Name:
DOB:
Chart:
Age:
Date:

Patient Information

Account # _____ **Patient Name**	**Patient Sex**
Social Security Number	**Date of Birth** _____ **Age** ____
Home Address	**Home Telephone #** _____ **Work Telephone #** _____
City, State & Zip Code	**Cell Telephone #** _____
Billing Address	**Emergency Contact Name & Phone**
City, State & Zip Code	**Relationship to Patient:**
Employment / Student Status: ☐ Full time employed ☐ Full time student ☐ Part time employed ☐ Part time student ☐ Unemployed ☐ Retired	**Employer Name & Address** **Occupation:**
Referring Physician: **Philip Kalman** **Family Physician:** _____	**Email Address (please print)** **Married** ☐ **Single** ☐ **Other** ☐ **Spouse's Name**
Ethnicity of Patient: ☐ **Hispanic Origin** ☐ **Non Hispanic Origin** ☐ **Unknown** ☐ **Declined to answer**	**Race of Patient:** **American Indian/ Alaskan Native** **Asian** **Black/ African American** **Native Hawaiian/ Other Pacific Islander** **White** **Unknown** **Declined to answer** **Preferred Language of Patient:** ☐ **English** ☐ **Spanish** **Other** _____

In compliance with the American Recovery and Reinvestment Act of 2009 (ARRA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

Financially Responsible Person (if different from above)

Full Name	**Social Security Number** _____
Address	**Home Telephone #** _____
City, State & Zip Code	**Work Telephone #** _____
Date of Birth _____	**Cell Telephone #** _____
Employer Name	**Relationship to the Patient (check one)** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Date Reviewed _____ Initials _____

Name:
DOB:
Chart:
Age:
Date:

Insurance Company Information

Primary Insurance Company Name		Secondary Insurance Company Name	
Address, City, State & Zip		Address, City, State & Zip	
Policy Holder	Date of Birth	Policy Holder	Date of Birth
Policy Holder Employer	Policy Holder SSN	Policy Holder Employer	Policy Holder SSN
Policy Number	Group Number	Policy Number	Group Number
Relationship to the Patient (check one) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other		Relationship to the Patient (check one) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to **Active Orthopedic**, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature _____ Date _____

Medicare Patients

If you are covered by Medicare, please read and sign the following:
In Medicare cases, **Active Orthopedic**, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature _____ Date _____

Name:
DOB:
Chart:
Age:
Date:

HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address: _____

I hereby authorize: **Active Orthopedic Medical Corporation** to disclose my protected health information in accordance with this authorization.

Please disclose my protected health information, as set forth below, to: _____

_____

Please indicate the information or types of information to be disclosed (including dates if necessary):

_____

_____

_____

*The purpose(s) of this authorization is: _____

This authorization may be revoked by me at any time except to the extent that the person(s) and/or organization(s) listed above have already acted in reliance upon this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to **Active Orthopedic Medical Corporation: 1051 E. Tuolomne Road #103; Turlock, CA 95382.**

_____. If not revoked by me, this authorization will terminate on: _____ (include date or event).

I understand that I may inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if I have any questions regarding the use or disclosure of my health information, I may contact the privacy officer at the health care provider authorized to disclose this information.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law.

I understand that the information in my health record may include information or references to the existence of and/or treatment for **drug and/or alcohol abuse, mental health, (psychiatric records, psychological records, etc.) sexually transmitted diseases, tuberculosis, genetics, Hepatitis B or C, or human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS).** This information will also be released unless I indicate by checking below that I do not want such information released:

DO NOT RELEASE _____

Photocopies and facsimile copies of this Authorization shall be deemed to be originals.

_____ _____

Patient or Legal Representative Date

_____ _____

Representative's authority to act on behalf of individual Witness

Name:
DOB:
Chart:
Age:
Date:

Thank you for choosing Dr. Patrick Guerrero, DO and Robert deBos, PA as your orthopedic specialists at Active Orthopedic Medical Corporation. We are committed to providing you with quality, affordable healthcare and your cooperation will be greatly appreciated. Some of our patients have questions regarding patient and insurance responsibility for services rendered, therefore we have outlined some payment and insurance policies that may answer some questions. Please read it and should you have further questions or concerns, please feel free to ask.

- **Insurance:** We are contracted with most insurance plans, including Medicare. If you are insured by a plan we contract with and do not have the insurance card/information, you will be asked to pay for the current visit and any future visits until we receive the information and verify coverage. If you provide us an insurance that we are not contracted with and you choose to continue treatment with our office you will be responsible for all charges at the time of service. There are instances where patients have dual coverage, meaning the secondary is covered through a spouse or parent. Dual coverage does not guarantee 100% coverage, as it varies on the primary insurance benefits, please contact your insurance for any additional details. It is the patient's responsibility to know and understand their medical benefits.

