ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

New Patient Information Form

Asif Jillani, M.D.

Patient Name: _____ DOB: _____ Date: _____

Height: _____ Weight: _____

Current Problem:

What is the area to be examined? _____ R or L

Describe your pain/discomfort? _____

What makes it worse? _____

What makes it better? _____

Do you have pain, numbness or tingling that radiates down your arms or legs? _____

When did you first notice it? _____

How did it start? _____

Have you ever had anything like this before? _____

Do you ever notice any (circle): ☐ Locking ☐ Popping ☐ Catching ☐ Clicking ☐ Give-way

If this is a Work Comp injury, was it reported? If so, when: _____

Describe the details about the injury? _____

What are your current work restrictions? _____

How long have you worked at this job? _____

Have you had any other work related injuries? Describe. _____

Prior Treatment for This Problem:

Please indicate when and duration of treatment if applicable.

☐ Epidural/steroid injections: _____ ☐ Therapy: _____

☐ Surgery: _____ ☐ Chiropractor: _____

☐ Medications: _____ ☐ Acupuncture: _____

☐ Other: _____

Past Diagnostic Studies (when):

☐ X-rays: _____

☐ MRI: _____

☐ CT/CAT Scan: _____

☐ EMG (nerve studies): _____

**This form and the information contained here is a part of your medical record. As such, it is confidential and will be kept in this office. The information contained here will not be released to any person/entity without your expressed written authorization.

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New Patient Information Form

Asif Jillani, M.D.

Medical Information:

Drug Allergies: _____

Which is your dominant hand (circle): Right / Left or Neither

What medications are you currently taking (include dosage): _____

_____

Do you have any medical problems (diabetes, thyroid disease, high blood pressure, heart disease, rheumatologic disease, etc.): _____

_____

Do any of your immediate family members (Father, Mother, Siblings) have any medical problems (cancer, heart disease, high blood pressure, rheumatologic disease, etc.):_____

_____

Name any surgeries/operations you have had (when): _____

Social History:

Do you smoke? ☐Yes ☐No How many packs per day? _____ How many years? _____

Do you drink any alcohol? Never/Rarely/1-2 per month/1-2 per week/1-2 per day/3-5 per day/ 5+ per day

Occupation: _____

Marital Status: ☐Married ☐Divorced ☐Single ☐Widow ☐Life Partner

Do you have children? ☐Yes ☐No

Living Status: ☐Live Alone ☐With Spouse ☐Skilled Nursing ☐With Other Family

General Systems:

Have you had any recent problems with:

☐Weight Loss	☐Cough/Wheeze	☐Headaches
☐Fevers/Chills	☐Shortness of breath	☐Dizziness
☐Night sweats	☐Chest pain	☐Loss of consciousness
☐Nausea/Vomiting	☐Palpations	☐Blurry vision
☐Upset stomach	☐Change in bowel/bladder	☐Loss of vision
☐Diarrhea	☐Frequent urination	☐Skin rash

Female Only:

