Orthopaedic Medical Group
We're with you every step of the way

Visit Checklist

To ensure a successful office visit, please bring the following items to your appointment.

- **Completed and signed forms included in this registration packet**
- **Treating or referring doctors referral form (if applicable)**
- **Photo identification – government issued ID preferred**
- **Insurance identification card (s)**
- **Recent images on film or CD (Xray, MRI, Ultrasounds, Scans, etc)**

New patients should arrive 30 minutes early, to allow enough time for registration to be completed. Patients whom arrive late maybe asked to rescheduled his/her appointment. A late fee or no show fee maybe applicable if appointment is not cancel 24 hour prior to appointment date/time

Failure to bring the necessary information may result in the appointment being canceled or rescheduled.

Should you have any questions please call the office during normal business hours.

1135 S Sunset Ave # 200
West Covina CA 91790
(626) 918-6655

14375 Pipeline Ave
Chino CA 91710
(909) 517-3885

412 W. Carroll Ste # 107
Glendora CA 91741
(626) 914-4890

ORTHOPAEDIC MEDICAL GROUP AND ATHLETIC REHABILITATION CENTER, INC.

1135 S. Sunset, Ave Ste # 200
West Covina CA 91790
(626) 918-6655 ~ Fax (626) 918-6633

14375 Pipeline Ave
Chino CA 91710
(909) 517-3885 ~ Fax (909) 517-3646
Physical Therapy (909) 517-3884

412 W. Carroll Ste # 107
Glendora CA 91741
(626) 914-4890 ~ Fax (626)963-8351

PATIENT: _____ **DATE:** _____
Last First Initial

HOME ADDRESS: _____
Street City State Zip

PHONE: _____**CEL#**_____ **DATE OF BIRTH:**_____ **AGE**:_____ **SEX**: M F

SOC. SEC. NO._____ **DRIVERS LICENSE#:** _____

EMPLOYER NAME: _____

ADDRESS: _____

BUSINESS #_____ **OCCUPATION**_____

NAME OF SPOUSE OR RESPONSIBLE PARENT:_____

EMPLOYER NAME: _____

ADDRESS: _____

BUSINESS# _____ **OCCUPATION** :_____

IN CASE OF EMERGENCY CONTACT: _____ **PHONE**:_____
(Nearest Relative not living with you)

REFERRING PHYSICIAN_____ **PHONE#**_____

PRIMARY INSURANCE:_____ **CARD HOLDER'S NAME:**_____

ID # _____ **GROUP#** _____ **DOB:**_____ **SS#**_____

SECONDARY INSURANCE: _____ **CARD HOLDER'S NAME:** _____

ID# _____ **GROUP#** _____ __ **DOB:**_____**SS#**_____

IS **THIS CONDITION DUE TO AN ACCIDENT**: YES: ____ NO ____ / AUTO ___ WORK ___ OTHER ___ **DATE OF INJURY** _____

DESCRIBE HOW ACCIDENT HAPPENED _____

IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO US FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER.

MEDICARE
NAME OF BENEFICIARY _____ HI CLAIM NUMBER_____
I request that payment of authorized Medicare benefits be made to me or on my behalf to ORTHOPAEDIC MEDICAL GROUP AND ATHLETIC REHABILITATION CENTER, for any service furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related service. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under title XVIII of the Social Security Act.

COMMERCIAL INSURANCE
I hereby authorize release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.**

_____ _____
Signature Date

The undersigned hereby consents to the care and treatment now and in the future of

_____ **by Orthopaedic medical Group and Athletic Rehabilitation Center. Inc**.
Name of patient
Thomas Bryan, M. D., Carlos Lugo, M.D., Vic A Osborne, M.D., Kee Wong, M. D., Brett Heslop, P.A.C

_____ _____
Patient Signature (or Signature of Parent Or Guardian If Minor) **Date**

Orthopaedic Medical Group and Athletic Rehabilitation Center, Inc.

Corporate office
1135 S. SUNSET AVE. SUITE 200 WEST COVINA, CA 91790

VOLUNTARY PRIOR EXPRESS CONSENT FORM

I, _____, "Health Care Consumer" understand that by engaging the services of Orthopaedic Medical Group or Athletic Rehabilitation Center Inc., "Service Provider" it will be important for Service Provider or the "Authorized Entities" to be able to communicate with me and have current contact information for me.

Authorized Entities: The term "Authorized Entities" shall mean the above referenced Service Provider, billing service(s), any related health care provider, physician, service provider, contractor, independent contractor, including, but not limited to, those that are located at the same physical location as Service Provider or to which Servicer Provider has referred services, and each of their respective successors, assigns, agents, representatives, employees, partners, parents, subsidiaries, affiliates, and billing service(s), collection agencies, of any of the previously listed persons/entities and all corporations, persons, or entities in privacy with any of them.

