Patient Meaningful Use Intake Form – Jeffrey Deckey, M.D.

Patient Name: _____ Date of Birth: _____

Preferred contact number: ☐Home ☐Work ☐Cell (____) _____

Demographics: Please check ONE box per section	
Race	☐Asian ☐Black or African American ☐Caucasian ☐Filipino ☐French ☐Hispanic ☐Italian ☐Middle Eastern/North African ☐Native American ☐Indian ☐Spanish American ☐Unknown ☐Other
Language	☐Arabic ☐Chinese ☐English ☐French ☐Japanese ☐Korean ☐Spanish ☐Thai ☐Vietnamese ☐Other
Ethnicity	☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown/Not Reported

Medications: Please CLEARLY list ALL current medication names		
1.	9.	17.
2.	10.	18.
3.	11.	19.
4.	12.	20.
5.	13.	21.
6.	14.	22.
7.	15.	23.
8.	16.	24.

Allergies: ☐No Known Allergies ☐ Other (List all Medication allergies) _____

Smoking: Do you smoke: ☐No ☐Yes ☐ Former Smoker

If yes, check all that apply: ☐cigarettes ☐chewing ☐cigars ☐pipe ☐smokeless

Family History: Has anyone in your family had any of the following problems?

☐ No significant past family history ☐ Unknown family history

Disease	**Mother**	**Father**	**Brothers**	**Sisters**	**Daughters**	**Sons**
High blood pressure/hypertension	☐	☐	☐	☐	☐	☐
Heart attack/Heart surgery	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer (please specify)						
Arthritis	☐	☐	☐	☐	☐	☐
Other (please specify)						

Signature: _____ Date of Visit: _____

PATIENT QUESTIONNAIRE
JEFFREY DECKEY, M.D.
SPINE

Name: _____ Sex: _____ DOB: _____ Age: _____

Occupation: _____

Who referred you to Dr. Deckey? _____

Who is your family or primary care doctor? _____

Height: _____ Weight: _____

State your reason for visit: _____

Where is your pain? (back, neck, arms, legs, right or left) _____

Any numbness or weakness? (Where?) _____

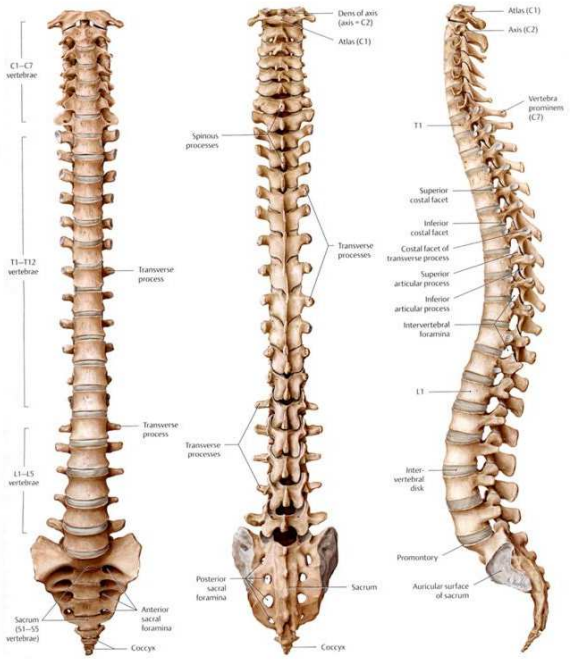
When did your pain start? _____

Have you had any history of this type of problem in the past? _____

If so, when? _____

What is your pain on a scale of 0 (no pain) to 10 (worst pain) _____

Is your pain (Mark all that apply): ☐ Getting worse ☐ Getting better ☐ Constant ☐ Intermittent



How did your pain start? (Mark all that apply)

☐ Suddenly ☐ Pulling
☐ Gradually ☐ Injured at work
☐ Lifting ☐ Auto accident
☐ Twisting ☐ Hit from behind
☐ Fall ☐ Sport injury
☐ Bending ☐ No apparent cause

What makes your pain worse? (Mark all that apply)

☐ Sitting ☐ Standing
☐ Walking ☐ Bending
☐ Lying down ☐ Lifting
☐ Bending backwards ☐ Twisting

What makes your pain better? (Mark all that apply)

- ☐ Sitting
- ☐ Standing
- ☐ Lying down
- ☐ Walking
- ☐ Leaning forward
- ☐ Leaning backwards
- ☐ Leaning on shopping cart
- ☐ Exercise

Have you had any diagnostic testing for your spine condition? (If yes, when and where?)

