

# TOSMG PATIENT INFORMATION FORM

Referred by: \_\_\_\_\_

**\*Is your complaint today work related? Y / N**

**\* Are you currently under the care of a skilled nursing facility (SNF)? Y / N**

Today's Date: \_\_\_/\_\_\_/\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender: M / F

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Marital Status: Single / Married / Divorced / Widowed

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Address: \_\_\_\_\_

E-Mail address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work status: regular duties / light duties / off work

First date missed: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Emergency Contact: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

## INSURANCE INFORMATION

Is your insurance plan an **HMO / PPO / EPO / Medicare / Workers' Compensation / Other**: \_\_\_\_\_

### PRIMARY INSURANCE

### SECONDARY INSURANCE

Insurance Company Name: \_\_\_\_\_ Insurance Company Name: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's D.O.B. \_\_\_/\_\_\_/\_\_\_ Insured's D.O.B. \_\_\_/\_\_\_/\_\_\_

Insured's Employer Name: \_\_\_\_\_ Insured's Employer Name: \_\_\_\_\_

Group and ID# \_\_\_\_\_ Group and ID# \_\_\_\_\_

Relationship to patient: Self/Spouse/Dependent Relationship to patient: Self/Spouse/Dependent

### \*\*\*\*\*CONSENT FOR MEDICAL TREATMENT & ASSIGNMENT OF BENEFITS\*\*\*\*\*

**PATIENT'S or INSURED'S SIGNATURE:** I authorize payment of medical benefits to the undersigned physician or supplier for services described below. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

**Signature of patient (parent if minor):** X \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

### \*\*\*\*\*PRESENT COMPLAINT\*\*\*\*\*

**Part of body:** \_\_\_\_\_ **Left/ Right/ Both** **Specific areas:** \_\_\_\_\_

**Onset:** \_\_\_/\_\_\_/\_\_\_ **gradual/ sudden** **Duration:** \_\_\_ days/ weeks/ months/ years **Pain scale (1-10):** \_\_\_\_\_

**Status:** improving/ worse/ stable/ resolved/ fluctuating **Frequency:** intermittent/ constant/ occasional/ rare

Does your pain radiate? Y / N Where? \_\_\_\_\_. **Quality:** aching/ burning/ dull/ sharp/ throbbing \_\_\_\_\_

**Context:** no injury/ injury/ sports injury/ motor vehicle accident Other: \_\_\_\_\_

**\*Describe:** \_\_\_\_\_

**Trauma: Type:** fall/ running/ direct blow/ twisting/ lifting/ crush **History of injury to area? Y/N Year:** \_\_\_\_\_

Where: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ or around: \_\_\_\_\_

**Aggravated by:** **Nothing**  
bending/ lifting/ movement/ walking/ sitting/ standing/ pushing/ pulling/ stairs **Other:** \_\_\_\_\_

**Relieved by:** **Nothing**  
splint/ ice/ heat/ massage/ therapy/ elevation/ exercise/ stretching / OTC medicines: \_\_\_\_\_

**Associated symptoms:** **Nothing**  
bruising/ instability/ tenderness/ weakness/ numbness/ tingling/ swelling/ limping/ locking/ decreased mobility

**TOSMG MEDICAL HISTORY FORM** NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**YOUR DOCTORS:** Please list your *current* doctors and their specialties:

DOCTOR	SPECIALTY	DOCTOR	SPECIALTY
1.		4.	
2.		5.	
3.		6.	

**MEDICAL CONDITIONS:** Please list *your* medical conditions:

1.	4.	7.
2.	5.	8.
3.	6.	9.

**SURGERIES:** Please list *any* surgeries you've had, including the left or right side and year:

SURGERY	YEAR	SURGERY	YEAR
1.		4.	
2.		5.	
3.		6.	

