# Patient Sign-In Sheet

(Please Print) Today's Date_____

Patient _____ Social Security No._____
First Middle Int. Last Name

Address_____Telephone (___)_____
Street City Zip

Occupation_____Birth Date_____ Age_____Sex___

Driver's License No._____

Employer-Name_____ Telephone(___)_____

Address_____

Married ☐ Single ☐ Divorced ☐ Widow(er ☐

Spouse/or Responsible Parent_____Social Security No._____

Address _____Telephone (___)_____
Street City Zip

Occupation_____Birth Date_____ Age_____Sex___

Driver's License No._____

Employer-Name_____ Telephone (___)_____

Address_____

IN CASE OF EMERGENCY-(Other than husband or wife)-Person not living with you:

Name _____ Relationship_____

Address_____ Telephone (___)_____
Can be out-of-town Street City State

PLEASE COMPLETE IF PATIENT IS UNDER 21 YEARS OF AGE OR A STUDENT:

Father's name_____ Mother's Name_____

Father's Occupation_____ Mother's Occupation_____

Father's Employer_____ Mother's Employer_____

Address_____ Address_____

MEDICAL INSURANCE (To be completed in all cases)

Primary Insurance Subscriber_____ Secondary Insurance Subscriber_____

Insurance Co._____ Insurance Co._____

Billing Address_____ Billing Address_____

Identification No._____ Identification No._____

Group Number_____ Group Number_____

IF INJURY, WHEN AND HOW DID IT HAPPEN?

Home ☐ Work ☐ Automobile ☐ Other_____

Date _____ Hour _____ Last Worked _____

If industrial injury, name and address of employer at time of injury_____

_____

Industrial Insurance Carrier:_____

REFFERED TO THIS OFFICE BY (Please include and telephone number of referring doctor)

_____

_____

Is Patient bringing outside x-rays?_____ From?_____

AUTHORIZATION:

The undersigned patient, or authorized individual acting on behalf of the patient understands and agrees as follows:

1. Doctor Greenbaum . . . . . reserves the right to designate any qualified physician to perform and administer care and treatment of the patient
2. Doctor Greenbaum . . . . . .are granted permission to release to the insurance carrier, employer, their representatives or referring physician, any information connection with any treatment rendered to patient, or in patients behalf at any time such information is requested.
3. I authorize payment of medical benefits to the doctor rendering services.
4. Patient shall pay to Doctor Greenbaum . . . . . Such sums as are or may become due for services rendered to the patient. It being understood that in the event patient's insurance company, if there be any, does not make payment, or only partial payment, this obligation shall be binding personally upon patient.

_____ _____

Date Patient, Parent, Guardian Signature

NAME:_____ DATE:_____

What is being examined today?_____ Which side? (RIGHT/LEFT)_____

Were X-RAYS/MRI taken? ☐ YES ☐ NO Did you bring them in? ☐ Yes ☐ No

1. DATE of accident, or HOW LONG have you had ILLNESS/PROBLEMS/SYMPTOMS:_____

2. BRIEFLY DESCRIBE illness/injury/symptoms requiring treatment below (@ HOW) and include:

a. WHERE it occurred: ☐ HOME ☐ SCHOOL ☐ OTHER (PLEASE SPECIFY):_____

☐ WORK (If so, did it occur while working for wages? ☐ YES ☐ NO ☐ UNSURE

☐ MOTOR VEHICLE ACCIDENT (if so, do you have auto insurance?) ☐ YES ☐ NO

b. HOW illness/problem/symptoms/accident occurred:_____

_____

_____

_____

_____

c. Is there a third party involved? ☐ YES ☐ NO

3. Have you seen a physician for this problem? ☐ YES ☐ NO

a. DOCTOR: _____ ADDRESS: _____

b. TREATMENT (special tests, injections, medications, etc.):

