ORTHOPAEDIC ASSOCIATES
820 S. AKERS · SUITE 220 · VISALIA, CALIFORNIA 93277
559.733.3346 · 559.625.0551 · FAX 559.733.5059 · FAX 559.734.8231

ORTHOPAEDIC AND PODIATRIC MEDICINE
☐ IAN C. DUNCAN, M.D.
☐ BRUCE N. LE, D.O., M.S.
☐ BURTON L. REDD, M.D.
☐ SETH CRINER, D.O., M.S.
☐ KAZI S. RAHMAN, D.P.M.
☐ JUN KIM, D.O., M.M.S.
☐ MATHIAS W. DANIELS, M.D.

For visual identification we photograph our patients, please **CHECK** if you **DO NOT** want this done: ☐
I hereby authorize directly to Othopaedic Associates Medical Clinic, Inc. All surgical and medical benefits otherwise pay-able to me for services performed. I hereby authorize the doctor to release all information necessary to secure the payment of benefits

Signature _____ Relationship _____ Date _____

*Note: please notify us if any of the above information changes during the course of your treatment.

I authorize Dr. _____ to examine me today for my medical condition and to prescribe medications for my treatment. In the event my physician refers me to another provider; I authorize release of my records to that provider for the purpose of coordination of care.

I authorize release to my insurance carrier, employer (in the case of a work-released injury), and/or attorney any information necessary to process and pay the charges incurred by me from this physician. I further authorize my physician to release records relating to my treatment to my referring and/or primary care physician. I acknowledge that I am responsible for any co-payments or balances due that remain unpaid by my insurance carrier.

I authorize my insurance carrier to make direct payment to the above named physician for all services performed.

_____ _____
Signature of patient or guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Orthopaedic Associates Medical Clinic, Inc. Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Orthopaedic Associates Medical Clinic, Inc. may disclose and use my protected health information.

Patient name _____

Signature _____ date _____

If signed by the patient's person representative, indicate:

Name of signer _____

Relationship to patient _____

If acknowledgment not signed, indicate reason no signed and efforts made to have acknowledgement signed:

_____

_____

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Medical Clinic, Inc.

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Consent to Receive Text Messages

By signing below, I authorize **Orthopaedic Associates Medical Clinic, Inc. (OAMC)** through its vendor Solution Reach to contact me by SMS text message to serve me better. **Orthopaedic Associates Medical Clinic, Inc.** will send me text messages through the OAMC texting service platform to help me or my family member stay healthy, including:

- timely reminders about upcoming appointments
- birthday greetings
- health care tips and topics
- information to help manage illnesses/diseases/conditions

I understand that message/data rates may apply to messages sent through **OAMC** to my cell phone and that I may receive up to 4 texts per month. Further, I understand that I may receive charges from my cell phone carrier for texts messages.

I know that I am under no obligation to authorize **OAMC** to send me text messages as part of my care.

I may opt-out of receiving these communications from OAMC at any time by calling (559) 733-3346 or by texting 'STOP' to the last SMS text message. To reinstate text messages from OAMC and opt back in simply text back the words “UNSTOP.”

*Your initial text message will contain the following HIPAA confidentiality statement.:

> **Confidentiality Notice:** “This text message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply text and destroy all copies of the original text message.”
>
> “Please be aware that unencrypted text communications can be intercepted in transmission, misdirected or re-directed and read by unintended recipients and may constitute a breach of privacy under HIPAA. Your use of text messages to communicate unencrypted sensitive or Protected Health Information (PHI) indicates that you acknowledge and accept the possible risks associated with such communication. Please consider communicating any sensitive information by a more secure means, including encrypted texts. If you do not wish to have your information sent by unencrypted texts, please contact the sender immediately (or text the word *‘stop’*) to no longer receive additional text messages.”

Print Name: _____ Date: _____/_____/_____

Signature: _____

My Cell/mobile phone number: (_____) _____ - _____

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Orthopaedic and Podiatric Medicine
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Orthopaedic Associates Medical Clinic
Patient Financial Policy

At Orthopaedic Associates Medical Clinic we are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Our fees for services are based on the level of professional skill required, the severity and complexity of the injury or illness, as well as the time spent treating you. The **patient or responsible party** is responsible for seeing that the entire bill is paid in full. Your clear understanding of our Financial Policy is important to our professional relationship.