**FAMILY MEDICAL HISTORY:** Please list the *status* of your family members with medical conditions

RELATIVE	STATUS	AGE	MEDICAL CONDITIONS
Father	Alive ___ Deceased ___		
Mother	Alive ___ Deceased ___		
Sibling #1 Bro/Sis	Alive ___ Deceased ___		
Sibling #2 Bro/Sis	Alive ___ Deceased ___		
Child #1 M/F	Alive ___ Deceased ___		
Child #2 M/F	Alive ___ Deceased ___		

**SOCIAL HISTORY:** Occupation: \_\_\_\_\_ Hand dominance: R\_\_ L\_\_ Ambidextrous\_\_

**Tobacco use:** No\_\_ Yes\_\_ Former: \_\_ **Quit Date:** \_\_\_\_\_ **Type:** Cigarettes/ Chew/ Pipe/ Cigar

Amount/ packs per day \_\_\_\_\_ # of years \_\_\_\_\_

**Alcohol consumption:** No\_\_ Yes\_\_ **Type:** Beer/ Wine/ Hard liquor: \_\_\_\_\_ # per day/ week/ month \_\_\_\_\_

History of alcohol abuse: No\_\_ Yes\_\_

**Recreational drug use:** No\_\_ Yes\_\_ **Type:** \_\_\_\_\_ **Have you ever used needles?** No\_\_ Yes\_\_ Year: \_\_\_\_\_

**ALLERGIES:** Please list *any medication allergies* or reactions to medications/ other agents:

ALLERGY:	REACTION:

**CURRENT MEDICATIONS:** Please list prescription and non prescription meds including herbal supplements

**PHARMACY:** CVS/ Walgreens/ Rite-aid/ Costco/ Pavilions/ Sav-on/ Other: \_\_\_\_\_

**Address:** \_\_\_\_\_ **Ph:** ( ) \_\_\_\_\_

MEDICATION	STRENGTH	DIRECTIONS	MEDICATION	STRENGTH	DIRECTIONS

**SYSTEM REVIEW:** Please check all that apply:

**Constitutional:** \_\_\_ Fever \_\_\_ Weight loss **Cardiovascular:** \_\_\_ Chest pain \_\_\_ Leg swelling **Psychiatric:** \_\_\_ Anxiety \_\_\_ Depression  
 \_\_\_ Night sweats \_\_\_ Irregular heartbeat \_\_\_ Insomnia  
**HEENT:** \_\_\_ Headaches \_\_\_ Hearing loss **Gastrointestinal:** \_\_\_ Abdominal pain **Hematologic:** \_\_\_ Bleeding \_\_\_ Clotting  
 \_\_\_ Vision loss \_\_\_ Black tarry/bloody stools \_\_\_ Bruising  
**Respiratory:** \_\_\_ Cough \_\_\_ Diarrhea **Immunologic:** \_\_\_ Environmental allergies  
 \_\_\_ Difficulty breathing \_\_\_ Nausea/Vomiting \_\_\_ Food allergies  
**Integumentary:** \_\_\_ Contact allergy **Neurological:** \_\_\_ Memory loss \_\_\_ Numbness **Other** \_\_\_\_\_  
 \_\_\_ Rash \_\_\_ Seizures \_\_\_ Tremors



### Patient Record of Disclosures

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check/circle all that apply):

#### Voice Communication

Home # \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_ Other# \_\_\_\_\_

- OK to leave message with detailed information: HOME / WORK / CELL / OTHER
- Leave message with call back number only: HOME / WORK / CELL / OTHER
- The following people are authorized to receive my medical information:

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

#### Written Communication

- OK to mail to home address
- OK to mail to work/office address
- OK to mail to a different address: \_\_\_\_\_
- Home fax: (\_\_\_\_) \_\_\_\_\_
- Work fax: (\_\_\_\_) \_\_\_\_\_

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

I have received *Torrance Orthopaedic and Sports Medicine Group Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that it may become necessary to disclose my protected health information to another entity as part of my medical treatment, payment of my account, or other health care operations as defined in the *Notice of Privacy Policies*. I consent to such disclosures for these permitted uses to include electronic interchange, telephone, facsimile and mail.

I understand that I may request restrictions regarding the use of my health information or revoke this consent by following the procedures outlined in the *Notice of Privacy Policies*. However, Torrance Orthopaedic is not required to agree with any restrictions I request and may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

**Note: Uses and disclosure for treatment, payment, operations (TPO) information may be permitted without prior consent in an emergency.**

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Name of Patient (if different)



### Non-Contracted Insurance Waiver

Torrance Orthopaedics and Sports Medicine Group is contracted with most major insurance plans' PPO products. We accept Medicare assignment and treat Workers' Compensation injuries, although we are not contracted with any Worker's Compensation MPNs. We are not contracted with any HMO products. We are providing you with the list of our current contracted third party plans. If you don't see your plan listed, please ask us about it.