_____

_____

4. Have you had a previous problem in this area? ☐ YES ☐ NO If so, please describe:

_____

_____

_____

_____

5. Have you lost time from work because of this current injury/problem? ☐ YES ☐ NO

If yes, DATE LAST WORKED:_____

6. Briefly describe your job activities: (lifting, pushing, pulling, driving, etc.)

_____

_____

7. Please describe present complaints:

_____

_____

_____

_____

8. Do you feel your symptoms are: ☐ IMPROVED ☐ MORE SEVERE ☐ REMAINED THE SAME

NAME _____ DATE _____

GENERAL HEALTH (Circle one) GOOD FAIR POOR

YES____ NO____ HAVE YOU EVER BEEN SERIOUSLY ILL?
YES____ NO____ HAVE YOU EVER BEEN HOSPITALIZED?
YES____ NO____ HAVE YOU HAD SURGERY?
WHEN _____
WHAT KIND _____

HAVE YOU EVER HAD:

YES____ NO____ CANCER
YES____ NO____ HEART TROUBLE
YES____ NO____ DIFFICULTY WITH BREATHING
YES____ NO____ LUNG DISEASE (for instance: pneumonia, asthma, or emphysema.)
YES____ NO____ JAUNDICE, HEPATITIS
YES____ NO____ DIABETES
YES____ NO____ FAINTING SPELLS
YES____ NO____ ALLERGIES TO MEDICATIONS (If yes, what medications and what type of reactions; rash, swelling, etc.) _____
_____

YES____ NO____ RHEUMATIC FEVER
YES____ NO____ HIGH BLOOD PRESSURE
YES____ NO____ ANEMIA OR BLEEDING PROBLEMS
YES____ NO____ OTHER SERIOUS HEALTH PROBLEMS: WHAT _____
_____
YES____ NO____ STOMACH ULCERS
YES____ NO____ TAKE MEDICATIONS REGULARLY (including birth control pills)
What kind _____
_____
YES____ NO____ SMOKE_____PKT/DAY
YES____ NO____ DRINK ALCOHOL (If so, do you have it daily, socially, occasionally, rarely)_____

HAVE YOU EVER HAD :

YES____ NO____ BROKEN BONES (If so, which ones and when)_____
YES____ NO____ HEAD INJURIES WHEN _____
YES____ NO____ NECK INJURIES WHEN _____
YES____ NO____ BACK INJURIES WHEN _____

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY EVER HAD :

YES____ NO____ CANCER
YES____ NO____ HEART DISEASE
YES____ NO____ LUNG DISEASES, TB, ETC.
YES____ NO____ DIABETES

HT:_____ WT._____ RIGHT/LEFT HANDED _____

ORANGE COUNTY
ORTHOPAEDICS &
SPORTS MEDICAL GROUP, INC.

BRADLEY S. GREENBAUM, M.D.

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.

Attached is your personal copy of out Notice of Privacy Practices. This notice 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. 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
  - Treatment
  - Payment
  - Health Care Operations
  - Notifications
  - Marketing
  - Research
  - Special Circumstances and the Law
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Please understand that this summary is not our Notice of Privacy Practices, nor is it a substitute for the notice. The actual notice should be given to you, as required by law, with this cover letter. If it was not, please contact our office manager at the address or phone number shown at the bottom of this page to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collection and retaining these signed acknowledgments.

If, after reviewing the notice, you decide that you do not want to retain your paper copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practice:

| _____ | _____ | _____ |
|---|---|---|
| Signature | Printed Name | Date |

15825 Laguna Canyon Rd. Suit 103 Irvine, California 92618 949.451.1454 Fax 949.451.1452

# ORANGE COUNTY ORTHOPAEDICS AND SPORTS MEDICAL GROUP, INC. FINANCIAL POLICY

## CO-PAYS AND DEDUCTIBLES

All Co-pays and Deductibles are required to be paid at the time of service. In the event of an emergency and the patient does not have the means to pay for Co-Pays, the patient will be given an envelope to mail the Co-pay, if Co-Pay is not received within 2 weeks a statement will be mailed to the patient and a statement fee of $10.00 will be added to the Co-Pay.

**HEALTH INSURANCE**

Orange County Orthopaedics & Sports Medical Group, Inc. will bill your health insurance carrier as courtesy to you if presented with the information and assignment of benefits at the time of service. All applicable co-pays and deductibles must be paid at the time of service.