Insurance: Billing of insurance is a courtesy we provide our patients and is not required by law. Our professional services are rendered to a person, not an insurance company. The insurance company is responsible to the patient and the patient is responsible to us. Therefore, if your insurance does not respond within 30 days the bill will become your responsibility. Please notify us if your insurance carrier or policy has changed.

Copayments: Your insurance contract REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay your co-pay prior to each visit.

Deductibles and Co-Insurance: We will verify your insurance benefits and, at the time of your appointment, you will be expected to pay a deposit towards an estimated amount owed. Following your appointment, as a courtesy we will bill your insurance company, and any patient responsibility portions are to be paid upon first receipt of your patient statement. If you have questions regarding any amount due after insurance has processed your claim please contact them directly.

Non-Covered Services: If your insurance plan determines that a service is not covered for any reason you will be responsible for payment of the charges. **Durable Medical Equipment (DME):** Some DME items may not be covered by your insurance plan and you will be asked to pay in full at the time of service. All items are new when given and cannot be returned.

Non-Participating Insurance Plans or "Out of Network": It is the responsibility of the patient to verify whether Orthopaedic Associates contracts with your insurance plan. Any outstanding balances are the responsibility of the patient. Insurance companies sometimes use the phrase "usual and customary" or "out of network" when discussing our fees. Insurance companies set their own "usual and customary" rates based on a wide geographic area and the fees we charge may differ.

Referrals: If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain this prior to your appointment and have it with you at the time of the appointment. If you do not have your referral you may be required to reschedule.

Workers Compensation/Other Accident Cases: In order for us to file a claim with your work comp or other liability carrier you must provide complete billing information. Without this information we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. We do not bill attorneys for medical services.

Self Pay/Uninsured: Payment in full is required for all self pay/uninsured patients. For new patients, a deposit of $250 is required on the day of your appointment before being seen by the provider. Any fees remaining will be collected following your appointment.

Minors of Divorced Parents and Child Custody Cases: Both parents are financially responsible for care rendered to minor children. We do not get involved in divorce situations and the parent that signs for the child will be financially responsible and any statements will be mailed directly to that parent.

Post-Operative Surgery Charges: Following most surgical procedures, related office visits are included and will not be charged during the 10 or 90 day post-operative period. Services such as x-rays, casting and materials, Durable Medical Equipment, and injections will be charged separately during this time.

Payment for services may be paid by cash, personal check, Visa, MasterCard, Discover, or American Express. **Responsible parties** will be responsible for any collection fees, interest, and other expenses necessary to collect on any account, including court costs should legal action be necessary to collect. Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $35 fee per check returned. ***Please sign that you have read and agree to this Financial Policy.***

ResponsiblePartySignature:_____Date:_____

Patient Name (if different from Responsible Party): _____

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HIPPA

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THE FOLLOWING:
PHYSICIANS, FAMILY, INSURANCE, SHORT TERM DISABILITY PROVIDERS, ETC.

PATIENT NAME (LAST, FIRST): _____DATE OF BIRTH: _____/_____/_____

NAME OF PARENT OR GUARDIAN IF PATIENT IS MINOR:_____

IN THE EVENT THAT OAMC MAY NEED TO GIVE YOUR TEST RESULTS OR MEDICAL INFORMATION, MAY *WE:*

_____ LEAVE DETAILED MESSAGE ON AN ANSWERING MACHINE

_____ LEAVE A MESSAGE WITH MY SPOUSE OR FAMILY MEMBER

_____ CALL YOU ON YOUR CELLULAR PHONE; THE PHONE NUMBER IS: (_____)_____

_____ CALL YOU AT WORK; THE PHONE NUMBER IS: (_____)_____

I GIVE ORTHOPAEDIC ASSOCIATES DOCTORS AND STAFF THE AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FAMILY, FRIENDS, CAREGIVER, PHYSICIAN, INSURANCE AND/OR SHORT TERM DISABILITY PROVIDER:

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE MEDICAL RECORDS DEPARTMENT OF ORTHOPAEDIC ASSOCIATES MEDICAL CLINIC, INC.

I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION SHARED IN THE PROCESS OF TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS HEALTH INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THIS AUTHORIZATION AND I NEED NOT SIGN THIS FORM IN ORDER TO ASSURE TREATMENT. I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED RE-DISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES. IF I HAVE QUESTIONS ABOUT THE DISCLOSURE OF MY HEALTH INFORMATION, I CAN RECEIVE FURTHER INFORMATION FROM MY DOCTOR OR HIS STAFF.