Is there any chance that you are pregnant? ☐Yes ☐No

When was your last menstrual cycle? _____

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Pain Drawing

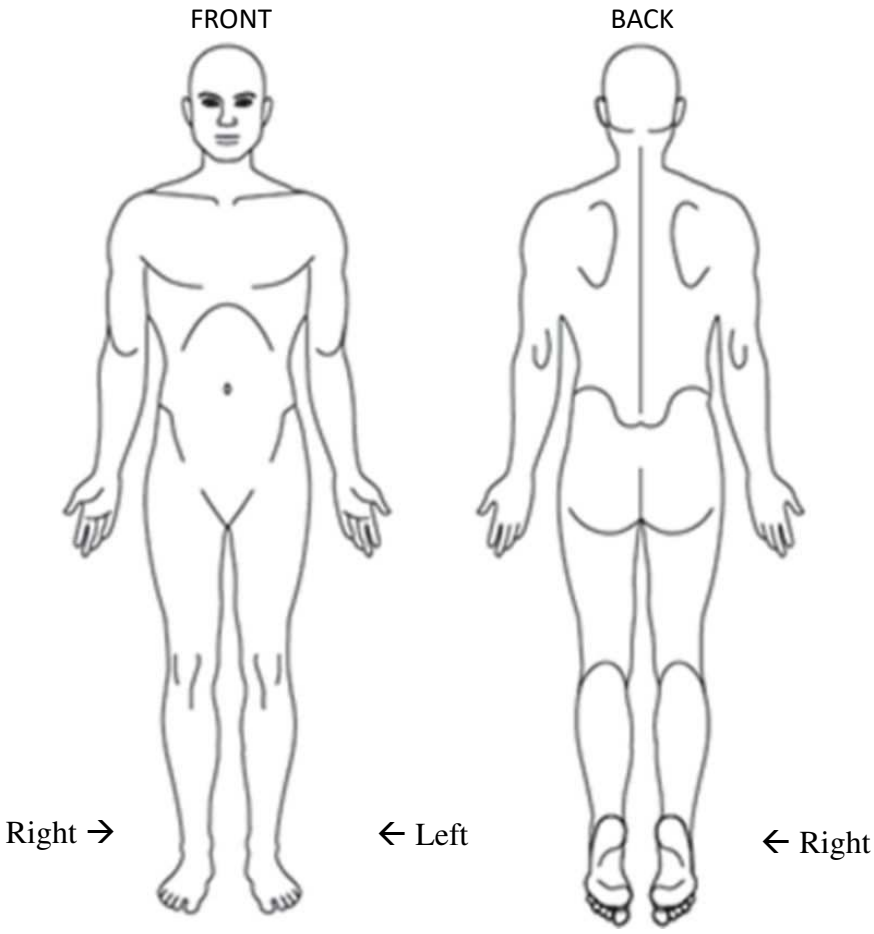
Name: _____ Date: _____

Where is your pain now?
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all the affected areas.

Use the symbols below to describe your symptoms:

NUMBNESS	^^^^^^^ ^^^^^^^ ^^^^^^^

PAIN	X X X X X X X X X X X X X X X X X X



Please mark on the line:

0 5 10

HOW BAD IS YOUR PAIN NOW?

PLEASE INDICATE WITH AN "X" THE AREA PERTAINING TO THE WORST AREA

ORTHOPAEDIC SPECIALTY INSTITUTE
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Asif Jillani, M.D.

Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate full with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances.

I will not share, sell, or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicines will be made only at the time of an office visit or regular office hours. No refills will be available during evenings or on weekends.

I agree to use _____ Pharmacy, located at _____, Telephone number _____, for filling prescriptions for all of my pain medicines.

I authorize the doctor and my pharmacy to cooperate fully with a any city, state, or federal law enforcement agency, including this state's Board or Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Asif Jillani, M.D.

Pain Management Agreement

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me.

This Agreement is entered into on this _____ day of _____, _____.

Patient signature: _____

Physician signature: _____

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

PATIENT REGISTRATION FORM

PATIENT INFORMATION: (Please use full legal name, no nicknames)			
Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Sex:	Social Security #:
Address:			
City:		State:	Zip:
Home Phone #:		Cell Phone #:	
E-mail Address:			Driver's License #:
Was this an injury? ☐ Yes ☐ No	If yes, where did your injury occur? ☐ Work ☐ Auto ☐ Home ☐ School		Date of injury:
Employer Name:		Occupation/Title/Position:	
Employer Address and Phone #:			
Emergency Contact Name:		Relationship:	Phone #:

GUARANTOR INFORMATION: (List person or insured name responsible for bill – use full legal name, no nicknames)			
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other			
Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Sex:	Social Security #:
Address:			
City:		State:	Zip:
Home Phone #:		Cell Phone #:	
Employer Name:		Occupation/Title/Position:	
Employer Address and Phone #:			

