SOUTH ORANGE COUNTY ORTHOPAEDICS, INC.

26730 Crown Valley Parkway / Suite 200
Mission Viejo. CA 92691

Appointment with Dr.

☐ Herbert Eidt, MD ☐ Michael Fitzpatrick, MD ☐ Samuel Park, MD

☐ Mark Elzik, MD ☐ Steve Rhyan, PAC

PATIENTS' INFORMATION – PLEASE PRINT

Date: _____/_____/_____

Legal Last Name: _____ Patient First Name: _____ MI _____

Address: _____ City, _____, CA Zip Code _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

DOB: _____/_____/_____ M / F (circle one) SS#: _____/_____/_____

Email Address:_____

Emergency Contact: _____Relationship: _____Phone: _____

☐ REFERRING PHYSICIAN ☐ PRIMARY CARE PHYSICIAN: _____
(FIRST AND LAST NAME OF PHYSICIANS)

How did you hear about us? ☐ Google ☐ Friend ☐ Yelp ☐ Referring Dr ☐ High School ☐ Other_____

PRIMARY INSURANCE (PLEASE CIRCLE ALL THAT APPLY)

MEDICARE MEDI-CAL PPO/PRIVATE HMO WORK COMP SELF-PAY OTHER: _____

CO-PAY: $ _____(**CO PAYMENTS ARE DUE AT THE TIME OF SERVICE)**

Date of Injury: _____ Work Related: Yes / No Auto: Yes / No

Insurance Name: _____Insurance Phone: _____

Billing Address: _____

Insured Subscriber's Name: _____DOB: _____/_____/_____

SS#: _____/_____/_____ID#: _____Group #: _____Effective Date: _____

Employer: _____

Employer's Address: _____Phone: _____

Relationship of Patient to Insured/Subscriber: Self Father Mother Child Other: _____

SECONDARY INSURANCE

Insurance Name & Billing Address: _____

Insured Subscriber: _____DOB: _____/_____/_____

ID# _____/_____/_____Group #: _____Effective Date: _____

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize SOUTH ORANGE COUNTY ORTHOPAEDICS, to perform such medical services, which in their medical judgment are necessary for the welfare of the patient identified above. I authorize them to furnish information to insurance carriers concerning this illness and/or injury. I hereby irrevocably assign all benefits, including major medical benefits, for medical services rendered to be paid directly to the doctor in accordance with California Insurance Code, Section 10133. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

SUBSCRIBER/INSURED SIGNATURE: _____DATE: _____

Considering you are seeing a specialist, this form must be submitted to your insurance company, whether your injury was due to an accident or specific injury.

RELEASE FORM

PATIENT NAME: _____

INJURED PART(S) OF BODY: _____

DATE OF ACCIDENT/INJURY/OR ONSET OF SYMPTOMS: _____

LOCATION INJURY OCCURRED: _____

HOW IT HAPPENED: _____

_____

RESPONSIBLE PARTY INFORMATION – **(IF DIFFERENT FROM PATIENT'S HEALTH INSURANCE): EXAMPLE – PATIENT'S AUTO INSURANCE**

NAME OF INSURANCE COMPANY: _____

INSURED NAME: _____ CLAIM #: _____

PATIENT HEALTH HISTORY

Your Health History is IMPORTANT. Please answer all questions thoroughly.

Name: _____ Today's Date: _____
Age: _____ Height: _____ Weight: _____

Hand Dominance: ☐ Right ☐ Left ☐ Ambidexterous

Chief Complaint

Why are you seeing the doctor today? _____
Date of Injury: _____ Date of Surgery: _____
Pain Level of Injury (0-10 where 0=none, 10=extreme): _____
Current problem is the result of a(n): **Check** all that apply

☐ Car Accident ☐ Work Accident ☐ Other: _____

Past Medical History

☐ Diabetes 1 or 2	☐ High Blood Pressure	☐ Heart Disease	☐ Lung Disorders
☐ High Cholesterol	☐ Kidney Problems	☐ Prostate Problems	☐ Thyroid
☐ Anemia	☐ Arthritis (Osteo or RA?)	☐ Gout	☐ Liver Disease
☐ Psychiatric	☐ Stroke	☐ TB	☐ Hepatitis (A, B, or C)
☐ Seizure	☐ Bleeding Disorders	☐ Polio	☐ Multiple Sclerosis
☐ Eating Disorder	☐ STD's	☐ AIDS/HIV	☐ Low Blood Pressure

Cancer Type & Current Status: _____
Other (please describe): _____

Medication & Dose	Reason For Medication	Medication & Dose	Reason For Medication

ALLERGIES (including what happens):

