Webster Orthopedics

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PATIENT REGISTRATION FORM

Full Legal Name_____ ____ _____ **Date of birth** ____/____/____
FIRST M.I. LAST MM DD YYYY

Social Security #_____ /_____/_____ ☐*Male* ☐*Female* **Marital Status:** ☐*Single* ☐*Married* ☐*Other*

Primary Care Physician _____**Referring Physician**_____

Race _____ **Ethnicity** _____ **Language**_____

Contact By: ☐*Phone* ☐*Email* ☐*Other* _____

Mailing Address (PO Box/Street) _____

Apt/Ste # _____ **City** _____**State**_____ **Zip/Postal Code**_____

Country _____ **Home Phone** (____)_____ **Cell Phone** (____)_____

Work Phone (____)_____ **FAX** (____)_____ **Email address**_____

**Given email addresses may be used by Webster Orthopedics and relevant medical affiliations.*

Employment Status: ☐Full-time ☐Part-time ☐Seasonal ☐ Retired ☐Unemployed ☐Student Self

Employer's Business Name_____Occupation_____

How did you hear about us? ☐ Employer ☐Social Media ☐Search Engine ☐Insurance ☐ Patient ☐Physician ☐Webster Website ☐ Yelp ☐ HealthGrades ☐ Magazine

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RESPONSIBLE PARTY INFORMATION: *Complete if patient is 17 or younger. Any legal guardian/parent presenting a minor patient for medical services is considered financially responsible for services rendered. Any minor patient accompanied by an adult other than their legal guardian/parent must present written and notarized authorization for medical treatment from the legal guardian/parent prior to services being rendered.*

Name _____ Rel. to Pt_____

Mailing Address (if different from above)_____

City _____ State _____ Zip/Postal Code _____ Phone #_____

Social Security # _____/_____/_____ **Date of birth** ____/____/____ Employer_____

Emergency Contact *(if different than responsible party listed in above section)*

Name _____ Rel. to Pt_____

Telephone Number (____)_____ City _____ State_____

HOW WILL SERVICES BE PAID?

Private Pay *(No Ins.)*☐ **Medical Ins.**☐ **Work Comp.**☐

******All patients are expected to pay in full at time of service. This does include deductibles and co-pays, unless other arrangements have been made directly with the business office (925)362-2104.All questions regarding insurance should be directed to the business office prior to services. Email addresses may be used exclusively by Webster Orthopedics and relevant medical affiliations.******

(V042017)

*Patient Name*_____*DOB*____/____/____*Date*_____

Your insurance card may have been scanned, however, in order to process your claim correctly, we need to have complete and accurate information. Please complete the section(s) below.

1-PRIMARY INSURANCE

Insurance Company Name_____

Claims Addr._____City_____

State _____ Zip/Postal Code_____ Country _____ Ph (____) _____

Insurance ID# _____ Policy/Group #_____

(IF OTHER THAN) SUBSCRIBER / POLICY HOLDER INFORMATION for PRIMARY Insurance

Name _____ Rel. to Pt_____

Date of Birth _____/_____/_____ Social Security # _____/_____/_____ Phone (____)_____

Address _____ City _____ State_____ Zip/Postal_____

Country _____ Employer *(if issued through employment)* _____

2-SECONDARY INSURANCE

Insurance Company Name_____

State _____ Zip/Postal Code_____ Country _____ Ph (____) _____

Insurance ID# _____ Policy/Group #_____

(IF OTHER THAN) SUBSCRIBER / POLICY HOLDER INFORMATION for SECONDARY Insurance

Name _____ Rel. to Pt_____

Date of Birth _____/_____/_____ Social Security # _____/_____/_____ Phone (____)_____

Address _____ City _____ State_____ Zip/Postal_____

Country _____ Employer *(if issued through employment)* _____

Work Related Injuries

Date of Injury_____ Claim Number_____

Worker's Compensation Carrier:_____ Adjuster's Name_____

Address_____City_____State_____Zip Code_____

Employer at time of injury_____Supervisor'sName_____Phone_____

Do you have an attorney? yes ☐ no ☐ If so who?_____

Patient/Guardian Signature:_____ Printed Name:_____Date:_____

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PATIENT HEALTH QUESTIONNAIRE

Name_____ **DOB**:_____ **Age**_____ **Todays Date**_____

Primary Care Doctor_____ **Referring Doctor**_____ **Height**_____ **Weight**_____

Drug Allergies: (Please indicate by checking the boxes below.)