Affiliated Health Funds  
Anthem Blue Cross  
Blue Shield of California  
Cigna  
Corvel PPO  
Beech Street  
Bellflower USD  
First Health  
Great West  
HealthNet  
Medicare  
Orange County Foundation EPO/PPO  
MultiPlan  
NPPN  
PHCS  
PPO Next  
Provider Select PPO

If you seek services of a **non-contracted/out of network provider**, your insurance plan may require a higher out-of-pocket amount from the patient/subscriber and in some cases there is no coverage for **non-contracted/out of network providers**. Please see our financial policy regarding Usual and Customary charges.

I have read and understand that my insurance coverage may be a **non-contracted** carrier for my services and therefore I may be financially responsible for all or part of my services in the form of a higher deductible or co-insurance amount.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature Patient/Parent/Guardian

\_\_\_\_\_  
Date



## **Non-Contracted Insurance Waiver Policy and Procedure**

### **Policy:**

The purpose of this policy is give instructions on the use of this waiver.

### **Procedure:**

- If patient presents with an insurance coverage with which the physician is not contracted, i.e., UnitedHealthcare, Galaxy PPO, etc, the patient must be informed of the non-contracted status and asked to read and sign the Non-Contracted Insurance Waiver.
- If the patient presents with an insurance card which does not completely identify the managed care contract, the patient should be asked to read and sign the Non-Contracted Insurance Waiver.



## Financial Policy

We would like to thank you for choosing us to provide your orthopaedic care. We are committed to providing you with excellent and affordable healthcare. Because you may have questions regarding personal and insurance responsibility for services rendered, we have developed this payment and financial policy. Please read it, ask for clarification if needed, and sign in the space provided. A copy of this policy will be given to you.

All patients must complete the Patient Information and Insurance Form before seeing the doctor.

**WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS**

### Regarding Insurance Billing

You must provide proof of insurance. If you are not able to provide proof of insurance coverage, you will be considered uninsured and you will be responsible for full payment at time of service. We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor listed on the Patient Information form.

- **PPO Plans (with which we are contracted):** We have agreed to take a discount from your insurance company. Your co-insurance and/or unmet deductible is your responsibility and is due at time of treatment. In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or coinsurance amounts. All co-pays will be collected at the time of service. **If your co-payment is not made at time of service, a \$20.00 administrative fee will be added to your account due and payable by you, not your insurance company.** If you are scheduled to have a surgical procedure you may be required to pay a \$250 deposit for outpatient surgery or \$500 deposit for in-patient surgery. This is a deposit which will secure your time on the doctor's surgery schedule. It will be applied toward any out-of-pocket expenses deemed patient responsibility by your insurance company. You *may* forfeit all or part of this deposit if you do not cancel your surgery in a timely fashion. Please ask the doctor's secretary for further details regarding this deposit.
- **Medicare:** We accept assignment with Medicare. Medicare pays 80% of their allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed amount as a courtesy; however, you are responsible for the balance regardless of payment from a secondary insurance. **We do not accept MediCal. You will be responsible for the full amount of the remaining 20% that Medicare does not pay.**

### Self-Pay Patients:

Please be prepared to pay for services as they are rendered. We will be collecting a \$250 fee upon check-in for new patients and \$125 upon check-in for established patients. If surgery is needed, an estimate of your charges will be provided and a 50% payment deposit is required prior to the procedure. The deposit is for our services only. We cannot estimate the charges you may incur by other providers involved with your treatment. *Any overpayments will be credited to the account and refunded to the payer after the full course of treatment has been completed.*

### Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Forms fee** – There is a fee of \$20.00 per form for completing disability and/or insurance forms. Payment for these is due when the form is dropped off. Please allow 5 business days to complete the form(s).

**No Show Appointments** – There is a \$25.00 fee for appointments not cancelled within 24 hours. This is not payable by insurance and must be paid prior to your next appointment.

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

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature Patient/Parent/Guardian

\_\_\_\_\_  
Date