**PAYMENT RESPONSIBILITY**

An anticipated insurance payment does not replace the patient's obligation to pay any outstanding balance. If insurance payment is not received within 30 days of the date of service, the patient will be held responsible for payment.

**RETURNED CHECKS**

There will be a $25.00 fee for any returned checks, and all discounts will be voided, patient will be responsible for full fees for services received plus the $25.00 fee returned check fee.

**WORKER'S COMPENSATION**

It is required at the time of service that the patient gives Worker's Compensation and health insurance information. Charges for services incurred as a result of a work-related injury will be billed to the Worker's Compensation carrier or the employer. Upon denial by Worker's Compensation, the health insurance carrier or the patient will be responsible.

**MANGAED CARE (HMO)**

Unless an authorization is obtained from your PCP, or your health care carrier, you will be responsible for payment in full at the time of service. Your insurance will be billed as a courtesy to you.

**REFUNDS**

All refunds must be requested in writing and a refund check will be mailed to the appropriate party within 2 weeks.

"I have read, understand and agree to the provisions of this policy."

_____ _____

Patient/Legal Guardian Signature Date

ORANGE COUNTY
ORTHOPAEDICS &
SPORTS MEDICAL GROUP, INC.

BRADLEY S. GREENBAUM, M.D.

**OUR PRIVACY PROMISE TO
OUR PATIENTS**

**YOUR INFORMATION IS IMPORTANT AND CONFIDENTIAL OUR POLICY REQUIRES THAT YOUR INFORMATION IS HELD IN COMPLETE CONFIDENCE.**

Authorization to leave Messages

I give my permission for the staff of Orange County Orthopaedics & Sports Medical Group, Inc. to leave messages on my telephone answering machine or with a family member such as information regarding medications, surgery, appointments and health care.

_____ _____
Signature of Patient/ Legal Guardian Date

_____
Patient Name-Please Print

_____ _____
Family Member's Name Family Member's Name

I do **not** give permission for the staff of Orange County Orthopaedics & Sports Medical Group to leave messages on my telephone answering machine or with family members.

_____ _____
Signature of Patient/ Legal Guardian Date

_____
Patients Name-Please Print

15825 Laguna Canyon Rd. Suit. 103 Irvine California 92618 949.451.1454 Fax 949.451.1452

# FINANCIAL POLICY

Thank you for choosing Orange County Orthopaedics and Sports Medical Group, Inc. We are committed to the success of your treatment. We hope you understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you to read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by the doctor.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any co-payment amount due, at the time of services are rendered. For patients with dual insurance coverage, we will bill both the primary and secondary insurance if you have provided us with the necessary information, PLEASE NOTE: AFTER 120 DAYS (4 MONTHS) OF ATTEMPTED COLLECTION FROM YOUR INSURANCE ALL BALANCES ARE DUE AND PAYABLE BY THE PATIENT. We will be happy to provide you with any documentation needed to obtain reimbursement from your insurance company.

Patients insured with plan which we are NOT contracted with will be required to pay for the first visit in full. For any follow-up visits you will need to pay 20% at the time services are rendered. There may be a 25% down-payment required prior to any surgery.

If you are insured with a plan which we ARE contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your co-payment at the times services are rendered.

Patients with no insurance coverage are expected to pay for services at the time services are rendered.

Failure to make payment arrangements, or pay outstanding balances within 30 days of notification of amount due, may results in termination of care from Orange County Orthopaedics & Sports Medical Group, Inc.

Our accepted methods of payment are cash, Master Card, Visa or check. If requested, a short payment schedule may be arranged for those patients who have special financial conditions.

It is the patient's responsibility to verify their benefits for their particular plan and to make sure all the proper authorizations have been obtained. Some insurance plans will reduce benefits if the insured is treating with doctors outside if the designated network or if the proper authorization.

Again, thank you for trusting us with your care. If you have any questions regarding financial responsibilities or payment options, please contact our insurance department.

"I have read, understand and agree to the provisions of this policy."

_____ _____

Patient/Legal Guardian Signature Date