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)
IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INS	Insurance Company:		Copay:	☐ HMO ☐ PPO ☐ POS
	Policy/ID #:		Group #:	
	Claims Address & Phone #:			
	Insured's Name:	Relationship:		Insured's Date of Birth:
	Insured's Employer:		Insured's Social Security #:	
SECONDARY INS	Insurance Company:		Copay:	☐ HMO ☐ PPO ☐ POS
	Policy/ID #:		Group #:	
	Claims Address & Phone #:			
	Insured's Name:	Relationship:		Insured's Date of Birth:
	Insured's Employer:		Insured's Social Security #:	

I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original. **Photo identification and insurance cards must be presented at the time of service to enable OSI to submit claims to your insurance carrier. Should identification and insurance cards not be presented, you will become a cash patient with payment in full due at the time of service.** This agreement will remain valid from this day forward to include all future services relating to the above patient.

SIGNATURE OF PATIENT/GUARDIAN _____ **DATE** _____

ORTHOPAEDIC SPECIALTY INSTITUTE

Medical Information Release Form (HIPAA Release Form)

Patient Name: _____Date of Birth: ___/___/_____ MR #: _____

If minor, Parent/Guardian Name: _____

Release of Information

I authorize the release of information including diagnosis, records, examination results, medication dose changes and billing/collection/claims information.
This information may be released to:

[ ] Spouse/Name: _____

[ ] Child(ren)/Name(s): _____

[ ] Other: _____

[ ] Information is not to be released to anyone other than me.

Messages

Please call: [ ] my home phone # _____ [ ] my cell phone # _____.
If unable to reach me:

[ ] you may leave a detailed message.
OR
[ ] please leave a message asking me to return your call.

[ ] Do not leave messages on my voicemail.

The best time to reach me is (day of week) _____ between (time) _____.

E-mail Messages/Portal

[ ] Use my e-mail or portal contact to send messages for me to contact the nurse for information.
OR
[ ] Use my e-mail or portal contact to leave detailed messages and information.
[ ] Attach lab results to e-mail/portal message.
My e-mail address is: _____.

This Release of Information will remain in effect until termination by me in writing. This release specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Signature: _____ Date: _____

Witness: _____ Date: _____

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Acknowledgement of Receipt of Notice of Privacy Practices and Notices to Consumers

Orthopaedic Specialty Institute

I hereby acknowledge that I received a copy of the medical practice's Notice of Privacy Practices as well as Consumers Notices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices and/or Consumer updates at each appointment.

NOTICE TO CONSUMERS

PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY

THE PHYSICIAN ASSISTANT COMMITTEE
(916) 561-8780
WWW.PAC.CA.GOV

NOTICE TO CONSUMERS

MEDICAL DOCTORS ARE
LICENSED AND REGULATED BY
THE MEDICAL BOARD OF CALIFORNIA

(800) 633-2322
WWW.MBC.CA.GOV

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate
Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

280 S. Main Street · Suite 200 · Orange, CA 92868 · Tel. (714) 634-4567 · Fax (714) 634-4569
16300 Sand Canyon Ave · Suite 511 · Irvine, CA 92618 · Tel. (949) 255-9890 · Fax (949) 255-9776

ORTHOPAEDIC SPECIALTY INSTITUTE

280 S. MAIN STREET · SUITE 200 · ORANGE, CA 92868 · TEL. (714) 634-4567 · FAX (714) 634-4569
16300 SAND CANYON AVE · SUITE 511 · IRVINE, CA 92618 · TEL. (949) 255-9890 · FAX (949) 255-9776

CONSENT FOR TREATMENT – NOTICE OF POLICIES

I hereby consent and authorize Orthopaedic Specialty Institute Medical Group of Orange County (OSI) healthcare providers to perform medical care, diagnostic tests, surgical care and other therapeutic measures, as may be indicated for my health and well-being. If I will not comply with the medical program of care provided or recommended, I understand that thereupon I relieve my physician(s), healthcare provider(s), medical staff, and the company, of all responsibility resulting from my action.

