T|O|S|C
THE ORTHOPEDIC SPECIALTY CENTER
OF NORTHERN CALIFORNIA

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Roseville CA 95678
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www.toscnorcal.com

PRIMARY CARE PROVIDER: _____ REFERRING PROVIDER: _____
VISIT WITH WHICH PROVIDER: ❑ DR. JAMIESON ❑ DR. McCLINTOCK

PATIENT INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ /_____ /_____ GENDER: ❑ MALE ❑ FEMALE SSN: XXX-XX- _____

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

(Please check the box to indicate your preferred means of communication)

❑ HOME PHONE: _____ ❑ WORK PHONE: _____

❑ CELL PHONE: _____ ❑ EMAIL: _____

EMPLOYER: _____ MARITAL STATUS: _____

RACE: ❑ AMERICAN INDIAN/ALASKA NATIVE ❑ BLACK/AFRICAN AMERICAN ❑ WHITE/CAUCASIAN ❑ ASIAN
❑ HAWAIIAN/PACIFIC ISLANDER ❑ OTHER ❑ UNKNOWN ❑ DECLINED

LANGUAGE: _____ ❑ INTERPRETER NEEDED: _____

SPOUSE'S NAME: _____ SPOUSE'S DATE OF BIRTH: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ OTHER PHONE: _____

HOW DID YOU FIND US? _____

PREFERRED PHARMACY: _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ DOB: _____ EFFECTIVE DATE: _____

INSURANCE ID#: _____ GROUP #: _____ PLAN #: _____

SECONDARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ DOB: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

OTHER INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ DOB: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

PROOF OF INSURANCE / ASSIGNMENT & RELEASE OF BENEFITS

Patients are required to show both proof of insurance and a Government issued photo ID at their initial and subsequent visits. The patient (or parent/legal guardian) is responsible for informing our office of any changes in your insurance coverage since your last visit. Please assure that notification is made no later than 24 hours prior to your appointment to avoid having to reschedule.

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **The Orthopedic Specialty Center of Northern California.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

SIGNED: _____ DATE: _____

_____FINANCIAL RESPONSIBILITY AGREEMENT:

Initials

I agree to assign insurance benefits to The Orthopedic Specialty Center of Northern California. We bill all insurance companies that we are contracted with as "network" providers as a courtesy to our patients. I acknowledge full financial responsibility for services rendered by The Orthopedic Specialty Center of Northern California and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co-Insurance, Pre-existing Clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility. I further authorize all insurance payments to be made directly to The Orthopedic Specialty Center of Northern California. Payment is expected at the time of service. We will file your insurance as a courtesy to you. If your deductible has not been met and/or you are responsible for a co-payment under your plan, we will expect the payment of such upon delivery of services and immediately upon the end of your visit. There will be a $30 fee for returned checks.

_____DURABLE MEDICAL EQUIPMENT (DME):

Initials

We will collect a deposit that will be applied to your co-insurance. We will bill your insurance for your DME product. Based on your insurance coverage, your DME could be applied towards your deductible or not be a covered benefit. We will bill you based on the determination of your benefit coverage plan.

_____PATIENT PRIVACY PRACTICES:

Initials

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent, or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our Notice of Privacy Practices policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

_____CONSENT TO TREATMENT AND RECORD RELEASE AUTHORIZATION:

Initials

I authorize The Orthopedic Specialty Center of Northern California to evaluate and treat me or my family member for any orthopedic illness or injury for which I seek medical care. I have read and understand the above clinic policies and I further acknowledge that I accept the terms outlined in each of the above policies. I hereby authorize The Orthopedic Specialty Center of Northern California to release to my referring physician, insurance company, or legal guardian, any information, including diagnosis and records of treatment, concerning my medical history and orthopedic care.

_____TELEPHONE CONSUMER PROTECTION ACT (TCPA):

Initials

I agree that the facility, The Orthopedic Specialty Center of Northern California or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

_____DISABILITY PAPERWORK/MISSED APPOINTMENT POLICY/RADIOLOGY AND LAB FEES:

Initials

Please give all forms regarding disability to the office staff. Please do not give these forms to the physician. Please note that there is a $25 completion fee per form. You will need to expect 3 business days for these forms to be completed. Fill out the portion of the disability form that is for the patient and leave physician's area blank.

We must be notified at least 24 hours in advance of an appointment cancellation/need to reschedule. A $45 fee may be charged for a no show or late cancellation of appointments. Payment of this fee is the responsibility of the patient and is not covered by insurance.

You may incur additional charges from providers outside your network for procedures done outside of our facility that may be part of your surgical procedure or radiological exam. This can include pathology, radiology and/or lab fees.