Xrays _____

MRI _____

CTscan _____

Myelogram _____

EMG _____

Discogram _____

Bone density exam _____

Have you had any treatment for your spine condition? If so, did it help? How many?

Physical therapy _____

Chiropractic care _____

Epidural injections _____

Have you had surgery on your spine? (Please describe, list dates, and surgeons)

_____

_____

Which medications do you take for your spine condition? (Please list names, dosages, and how many per day)

_____

_____

Which physicians have you seen for this condition? _____

Was this a work injury? ☐ Yes ☐ No

If so, when were you injured and how? _____

Are you still working? If not, when was your last day of work? _____

How long have you worked for your employer? _____

MEDICAL HISTORY

Please list all medical problems whether you are taking medications for it or not.

_____

PAST SURGERIES

Please list all surgeries.

_____

MEDICATIONS

Please list all medications you are currently taking including frequency and dosages.

_____

ALLERGIES

Please list all medication allergies and describe reaction.

_____

FAMILY HISTORY

Do you have any family (relatives) history of the following? Please describe.

Heart Disease _____

Diabetes _____

Cancer _____

Osteoporosis _____

Scoliosis _____

SOCIAL HISTORY

Do you smoke? _____ If yes, how much per day? _____

Do you drink? _____ How much? _____

Are you married? _____ Do you have children? (If yes, how many?) _____

Where do you live? _____

REVIEW OF SYSTEMS (Please circle all that apply and list any others)

Constitutional (fevers, weight loss, weight gain, difficulty sleeping, night sweats)

Head, Ears, Eyes, Nose, and Throat (difficulty swallowing, cough, sleep apnea, vision loss, difficulty breathing, hearing loss) _____

Cardiac (high blood pressure, chest pain, coronary artery disease, coronary stents/angioplasty, heart attack, irregular heart beat) _____

Pulmonary (asthma, emphysema, COPD, shortness of breath, cough, pneumonia) _____

_____

Endocrine (diabetes, hypothyroid, hyperthyroid) _____

Genitourinary (bladder infections, prostate hypertrophy, urinary frequency, urinary retention, urinary incontinence) _____

Gastrointestinal (ulcer disease, gallstones, constipation, diarrhea, colitis, diverticulitis, GERD)

_____

Hematological (bleeding disorder, history of deep venous thrombosis, pulmonary embolus, blood clots)

_____

Infectious Disease (HIV, Hepatitis B, Hepatitis C) _____

Musculoskeletal (osteoarthritis, rheumatoid arthritis, osteoporosis, fibromyalgia, ankylosing spondylitis, scoliosis)

_____

Neurological (seizures, numbness, weakness, balance problems, headaches, difficulty walking, difficulty performing fine movements with fingers, peripheral neuropathy, migraines, history of stroke, multiple sclerosis)