UNLESS OTHERWISE REVOKED THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: IF I FAIL TO SPECIFY A DATE, THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE SIGNATURE ON THIS FORM.

_____ _____

PATIENT OR GUARDIAN SIGNATURE *DATE (MM/DD/YYYY)*

ORTHOPAEDIC ASSOCIATES MEDICAL CLINIC, INC. MEDICAL QUESTIONNAIRE

Due to government requirements that physicians document complete medical information on each patient, we ask you to complete the following detailed form in its entirety. Should you have trouble with any questions, please feel free to ask our staff for assistance. Some of the information may be sensitive; rest assured that the staff of OAMC will keep this information confidential. Thank you for your cooperation.

PATIENT IDENTIFICATION

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Who is your Primary / Family doctor? _____

How were you referred to our office? ☐ Self ☐ ER (which one?) _____

☐ Primary MD (name) _____ ☐ Other (list name) _____

Have you see any other doctors in this office / group (whom)?_____

PRESENTING COMPLAINT / PROBLEM

Reason for visit: _____ Date of Injury?_____

Cause of injury:_____ Where occurred? _____

Work related? ☐ Yes ☐ No _____ Previous injury?_____

Previous studies? *Where* performed & date?

X-rays_____ MRI _____

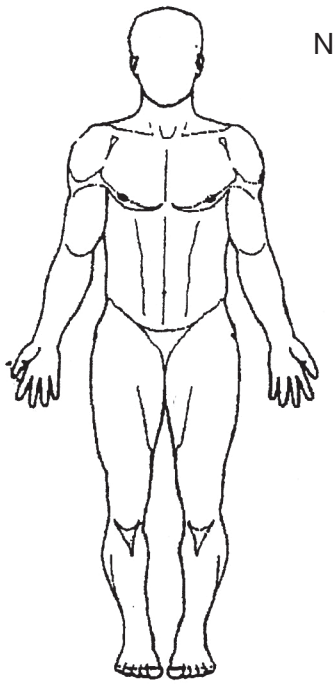
CT Scan_____ Bone scan _____

Other _____

PAIN DRAWING

Be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation.Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

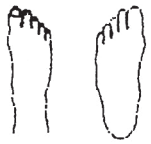
Numbness = = = = Pins & Needles o o o o Burning pain x x x x Stabbing Pain / / / / Aching Pain ((((

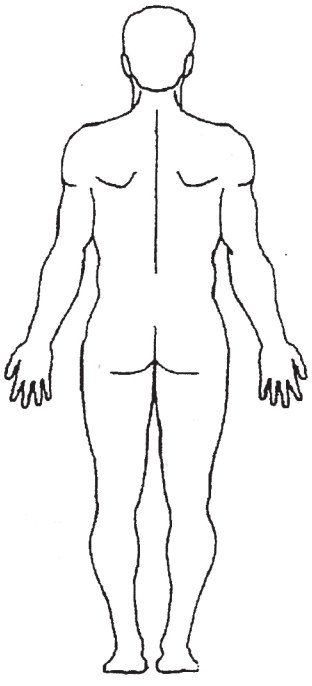


No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10

PAIN SCALE





MEDICATIONS - INCLUDE HERBAL SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS					
Medication	Dose	# Times Per Day	Medication	Dose	# Times Per Day

SOCIAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children living? _____

Presently living alone? ☐ Yes ☐ No Stairs at home? ☐ Yes ☐ No Number of steps _____

Occupation _____ Still at work? ☐ Yes ☐ No If no, last date worked _____

How long at present job? _____

Physical demands of work: (check below)

☐ Heavy ☐ Moderate ☐ Light ☐ Lifting ☐ Pushing ☐ Squatting ☐ Prolonged standing ☐ Sitting

Sports / Exercise prior to injury? ☐ Yes ☐ No ☐ Past What type? _____

Number of times / week _____ ☐ Recreational ☐ School / College level ☐ Semi / Professional

How has injury affected these activities? _____

Are you claustrophobic? ☐ Yes ☐ No Do you have any metal in your body? ☐ Yes ☐ No

Other symptoms? Please specify _____

_____

Email address _____

Name of Pharmacy _____

Pharmacy Address _____ Pharmacy Phone _____

Patient Signature _____ Date _____

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Understanding Your Health Record Information

NOTICE OF PRIVACY PRACTICES

Each time you visit OAMC; a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
- Understanding of what is in your medical record and how your health information is used to help you to:
    * ensure its accuracy
    * better understand who, what, where, and why others may access your health information
    * make more informed decisions when authorizing disclosures to others.