- **Co-payments, Co-Insurance and Deductibles:** All co-pays must be paid at the time of service. If your insurance does not have a co-pay benefit you will be asked to pay a portion of your deductible or your co-insurance, if applicable. Deductibles are applied to all office visits/treatments and must be met before your co-insurance amount applies. This arrangement is part of your contract with your insurance company and we must comply with all these contracted agreements. We do accept cash, check and major credit cards as payment. If your check is returned for insufficient funds, there will be an assessed fee of $50.00 added to your account balance, and we will no longer be able to accept checks as a form of payment. We, however, do not accept check payments from patients being seen without insurance, nor do we take liens of any kind.

- **Proof of Insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current insurance card(s) to verify coverage and benefits. If you fail to provide us **ALL** the correct insurance information at the time of service you may be responsible for all charges incurred. We will attempt to contact you regarding missing insurance, but failure to provide our office within a timely manner will result in patient responsibility.

- **Non-Covered Services:** Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or medically necessary by your insurance carrier. Proof of insurance, authorization, etc. does not guarantee payment.

- **Claims Submission:** As a courtesy we will submit your claims and assist you in every way we reasonably can to help get your claim paid. Your insurance company may need you to supply them with additional information, such as a questionnaire. It is your responsibility to comply with their request. Please be aware failure to provide your insurance with this information will result in your claim(s) becoming your responsibility and treatment request(s) may be delayed until payment is received by either the patient or insurance carrier. If we later receive a payment from your insurer, we will refund you any overpayment owed. Please allow up to 2 weeks for refund requests to process.

- **Coverage Changes:** If your insurance changes, please notify our office before your next visit so we can make the appropriate changes and verify coverage. It is the patient's responsibility to notify us on any changes to their medical plan. Failure to provide us the correct insurance update may result in patient responsibility.

- **Non-payment:** Once your account is over 90 days past due from your first statement, you will receive a letter stating that you will have 15 days to contact our office to make a payment on the account. Payment plans can be arranged, but the patient or responsible party will have to contact our office and arrange that with our billing department. Please be aware that if your balance remains unpaid, we may refer your account to our collection agency Pacific Credit Services (PCS). Once this happens the patient and any immediate family members may not

Name:
DOB:
Chart:
Age:
Date:

continue treatment until the account is paid, and may be discharged until further notice. If an account is sent to collections and you would like to continue treatment, the account will have to be paid in full to PCS and a good faith deposit of $500.00 will have to be collected by AOMC prior to scheduling any appointments. Any money remaining after the completed treatment will be refunded to the patient or responsible party, please allow up to 2 weeks for processing.

- **Missed Appointments:** There is a $50.00 no show/missed appointment fee. We will courtesy adjust the first (1st) no show/missed appointment, but after that the fee will be applied to your account and will have to be paid in order to continue treatment.
- **Cancellation and No Show Policy:** Your physician has ordered orthopedic care as an important component of your medical treatment plan. It is essential that **YOU KEEP ALL** scheduled appointments to maximize your recovery process. If you are late for your appointment, please contact our office so we can try our best for you to be seen by the specialist, if time allows. If we cannot accommodate you at that time we will reschedule the appointment for another day. If you fail to keep your appointments and do not notify our office, you may jeopardize your care and your workers compensation benefits for those patients with industrial insurance. After the **THIRD (3rd)** missed appointment, you may be discharged from this facility and we will notify ALL appropriate parties. Frequent cancellations are also subject to discharge for non-compliance.

I have read and understand the above statements. It is my understanding that I am financially responsible to Active Orthopedic Medical Corporation for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to Active Orthopedic Medical Corporation. I agree to pay the full amount of all charges incurred by the above named patient that are not covered by my insurance carrier.

NAME OF PATIENT OR GUARANTOR (PRINT)

SIGNATURE

DATE

Financial Policy has been reviewed by patient and verbally verified understanding by AOMC Employee

AOMC REPRESENTATIVE

Name:
DOB:
Chart:
Age:
Date:

Patient Medical History

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Have you ever been treated for this problem before? ☐ Yes ☐ No

Date of Injury/ Onset of problem _____

Current problem is a result of: *Check all that apply:*

☐ Car Accident ☐ Work Accident ☐ Other *(specify)* _____

Have you had previous medical treatment for this? *(give details and general dates)*

☐ None
☐ Emergency Room _____
☐ X-rays _____
☐ MRI _____
☐ Injection _____
☐ Physical Therapy _____
☐ Surgery _____
☐ Nerve Test (EMG) _____