Past Surgical History

Surgeries	Year	Complications/Outcome

Have you ever had any problems with anesthesia? ☐ No ☐ Yes ☐ Never had anesthesia
If yes, please describe:

_____

Do you have sleep apnea? ☐ No ☐ Yes

Social History

Occupation: _____

☐ Work in Home ☐ Employed ☐ Student ☐ Retired

Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children? ☐ No ☐ Yes # _____

Do you live alone? ☐ No ☐ Yes What sports do you play?_____

Do you have a history of substance abuse? ☐ No ☐ Yes What? _____

Drink Alcohol? ☐ No ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ 1-2 x/year

Currently Smoking? ☐ No ☐ Yes _____Packs per day for _____years

Quit Smoking? ☐ This year ☐ >1 year ☐ > 5 years ☐ > 10 years

Previously smoked _____packs per day for _____years.

Have you used other tobacco products? ☐ No ☐ Yes What? _____

Family History

Relation	Age	State of Health	Age of Death	Medical Conditions or Cause of Death
Father				
Mother				

Review of Systems

Are you currently having or have you had problems with your:

	Circle		Describe all Yes Responses:
Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Irregular Heart Beat	No	Yes	_____
Digestion	No	Yes	_____
Bowel Movement	No	Yes	_____
Bladder Problem	No	Yes	_____
Bleeding Problems	No	Yes	_____
Balance Problems	No	Yes	_____
Numbness/Tingling	No	Yes	_____
Blackout/Fainting	No	Yes	_____
Headaches	No	Yes	_____
Breast Mass	No	Yes	_____
Psych Problems	No	Yes	_____
Fevers/Chills	No	Yes	_____
Chest Pain	No	Yes	_____
Difficulty Breathing	No	Yes	_____
Skin Issues	No	Yes	_____
Pregnant	No	Yes	_____

Are all immunizations up to date? ☐Yes ☐No, immunization due for_____

I certify that the above information is correct to the best of my knowledge, I will not hold my Doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Notice of Privacy Practices

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

The Notice of Privacy Practices explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. The policy in its entirety can be requested from the receptionist or found on our web-site. Please review it carefully. For your convenience the following is a summary of the information discussed in the notice.

- Our Pledge
- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information for:
  - Treatment
  - Payment
  - Health Care Operations
  - Notifications and Special Circumstance and the Law
  - Research and Marketing
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Your agreement only acknowledges that we have made available for your review a paper copy of our Notice of Privacy Practices and have retained a copy of this acknowledgement as required by law.

DME Acknowledgement of Driving Impairment

(Not applicable for patients under 16 years of age)

While under the care of your Physician, you may be fitted into Durable Medical Equipment, or DME (Cain, Walking Boots, Shoulder Slings, etc). While the DME is to be utilized to protect or support your condition, by wearing the DME, it may impair your ability to operate automotive vehicles.

You might not be able to operate a vehicle safely due to the use of your DME, please arrange for proper transportation and use the proper precautions. If you have any questions regarding this matter, please ask your Physician.

Prescription Refill Policy

at South Orange County Orthopaedic Office

The patient is responsible for knowing when medication(s) will need to be refilled. The specific protocol is outlined below. All patients are requested to execute acknowledgement that they have read the protocol and agree with its requirements.

- It is the policy of South Orange County Orthpaedics that medications will only be refilled between 9am to 3pm, Monday – Friday.
- **No prescription refills will be given on Saturday, Sunday or holidays.**
- At least 48 business hours are needed to process a refill request.
- Early refills will not be authorized.
- Medications or prescriptions will not be replaced if lost or misplaced.
- If your physician is not in the office, or is unavailable, you may have to wait until he/she returns for medication refills to be authorized.
- Non-controlled/non-narcotic prescriptions require a follow up appointment every 3-6 months.
- Controlled-substances/narcotic prescriptions require a follow up appointment every 30-90 days.
- Prescriptions may be picked up between 9am – 12pm and 2pm – 5pm. Our office is closed for lunch from 12pm – 2pm.
- When picking up a prescription for a controlled substance, you may be asked to provide a valid form of picture identification.

The physicians of SOCO do not routinely prescribe narcotics on a long term basis, nor do we administer narcotics by injection at our office. Individuals who are seeking "pain killers" for chronic use will be advised to make an appointment with a pain management or primary care physician.

Medication Acknowledgement of Driving Impairment

(Not applicable for patients under 16 years of age)

While you are under the care of your Physician, you may be prescribed medication that could impair your ability to operate a motor vehicle, heavy machinery or equipment.