Your Health Information Rights ~

Although your health record is the physical property of OAMC, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorizations to use or disclose health information except to the extent that action has already been taken

Our Responsibility ~

Orthopaedic Associates is required to:

- Maintain the privacy of your health information
- Provide you with a notice to its legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem ~

If you have any questions and would like additional information, you may contact the Medical Records/Credentialing Coordinator at 559-625-0551.

If you believe your privacy rights have been violated, you may file a complaint with the Administrator, Office Manager or the Medical Records Credentialing Coordinator, There will be no retaliation for filing a complaint.

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Orthopedic Surgery · Board Certified

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- ☐ Mathias W. Daniels, M.D.

PATIENT INFORMATION

NAME_____
ADDRESS_____
CITY_____ST_____ZIP_____
DATE OF BIRTH_____AGE_____
SOCIAL SECURITY # _____
HOME PHONE _____
CELL PHONE _____
EMAIL ADDRESS _____
EMPLOYER _____
ADDRESS _____
CITY _____ST_____ZIP_____
WORK PHONE_____
OCCUPATION_____
SEX _____ RACE _____ LANGUAGE _____
ETHNICITY_____MARITAL STATUS_____

SPOUSE/PARENT INFORMATION

NAME _____
ADDRESS _____
CITY _____ST_____ZIP_____
DATE OF BIRTH _____
SOCIAL SECURITY #_____
HOME PHONE _____
CELL PHONE _____
EMAIL ADDRESS _____
EMPLOYER _____
ADDRESS _____
CITY _____ST_____ZIP_____
WORK PHONE _____
OCCUPATION _____

EMERGENCY CONTACT_____ PHONE #_____
REFERRED BY _____ PRIMARY CARE PHYSICIAN _____
PHONE NUMBER PREFERRED FOR APPOINTMENT REMINDERS _____

PRIMARY INSURANCE

PLAN NAME _____
BILLING ADDRESS _____
CITY _____ST _____ZIP_____
GROUP # _____
SUBSCRIBER # _____
EFFECTIVE DATE _____
INSURED NAME _____
RELATIONSHP TO PATIENT_____
PHONE #_____

SECONDARY INSURANCE

PLAN NAME _____
BILLING ADDRESS _____
CITY _____ST_____ZIP_____
GROUP # _____
SUBSCRIBER # _____
EFFECTIVE DATE _____
INSURED NAME _____
RELATIONSHP TO PATIENT _____
PHONE # _____

DOES YOUR INSURANCE REQUIRE AN AUTHORIZATION PRIOR TO SEEING A SPECIALIST? Yes___ No___
DO YOU HAVE A COPAYMENT? Yes ___ No ___ AMOUNT $_____

WORKERS' COMPENSATION INSURANCE INFORMAITON

INSURANCE NAME _____
ADDRESS _____
CITY _____ST _____ ZIP _____
PHONE _____
ADJUSTER _____
PHONE _____
FAX _____
NCM _____
PHONE _____
FAX _____

EMPLOYER DURING INJURY _____
ADDRESS _____
CITY _____ST _____ZIP_____
PHONE _____
DOI _____ CL# _____BODY PART _____
DOI _____ CL# _____BODY PART _____
DOI _____ CL# _____BODY PART_____

INT NEEDED? Y____ N____ PHONE _____
NAME OF AGENCY _____

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Regarding Your Recent Visit:

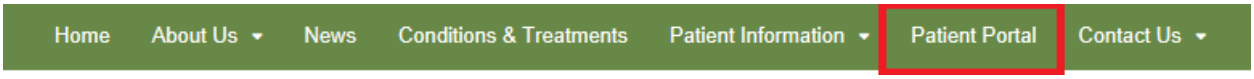
Clinical documentation for your recent visit is available on the Patient Portal Account – where you have secure, anytime, anywhere access to your important health information. You can communicate with your doctor and our staff with secure messaging.

Instructions to Sign Up For The Patient Portal

*Your email must be on file at Orthopaedic Associates

1. Go to www.thebonesurgeons.com

2. Click on the "Patient Portal" located on the top menu:



3. Click on the small orange box that says "patient portal" 

4. Go to "sign up," complete the information, click "Login"

5. You will be sent an email confirming your registration, click on the link and "login."

6. If you have questions or have issues logging in please email us at: info@bonesurgeons.com