Monterey Joint Replacement & Sports Medicine

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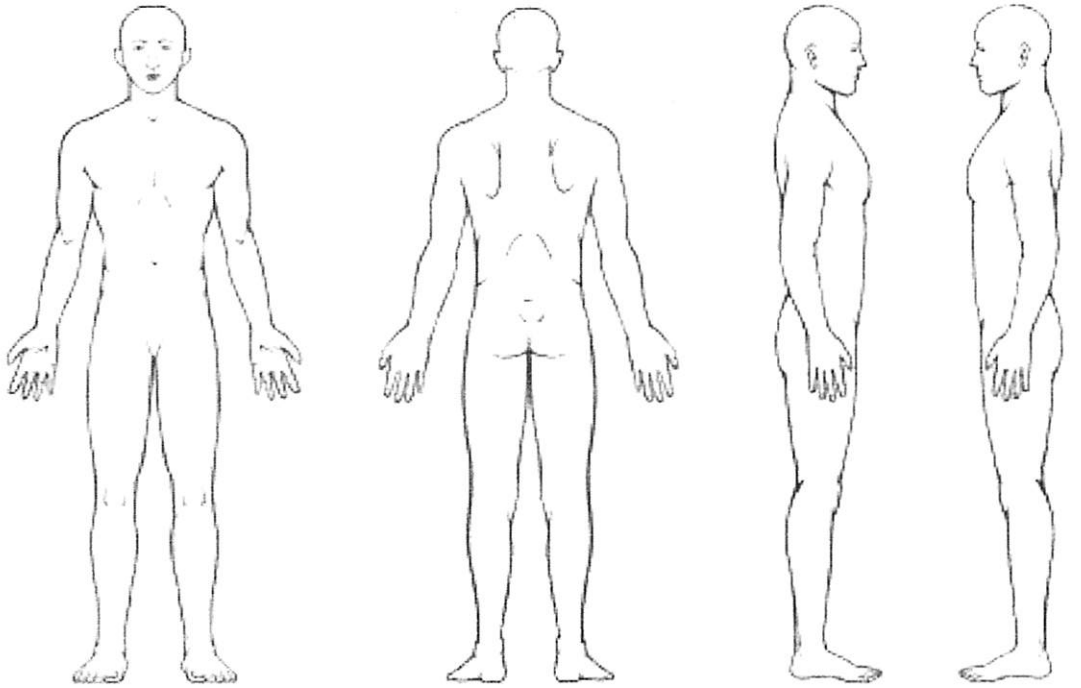
Patient Name: _____ Date: _____

Please indicate where there is any pain, numbness, weakness and/or swelling.



LEVEL OF PAIN **No Pain 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 Intense Pain**

If possible please give a brief description of patients symptoms and/or complaints.

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Patient

Last Name _____ First Name_____ M.I. _____

Male / Female Date of Birth _____/_____/_____ Age _____ Social Security # _____-_____-_____

Address _____City_____ State _____ Zip_____

Home Phone (_____) _____ Cell (_____) _____ Work/Office (_____) _____

Email Address _____

Emergency Contact (_____) _____ Name_____

Employers Name_____ Phone (_____) _____

Primary Doctor

Name _____ Phone (_____) _____ Fax (____) _____

Address _____ City_____ State _____ Zip_____

Referring Doctor if Different From Primary

Name _____ Phone (_____) _____ Fax (____) _____

Address _____ City _____ State_____ Zip _____

Insurance

Primary Insurance _____ Policy #_____ Group # _____

Address _____ City _____ State _____ Zip _____

Phone Number (_____) _____

Guarantor (responsible policy holder)

Last Name _____ First Name _____ M.I. _____

Address _____ City _____ State _____ Zip_____

Home Phone (_____) _____ Cell (_____) _____ Work/Office (_____) _____

Male / Female Age _____ Date of Birth _____/_____/_____ Social Security # _____-_____-_____

Employers Name _____ Phone (_____) _____

Secondary Insurance _____ Policy # _____ Group # _____

Address _____ City _____ State _____ Zip _____

Phone Number (_____) _____

Guarantor (responsible policy holder)

Last Name _____ First Name _____ M.I. _____

Address _____ City _____ State _____ Zip_____

Home Phone (_____) _____ Cell (_____) _____ Work/Office (_____) _____

Male / Female Age _____ Date of Birth_____/_____/_____ Social Security # _____-_____-_____

