healthcare provider) to use and disclose the protected health information described below to the follow person(s) _____(individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from the below dates:

_____ to _____ OR ☐ all past, present, and future periods.

3. Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

☐ I authorize the release of my complete health record with the exception of the following:

- □ Mental health records
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effective until date listed in item (2) above, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Printed name of patient/guardian	Signature of patient/guardian	Date

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NOTICE OF PRIVACY PRACTICES

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.

Uses and Disclosures:

Treatment: Your health information may be used by our staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by our staff members.

Payment: Your health information may be used to seek payment from your health plans, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities of Mink Radiologic Imaging. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosure require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit and written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Appointment reminders: Your health information may be used by our staff to send you appointment reminders.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request instructions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice.

Mink Radiologic Imaging Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office manager.

Complaints

If you would like to submit a comment or compliant about our privacy practices, you can do so by sending a letter outlining your concerns to:

HIPPA Compliance Department
8670 Wilshire Boulevard, Suite 101
Beverly Hills, CA 90211

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practice is:

Bryon Rose
Privacy Office
8670 Wilshire Boulevard, Suite 101
Beverly Hills, CA 90211

Effective Date

This Notice is effective on or after April 14, 2003.

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

_____ _____

Signature Date

MINK RADIOLOGIC IMAGING

PREGNANCY RELEASE FORM

It is recognized that *ionizing radiation* can be harmful to a fetus and that the effects of a *magnetic field* on a fetus has been undetermined as of yet. It is the policy of Mink Radiologic Imaging that females who are pregnant or suspect that they are pregnant should not have an exam that utilizes ionizing radiation or magnetic fields unless the referring physician and/or radiologist determine the exam is medically necessary. Mink Radiologic Imaging requires confirmation of pregnancy/non-pregnancy for females of childbearing age prior to performing a radiological exam. Childbearing age is considered to be between 10-55 years of age.

NEGATIVE PREGNANCY STATUS:

_____ I am not pregnant _____
Patient Initials

UNCLEAR PREGNANCY STATUS:

_____ I have decided to reschedule the exam/procedure until my pregnancy status is confirmed. Mink Radiological Imaging personnel will notify my physician of the delay of my exam.

POSITIVE PREGNANCY STATUS:

Radiation to the embryo/fetus is minimally associated with but not limited to the following risks: increased risk of childhood cancer, congenital abnormality, mental retardation, small head size and miscarriage. The effects of a magnetic field on a fetus has been undetermined as of yet. The possible risk vs. benefit of the exam/procedure has been discussed with me. I have been given the opportunity to ask questions about the proposed imaging procedure, and its risks and alternatives. I have sufficient information to give this informed consent. The form has been explained to me, I have read it or had it read to me, and I understand its contents.

_____ I have read and fully understand the above and hereby give my consent to have an X-ray or MR procedure performed. I have been informed of the estimated risks to my embryo or fetus. _____
Patient Initials

_____ Declined to undergo the exam/procedure _____
Patient Initials

By signing below, I agree that the above statements are true and hereby release Mink Radiologic Imaging from any complications that may occur from exposure to ionizing radiation or a magnetic field and assume responsibility for my decision to undergo the procedure/exam.

_____ _____
Patient/Guardian Signature Date/Time

_____ _____
Mink Radiological Imaging Technologist Date/Time