CONGRESS ORTHOPAEDIC ASSOCIATES , INC

800 S. Raymond Avenue
Pasadena, CA 91105
Phone: (626) 795-8051

289 W. Huntington Dr. Suite. 103
Arcadia, CA 91107
Phone: (626) 821-0707

First Name:
Last Name:
DOB:

Patient Information

First Name:	Last Name:	MI:	DOB:
Home Phone:	Driver's License:	Marital Status:	Single Married
Cell Phone:	Email:		Separated Divorced
Business Phone:			Widowed

Patient Address Information

Physical Address:	City:	State:	Zip Code:
Mailing Address: (if any)	City:	State:	Zip Code:

Employment Information

Current employer:	Occupation:	Address:
City:	State:	Zip Code:

Private Primary Insurance

Primary Insurance:	Effective Date:	Policy ID:	Group:
Subscriber's Name:	Date of Birth:	Relationship to Patient: Self Spouse Parent Other:	
Secondary Insurance:	Effective Date:	Policy ID:	Group:
Subscriber's Name:	Date of Birth:	Relationship to Patient: Self Spouse Parent Other:	

Worker's Compensation or Personal Injury Information

Were you Injured on the Job? Yes No Did you file a Workers Compensation Claim? Yes No

Industrial Carrier:		Name of Claim Examiner:
Claim Number:	Date of Injury:	Phone Number:

Were you injured at home?	Yes	No	Did you file a home owner's claim?	Yes	No
Were you involved in a Auto injury?	Yes	No	Did you file an Auto claim?	Yes	No
Were you injured at School?	Yes	No	Did you file an Accident claim?	Yes	No
Area of Body Injury? ______			Have you received treatment for this injury?	Yes	No

Briefly describe your treatment to date:

Emergency Contact

Name:	Relationship:	Home Phone: Cell Phone:

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The Shareholders of Congress Orthopaedic Associates, Inc.: Richard C. Diehl, M.D., Gregory J. Adamson, M.D., James A. Shankwiler, M.D., Michael J. Fraipont, M.D., William M. Costigan, M.D., Todd B. Dietrick, M.D., Kenneth R. Sabbag, M.D., Thomas G. Harris, M.D., Roy F. Ashford, M.D., Gary M. Moscarello, M.D., John T. Quigley, M.D., Rishi Garg, M.D., Joe Y.B. Lee, M.D., Timothy Jackson, M.D., Steven Lin, M.D., Pamela Luk M.D,; hold ownership in Congress Medical Surgical Center. This Outpatient Surgery Center/Extended Stay Facility is located at 800 S. Raymond Avenue, Pasadena, CA 91105. In addition they hold an ownership interest in Senate Surgical Distribution, LLC, a Company which sells implantable medical devices to the hospital or ambulatory surgery center to which you may be referred. If you have been referred for surgery it is possible that in connection with your surgery your physician will order one or more implantable medical devices which will be provided by Senate Surgical Distribution, LLC.

Please note that you have the right to obtain medical devices or hospital or ambulatory surgery services from any provider of your choosing, unless your ability to choose the providers of such services is limited by the terms of your health insurance coverage.

AUTHORIZATION TO PAY PHYSICIAN/ ASSIGNMENT BENEFITS

I, the undersigned, have insurance coverage with ________________________________ Insurance Company(ies) and assign directly to Congress Orthopaedic Associates, Inc. all medical and surgical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payments of benefits. I authorize use of this signature on all my insurance submissions.

Signature: **Print:** **Date:**

PATIENT CONSENT

I agree that Congress Orthopaedic Associates may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. In addition I authorize appointment reminders via text message. I understand that I can electronically opt out of these types of messages.

Signature: **Print:** **Date:**

MEDICAL AUTHORIZATION:

I request that payment of authorized medical benefits be made on my behalf to Congress Orthopaedic Associates, Inc. for any services furnished to me. I authorize any holder of medical information about me to be release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim or other health insurances as indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims. My signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physicians or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

My signature acknowledges that the information provided hereto is true and that I have understood all disclousures to the best of my knowledge.

