Welcome Letter

Welcome! Thank you for choosing Pediatric Orthopaedic Specialists of Orange County. Your health care needs are our most important priority. Our goal is to be available and responsive to your needs. The following information is provided to introduce you to our practice and help you plan your office visit. Please let us know if you have any questions or would like additional information.

- Office hours are 8AM to 5PM Monday through Friday
- Please call (714) 633-2111 during regular office hours to schedule an appointment.
- Our office does not provide childcare supervision during appointments. No children under age 12 may be left unaccompanied in the waiting room.
- You will receive a call 48 hours prior to your appointment to confirm your appointment.
- If you are unable to keep an appointment, please call the office in advance. After hours, you may leave a message with our exchange service.
- Our specialty practice has a "No Show" fee of $25 is charged if you do not cancel 24 hours in advance, an exception will be made for an emergency. A 24 hour notice is needed so that we can offer your appointment time to another patient.
- If you are running late for an appointment, please call our office so we are aware and accommodate your arrival with our schedule.
- If you need to contact the physician after hours your call will be answered by our exchange service. The on-call physician will be notified and respond to your call.
- Please bring a photo ID to your visit as a part of our privacy/identity theft program.
- Pediatric Orthopaedic Specialists of Orange County maintains compliance with federal and state HIPPA privacy laws. If you would like health information released to yourself or another person you must sign a HIPPA release form identifying the individual to whom you want the information released.
- Co-pays are due at the time of the appointment and bills are payable within 30 days of receipt. We bill insurance on your behalf; however, the balance due is your responsibility.
- Once you are a registered patient you may communicate with Pediatric Orthopaedic Specialists of Orange County through the patient portal (does not currently provide communications by email or electronic transmission).
- Our office does not permit photography, video or audio recording in the office.
- Please be advised that we fit in patients with emergency conditions and at times find it hard to stay on schedule. Please know that we do respect your time, and we will make every effort to see you as close to your scheduled time as possible.

Thank you for choosing Pediatric Orthopaedic Specialists of Orange County. We look forward to providing you with the highest quality of services to support your health care needs. Wishing you the best of health.

Sincerely yours,

Pediatric Orthopaedic Specialists of Orange County

PEDIATRIC ORTHOPAEDIC
SPECIALISTS OF ORANGE COUNTY
POSOC

PEDIATRICIAN / PRIMARY CARE PHYSICIAN

REFERRED: ☐YES ☐NO

PEDIATRICIAN / PRIMARY CARE PHYSICIAN NAME: _____

ADDRESS: _____

PHONE: ( ) _____ FAX: ( ) _____

PATIENT REGISTRATION

FIRST NAME: _____ LAST NAME: _____ M.I. _____

DATE OF BIRTH: _____/_____/_____ GENDER: ☐MALE ☐FEMALE HEIGHT: _____ WEIGHT: _____

HOME ADDRESS: _____

PREFERRED PHARMACY NAME & ADDRESS: _____

PRIMARY CONTACT (PLEASE CHECK ONE):

☐FATHER ☐MOTHER ☐GUARDIAN

NAME: _____

ADDRESS: ☐SAME AS PATIENT

_____

☐HOME ☐CELL TEXT: ☐YES ☐NO

PHONE NUMBER: ( ) _____

EMAIL: _____

EMPLOYER: _____

LAST 4 DIGITS OF SSN: _____ DOB: _____

SECONDARYCONTACT (PLEASE CHECK ONE):

☐FATHER ☐MOTHER ☐GUARDIAN

NAME: _____

ADDRESS: ☐SAME AS PATIENT

_____

☐HOME ☐CELL TEXT: ☐YES ☐NO

PHONE NUMBER: ( ) _____

EMAIL: _____

EMPLOYER: _____

LAST 4 DIGITS OF SSN: _____ DOB: _____

** I AUTHORIZE THE PHYSICIANS AND STAFF OF ADULT AND PEDIATRIC ORTHOPEDIC SPECIALISTS TO LEAVE DETAILED MESSAGESAT THE PHONE NUMBER(S) LISTED ABOVE REGARDING MY CHILD'S HEALTH, APPOINTMENTS, TEST RESULTS, AND BILLING UNLESS OTHERWISE SPECIFIED HERE:

IF PARENTS ARE DIVORCED OR SEPARATED, WHAT ARE THE LEGAL CUSTODY ARRANGEMENTS FOR THIS CHILD?