_____

Skin (psoriasis, eczema) _____

Psychiatric (depression, bipolar, anxiety, manic) _____

Pain Drawing

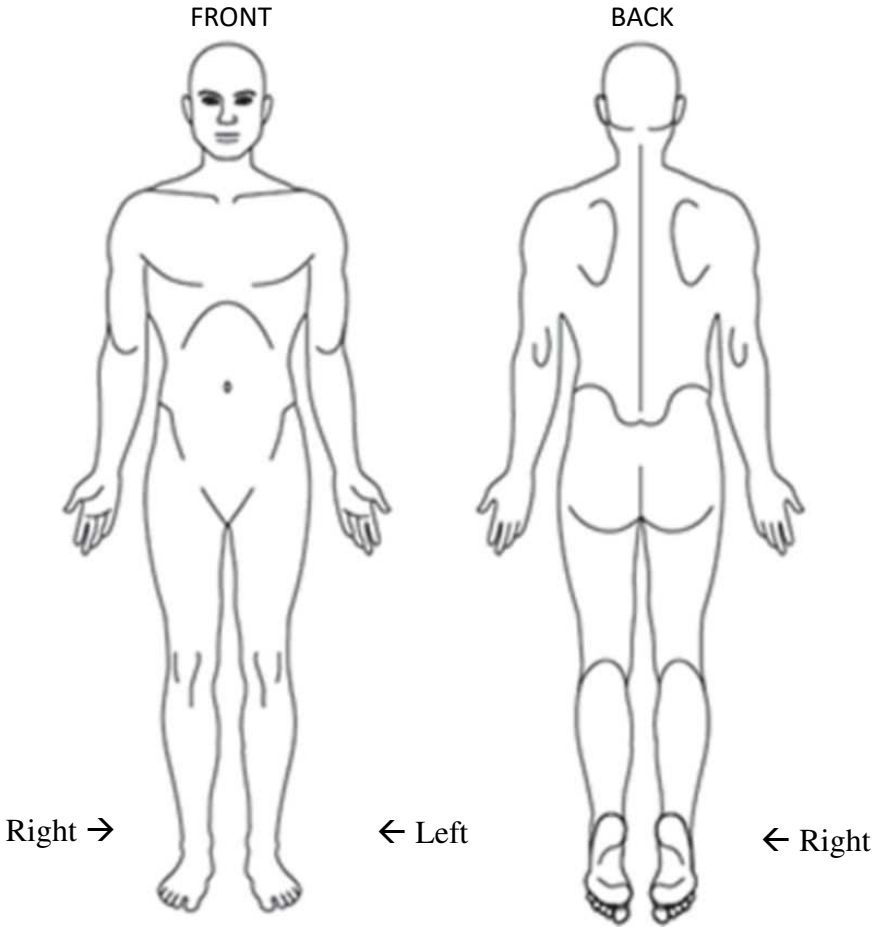
Name: _____ Date: _____

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



0 5 10

Please mark on the line: ●——————————●

HOW BAD IS YOUR PAIN NOW?

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

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Accident/Injury Information Form

Name: _____ Doctor: _____

To help us process your insurance claim quickly and efficiently please provide us with your accident/injury details:

When did your accident/injury occur? _____

_____

_____

Where did your accident/injury occur? _____

_____

_____

How did your accident/injury occur? _____

_____

_____

Signature: _____ Date: _____

Thank you for your assistance.

PLEASE READ

Jeffrey E. Deckey, M.D.

Medication Rx Protocols and Patient Responsibility Form

Narcotic medications will not be dispensed to any patients without approval from Dr. Jeffrey E. Deckey or his Physician Assistant.

NSAIDS (i.e. Motrin, Naprosyn) or COX-2 (Celebrex) medications may be dispensed to pre-operative and to post-operative patients 3 months after surgery. Stop any anti-inflammatory and aspirin containing products ten days prior to surgery.

Requests for medication refills will only be honored by pharmacy requests via fax within 72 hours advance notice. NO refills will be granted by patient requests!! Pharmacy requests via fax will be presented to the Physician Assistant on Tuesdays, Thursdays, or Fridays for authorizations.

Medication refills will not be available after office hours, weekends or holidays.

Medication refills will not be granted by walk-in patients without prior written authorization by Dr. Jeffrey E. Deckey or his Physician Assistant.

All medication dispensed to the patient is the responsibility of the patient, and is to be taken as directed by Dr. Jeffrey E. Deckey or his Physician Assistant. No refills will be granted for patients who missed their last scheduled appointment.

I, _____ understand and agree with the instructions
(Print name)
given to me by Dr. Jeffrey E. Deckey.

Patient Signature _____ **Date** _____

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_____