Beneficiary Signature: **Print:** **Date:**

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Patient Intake Sheet

Height: ________ Weight: ________ Dominant Hand: ☐ Right ☐ Left Affected Side: ☐ Right ☐ Left ☐ Both

Referring Physician: ____________________ Primary Care Physician ____________________

***What specific problem are you being seen for today?** ____________________

Date of Injury / Start of Symptoms: ____________ Is it getting better or worse? ____________

Type of Symptoms (Check all that apply): - - - - - - - - - - - - - - ☐ Pain ☐ Numbness ☐ Weakness ☐ Instability ☐ Stiffness

Quality of Symptoms (Check all that apply): - - - - - - - - - - - - ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Pins and Needles

When do Symptoms occur (Check all that apply): - - - - - - - - - ☐ Always ☐ Night ☐ Day ☐ Morning

Pain Level (1-10) : _____ ☐ Lifting ☐ After Activity ☐ At Rest

Have you been seen for this problem before? ☐ No ☐ Yes ☐ When? ____________

Any previous treatment? ☐ Medication ☐ Splint ☐ X-Rays ☐ Injections ☐ Therapy ☐ Other:

Past Medical Problems? ☐ Hypertension ☐ Heart Diease ☐ Diabetes Mellitus (☐ Type 1 ☐ Type 2) ☐ Other: ____________

Previous Surgeries (Please List): ____________________

Medications: ____________________

Allergies: ____________________

Family History of Disease: ☐ Lupus ☐ Cancer ☐ Rheumatoid Arthritis ☐ Other:

Occupation: ____________ How long have you been at your current job? ____________

Are you currently working? ☐ Yes ☐ No Avocations (sports, activities, hobbies): ____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how many? - - - - - - - - - - ____________

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? ____________

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? ____________

Have you used illicit drugs? ☐ Yes ☐ No If yes what drugs? For how long?

Do you currently, or have you ever had any problems with the following? (Check all that apply)

Skin:	☐ Rashes	☐ Eczema	☐ Psoriasis	☐ Cancer	
Ears/Nose/Throat:	☐ Headaches	☐ Blurred Vision	☐ Loss	☐ Hearing Loss	
Cardiac/Heart:	☐ Palpitations	☐ Chest Pains	☐ Swollen Ankles	☐ Hypertension	☐ Rheumatic Fever
Lungs/Respiratory:	☐ Lung Disease	☐ Emphysema	☐ Asthma	☐ Wheezing	☐ Shortness of Breath
Gastrointestinal:	☐ Ulcers	☐ Weight Loss	☐ Abdominal Pain	☐ Blood in Stools	☐ Bowel Problems
Bladder/Kidney:	☐ Frequent Urination	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems	
Musculoskeletal:	☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Gout		
Conditions:	☐ Depression/Anxiety	☐ History of Cancer	☐ Fibromyalgia	☐ Other:	

***Please have intake paperwork completed 15 minutes before your appointment or you may need to be rescheduled.**

The information above is accurate to the best of my knowledge: **Patient Signature:**____________________ Date:__________

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Patient Intake

Primary Care Information		
Primary Care Name:	Address:	Phone
Who referred you to our practice?:		

Pharmacy Information		
Pharmacy Name:	Address:	Phone:

Preferred language: ____________________ **Please check ethnicity:** Hispanic Origin
Non-Hispanic Origin

Please select your race: American Indian Asian Black / African American
Native Hawaiian White Unknown

Have you had your pneumonia injection this year? **YES** **NO**

Have you had your flu shot for current flu season? (October - March) **YES** **NO**

Smoking Status: Never Smoked Former Current Heavy Smoker Current Light Smoker

Date started smoking __________________ Date stopped smoking ______________

Are you currently being treated for diabetes? **YES** **NO**

Patient Signature:____ Date:______________

OFFICE USE ONLY

Physician DX Lower Ext Exam		
Dorsalis Pedis (R/L)	Normal	Abnormal
Posterior Tibial (R/L)	Normal	Abnormal
Monofilament Exam	Normal	Abnormal
Visual Exam of Foot	Normal	Abnormal

Referral / Out **Patient Education: (circle) Yes No**

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Last Name:

DOB:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT THE PATIENT MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This medical practice is required and permitted to make uses and disclosures of an individual's personal health information for purposes of treatment, payment and health operations. It is necessary to share specific and appropriate levels of confidential information about an individual, for example: when submitting claims to insurance companies, retaining records in our office concerning the individual's treatment, or the sharing of information between staff members to process paperwork related to office operations.

Other purposes listed below are either permitted or required to use or disclose confidential information without the individual's written authorization:

a) Uses and disclosures for public health activities
b) Reporting about victims of abuse, neglect or domestic violence
c) Disclosures for health oversight activities
d) Disclosures for judicial and administrative proceedings
e) Disclosures for law enforcement purposes
f) Uses and disclosures about decedents
g) Uses and disclosures for cadaveric organ, eye or tissue donation purposes
h) Disclosures to avert a serious threat to health or safety
i) Uses and disclosures for specialized government functions

Other uses and disclosures will be made only with the individual's written authorizaiton and that the individual may revoke such authorization. This office also may contact individuals and may leave messages to provide appointment reminders or information regarding treatment.