☐ NO KNOWN DRUG ALLERGIES

☐ Novocain etc. ☐ Penicillin ☐ Keflex ☐ Erythromycin ☐ Other antibiotic: _____

☐ Sulfa drugs ☐ Aspirin ☐ Codeine ☐ Morphine ☐ Percocet ☐ Oxycontin ☐ Other painkillers _____

☐ Latex ☐ Eggs/Yolk ☐ Sulfites ☐ Tetracycline ☐ Iodine/shellfish ☐ Ibuprofen etc

Please specify any others: _____

Please specify type of reaction: _____

Medicines: (Please list any medications or supplements that you take **REGULARLY**, with dose/frequency.) (Print Clearly)

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Social History:

Occupation_____Employer_____

Marital Status _____

Lives with (check all that apply):

☐ Spouse ☐ Children ☐ Parents ☐ Mother ☐ Father ☐ Grandparents ☐ Foster Care ☐ Roommates

Social Habits: **(It is now required that we ask the below information)**

Tobacco - Do you smoke or use tobacco products?_____ Check all that apply: ☐ Cigarettes ☐ Cigars ☐Chewing ☐Tobacco

How much?_____/day. Number of Years using _____ If you quit, when?_____

Recreational Drugs-Do you use recreational/illicit drugs?_____ Which drugs? _____

Exercise-Do you exercise on a regular basis? ☐Yes ☐No Type of Exercise: _____

Times per week: _____

Review of Systems: Have you experienced any of the following in the last few weeks of months?

Please check the complaint and detail below. If you have no comp;aints in the category, please check: ☐ **NONE**

General:
- ☐ Fever
- ☐ Chill
- ☐ Sweats
- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Weight Loss
- ☐ Weight Gain

Cardiovascular:
- ☐ Chest Pains
- ☐ Fainting
- ☐ Leg Swelling
- ☐ Shortness of Breath
- ☐ Murmur

Respiratory:
- ☐ Cough
- ☐ Cold
- ☐ Wheezing
- ☐ Painful Breathing
- ☐ Tuberculosis

Eyes/Ears/Nose/Throat
- ☐ Glasses
- ☐ Contacts
- ☐ Double Vision
- ☐ Impaired Hearing
- ☐ Runny Nose
- ☐ Nosebleeds
- ☐ Sneezing
- ☐ Dentures
- ☐ Dizziness

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Loose Stools
- ☐ Blood in Stools
- ☐ Abdominal Pain

Skin:
- ☐ Open Sores
- ☐ Boils
- ☐ Wound Breakdown
- ☐ Tender Spot
- ☐ Rash

Neurological:
- ☐ Weakness
- ☐ Numbness
- ☐ Paralysis
- ☐ Loss of Consciousness
- ☐ Headache
- ☐ Tremor
- ☐ Slurred Speech

Genitourinary:
- ☐ Urine Incontinence
- ☐ Urinary Frequency
- ☐ Blood in Urine

Endocrine:
- ☐ Fatigue
- ☐ Hyperactivity
- ☐ Excessive Thirst

Heme/Lymphatic:
- ☐ Bruising
- ☐ Bleeding
- ☐ Lymph Node Swelling

Allergic/Immunologic:
- ☐ Hives
- ☐ Persistent Infections
- ☐ HIV Exposure
- ☐ Past Blood Transfusion

