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BeachOrthopaedics.com

BEACH ORTHOPAEDIC
SPECIALTY INSTITUTE

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Welcome to Beach Orthopaedic Specialty Institute (BOSI). We hope that the following information will be helpful to you. We respect your time and would like to help make your visit as efficient as possible.

PLEASE BRING THE FOLLOWING ITEMS TO YOUR VISIT:

- **NEW PATIENT FORMS**
  - Please complete the following registration and history forms and bring them to your visit or plan to arrive 30 minutes before your scheduled appointment time to complete these forms.
  - Printing and completing the forms prior can save you time on the day of your visit.

- **MEDICAL INFORMATION**
  - IMAGING STUDIES: You must bring a copy of any prior MRI or CT imaging studies to your visit (CD or film copy ok). Failure to bring your studies may require us to schedule an additional appointment.
  - PERTINENT MEDICAL RECORDS: Please bring any recent medical records (within past 5 years) related to the medical condition you are being treated for today.
    - Operative notes from previous surgeries
    - Discharge summaries from ER visits or recent hospital stays
    - List of current medical problems and medications you currently take

- **MEDICAL INSURANCE CARD/FINANCIAL INFORMATION**
  - Please bring copies of all insurance cards.
  - We collect co-pays at the time you check in for your appointment before seeing the doctor.
  - Before your appointment, please verify that your insurance allows treatment at our office. Be aware that your insurance reimbursement may not cover the full cost of your visit. Regardless of insurance, payment remains your personal responsibility.

Please note that patients under the age of 18 must be accompanied by a parent or guardian

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CLINICAL PATIENT INFORMATION AND MEDICAL HISTORY

(Please type or print legibly)

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Wt _____ Ht _____ Hand dominance: ☐ Right ☐ Left

Referring Physician: _____ Primary Care Physician (if any): _____

CHIEF COMPLAINT: (what are you here for today?) _____ Date of Injury: _____

Where did the injury occur? ☐ Work ☐ Other _____

How EXACTLY did the injury occur? _____

Have you been treated for this problem by another doctor? ☐ Yes ☐ No If so, who? _____

Prior Treatments: ☐ None ☐ Bracing ☐ Pain Medications ☐ Injections ☐ Chiropractic ☐ Surgery ☐ Other

What is your pain on a scale of 0-10, zero is no pain, 10 is severe disabling pain

(i.e. causes sweating, tears, high heart rate, etc.) 1 2 3 4 5 6 7 8 9 10

What makes the pain worse? (activities, body positioning, etc.) _____

What relieves the pain? (medications, ice, heat, therapy, activity modifications, body positioning, etc.) _____

Do you have any mechanical symptoms with your pain? Locking, popping, catching? If so, when does it occur?

_____

Do you feel any instability with your current problem? Buckling, shifting, giving way? _____

☐ Other (please list) _____

PREVIOUS SURGERIES: Related to this problem only (list type of surgery, right or left side, year, where, by whom, etc.)

1. _____
2. _____
3. _____

PREVIOUS SURGERIES: (Do Not include surgeries related to your current problem)

1. _____
2. _____
3. _____

Any problems with anesthesia during previous surgeries? If so, what were they specifically? _____

_____

_____

_____

POS Reorder # 1707113

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CLINICAL PATIENT INFORMATION AND MEDICAL HISTORY CONTINUED

(Please type or print legibly)

CURRENT MEDICATIONS: (list medication and dosage, if known)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

KNOWN ALLERGIES: (list allergy and reaction) _____

_____

MEDICAL HISTORY: (please check previous or current conditions)

☐ None	☐ Anemia	☐ COPD/Lung Disease	☐ High Blood Pressure	☐ Prostate
	☐ Arthritis	☐ Depression	☐ High Cholesterol	☐ Stomach Ulcers/Reflux
	☐ Asthma	☐ Diabetes	☐ HIV/AIDS	☐ Seizures
	☐ Blood Clots/DVT	☐ Heart Disease	☐ Liver Disease	☐ Thyroid Disease
	☐ Cancer	☐ Hepatitis	☐ Osteoporosis	☐ Vascular Disease

☐ Other (please list) _____

SOCIAL HISTORY: Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____ Hobbies: _____

Do you smoke: ☐ Yes ☐ No Packs/Day? _____ Do you drink alcohol? ☐ No ☐ Rare ☐ Social ☐ Daily

FAMILY HISTORY: (check all that apply) ☐ Heart Disease ☐ Diabetes ☐ Bleeding Disorders

☐ Arthritis ☐ Osteoporosis ☐ Other _____

REVIEW OF SYSTEMS: (Check any positives)

