ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

SOUTH ORANGE COUNTY ORTHOPAEDICS, INC

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**

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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
26730 Crown Valley Pkwy · Suite 200 · Mission Viejo, CA 92691 · Tel. (949) 364-2154 · Fax (949) 264-2110

CONSENT FOR TREATMENT – NOTICE OF POLICIES

I hereby consent and authorize South Orange County Orthopaedics (SOCO), a division of Orthopaedic Specialty Institute Medical Group of Orange County (OSI) care providers to perform medical care, diagnostic tests, surgical care, and other therapeutic measures, as may be directed for my health and well-being. If I will not comply with the medical program of care provided or recommended, I understand that by doing so I release my physician(s), health care provider(s), medical personnel, and the company, from all liability resulting from my action.

I also authorize OSI/SOCO, all physician associates, and all partner agencies to collect, maintain, and disclose all of my information that may be required for the processing of any third-party payer claims (including, but not limited to, insurance, Medi-Cal, Medicare, TRICARE, work-comp, etc.).

I acknowledge that I have been given the ability to review OSI/SOCO policies, including financial policy.

FINANCIAL POLICY

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

- **OSI/SOCO 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 20% coinsurance of the amount allowed by Medicare.
  - **PPOs and HMOs contracted** – you are responsible for payment of the copay and deductible at the time of service, as well as any charges for which you have not secured prior authorization (if required).
  - **Non-contracted PPOs** – you are responsible for all amounts not covered. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if it is not paid by insurance within 60 (60) days.
  - **Self-pay (uninsured)** - you are expected to pay in full at the time of service.
  - **Workers' Compensation** – you are not responsible for any charges unless the case has been dismissed or denied.

- **Personal Injury/Car Accidents** – you are responsible for all amounts not covered. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if it is not paid by insurance within 60 (60) days.
- **Surgery deposits** – once the surgery decision is made, our surgery coordinator will contact your insurer 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 your pre-operative appointment time.

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- **Medical Records** – all requests for medical records are subject to a preparation fee. Any additional costs related to shipping and handling will be added to these costs (if applicable).
- **Related divorce** – the parent who authorizes treatment for a child will be the parent responsible for charges related to that care. If the Divorce Decree requires the other parent to pay all or part of the costs of treatment, it is the authorizing parent's responsibility to charge the other parent.
- **Bad** debt-Patients who fail to pay bills within 90 (90) days of the date of declaration will be referred to a collection agency, and may be discharged from the practice for non-payment.
- **MRI Failed Appointment Fee** – we reserve the right to charge $25 (twenty-five) for each uncanceled failed appointment at least 24 hours prior to 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 customary and usual for our area. You are responsible for payment, regardless of any insurance company's arbitrary determination of customary and customary charges.

- **Financial responsibility** – based on our contractual agreements with insurance companies and our internal policies, we inform you of the following:
  - Your health insurance deductibles and expenses deemed not covered by your insurance company will be your financial responsibility.
  - All amounts owed by you, such as office visit co-pays and non-covered services or supplies, are due at the time of service.
  - If you are unwilling to pay the amounts due at the time of the visit, you will be asked to reschedule the appointment, unless the doctor determines that your medical condition prohibits it.

1. **Method of Payment** - our office accepts the following forms of payment: credit cards, cash, money orders and checks. A service charge of $25 (twenty-five dollars) will be assessed to your account for any check returned 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.**

Signing in the box below indicates that you are acknowledging and agreeing to all of the above. You further understand and agree that your consents/assignments remain in effect until you decide 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 ____________

ORTHOPAEDIC SPECIALTY INSTITUTE
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SOUTH ORANGE COUNTY ORTHOPAEDICS, INC

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, test results, medication dosage changes, and billing/collection/claims information.

This information may be released to:

☐ Spouse/Name: _________________________________
☐ Child(ren)/Name(s): ____________________________
☐ Other: ____
☐ Information should not be released to anyone but me.

Messages

Please call: ☐ my home phone # _________________ ☐ my cell phone # ___________________.

If unable to reach me:

☐ You can leave a detailed message.
☐ Please leave a message asking me to return your call.
☐ Don't leave messages on my voicemail.

The best time to get to me is (day of the week) ______________ between (time) ____________.

E-mail Messages/Portal

☐ Use my email or portal contact to send messages for me to contact the nurse for information.
☐ Use my email or portal contact to leave detailed messages and information.
☐ Attach lab results to the email/portal message.
My email address is: _____________________________________

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

Signature:____ Date: ______________________

Witness:____ Date: ______________________

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

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

TO CHECK UP ON A LICENSE OR TO FILE A COMPLAINT GO TO:
WWW.MBC.CA.GOV
LICENSECHECK@MBC.CA.GOV
(800) 633-2322

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: ____

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Notice to Patients About Open Payments Database

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

I hereby acknowledge that I have received a copy of the Notice to Patients About Open Payments Database. 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 to Patients About Open Payments Database updates at each appointment.

Signature: ______________________________ Date: ______________________________

Print Name: ______________________________

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: ____

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