Please refrain from operating a motor vehicle under the influence of prescribed medications that impair judgment. Arrange for proper transportation and use the proper precautions when taking prescribed medications. If you have any questions, please ask your Physician or your pharmacist.

Diagnostic Testing Results

While under the care of a Physician/Provider with SOCO, you may be sent to have diagnostic testing performed (MRI, CT-scan, bone scan, lab work). It is the patient's responsibility to return to the office to receive the results of any diagnostic testing. Most testing is completed at an outside facility. It is the patient's responsibility to obtain the results of all tests in addition to ensuring all outside results are sent to the Physician's office prior to the follow up appointment. Reports may be faxed to (949) 364-2110. SOCO is able to directly access testing performed at _____.

FINANCIAL POLICY

We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and agree to, prior to any treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, and DISCOVER.

Insurance Billing

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.

HMO Plans (with which we are contracted): All co-pays must be satisfied at every visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every visit. You are responsible for obtaining authorization and approval for treatment with your Medical Group or PCP prior to treatment.

PPO Plans (with which we are contracted): We have negotiated rates with your insurance company. Your co-insurance and unmet deductible is your responsibility and payment is due at the time of your treatment.

In the event that 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.

Co-pays & Deductibles: All co-pays, unmet deductible, or patient share of cost is due at the time of service.

Medicare: We accept assignment with Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy; however, you are responsible for any remaining balance regardless of payment from a secondary insurance.

Surgery Deposits: Deposits are due in full prior to the scheduled procedure. Deposit amounts vary based on your share of costs and include any unpaid deductible or co-insurance. SOCO charges only for professional services provided by your physician. You will receive separate billing from the facility where your procedure is performed, the anesthesiologists and other assistants that your surgeon may require.

Durable Medical Equipment (DME): DME is provided as ordered by your physician. Your insurance will be billed in accordance to your insurance coverage guidelines; however, you will be responsible for any unmet deductible and co-insurance rates. Some DME products are not covered by insurance, in which case, you will be notified of the item and its cost. DME is intended for single patient use only and is not subject to returns.

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.

Outside Collections: If unable to make payment in full, contact the billing department immediately to make payment arrangements. If the account is referred for collections, you will be responsible for the balance of your account plus a collection agency charge of 25% of the balance and reasonable attorney's fees. If your account becomes delinquent or is referred for collections, your provider and/or any collection agent of your provider has authorization to obtain your credit report to assist them in the collection of your bill.

Uninsured or Self-Pay Patients

All services must be paid in full at the time of your treatment. Our office can provide you with an estimate of the cost of treatment prior to your visit with the physician. We are willing to extend a discount of 42% off of our usual and customary fees for full payment at the time the services are rendered.

Other Services and Fees

Returned Checks: A $25.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter. If any discount was applied to the pricing of the service(s) the discount will be revoked and you will owe the full price of the service(s) rendered in addition to the aforementioned fee.

Administrative Fee: All co-pays will be collected at the time of service. If a patient does not submit payment at the time of service, the patient will be billed for the co-pay and a $25.00 Administrative Fee will be added to the cover cost of billing and collections.

Medical Records: All Medical Record requests are subject to a clinical preparation fee of $15.00. For diagnostic films, such as an X-ray, MRI, and CT scan, you will be charged the actual cost of the films printed. The actual cost of shipping and handling will be added if applicable.

Paperwork Fees: We do charge for completing paperwork on your behalf. This fee covers our costs and time involved in accessing your medical records, reviewing the documents, completing and signing the forms. We require a $35.00 fee for any document that is 3 pages or less and $50.00 for any document that is 4 or more pages. These fees must be paid prior to the forms being completed.

Referrals for Physician & Ancillary Services: When being referred to an outside organization as part of your care (i.e. Physical Therapy, MRI, DME Providers, Physicians, etc.), NOI does not verify if these organizations are preferred providers with your insurance plan. Please verify this directly with your insurance company prior to obtaining services.

If you choose to seek care at a non-preferred/non-participating provider for ancillary services, you may be responsible for higher copayments and costs in excess of your insurance company's allowable amounts, up to the non-preferred provider's total billed charges. Patients accept the financial responsibility for any additional cost for service when obtaining services from a non-preferred/non-participating provider regardless of being referred by Newport Orthopedic Institute. For assistance locating a preferred provider for ancillary services, you may contact your insurance company directly.

I have read and understand the policies and fees, and I agree to these terms. I hereby give a lifetime authorization for payment of insurance benefits made directly to Newport Neurohospitalist Medical Group, Inc. I understand that I am financially responsible for all charges and fees whether or not they are covered by insurance. I hereby authorize Newport Neurohospitalist Medical Group, Inc. to release all information and medical records necessary to secure payment for my services. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature: _____
Print Name: _____ Date: _____

Signature of responsible party if not signed by the patient:

Signature: _____
Print Name: _____ Date: _____
Relationship: _____

South Orange County Orthopaedics, Inc.