	General	☐ Fatigue	☐ Weight Loss/Gain	☐ Fever/Chills
	Heart	☐ Shortness of Breath	☐ Chest Pain	☐ Palpitations
	Lungs	☐ Productive Cough	☐ Wheezing	☐ Coughing Up Blood
	GI	☐ Heartburn	☐ Abdominal Pain	☐ Nausea/Vomiting
	Urinary/Reproductive	☐ Blood In Urine	☐ Incontinence	☐ Sexual Dysfunction
	Skin	☐ Skin Lesions	☐ Psoriasis	☐ Chronic Rash
	Neurological	☐ Seizures	☐ Migraines	☐ History of Stroke
	Musculoskeletal	☐ Joint Pain	☐ Joint Swelling	☐ Muscle Pain
	Psychiatric	☐ Depression	☐ Anxiety	☐ Mood Swings
	Hematologic	☐ Easy Bruising	☐ Easy Bleeding	

Patient Signature _____ Date _____

POS Reorder # 1708258

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PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

(Please type or print legibly)

Chart # _____ **Physician** _____ **Date** _____

Patient Name
(Last) _____ (First) _____ (Middle) _____

Social Security # (optional) _____ Drivers License # _____ State _____

Date of Birth: _____ Age: _____ Sex ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Race: ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander
☐ American Indian-Alaskan Native ☐ Other Race ☐ Refused ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Preferred Language: ☐ English ☐ Other _____

Home Phone: _____ Cell Phone: _____

Business Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: ☐ Same as above

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Injury: _____ If not injury, when did pain begin _____

Reason for Visit: _____ Body part: _____ ☐ R ☐ L

How did you hear about our office? ☐ Website ☐ Social Media ☐ Magazine ☐ Emergency Room/Urgent Care
☐ Primary Care Doctor ☐ Current Patient ☐ Other _____

INSURANCE

Primary: _____

Name of Insured: _____

SS#: _____ Date of Birth: _____

Relationship: ☐ Self ☐ Spouse ☐ Other _____

Secondary: _____

Name of Insured: _____

SS#: _____ Date of Birth: _____

Relationship: ☐ Self ☐ Spouse ☐ Other _____

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Is this a worker's compensation/personal injury claim? ☐ Yes ☐ No If yes, please complete below

Insurance company: _____

Date of Injury: _____

Adjuster's Name: _____

Claim #: _____

Phone: _____

Fax: _____

IF PATIENT IS A MINOR OR A STUDENT:

School Name: _____

Address: _____

Phone: _____

Father's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

Mother's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize BOSI or insurance company to release any information required to process my claims, determine the benefits payable for related equipment or services to the organization, the Health Care financing administration. A copy of this authorization will be sent to the Health Care financing administration, my insurance company or other entity if requested. I, the above listed, authorize and direct the above listed insurance company to pay by check, made out and mailed to BOSI, 3851 Katella Avenue, Suite 202, Los Alamitos, CA 90720. If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct the above mentioned insurance company to make the check to me and mail it as follows to: BOSI, 3851 Katella Avenue, Suite 202, Los Alamitos, CA 90720.

If the patient is less than 18 years of age, guarantor must sign.

Signature of Financially Responsible Party: _____

Relationship to Patient: _____

Date: _____

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COMMUNICATION CONSENT

HIPAA privacy guidelines prevent us from leaving messages regarding appointments or any other medical matter. In order to communicate with you efficiently regarding appointment confirmations or changes, please sign below. This will give us permission to leave a message on your answering machine, cell phone, email or with a family member.

This waiver will only apply to messages regarding appointments or the need for the Doctor or staff to speak with you. No other medical information will be communicated.

I give permission for the Doctors or their staff to contact me in the following way:

- ☐ Cell Phone
- ☐ Home Phone
- ☐ Email
- ☐ Family Member
- ☐ All of the above

Patient Signature _____ Date _____

PHARMACY INFORMATION

Please provide name, address and phone number of your pharmacy of choice.

Pharmacy Name _____ Phone Number _____

Pharmacy Address _____

NO ACCIDENT/INJURY

I hereby state with my signature that I was not involved in any auto accident, slip, fall, or work injury. My treatment is in no way associated with any 3rd party, and no other party is responsible or liable for the cost of my treatment.

Please process and pay all claims immediately.

Patient Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT FORM

The Notice of Privacy Practices for BOSI provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Portability and Accountability Act of 1996.

HOW WE CAN USE YOUR INFORMATION:

We can use and give your information to anyone who is part of taking care of you. This includes different doctors, nurses and therapists. We can also give out information to Medicare or any insurance company, or individual who may be responsible for paying for your care.

We use medical information about you to provide you with services. We may use your information to find ways to improve how we can take care of you. Some state or federal laws require us to report certain diseases, abuse and crimes. We may also share information to find programs or services that might help you get better or stay better.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations, including appointment reminders by postcard or messages on an answering machine.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

You have the following rights:

- To read your records and have copies made. Requests to review and receive copies should be made in writing to BOSI. If it is a billing record, please contact our billing department. We will get the records to you in 30 to 60 days, depending on where they are stored.
- To ask us to correct information that we have created including encounter notes and billing statements. This request must also be made in writing and sent to our Privacy Officer along with the reason(s) that support your request.
- To know who has seen your information if we have shared it for reasons other than to take care of you and to get paid. This request can also be made by contacting the Privacy Officer.
- To complain to Sports and Spine Orthopaedics through the Manager or the Department of Health and Human Services if you believe we have not followed the law and Notice of Privacy Practices.