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ Mood Swings

Musculoskeletal:
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Stiffness

Other: _____

_____

Pregnancy- Estimated Due Date: _____

Past Medical History:
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Esophageal
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatal Hernia
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Pneumonia

Family Medical History:
- ☐ Patient denies any significant Family History
- ☐ Anesthesia/ Surgical Complications
- ☐ Asthma/Breathing Problems
- ☐ Bleeding Disorder
- ☐ Blood Clots/Phlebitis
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Connective Tissue Disorder
- ☐ COPD Chronic Obstruction Pulmonary Disease
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Disease/Heart Attack/Chest Pains
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Strokes/ Transient Ischemic Attacks (TIA)
- ☐ Thyroid Disease

Have you or a family member ever been diagnosed with a blood clot in a leg or lung? **□ YES □ NO**

If "YES", who had the clot? _____

Are you under the care of a Cardiologist?: **□ YES □ NO**

Name: _____

Contact Info: _____

Have you ever had problems with Anesthesia in the past? **□ YES □ NO**

If YES, please explain: _____

_____

Previous Hospitalizations? _____

_____

_____

_____

_____

Please list Surgeries/Complications/Diagnoses along with the DATE

Surgery	**Year**	**Complications**
1.		
2.		
3.		
4.		

Have you had an Influenza shot this year? **□ YES □ NO**

If Over 65 Years Old:

Do you have any Advanced Care Directives? **□ YES □ NO**

If yes, please give the name of your Power of Attorney or Surrogate Agent_____

Fall Risk Assessment:

Ambulation: **□ Normal □ Unsteady □ Needs assistance (cane, crutches, etc.) □ Unable to walk**

Have you fallen in last 12 months? **□ YES □ NO**

If so how many times? _____ **Did it result in an injury?** **□ YES □ NO**

For future office visits: Have there been any changes to your personal information, allergies, medication or surgical history?

NO YES (explain) _____ **Date:** _____ **Initial:** _____

Patient Signature: _____ **Date:** _____

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Patient Name:_____

Date:_____

HISTORY OF PROBLEM

Please explain briefly why you are seeing the doctor: ☐Left ☐Right_____

_____

First Symptom or Date of Injury:_____

How did the injury occur and when?_____

Was an automobile involved:

☐ YES ☐ NO Date of accident:_____

Name of Attorney:_____ Phone:_____

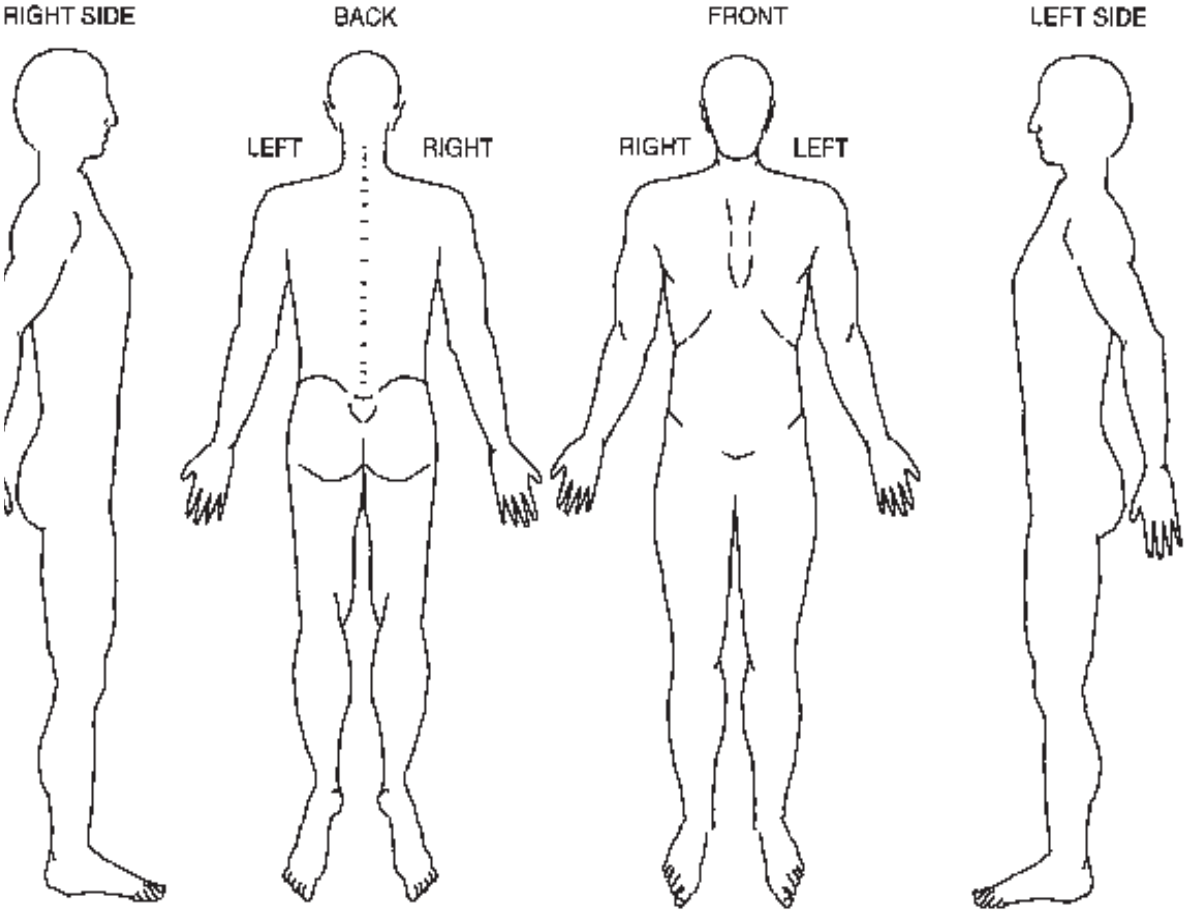
Was this Injury at work?

☐ YES ☐ NO

☐ (Check Here) If this is a Workers Comp injury

☐ (Check Here) If you are filing under private insurance

PLEASE MARK WITH AN X WHERE YOU ARE EXPERIENCING PAIN



Please "X" pain description:

- ☐ Aching
- ☐ Burning
- ☐ Dull
- ☐ Heaviness
- ☐ Joint Locking
- ☐ Loss of Motion
- ☐ Numbness
- ☐ Radiating
- ☐ Sharp
- ☐ Stinging
- ☐ Swelling
- ☐ Tingling
- ☐ Weakness

Pain Level: (circle) 0 1 2 3 4 5 6 7 8 9 10

none worst

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Webster Patient Notifications

Workers Compensation Medication Notification:

Please note you have a choice between obtaining the prescriptions from our office or have us provide you with a prescription to be filled at a pharmacy of your choice. _____Patient Initials

Physician Assistant Consumer Notification:

Physician Assistants are licensed and regulated by the Physician Assistant Committee
(916) 561-8780 www.pac.ca.gov _____Patient Initials

Notice Regarding Disclosure of Physician Ownership Interests:

The following physicians: *Joseph R. Donnelly, MD; Kendrick E. Lee, MD; Thomas W. Peatman, MD; Joshua C. Richards, MD; Kevin M. Roth MD; Aaron K. Salyapongse, MD; J. Theodore Schwartz Jr., MD; Eric S. Stuffmann, MD; Michael D. Tseng, MD; Stephen R. Viess, MD* hold ownership interest in the following and may refer you to one or more of these services in connection with your care and treatment:

* 80 Grand, LLC
*Castro Valley Open MRI
*East Bay Ortho Co Management
*East Bay Special Surgery
*Fremont Surgery Center
*Hand Therapy Clinics
*High Field MRI in Dublin/Pleasanton
*Open MRI of San Ramon
*Pleasanton Surgery Center
*Redwood Surgery Center
*San Ramon Surgery Center
*Sports Physical Therapy in San Ramon
*The Surgery Center of Alta Bates
*Thorn, Lau, Chin, LLC
*Webster Wellness Center in Berkeley
*Webster DME distribution
*Webster Surgery Center
(Castro Valley, Oakland & Pleasanton)

Please note that you have the right to obtain MRI services, medical devices or physical therapy 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.

