LONG BEACH LAKEWOOD
ORTHOPEDIC INSTITUTE

3828 Schaufele Ave., Suite 320
Long Beach, CA 90808
(562) 348-4588

5750 Downey Ave., Suite 308
Lakewood, CA 90712
(562) 633-3787

Welcome to Long Beach Lakewood Orthopedic Institute. We hope that the following information will be helpful to you. In order to make your visit as efficient as possible, ***please have the following items available at the time of your appointment.***

- **NEW PATIENT FORMS**
  - Please complete the following registration and history forms and bring them to your visit or plan to arrive 30 minutes prior to 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.
  - 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.

LONG BEACH LAKEWOOD ORTHOPEDIC INSTITUTE

PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

(Please type or print legibly)

Date _____

Patient Name

_____

(Last) (First) (Middle)

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

Drivers License #: _____ State: _____

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: _____

Email: _____

Home Address: _____

_____ City: _____ State: _____ Zip: _____

Mailing Address: ☐ Same as above _____

_____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Address: _____

_____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Address: _____

_____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Referring Physician: _____ Phone: _____

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

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

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

LONG BEACH LAKEWOOD ORTHOPEDIC INSTITUTE

INSURANCE

Primary: _____

Member ID#: _____ Group #: _____

Name of Insured (Policy Holder): _____

Date of Birth: _____ SS#: _____ Relationship: ☐ Self ☐ Spouse ☐ Other _____

Secondary: _____

Member ID#: _____ Group #: _____

Name of Insured (Policy Holder): _____

Date of Birth: _____ SS#: _____ Relationship: ☐ Self ☐ Spouse ☐ Other _____

IF PATIENT IS A MINOR OR A STUDENT

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 Long Beach Lakewood Orthopedic Institute 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.

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

Signature of Financially Responsible Party: _____

Relationship to Patient: _____

Date: _____

LONG BEACH LAKEWOOD
ORTHOPEDIC INSTITUTE

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 _____

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 _____

LONG BEACH LAKEWOOD ORTHOPEDIC INSTITUTE

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT FORM

The Notice of Privacy Practices for Long Beach – Lakewood Orthopedic Institute 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 Long Beach – Lakewood Orthopedic Institute. 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 Long Beach – Lakewood Orthopedic Institute 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

Patient Signature/Patient Representative Signature

Date Signed

LONG BEACH LAKEWOOD ORTHOPEDIC INSTITUTE

PATIENT FINANCIAL AGREEMENT

Our goal at Long Beach Lakewood Orthopedic Institute is to provide our patients with the best medical care available. A clear understanding of our financial policy is essential in having a successful doctor/patient relationship.

Payments For Services
Please be advised that copayments are due in full at the time of service. Our office staff is happy to assist you, however, it is your responsibility to be aware of your health insurance benefits and how to obtain them. Our office will verify insurance eligibility, however, we cannot be held responsible for information received when verifying insurance benefits, since it is not a guarantee of payment or eligibility. Ultimately you as the patient are responsible for the payment of your bills, not your insurance company. If your insurance company fails to pay your claim(s) for whatever reason, you are responsible for the charges incurred.

HMO patients are required to have all services and office visits pre-authorized prior to scheduling appointments. Please notify us of any changes in your insurance coverage so that we can make our best efforts at attempting to obtain accurate prior authorization for your visit as needed.

Long Beach Lakewood Orthopedic Institute's professional fees will be billed to your insurance company on your behalf as a courtesy to you. 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 90 days, the entire balance becomes immediately due and will revert to patient responsibility.

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, you are as such assuming responsibility for the payment of these services whether the insurance company pays or not.
If you do not have insurance, you will be expected to pay for all services at the time that they are rendered.

Payment Methods
Our practice accepts cash, checks, Mastercard, VISA, and Discover for your convenience. All returned checks will be charged a $25 fee or the actual bank charge if it exceeds $25.

Surgical Procedures
We will attempt to obtain prior authorization on all surgeries and procedures with your insurance company prior to your surgery date. Please be aware that in addition to the physician and hospital charges, there will likely be additional charges and bills from anesthesiologists, assistant surgeons, laboratory/radiology, and internal medicine physicians. Please note, we are not associated with any of these entities and have no control over their fees or contracts. We are unable to provide information as to their in or out of network status with your insurance.

Release of Information
Long Beach Lakewood Orthopedic Institute may disclose all of any part of your medical records and/or financial ledger to any person or corporation that:
- May be liable under contract to us for reimbursement for services rendered
- Any health care provider for the purpose of continued patient care.

Medical Consent
I consent to evaluation and treatment at Long Beach Lakewood Orthopedic Institute as instructed by the treating physician. I reserve the right to refuse specific services at any time.
My signature below indicates that I have read, understand, and agree to the above statements.

Patient/Legal Representative	Relationship to Patient
Print Patient Name	Date

LONG BEACH LAKEWOOD ORTHOPEDIC INSTITUTE

CLINICAL PATIENT INFORMATION AND MEDICAL HISTORY

(Please type or print legibly)

Name: _____ Date: _____

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

Wt _____ Ht _____ Hand dominance: ☐ Right ☐ Left

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 ☐ Medications ☐ Injections ☐ Physical Therapy ☐ Surgery ☐ Other

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. _____
4. _____
5. _____

LONG BEACH LAKEWOOD ORTHOPEDIC INSTITUTE

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	☐ Arthritis	☐ Depression
	☐ Asthma	☐ Diabetes	☐ Blood Clots/DVT	☐ Heart Disease
	☐ Cancer	☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
	☐ HIV/AIDS	☐ Liver Disease	☐ Osteoporosis	☐ Prostate
	☐ Stomach Ulcers/Reflux	☐ Seizures	☐ Thyroid Disease	☐ Vascular Disease

☐ Other (please list) _____

Do you smoke: ☐ No ☐ Yes 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 all that apply)

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 _____

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24 HOUR CANCELLATIONS AND NO SHOW POLICY

Our office require a full 24-hour notice in the event of a cancellation.

You may call and leave a message after hours on our exchange at (562) 633 – 3787.

There is a $50.00 charge for a cancellation or no show without 24-hour notice. This charge is **not covered by your insurance.**

If you fail to show or notify our office you will be sent a bill for $50.00. You may pay by calling in over the phone when you receive a bill or you will have to pay before you will be allowed to make another appointment. You may not be able to be treated until the fee is paid.

I have read and understand the "24 Hour Cancellations and No Show Policy" and have signed this document with the knowledge that if the policy is violated then I am responsible for the $50.00 fee.

_____

Printed Patient Name

_____

Signature

_____

Date