Voluntary Communication Consent: I hereby voluntarily grant consent for Service Provider or the Authorized Entities to contact me, my spouse, and where applicable legal guardian or representative, using an automatic telephone dialing system or an artificial or prerecorded voice, via e-mail, or via SMS text messages and any other forms of electronic communication. I also give my voluntary express consent for the Authorized Entities to communicate with me for any reason at any telephone or cellular phone number or email address I provide or may utilize, regardless of how Service Provide or the Authorized Entities obtains such contact information. Service Provider and Authorized Entities will treat any email address I provide as my private email address that is not accessible by unauthorized third parties.

I understand that my agreement to the terms of this Prior Express Consent Form is optional and not a condition of any Service Provider or Authorized Entity's willingness to provide services to me. I further promise to notify Service Provider and Authorized Entities if any telephone number, email address or other contact information that I provided to Service Provider or the Authorized Entities changes or is no longer used by me. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to Service Provider and any Authorized Entities that contact me.

I hereby consent and authorize that a photocopy of this authorization may be considered as valid as the original.

Signed:_____

Print Name: _____

Date:_____

My home/ landline telephone number(s):_____

My cell phone number(s):_____

My email address:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ORTHOPAEDIC MEDICAL GROUP AND ATHLETIC REHABILITATION CENTER INC.
Corporate office
1135 S.SUNSET AVE SUITE 200 WEST COVINA, CA 91790

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Please contact The U.S. Department of Health and Human Services for more information about HIPAA

HHS
Office of Civil Rights
(202) 619-0257 toll free (877) 696-6775

Meaningful Use Patient Registration Form:

In compliance with the HITECH Act (HER) to attain Meaningful Use we are required to capture demographic data including your preferred language, race and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process. Please complete the information below.

Patient Name: _____ **DOB**: _____ **AGE:** _____
Email: _____
Race:
_ African-American
__ Arabic
__ Asian
__ Caucasian
__ Filipino
__ Hispanic
__ Other

Ethnicity:
__Hispanic
__ Non – Hispanic

Primary Language:
__ Arabic
__Chinese
__English
__French
__Korean
__Spanish
__ Other _____

Tobacco Use:
Never: ____
Current Every Day Smoker: ____
Current Smoker – Does not Smoke Every Day; ____
Former Smoker: ____

Rx History: Yes:__ No:__ Granting permission to view a patient's prescription history from external sources.

Patient Signature: _____ Date: _____

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Locations: West Covina- Chino- Glendora
Thomas Bryan, M.D. Carlos Lugo, M.D. Vic Osborne, M.D. Kee Wong, M.D. Brett Heslop, P.A.C

POLICY

As a courtesy to our patients we attempt to call the patient/guarantor for an appointment reminder. Calls for appointment reminders are not guaranteed, and the fee is not waived if an appointment reminder is not made.

Beginning in October 2012 you will be charged a $25.00 service fee for appointments not cancelled at least 24 work day hours prior to the appointment.

For second missed appointments- you will be charged $40.00, which is due and payable prior to rescheduling any new appointment.

Late appointment arrivals – If you arrive more than 15 minutes late, we reserve the right to reschedule your appointment, so we may meet the needs of those patients who arrived on time. If this occurs, it will be considered a missed appointment and a $25.00 fee will be charged.

Signature: _____ Date:_____

To Our Patients:

This notice has been prepared to inform you that the ORTHOPAEDIC MEDICAL GROUP and ATHLETIC REHABILITATION CENTER, INC. is a California Corporation and that the ATHLETIC REHABILITATION CENTER and physical therapy facilities associated with it are integral parts of said corporation.

The doctors further wish to inform you that one or more of the above-named Orthopaedic surgeons have a significant beneficial interest in the following healthcare facilities:

1. SAN GABRIEL VALLEY SURGICAL CENTER.
2. CASA COLINA SURGERY CENTER.

We feel that competent and qualified medical services and procedures are provided by these facilities. *However, you have the absolute right to use any alternative facility of your choice.* You are not obligated to use any facility recommend by your physician. Your physician will be happy to recommend and discuss other facilities which provide the same medical services or procedures.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT AND ANY QUESTIONS I HAVE CONCERNING THE ABOVE MATTER HAVE BEEN ANSWERED.

Signature: _____ Date:_____

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Patient Authorization and Responsibility Form

Patient Name: _____ Date of Birth_____

I, the undersigned, herby acknowledge and agree to the following terms and conditions:

Authorizations/assignment of Benefits:

I hereby authorize and assign payment any benefits due me under the terms of any insurance policy or policies that may cover the procedure performed on me, or my dependent(s) by Orthopaedic Medical Group and Athletic Rehabilitation Center, Inc., (hereinafter referred to as OMG) directly to OMG at the address designated by OMG on my claim form submitted to my insurance carrier_____, I agree that payment to OMG pursuant to this authorization/assignment by my insurance company shall discharge said insurance company of any and all obligations under the policy to the extent of such payment. I understand and agree that I am financially responsible for charges not covered by this authorization/assignment and I authorize OMG to contact my employer for the purpose of determining the existence and extent of any insurance benefits.