The following is a nonexclusive list of five other MRI providers located within the general area of Dublin and San Ramon and Oakland.

- Alliance Imaging, 6001 Norris Canyon Road, San Ramon CA 94583 (925)-275-0634
- Golden View Imaging, 1393 Santa Rita Rd, Pleasanton CA 94566 (925)-846-5888
- Pleasanton Imaging, 5860 Ownes Dr., #150, Pleasanton, CA 94588 (925)-467-1400
- Alta Bates Summit Medical Center-MRI Center, 5730 Telegraph Ave., Oakland, CA 94609 (510) 654-5855
- NorCal Imaging, 3200 Telegraph Ave, Oakland, CA 94609 (510) 663-1950

Date: _____

Patient Name(print): _____

Patient Signature: _____

Signature of Parent or Guardian: _____

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Webster Financial Policy

Payment Options:

CASH: Please note: New Patient Deposit of $311.00 and Established Patient Deposit of $150.00 will be required prior to being seen by the provider. At the end of your visit, the total cost of your services will be calculated to determine if additional money is due from you or if you will receive a refund. Your service will be totaled out and we will either collect the remaining balance or refund you the credit.

COPAYMENT: As required by your insurance company, copayment is required at the time of service. If you are unable to pay your copay at the time of service, your visit may be rescheduled. If your visit is accommodated, there will be a $5 service fee for all processed co-payments.

COINSURANCE: If your insurance assigned a coinsurance percent instead of a copay amount (listed on your card i.e. 20%), we will collect that estimated percentage. We collect $10 for every 10% coinsurance, $20 for every 20% coinsurance etc. Since this is only an estimate, you may owe more once your insurance carrier processes your claims.

CREDIT CARDS: Visa, MasterCard and American Express are accepted.

CHECKS: Checks are accepted but please note that a return check fee of $35 will be charged on all returned checks. Cash or credit card will be required for future payments.

SURGERY: In the event you are scheduled for surgery, we will verify your insurance benefits and notify you of your estimated co-insurance and/or deductible amounts. These amounts will be collected prior to your surgery date and will be applied to the surgery balance and/or any outstanding balances. Please note that you will receive separate bills from providers outside of Webster Orthopedics such as for anesthesiology, surgery center facility fees and durable medical equipment items.

Insurance Billing Policies:

We bill your insurance as a courtesy to you. In order to do so, we require your current insurance information and a copy of your insurance card. **We also require your social security number for our records.** Your financial records and your health care records are kept confidential and secure. **If you choose to not give your social security number, you will be required to pay the cash pay deposit amount of $311.00 in order for us to file your insurance claim**. Once your insurance pays we will issue any applicable refund or bill any remaining balance.

It is your responsibility to make sure the insurance we have on file is the most current. ***Any claim that needs to be resubmitted due to a new insurance, incomplete or outdated information may incur a $25 administrative refiling fee.***

Medicare: We accept assignment with Medicare. One secondary insurance claim will be filed as a courtesy.

Non Contracted Plans: We submit one insurance claim as a courtesy. After 30-days the balance is patient responsibility.

Motor Vehicle Claims: We submit one insurance claim as a courtesy. After 30-days the balance is patient responsibility.

Third Party Claims: We DO NOT bill third party claims.

HMO/Medical Group Plans:

A referral is required from your Primary Care Physician prior to each appointment. If you do not have an authorization or referral, you may be required to reschedule or sign a waiver stating you will be responsible for any denied services.

