OSNC Orthopaedic Specialists of North County

Oceanside Office: 3905 Waring Road, Oceanside, CA 92056
Carlsbad Office: 6121 Paseo Del Norte, Ste. 200, Carlsbad, CA 92011
Vista Office: 1958 Via Centre Drive, Vista, CA 92081

Ph: 760-724-9000 Fax: 760-724-3686 | www.orthonorthcounty.com

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Patient Information

Chart: _____

Patient name: _____ Date: _____
Address: _____ Ph: _____
City: _____ State _____ Zip _____Cell: _____
Email address:_____ Birthdate: _____
Family physician: _____Referring physician: _____
Sex: M F (circle one) Referring source (name) _____
SSN: _____Marital status: _____Drivers license: _____
Any previous names: _____
Employer name: _____ Occupation: _____
Employer address: _____ Work ph: _____
City _____ State _____ Zip_____
Emergency contact: _____Ph: _____

Person responsible for payment: Self: _____
Address: _____City: _____State: _____Zip: _____
Home phn: _____ Work phone: _____
1st Ins. company: _____ Name of insured: _____
SSN of insured : _____Birthdate of the insured: _____
Address: _____City_____State_____Zip_____

Employer: _____Ins. ID# _____Group# _____
2nd Insurance co. _____Name of insured: _____Group#_____
SSN of Insured: _____Birthdate of insured: _____/ _____/_____
Address: _____

Employer: _____Ins. ID#_____Group # _____

I hereby authorize and consent to examination and treatment as deemed necessary by physicians of Orthopaedic Specialists of North County, A Medical Group, Inc. I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any costs incurred by Orthopaedic Specialists of North County, a Medical Group, Inc. in the event of account delinquency, all amounts due including, but not limited to, reasonable attorney's fees.
I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Orthopaedic Specialists of North County, a Medical Group, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I further authorize the release of all information necessary to secure payment.
I understand and agree that payment by the responsible party will not be delayed or withheld because of any dispute between the responsible party and any insurance company, reimbursing agency, third party payer or because of pending legal claims.

Date: _____Responsible party: _____

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Name:_____ **DOB:**_____ **Acct.#:**_____ **Chart#:**_____

Patient Consent for Treatment / Release of Information / Communication Authorization

TO OUR PATIENTS: Before you begin treatment at Orthopaedic Specialists of North County (ONSC), the law requires that we explain your rights and responsibilities while a patient at OSNC. If you have a complaint or concern about your care, please discuss it with your provider or a manager. If your concern remains unresolved, you may call the privacy officer, Barritt Burke at 760 477-2104. Please read and sign the sign below. We will, unless you object, do the following and use communications like post cards, telephone, about your appointments, email, faxing, paging, email voice messaging to reach you, alert you, and leave you messages. Your signature at the bottom connotes agreement and understanding. We may also use a sign-in sheet at the front desk and ask that you sign your name. We have your permission to acquire your medication history: Initial _____

CONSENT FOR TREATMENT: By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that this could include lab tests, xrays, education or other diagnostic procedures. I understand that my Provider is available to explain the purpose of the procedures and treatment and that I have the right to refuse recommended treatment. My provider has my permission to secure any of my medical records for the purpose of treating me and communicate with my PCP or other medical providers as necessary. A record of my visit can be set to my referring physician. w will also communicate with any agency as provided by law, such as the CA State Workers Compensation Board, or employer in the case of Workers' Compensation injury. Initial _____

RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW: I understand that it is important that medical providers have access to any of my medical records which will help them to safely treat me and manage my medical care. I agree and understand that a copy of my medical records including AIDS, HIV, Behavioral Health Service, Psychiatric Care, and treatment foe alcohol or drug use will be included as part of my health information for purposes of my medical care and for business operations. I also agree that OSNC can release my medical records to accrediting or regulatory agencies if those agencies request my records.
The following people may have access to my medical information at OSNC: Please list by relationship & name: i.e., wife; Jane Smith.

1) _____ 2) _____ 3) _____

Others involved in your healthcare. We may disclose to a relative (or any other person you identify) your health information that directly relates to that person's involvement in your health care or who has responsibility for payment of your healthcare. We may also use or disclose your health information to notify or assist in notifying a relative or any other person responsible for your health care. We may also use or disclose your health information to notify or assist in notifying a relative or any person responsible for your care of your location, general condition.