Financial Responsibility:

I understand that my insurance company is being billed as a courtesy and I agree that I am financially responsible to pay for any charges not covered by my insurance company. Should my account become delinquent, I agree to pay interest on the outstanding balance owed at the maximum amount permitted by law. If OMG undertakes collection efforts to recover any past due amounts, I agree to pay all reasonable costs incurred, including attorney's fees.

Authorization to Release Information to OMG:

I hereby authorize any insurance company, employer, hospital, physician, or utilization review representative to release to OMG any and all information with respect to me or my dependent(s) which may have bearing on any benefits payable by my insurance company for the procedure performed by OMG on me or my dependent(s). I agree that this authorization shall remain effective for one (1) year from the date indicated below.

Designation of Authorized Appeal Representative:

I hereby designate OMG and/or their authorized agents as my authorize representative to pursue my appeal rights.

_____ _____ _____

Patient Signature or Legal Representative **Print Name** **Date**

Orthopaedic Medical Group
We're with you every step of the way

MEDICAL HISTORY DOCUMENTS

Date:_____

Patient Name:_____ DOB:_____

Past Medical History:
(check all that apply)

- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Osteoporosis
- ☐ Vascular Disease
- ☐ Glaucoma
- ☐ Thyroid Disease
- ☐ Gout
- ☐ Stomach or intestine disorder- such as gastrointestinal disorder, ulcers, or gallbladder diseases.
  If yes, please list:_____
- ☐ Neurological disorder- such as Parkinson's multiple sclerosis or seizure disorder
  If yes, please list:_____
- ☐ Heart disease and or conditions such as heart murmur, heart attack, heart failure, angina
  If yes, please list:_____
- ☐ Respiratory conditions such as asthma, bronchitis, pneumonia, COPD, or other
  If yes, please list:_____
- ☐ Blood / Bleeding disorder- such as ☐ anemia or ☐ hemophilia
- ☐ Diabetes- if yes please specify type: _____
- ☐ Arthritis- if yes, please specify type if known:_____
- ☐ Cancer- if yes, please specify type: _____
- ☐ Other- Please provide any other medical history you would like to share: _____

Name:_____ DOB:_____

HAVE YOU HAD ANY PRIOR SURGERIES OR HOSPITALIZATIONS?: YES or NO

REASON:

_____

_____

_____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? : YES or NO

If YES- Please list below:

_____ _____

_____ _____

_____ _____

ARE YOU ALLERGIC TO ANY MEDICATIONS?: YES or NO

If YES- Please specify below and state the reaction:

_____

_____

_____

Patient Name: **DOB:**

FAMILY HISTORY:

Check all that apply	Father	Mother	Brother	Sister
Heart Disease	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯
Stroke	◯	◯	◯	◯
Cancer	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯
Bleeding Disorder	◯	◯	◯	◯
Family History Unknown	◯	◯	◯	◯

SOCIAL HISTORY:

Do you currently smoke? Yes or No / If Yes, how much per day? _____ Former Smoker Y /N

Did you have a drink containing alcohol in the past year? Yes or No
If Yes, how many per day? _____ How many per week or month? _____

Exercise Routine: _____

WOMEN:

Are you pregnant? Yes or No

Planning Pregnancy? Yes or No

Patient Name:_____ **DOB:**_____

Do you presently have or have you recently had any of the following: Yes or No
(If yes circle all that apply)

CONSTITUTIONAL
Shaking chills
Night sweats
Fatigue persistently or easily
Fever
Weight gain / Weight loss

RESPIRATORY
Chronic / recurrent cough
Shortness of breath

MUSCULOSKELETAL

Joint pain or swelling

GASTROINTESTINAL

Abdominal pain
Blood in stool / black stools
Nausea or vomiting

NEUROLOGICAL

Muscle weakness or paralysis
Numbness in arms or legs
Dizziness or headache

HEMATOLOGIC

Easy bruising
Bleeding easily or hard to stop bleeding

PSYCHIATRIC

Depression
Sleep disturbances / insomnia

IMMUNOLOGIC / ALLERGIC

Severe food allergy
Latex allergy
Frequent infections

CARDIOVASCULAR

Chest pain
Palpitations or irregular heart beat
Varicose veins
Swelling of feet or ankles

ANESTHESIA COMPLICATIONS

Yes _ Myself or family member
No _ No known anesthesia reactions

PATIENT SIGNATURE: _____ ***DATE:***_____

Reviewed by: _____ ***Date:*** _____