This consent allows the practice to disclose my medical information to the following people:

☐ Please do not disclose my health information to anyone

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

_____ _____

Patient Name Date Signed

_____

Patient Signature

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SPECIALTY INSTITUTE

SERVICE AND FINANCIAL AGREEMENT

PAYMENT FOR SERVICES:

Except as noted below, co-payments are due in full at the time of service. Our office staff is here to assist you. However, it is your responsibility to be aware of your health insurance benefits and how to obtain them. Please be aware that you are ultimately responsible for payment of your bills; not your insurance company. If your insurance company fails to pay your claim(s) for whatever reason, you are still responsible for the charges incurred.

Please inform the staff if preauthorization is required by your insurance. HMO patients are required to have all services and office visits preauthorized before scheduling appointments. Please notify us of any changes in your contact information or insurance coverage.

As a courtesy, BOSI's professional fees will be billed to your insurance company on your behalf. Once payment is received from your insurance company, your balance, if any, will be due within 30 days. If your insurance fails to pay within 60 days, the entire balance becomes immediately due.

Whether BOSI is in or out of network with your insurance company, please understand that your insurance company may deny coverage for a particular treatment, surgery, or piece of equipment. If you agree to that treatment, surgery or piece of equipment, for instance, you are assuming responsibility for payment regardless of whether your insurance company pays for it or not.

HOSPITAL PROCEDURE/SURGERY:

We will attempt to pre-authorize all surgeries and procedures with your insurance company prior to any surgery being scheduled. Please be aware that in addition to the physician and hospital charges, there will likely be additional bills for anesthesiologists, assistant surgeons, laboratory/radiology tests, and internal medicine physicians. BOSI is not associated with these entities and has no control over them or their fees. We also do not know whether they are in or out of network for your insurance.

MEDICAL RECORDS TRANSFERS:

Any requested copies of your medical records require a signed release form. A fee to cover the cost of copying and mailing is due prior to release of records.

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SPECIALTY INSTITUTE

METHODS OF PAYMENT:

For your convenience, we accept cash, personal checks (U.S. dollars), Cashier check, MasterCard, Visa, Discover, and American Express. A $25.00 bank fee (or the actual bank charges if more than $25.00) is charged on all returned checks, and nonpayment orders.

RELEASE OF INFORMATION:

BOSI may disclose all or any part of your medical records and/or financial ledger, to any person or corporation
(1) which is or may be liable under contract to BOSI for reimbursement for services rendered, and
(2) any healthcare provider for continued patient care.

MEDICAL CONSENT:

I consent to routine evaluation and treatment under general and specific instructions of BOSI. If necessary, I agree to emergency treatment and/or transport to the nearest available hospital. I reserve the right to refuse specific services at any time.

Initials: _____ I hereby authorize and give consent to routine evaluation and treatment to my daughter/son, and/or transport to the nearest available hospital. I reserve, as guardian or legal representative to my daughter/son, and/or dependent, the right to refuse specific services at any time.

FINANCIAL RESPONSIBILITY:

I have read and understand the above statements regarding my financial responsibility and the release of information. I accept full financial responsibility for my treatment regardless of whether my insurance company pays my bills. If my account becomes delinquent and is referred to a collection agency or attorney, I agree to pay all collection expenses, attorney and court costs associated with such. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I acknowledge that if my child/dependent is cared for by BOSI that I will be responsible for the payment of services provided under the same terms and conditions.

DIVORCED PARENT:

We do not second party bill. The parent bringing the child to our facility is responsible for payment of all required co-payments, deductibles, and all other expenses incurred at the time services are rendered.

Initials: _____

HMO or OTHER CONTRACTED PATIENTS:

For authorized covered services, I agree to pay BOSI my portion of charges for the requested services and understand that exact amount of my obligation may not be known to me until after my healthcare plan has processed the claim. BOSI may bill my insurance and receive payment for services provided to me under the provisions of my plan's contract with BOSI. For services not covered by my insurance (authorization denied) I agree and understand that I may be asked to pay the full amount of BOSI standard fee for the services provided at the time of services.

Initials: _____

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PATIENTS WITH NON-CONTRACTED HEALTH PLANS:

I authorize BOSI to bill my insurance company. I understand that any pre-determination of benefits by my insurance company is an estimate and the actual benefit payment will not be determined until the claim is processed. I agree to pay BOSI in full for services provided to me regardless of the amount reimbursed to me by my insurance company. I am responsible for paying all outstanding charges after 60 days.

This assignment/financial agreement will remain in full force and effective until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Signature of Patient and/or Legal Representative	Relationship to Patient
Print Name	Date
Witness Signature	Date