☐PHYSICAL CUSTODY – NAME: _____ RELATIONSHIP TO PATIENT: _____

☐LEGAL CUSTODY: ☐JOINT ☐SOLE – NAME: _____

IF SOLE LEGAL CUSTODY, PLEASE PROVIDE LEGAL DOCUMENTATION TO BE SCANNED INTO PATIENT'S CHART

CAREGIVER AUTHORIZATION: The following relative(s) and/or caregiver(s) have permission to make medical decisions on behalf of my child including physical exams, x-rays, casting, in office procedures and/or any other medical care advised by the provider and staff at the time of treatment. This authorization will be effective until further written notice.

Name/Relationship to patient: _____ **Name/Relationship to patient:** _____

INSURANCE

PRIMARY INSURANCE

SUBSCRIBER: ☐FATHER ☐MOTHER ☐SELF

PLAN NAME: _____

ID #: _____

SECONDARY INSURANCE

SUBSCRIBER: ☐FATHER ☐MOTHER ☐SELF

PLAN NAME: _____

ID #: _____

I hereby attest that I am an eligible member of a contracted health plan as noted above. I agree, that should it be determined that I am ineligible or services are denied to me under the health plan noted above, that I will be responsible for payment to: **ADULT AND PEDIATRIC ORTHOPAEDIC SPECIALISTS**.

I DECLARE THE INFORMATION I PROVIDED ABOVE IS CORRECT AND IF THERE ARE ANY CHANGES I WILL NOTIFY THE OFFICE IMMEDIATELY.

NAME/SIGNATURE: _____ DATE: _____

PEDIATRIC ORTHOPAEDIC
SPECIALISTS OF ORANGE COUNTY
POSOC

Dr's Weinert, Rosenfeld, Dobyns, Aminian, Lalonde, Schlechter, McMichael, Davis, Majumdar, Kalra, Misaghi and Cao
1310 W. Stewart Dr. Suite 508, Orange, CA 92868 Tel: (714) 633-2111 Fax: (844) 387-7625 25982
Pala Dr. Suite 230, Mission Viejo, CA 92691 Tel: (949) 600-8800 Fax: (844) 374-4221
4980 Barranca Parkway, Suite 220, Irvine CA 92604

CHILD'S MEDICAL HISTORY

Patient's Name_____Today's Date_____
Sex ☐ F ☐ M Date of Birth_____Age___(Years)____(Months) Height____Weight_____
Pediatrician_____Fax#_____

PROBLEM (DURATION, CHIEF COMPLAINT, PRIOR TREATMENT)

DateofInjury/Onset ofSymptoms:_____/_____/_____
Please describe Injury and Symptoms:_____
_____
_____

MOTHER'S PREGNANCY HISTORY

Of Children in the Family_____Is this the 1st, 2nd, 3rd_____Child?
Of Pregnancies_____Full Term_____Premature_____
Birth Weight: Lbs._____OZ._____
Maternal Illness:_____
Operations during this pregnancy_____
Delivery: (Please Circle One) C-Section Breech Vertex Natural Neonatel Problems (breathing difficulties, deformities, etc)_____

CHILD'S DEVELOPMENT HISTORY

At what age did the child: Sit_____Stand_____Walk_____Talk_____
Illness (include unusual childhood)
Diseases_____
_____
Operations_____
Injuries_____
Allergies_____
Immunizations_____
Present Medications_____
Recent Illnesses_____
Family Illness (heredity)_____

Signature_____Date_____

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OUR PRIVACY PROMISE TO YOU, OUR PATIENTS

YOUR INFORMATION IS IMPORTANT AND CONFIDENTIAL. OUR POLICIES REQUIRE THATYOUR INFORMATION BEHELD IN COMPLETE CONFIDENCE.