Worker's Compensation: It is your responsibility to inform Webster Orthopedics that your care is for a work-related injury. If the claim is DENIED or closed you will be responsible for all charges.

Durable Medical Equipment:

During your visit, medical products may be recommended and/or dispensed to assist you with the healing process. A deposit may be required in order to dispense these products to you. After the insurance processes your claim, the deposit is applied and you become responsible for any unpaid residual balance. Please note, these charges may be reflected on your bill from Webster Orthopedics or you may receive a separate bill from Breg. (Our DME vendor)

Administrative Fees:

-There will be a **$25.00 no-show** charge assessed for any appointment that is not cancelled within a 24-hour period prior to the appointment date and time.
-Physical Therapy and MRI will charge **$50.00 no-show** for any appointment that is not cancelled within a 24-hour period prior to the appointment date and time.
-Form Completion Fee: $15.00
-Diagnostic Images: CD Fee $5.00; Analog Film $10.00 per sheet.
-Medical Records $15.00 (1-50 pages); 51+ pages = $15 + 0.25pp; plus CA sales tax & USPS postal rates (based on package weight). CD Fee: $5.00.

Delinquent Accounts: Any account that is unpaid for more than 60 days will be considered delinquent unless you have signed a payment agreement with Webster. Those accounts considered delinquent will be forwarded to an outside collection agency which will impact your credit rating.
If your account is past due and considered delinquent, we may be forced to suspend all but emergency care until payment is received. Please contact the billing office to discuss any issues you may be having at 925-314-8460.

My signature indicates that I have read, understand and agree to the Financial Policy of Webster Orthopedics.

Patient/Guardian Signature_____Date_____

Patient/Guardian Printed Name _____Patient's Date of Birth_____

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Patients Name_____

MEDICARE PATIENTS ONLY

LIFETIME BENEFICIARY AUTHORIZATION

I request payment of authorized Medicare benefits be made either to me or on my behalf to Webster Orthopedics for any service furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine these benefits payable to related service.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician 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. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

MRI Disclosure:

Certain diagnostic tests such as MRI include both a professional component (representing the physician's interpretation of the test) and a technical component (representing the test itself). Webster Orthopedics shall bill Medicare Part B directly for the technical component of diagnostic services while the Radiologist, California Advanced Imaging, bills Medicare for the professional component. You may receive additional correspondence from California Advanced Imaging in the form of an explaination of benefits (EOB) or other document.

Authorization to Obtain Medication History

By signing below, I hereby authorize Webster Orthopedics to obtain Medication History related to the patient above, from Community Pharmacies and /or Pharmacy Benefit Managers for the purpose of Continued Treatment.

Date:_____

Patient/Legal Representative or Parent/Legal Guardian Print Name_____

Patient/Legal Representative or Parent/Legal Guardian Signature_____

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

PATIENT NAME _____BIRTHDATE:_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
  - Including said healthcare professional obtaining medical history from the patients' pharmacy, health plans, and other healthcare providers.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

Please refer to "Notice of Privacy Practices" Brochure, refer to the "Request Restrictions" section. This brochure is available in the office or online at www.websterorthopedics.com/privacy-policy.

Please answer the following 3 questions:

I request the following restrictions to the use or disclosure of my health information:

#1 Medical Information can be discussed with

- ☐ Patient only
- ☐ Family member or friend
  Please List Name/Relationship

  _____
  _____
  _____
  _____
  _____
- ☐ Physician _____
- ☐ Other _____
- ☐ No Restrictions
- ☐ Other Restrictions_____

#2 Detailed messages regarding test results can be left on answering machine

- ☐ Yes Phone Number _____
- ☐ No

#3 Webster Orthopedics utilizes an automated appointment reminder system. Please choose how you would like to receive the reminder.

- ☐ Automated voice message
- ☐ Text
- ☐ None of the above

PATIENT:

_____ _____ _____

Signature of Patient or Legal Representative Date Witness Signature

Relationship to Patient _____