_____DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE:

Initials

I agree that the practice may disclose my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, The Orthopedic Specialty Center of Northern California will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ Phone #: _____

Print Name: _____ Phone #: _____

Print Name: _____ Phone #: _____

ACKNOWLEDGMENT:

- I acknowledge that I have received access to the "Notice of Privacy Practices" for The Orthopedic Specialty Center of Northern California. I have read and understand the "HIPAA & Release of Medical Information Policy".
- I hereby authorize The Orthopedic Specialty Center of Northern California to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to the physician for any and all charges incurred by myself and/or dependents.
- I have read and understand the "Physician's Consent" and the "Disclosure of Financial Interest".
- I further acknowledge and understand that I accept the terms outlined in each of the policies.
- I understand that no warranty or guarantee has been made to me relative to result in care or medical outcome.

X _____ _____

Patient or Guardian Signature Date

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MEDICAL HISTORY

Do you have a history of:

Smoking	YES ❑	NO ❑			
Blood clots/excessive-bleeding	YES ❑	NO ❑	Arthritis	YES ❑	NO ❑
Diabetes	YES ❑	NO ❑	Hypertension	YES ❑	NO ❑
Adverse Reaction to Anesthesia	YES ❑	NO ❑	Cancer	YES ❑	NO ❑
Cardiac Disorders	YES ❑	NO ❑	Mental Health Disorders	YES ❑	NO ❑
Sleep Apnea	YES ❑	NO ❑	Do you use a CPAP?	YES ❑	NO ❑

Other diagnosis: _____

ALLERGIES

Are you allergic to any medications? YES ❑ NO ❑ Are you allergic to metal? (Nickel, Jewelry, Etc...) YES ❑ NO ❑

If yes, list the source and your reaction.

Allergies	
1.	3.
2.	4.

MEDICATION AND DOSAGE

If you brought a list, please attach.

Medication	Strength	# of pills per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

REVIEW OF SYSTEMS

Are you currently or have you had problems with:

Please describe all yes answers

Skin	YES ❑	NO ❑
Ears, Nose, Throat	YES ❑	NO ❑
Cardiac/High blood pressure	YES ❑	NO ❑
Lungs, (Asthma, Infection)	YES ❑	NO ❑
Stomach/Digestion	YES ❑	NO ❑
Bladder/Bowel problems	YES ❑	NO ❑
Hematologic/Bleeding problems	YES ❑	NO ❑
Diabetes	YES ❑	NO ❑
Cancer	YES ❑	NO ❑
Musculoskeletal	YES ❑	NO ❑
Neurological	YES ❑	NO ❑
Psychiatric problems	YES ❑	NO ❑
Reproductive/Sexual Problems	YES ❑	NO ❑
Fever/Chills	YES ❑	NO ❑
Night Sweat	YES ❑	NO ❑
Night Pain	YES ❑	NO ❑
Unexpected Weight Loss	YES ❑	NO ❑

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FAMILY HISTORY

Relationship	No known problems	Adverse reaction to anesthesia	Arthritis	Asthma	Autoimmune disorders	Blood Clots / Excessive Bleeding	Cardiac disorders	Cancer	COPD	Depression	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Hypothyroidism	Hyperthyroidism	Osteoporosis	Stroke
Mother																		
Father																		
Sister																		
Brother																		
Son																		
Daughter																		
MGM																		
MGF																		
PGM																		
PGF																		

Location of Pain _____

What makes it worse _____

What makes it better _____

Any prior non-operative treatment for this pain (PT, Injections, ETC) _____

If so, when _____

Have you had a previous surgery on this body part before _____

If yes, type of surgery _____

When _____

Surgeon _____

PAIN		WHAT HAVE YOU TRIED			
None		Physical Therapy		Chiropractic	
Mild / Occasional		Medications		Acupuncture	
Mild (Stairs only)		Exercise		Surgery	
Mild (Walking and Stairs)		Brace		Other	
Moderate - Occasional					
Moderate - Continual					
Severe					

FOR DR. JAMIESON'S PATIENTS ONLY

WALKING		WALKING AIDS USED		STAIRS	
Unlimited		None		Normal Up and down	
Six Blocks (30 minutes)		Cane/Walking stick for long walks		Normal Up down with rail	
Two or three blocks (10 - 15 minutes)		Cane/Walking stick most of the time		Up and down with rail	
Indoors only		One crutch		Up with rail, down unable	
Bed and chair only		Two Canes/Walking sticks		Unable	
		Two crutches or not able to walk			

Patient Signature: _____ **Date:** _____