PARTICIPATING INSURANCE / BILLING PROCESS / MEDICATE / MEDICAID ASSIGNMENT OF BENEFITS-PAYMENT OSNC MEDICAL BILLS. I request that payment of my bills by the "third payer" be made to OSNC on my behalf for any services furnished to me by or in OSNC. I assign the benefits payable for physician services to OSNC or physician furnishing the services. In consideration of office visits, I agree to pay OSNC for all the charges not covered by any third party payer. I have been provided a copy of the financial policy of OSNC. I understand I will be billed $50.00 for a "no show" appointment, and $25 processing charge for rebilling any charge not paid within a 30 day period. We will charge $35.00 NS fee for any 'bounced' check and $25 fee for co-pays which are not paid at the time of service and have to be billed. There is a fee for completing insurance forms not related to physician reimbursement. Initial _____

RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES: In many instances, a "third party payer" will pay a portion or all of my medical bills related to today's visit. In order for a "third party payer" to pay any or all of my bills related to today's visit at OSNC, I understand the "third party payer" may require information about the medical care and treatment I received. I authorize OSNC or its related entities to release to the "third party payer" any information needed to determine the payments related to the medical treatment I receive.

PATIENTS RIGHT TO PRIVACY: I acknowledge that I have been made aware of OSNC's privacy practices and HIPAA regulations which are posted in the reception area or website. I have been offered a copy of OSNC's notice of privacy practices to keep for myself.

AUTHORIZATON TO COMMUNICATE VIA EMAIL, ANSWERING MACHINE, ETC.: I authorize OSNC to leave messages about my Private Health information for me on my answering machine, email, or text if I have provided that information. We may leave messages on your answering machine or with an individual that answers your home phone; we may call your place of employment to give you information about your visit. We may schedule appointments for follow-up visits or diagnostic tests while you are at our check-out window. We may send post cards and other correspondents. I understand I have the right to revoke this consent, in writing, at any time except where Orthopaedic Specialists of North County has already made a disclosure in reliance on this content. This authorization expires 5 years from date noted unless withdrawn in writing.

I understand that if NO objections is noted above, I am giving my consent for ALL listed above.

_____

Patient or authorized signature Date

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Spine Clinic / Initial Evaluation for INJURED WORKER

Name: _____ **Chart:** _____ **Date:** _____

Referring doctor: _____ **Auth#**_____

1. Your current occupation: _____
2. Your direct supervisor's name / phone: _____
3. Hours worked per week: _____ Days per week: _____
4. What are the physical demands of your current occupation? _____
5. What tools or machinery do you routinely use? _____
6. Estimated weight that you life during your shift?_____lbs
7. Days per week you life this weight: _____
8. Estimate of the amount of weight you life with co-workers during shift: _____lbs
9. How many times per day do you life this amount? _____
10. What was your occupation at the time of your injury? _____
11. Who was your employer at the time of your injury? _____
12. How long had you worked there at the time of your injury? _____
13. How long have you been in this line of work? _____
14. Were you working anywhere else at the same time? _____yes _____no

    If yes, where did you work and what were your duties: _____

    If yes, how long did you work at both places?_____

Are you still working a tboth places? _____yes _____no

Are you still working at your 2nd job? _____yes _____no

15. List places of employment for the past 10 years:

    Employer:_____Employer: _____

    Employer:_____Employer: _____

    Employer:_____Employer: _____

    Employer:_____Employer: _____

    Employer:_____Employer: _____

16. Specific date of your injury? _____If no date, when did you have problems? _____
17. Tell in your own words what happened and when you began to feel problems: _____
18. Did you continue to work after your injury? _____yes _____no

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Name: _____ **Chart:** _____ **Date:** _____

19. When did you report the injury?
20. List the body areas that were injured:
21. Had you ever injured this body area before the recent date of injury? ☐ yes ☐ no
22. Have you ever had disability in this body area that was not work-related? ☐ yes ☐ no
23. Have you been released from care by any physician? ☐ yes ☐ no
24. Did you return to any type of work? ☐ yes ☐ no
25. Are you currently working for the same employer ☐ yes ☐ no
26. If you did not return to work when you were released from medical care, explain reason:

_____

_____

27. When did you last work? _____
28. List all dates that you did not work:

From_____ To _____ From_____ To _____

From_____ To _____ From_____ To _____

29. List all dates that you performed light duty:

From_____ To _____ From_____ To _____

From_____ To _____ From_____ To _____

30. When did you return to regular duty? _____
31. Since this recent injury, have you had any other injuries? ☐ yes ☐ no
32. Many people recovering from a work-related injury have concerns. Please check any that apply to you.

☐ Won't be able to return to your usual job
☐ Will not enjoy your current job
☐ Will be re-injured if you return to your usual job
☐ Will need vocational training to return to a new job
☐ Will not be able to return to any job
☐ Have conflicts with someone at current job
☐ Interactions with insurance co. or employer
☐ Recovery will take a long time
☐ Financial distress during recovery
☐ Will need an attorney to assist in your case
☐ How age and general health will affect your recovery
☐ Participating in a physical rehabilitation program
☐ Feelings of depression, frustration, anger, fear, anxiety
☐ Use of tobacco, alcohol, or caffeine
☐ Pain medications you are taking
☐ Substance abuse in the past or present
☐ Lack of information about workers' compensation
☐ Conflict with someone in your home