MEDICAL HISTORY

Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Kidney Problems	☐	☐	Pulmonary Embolism
☐	☐	Arthritis	☐	☐	Gallbladder Problems	☐	☐	Liver Disease	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Gout	☐	☐	Lung Problems	☐	☐	Sexually Transmitted
☐	☐	Birth Defects	☐	☐	Heart Disease	☐	☐	Phlebitis	☐	☐	Disease
☐	☐	Bladder Problems	☐	☐	Hepatitis	☐	☐	MRSA / Staph Infection	☐	☐	Stroke / TIA
☐	☐	Bleeding or Bruising	☐	☐	HIV / AIDS	☐	☐	Osteoporosis	☐	☐	Tuberculosis
☐	☐	Cancer Type _____	☐	☐	High Blood Pressure	☐	☐	Peripheral Vascular	☐	☐	Thyroid Problems
☐	☐	Diabetes	☐	☐	High Cholesterol	☐	☐	Disease	☐	☐	Ulcer Type _____
☐	☐	DVT / Blood Clots	☐	☐	Intestinal/ Bowel Problems	☐	☐	Polio			
						☐	☐	Psychological problems			

Are there any other medical problems we should know about? _____

Are you right or left-hand dominant? ☐ Right ☐ Left

Are you or could you be pregnant? ☐ Yes ☐ No

Do you exercise or participate in sports regularly? ☐ Yes ☐ No

Type and Frequency: _____

MEDICATIONS *Please list all medications you take with or without a prescription (use extra paper if needed)*

Medication Name	Dosage / # per day	Reason for taking

Pharmacy Name: _____ **City/Street:** _____

ALLERGIES *Please describe any current or past allergic reactions*

Allergy to (drug)	Reaction (itching, cough, hives, etc)	How was / is the reaction treated?

I DO NOT have any allergies

SURGERIES AND HOSPITALIZATIONS

Arthroscopy _____ Year _____ Physician _____ Complication? _____

Joint replacement _____ Year _____ Physician _____ Complication? _____

Bone or joint reconstruction _____ Year _____ Physician _____ Complication? _____

Spine surgery _____ Year _____ Physician _____ Complication? _____

Other general surgery _____ Year _____ Physician _____ Complication? _____

_____ Year _____ Physician _____ Complication? _____

Other hospitalizations _____ Year _____ Physician _____ Complication? _____

I HAVE NOT HAD any surgeries or hospitalizations

Name:
DOB:
Chart:
Age:
Date:

FAMILY HISTORY

Have your mother, father, grandparents, brothers or sisters been treated in the past or are they currently receiving treatment for any of the following conditions?

Yes	No		Yes	No		Yes	No		
☐	☐	Alzheimer's	☐	☐	Diabetes	☐	☐	Osteoporosis	Other _____
☐	☐	Arthritis	☐	☐	Gout	☐	☐	Stroke	_____
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	Sudden Death	_____

SOCIAL HISTORY

Do you smoke or chew tobacco? ☐ Yes ☐ No Start Date: _____ Quit Date: _____ Packs per day: _____

☐ Current Everyday Smoker ☐ Current Someday Smoker ☐ Never Smoker ☐ Former Smoker

Do you drink alcoholic beverages? Yes No Amount and frequency: _____

Do you use recreational drugs? ☐ Yes ☐ No Type and frequency: _____

REVIEW OF SYSTEMS

Please check the following symptoms you have experienced on a regular basis:

GENERAL
- ☐ Fever
- ☐ Weight change
- ☐ Hormonal problems
- ☐ Other _____
- ☐ NONE

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fluid/ Swelling in extremities
- ☐ Other _____
- ☐ NONE

KIDNEY/ BLADDER
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Other _____
- ☐ NONE

EYES
- ☐ Glasses/ Contacts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other _____
- ☐ NONE

RESPIRATORY
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Wheezing
- ☐ Other _____
- ☐ NONE

EARS, NOSE, THROAT
- ☐ Difficulty swallowing
- ☐ Ear pain
- ☐ Seasonal allergies
- ☐ Hard of hearing
- ☐ Other _____
- ☐ NONE

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Diarrhea/ Constipation
- ☐ Abdominal pain
- ☐ Nausea/ vomiting
- ☐ Other _____
- ☐ NONE

SKIN
- ☐ Rashes
- ☐ Lumps
- ☐ Other _____
- ☐ NONE

HEMATOLOGIC/ LYMPHATIC
- ☐ Anemia
- ☐ Blood problems
- ☐ Clotting disorder
- ☐ Lymph Problems
- ☐ Other _____
- ☐ NONE

NEUROLOGICAL
- ☐ Headaches
- ☐ Numbness
- ☐ Tingling
- ☐ Seizures
- ☐ Weakness
- ☐ Other _____
- ☐ NONE

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Other _____
- ☐ NONE

Pain Scale - If you are having pain, please rate the intensity of your pain on a scale of 1 -10.

Patient Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

BC1