Employers Name _____ Phone (_____) _____

Medical History

Height _____ **Weight** _____

What are your chief complaints/injuries? _____

_____

Have you had any previous X-Rays/ MRI for your current problem? YES NO

If yes, where? _____

Have you had any previous surgeries or hospital admissions? YES NO

If yes, Explain _____

Are you allergic to Latex? YES NO

Are you allergic to or have you had any reaction to any medications? YES NO

If yes, list the substance you are allergic to or had a reaction to. _____

Are you currently taking any medications? **YES** NO **If yes, please list:**

Medication	Dosage	Medication	Dosage

Do you have any difficulty/ problems with any of the following? (Please circle all that apply)

Head Eyes Ears Nose Throat Lungs Asthma Ulcers Thyroid Bowels Kidneys Heart Diabetes Gallbladder High Blood Pressure Cancer Bruising or Bleeding Problem Blood Clots Severe Snoring

Other: _____

If you circled any of the above please explain _____

_____

Are you Claustrophobic? YES NO

Do you use Tobacco? YES NO Do you drink alcohol? YES* NO *Frequency? _____

Patient Signature _____ Date_____

CONSENT FOR TREATMENT IF PATIENT IS A MINOR

I grant Monterey Joint Replacement and Sports Medicine the authority to administer treatment And perform such procedures as many are deemed necessary for the above patient.

Print Name _____ Relationship to Patient _____

Signature _____Date_____

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I herby acknowledge that I have received a copy of this office privacy practices. I further acknowledge that a copy of the current notice will be posted in the reception area. I will be offered a copy of any amendment to this notice of privacy practices.

Signature _____ Date_____

MEDICAL INFORMATION RELEASE FORM
(HIPAA Release Form)

Name _____ Date of Birth. _____/_____/_____

Medical information may be released to:

[ ] Spouse _____

[ ] Child_____

[ ] Other _____

[ ] **Information is not to be released.**

This ***Release of Information*** will remain in effect until terminated by me in **writing.**

MESSAGES

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] _____

Signature _____ Date _____

Witness _____ Date _____

Monterey Joint Replacement and Sports Medicine

FINANCIAL POLICY

Payments:

Full payment and/or co-payments are due at the time services are rendered. We accept cash, checks and credit cards.

Payment for Procedures or Surgery

If you are scheduled to have a procedure we can provide you with a best estimate of charges, however until the procedure is performed, it is not possible to quote the exact amount. Our office will call your insurance company to obtain authorization, if required, and an estimate of the portion that is your responsibility. ***Pre-authorization is not a guarantee of payment.*** Any estimated out of pocket expenses are due prior to your procedure.

Insurance:

As a courtesy to our patients, we will bill your primary and secondary insurance carriers. We do not guarantee that your insurance will cover our services. It is your responsibility to keep our office updated with your most current insurance information and to verify that you have coverage for services provided by our office. We are contracted providers for most insurance carriers. We recommend that you verify this information prior to being seen in our office.

An itemized statement will be sent to you after your insurance company has processed your claim for services. If your insurance company has not processed your claim within 45 days, we reserve the right to bill you for the full balance.

My options if I don't have insurance:

Full payment is due at the time of services. If you do not have insurance and cannot pay your balance in full, our office manager will discuss payment options will you.

Return Checks Policy/ Non-payment of services:

Checks returned to our office for insufficient funds are subject to a $25.00 service charge. Every effort will be made to work with our patients on reasonable payment plan; however, we reserve the right to send an account with a balance over 90 days old to an outside collection agency. If it becomes necessary to send account to collection, the patient may be discharged from the practice.

I have read and understand the terms of this financial policy. I agree to comply with the terms set forth in this policy for services rendered by Monterey Joint Replacement and Sports Medicine.

Patient Name _____

Patient Signature _____ Date_____

Universal Injury or Accident Statement

Last Name _____ First Name _____ M.I. _____

Is the condition for which you are receiving treatment due to an accident or injury?

_____ No

_____ Yes (continue with this section)

Date of Injury _____/_____/_____

Give a brief description and location of the accident:

_____

_____

_____

A. Is the condition for which you are receiving treatment due to a motor vehicle accident?

_____ No (proceed to part B)

_____ Yes

B. Is the condition for which you are receiving treatment due to a work related injury?

_____ No

_____ Yes (continue with this section)

Name of Employer _____ Phone Number (_____) _____

Human Resources Contact _____ Phone Number (_____) _____

Workers Compensation Insurance _____ Claim Number _____

Adjuster Name_____ Phone Number (_____) _____

Claim Address_____ City_____ State _____ Zip _____

Is there a possible third party liability settlement? No Yes

If **YES**, complete the following section:

Name of Insurance: _____ Phone Number: _____

Adjuster's Name: _____ Phone Number: _____

I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury and the nature of the treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non- covered" service and may make me personally liable for the medical charges incurred.

Signature_____ Date _____