The federal government has granted patients several new rights under the privacy regulations. These are as follows:

a) The right to request restrictions on certain uses and disclosures, for example: an individual may request that this office not leave messages with other family members or on a home voice-mail system regarding certain treatment. Please note that the practice is not required to agree to all requested restrictions.
b) The right to receive confidential communicaitons, for example: on a home voice-mail system
c) The right to inspect and copy protected health information, for example: clinical records, billing records or other records used to make decisions regarding your care and treatment.
d) The right to amend protected health information, for example: an individual may request information be amended in your records if he/she feels it is incorrect.

e) The right to receive an accounting of disclosures of protected health information, for example: disclosures permitted or required by the office to be made in the ordering of a needed medical test.
f) The right of an individual's receiving notice electronically to obtain in a paper copy of that notice.

This practice is also required to abide by the terms of this notice and we reserve the right to change the terms of this notice and make new notive provisions effective for all confidential information we maintain. Any revised notices will be given to you at this office and a request for your signature on acknowledgment form will be requested.

Individuals may complain to the practice and to the Secretary of the Department of Health and Human Services if they believe their privacy rights have been violated and without retaliation from this practice.

For further information you may contact:

Veronica Camerena
Administrator
Congress Orthopaedic Associates, Inc
800 S. Raymond Avenue
Pasadena, CA 91105
Phone: (626) 795-8051

ACKNOWLEDGMENT OF NOTICE

I acknowledge receipt of
Congress Orthopaedic Associates, Inc
Notice of Privacy Practices

Patients Signature **Date**

Patients Name

[HIPAA]

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Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions. If you need further information about any of these policies, please ask to speak with one of our billing specialist at (626) 795-7035.

How May I Pay?

We accept payment by cash, check, Visa, Mastercard, American Express and Discover.

Do I Need A Referral?

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be re-scheduled.

What is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If you have:	You are responsible for:	Our staff will:
HMO, PPO, POS & EPO plans with which we have contract.	**If the services you receive are covered by the plan:** All applicable co-pay and deductibles are requested at the time of service.	Call your insurance company ahead of time to determine copays, deductibles and non-covered services for you.
	If the services you receive are not covered by the plan: Payment in full is requested at the time of service.	File an insurance claim on your behalf.
HMO- which we are not - contracted	Payment in full for office visits, x-ray, injections and other charges at the time of service.	Provide you with all the necessary information for you to submit these services to your insurance
Out of Network or Indemnity Plans	Payment of any out-of network co-insurance, deductible and co-pays.	Call your insurance company ahead of time to determine out of network benefits, co-pays, deductibles and non-covered services. We will file an insurance claim on your behalf.

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Medicare	If you have regular Medicare and have not yet met your $162.00 deductible, we will ask that it be paid at the time of service. Also any services not covered by the Medicare program will be collected at the time of service.	File the claim on your behalf as well as any claims to your secondary insurance.
	If you have Medicare as your primary insurance and also have secondary insurance or Medigap: No payment is necessary at the time of service. **If you have Medicare as your primary insurance but do not have a secondary insurance:** Your 20% co-insurance will be collected at the time of service.	
Medi-cal	If Medi-cal is your primary insurance you are responsible to pay for services at the time of service, we are not contracted with Medi-cal.	We will work with you to settle your account. Please ask to speak to one of our billing representative.
	If Medi-cal is your secondary insurance you are requested to pay the 20% co-insurance at the time of service.	
No Insurance:	Payment is due at the time of service.	We will work with you to settle your account. Please ask to speak to one of our billing representative.

If your physician recommends surgery, you will need to speak to the appropriate surgical scheduler. They will be able to answer specific questions about the surgery scheduling process and discuss any paperwork that is needed. Our Pre-certification department will verify benefits and request prior authorization from your insurance. In addition to these services one of our billing specialist will be contacting you to go over any financial responsibility prior to surgery.

What if my child needs to see the physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined above.

The undersigned agrees to pay for all services rendered if insurance does not pay. The undersigned also agrees to pay court costs and a reasonable attorney fee in the event legal action is required to enforce this agreement.

I authorize my Insurance benefits be paid directly to Congress Medical Associates, Inc.

I authorize Congress Medical Associates, Inc. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date: ____________ **Signature:** ____________ **Print Name**: ____________