Herbert C. Eidt, MD • Michael J. Fitzpatrick, MD • Samuel W. Park, MD • Mark E. Elzik, MD

This agreement between the patient _____ (print Patient's name) and Prescribing Physician (Doctor) is for the purpose of establishing agreement between Doctor and Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient agree this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor-patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor to the Patient:

- I understand the reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.
- I realize that the medications have potential side effects and adverse reactions and I will have the recommended laboratory studies required to keep the regimen as safe as possible.
- I understand the potential negative side effects of these medications including drowsiness, sedation, dependence, respiratory depression, addiction, constipation, and problems with cognition. I will alert the physician of any of these symptoms immediately if they occur.
- I realize that controlled medications can have life threatening adverse effects if used improperly or not under the specific instructions of the physician. Any improper use of controlled substances without the approval of the supervising physician is subject to review and may lead to breakage of this Doctor and Patient agreement.
- I realize that in order to maintain trust in the doctor-patient agreement, I may be subject to urine drug toxicity screenings at the discretion of the physician.
- I have been advised and understand the dangers of operating an automobile or heavy machinery while under the influence of these medications.
- I understand I should not be consuming alcohol on these medications; any deviance from this understanding must be approved by the physician.
- Early request for refills may not be honored and regular requests for early refills may lead to documentation of non-compliance.
- I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used any medication for at least four days.
- I will not use any illegal controlled substances, including marijuana, cocaine, amphetamines etc.
- I will not share, sell, or trade my medication for money, goods or services.
- **I will not fill a prescription for pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Doctor**. I understand is it against the law to do so. If another physician (including dentists) prescribes pain medication for me, **the Doctor must approve arrangements prior to filling the prescription for pain medication to verify no duplication.**
- I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.
- I agree to use _____Pharmacy, located at _____, telephone number _____ _____, for all my pain medication. **If I change pharmacies for any reason, I agree to notify the Doctor at the time I receive a prescription**, and advise my new pharmacy of any prior pharmacy's address and telephone number.
- I agree to waive any applicable privilege or right of privacy of confidentiality with respect to the prescribing of my pain medication. I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the California Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize the Doctor to provide a copy of this agreement to the pharmacy.
- I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.
- I understand that this medication regiment will be continued for a period of no more **than 2 months**. My case will be reviewed at the end of that period. If there is no evidence that I am improving or that progress is being made to improve my function or my quality of life, the regiment will be tapered to my pre-trial medications and my care will be referred back to my primary care physician.

Doctor and Patient agree this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively, and failure of the patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This agreement is entered into on _____ day of _____, _____.

_____ _____ _____

Patient's signature Doctor's Name Witness

South Orange County Orthopaedics, Inc.

Herbert C. Eidt, MD • Michael J. Fitzpatrick, MD • Samuel W. Park, MD • Mark E. Elzik, MD

By signing below you are acknowledging that you have received, read, and agree to South Orange County's:

Financial Policy (attached)
_____ I have read the Financial Policy. I understand and agree to this Financial Policy.
Initials

Notice of Privacy Practices (attached)
_____ I hereby acknowledge the receipt of the Notice of Privacy Practices. A personal
Initials copy of the Privacy Practices will be available per my request.

Prescription Refill Policy (attached)
_____ I have read the Prescription Refill Policy. I understand and agree to this
Initials Prescription Refill Policy.

Medications Acknowledgement of Driving Impairment (attached)
_____ I have read and understand the Medications Acknowledgment of Driving
Initials Impairment. (Not applicable for patients under 16 years of age)

DME Acknowledgement of Driving Impairment (attached)
_____ I have read and understand the DME Acknowledgment of Driving Impairment.
Initials (Not applicable for patients under 16 years of age)

Acknowledgement of Diagnostic Testing Results (attached)
_____ I have read and understand the Diagnostic Testing Results.
Initials

Signature of Patient or Responsible Party Printed Name Date

Use or Disclosure of Personal Health Information Authorization

I authorize the release of my patient health information to the following personal contacts (Spouse, Child, Assistant, etc). I understand it is my responsibility to notify SOCO of any changes in the information below.

Name Relationship

☐ Appointment Information
☐ Treatment Information
☐ Billing Information

Name Relationship

☐ Appointment Information
☐ Treatment Information
☐ Billing Information

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to SOCO's Privacy Officer:

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