Iunderstandthat,underthe Health Insurance Portability & Accountability Act of 1996("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

Obtain payment for services.
Conduct normal health care operations

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the usesand disclosure of my healthinformation. Iunderstand that thisorganization has the right to change its "Notice of Privacy Practices" from time to time and that Imay contact this organization at 714-633-2111 at any time to obtain a current copy of the "Notice of Privacy Practices" I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

PATIENT NAME: _____

PATIENT REPRENSENTATIVE: _____

SIGNATURE: _____

DATE: _____

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Consent for Electronic Mail ("Email") Use

APOS ("Office") offers patient the opportunity to communicate by Email for non-urgent matters. This form provides the guidelines regarding Email communications, and documents your consent.

IN CASE OF A MEDICAL EMERGENCY, DO NOT USE E-MAIL. CALL 911

EmailUse	Email communications should be between the office and an adult patient 18 years of age or older, or the parent or guardian of a minor.
Do Not Use EmailFor	Do not use Email for communicating sensitive medical information such as sexually transmitted diseases, HIV, hepatitis, substance abuse, mental health or presence of malignancy. Do not use Email to request records. Please call your office.
Privacy, Security & Confidentiality	Although the office has implemented reasonable technical safeguards, the office cannot and does not guarantee the privacy, security or confidentiality of any Email messages sent or received over the Internet. There is a potential that Email sent or received over the Internet can be intercepted, altered, forwarded, and / or read by others. The office is not responsible for Email messages that are lost due to technical failure during composition, transmission, or storage. The office will not forward Emails to independent third parties without your prior written consent, except as authorized or required by law. If any of this is a concern to you, you should not communicate with the office through Email.
Creatinga Message	In the "Subject" line of the email, please include general topic of your message (i.e., prescription, appointment, medical advice, billing question). Inthebodyof themessage, pleaseincludethepatient'snameanddateof birth. Thisinformationis necessary to verify your identity and make sure we pull the correct medical file.
Contentofthe Message	Email should only be used for non-sensitive and non-urgent issues. Email communications are appropriate for the following type of transactions: • Appointment scheduling • Prescriptions / refills • General medical advice after an initial face-to-face visit • Lab/Test Results • Referrals • Attachments such as: physical education excuse note, etc.
Response Time	Although APOS will endeavor to read and respond within 24 hours to any Email, we cannot guarantee that any particular Email will be responded to within any particular period of time. If you have not received a response within 3 days, please call our office.
Documentation InMedicalRecord	Email communications regarding treatment will be documented in your medical record by placing a copy of the message in your file.
Ending Email Relationship	You may discontinue using Email as a means of communication by sending an email or letter to the office.

Iacknowledgethat Ihaveread andfullyunderstandthisconsent formandthat I voluntarilyrequest theuseof Email asoneform of communication with theoffice.

Email Address: _____

_____ _____
Signature of Patient, Parent or Personal Representative Date

_____
Relationship (if other than patient)

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PATIENT CONSENT AND WAIVER FORM

I,_____, understand that I am, or will be, responsible for all of the charges associated with my appointment today, as well as any subsequent appointments relating to the testing, x-rays, diagnosis, and all treatment, including, but not limited to the following items:

1. **ALL DURABLE MEDICAL EQUIPMENT, IF NOT COVERED BY INSURANCE PLAN.**

2. **NO REFERRAL AT TIME OF VISIT:** If you wish to be seen today, but did not bring a referral with you, nor do you have a valid referral already here in the office, you will be responsible for all charges.

3. **NO INSURANCE:** You will be responsible for all charges associated with all visits.

4. **MISSED APPOINTMENTS:** Appointments are confirmed prior to your appointment date. If an appointment is cancelled up to 24 hours prior, you will not be charged. If you fail to show up for your confirmed appointment, you will be charged $25.00.

5. **CHANGES IN INSURANCE:** All co-pays and fees are due in full at the time of service.

6. **DELINQUENT ACCOUNTS:** In the event that your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing costs and processing fees.

7. **I authorize** my physician to access my medication history.

Patient or Responsible Party:

Signature_____Date_____