I also authorize OSI, all associated physicians and all associated agencies, to gather, maintain and release any and all of my information that might be required for processing of any of all claims for third party payers (including but not exclusive of, private insurance, Medi-Cal, Medicare, Tricare, Work-Comp, etc.)

I acknowledge that I have been given the ability to review OSI's policies including Financial Policy.

FINANCIAL POLICY

- We will submit claims to your insurance company for all medical services rendered at OSI. Any other services related to your medical care not rendered at OSI (i.e. laboratory, pathology, hospital fees, outpatient surgery center fees, anesthesiologist, co-surgeon, etc.), will be billed by the entity providing those services. It is **your** responsibility to verify that OSI is part of your insurance plan. We will attempt to verify your eligibility and benefits with your insurance carrier; however, this does not guarantee that they will pay for the services provided, and you will remain financially responsible if they do not provide payment.

- **OSI accepts the following insurance plans**:

  - **Medicare** – pays 80% after the deductible has been met. We will bill your coinsurance for the remaining 20% as a courtesy; however, you are responsible for the 20% coinsurance of the Medicare allowable amount.
  - **Contracted PPOs and HMOs** – you are responsible for the payment of co-pay and deductible at the time of the service, as well as for any charges for which you failed to secure prior authorization (if necessary).
  - **Non-Contracted PPOs** – you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
  - **Self-Pay** (uninsured) - you are expected to pay in full at the time of the service.
  - **Worker's Compensation** – you are not responsible for any charges unless the case has been dismissed or denied.

Initials_____

- **Personal Injury/Motor Vehicle Accidents -** you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
- **Surgery Deposits** – once the decision for surgery is made, our surgery coordinator will contact your insurance carrier to confirm eligibility benefits and obtain authorization. The surgery coordinator will provide you with an estimated cost of your surgery. This amount will be collected as a deposit at or before the time of your pre-operative appointment.
- **Medical Records** – all medical records requests are subject to a preparation fee. Any additional costs related to shipping and handling will be added to these costs (if applicable).
- **Divorce Related** – the parent authorizing treatment for a child will be the parent responsible for the charges related to that care. If the divorce decree requires the other parent to pay all, or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- **Bad Debt** - patients who do not pay bills within 90 (ninety) days of the statement date, will be referred to a collections agency, and ***may be discharged from the practice for non-payment.***
- **Failed Appointment Charge for MRI –** we reserve the right to charge $25 (twenty-five) for each failed appointment not canceled at least 24 hours before the scheduled appointment time. This charge is not covered by your insurance.
- **Usual and Customary Rates -** our practice is committed to the best treatment for our patients. Our charges are considered usual and customary for our area. You are responsible for payment, regardless of any insurance company's arbitrary determination of usual and customary charges.

- **Financial Responsibility** – based on our contractual agreements with the insurance companies and our internal policies, we are informing you of the following:
    - Your health insurance deductibles and any expenses deemed not covered by your insurance company will be your financial responsibility.
    - All monies owed by you, such as office visits co-payments and non-covered services or supplies, are due at the time of the service.
    - If you are not prepared to pay any amounts due at the time of the visit, you will be asked to re-schedule the appointment, unless the physician determines that your medical condition prohibits this.

- **Method of Payment** - our office accepts the following forms of payment: credit cards, cash, money order, and checks. A $25 (twenty-five dollar) service charge will be assessed to your account for any returned check by your bank. This charge is not covered by your insurance.

Thank you for understanding our policies. If you have any questions or concerns, please do not hesitate to contact our office at **(714) 634-4567.**

By signing in the box below indicates that you are acknowledging and are in agreement with all of the above. Further, you understand and agree that your consents/assignments remain in effect until you choose to revoke them in writing.

_____

(Signature of Patient or Authorized Representative) (Printed Name) (Date)

_____

(If signed Above by Representative, Relationship of Signer to Patient) (Name of Patient if Different from Above)

Initials_____