Dr's Weinert, Rosenfeld, Dobyns, Aminian, Lalonde, Schlechter, McMichael and Davis
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

PEDIATRICIAN/PHYSICIAN/PCP:_________________________________ Referred?___________________

Physician's Address: _________________________________ City_____________ State____ Zip________

Physician's Phone #: (_____)___________________ Fax #: (______)______________________________

NAME OF PATIENT: Last___________________ First_____________________ Middle________________

Home Address:____________________________________ City_____________ State____ Zip___________

Home Phone #: (____)__________________ Date of Birth: ___ /___ /___ Age: _____ Sex ☐ M ☐ F

FATHER'S NAME: Last_____________________ First__________________ M.I.___ SS#: ____-___-_____

Date of Birth: ___ / ___ / ___ E-Mail Address:____

Home Address: ___________________________________ City_____________ State____ Zip___________

Home Phone #: (___)__________ Work #: (___)__________ Cell #: (___)__________ Text: Yes☐ No☐

Employer: ____

Employer Address: ________________________________ City_____________ State____ Zip___________

MOTHER'S NAME: Last____________________ First__________________ M.I.___ SS#: ____-___-_____

Date of Birth: ___ / ___ / ___ E-Mail Address:____

Home Address: ___________________________________ City_____________ State____ Zip___________

Home Phone #: (___)__________ Work #: (___)__________ Cell #: (___)__________ Text: Yes☐ No☐

Employer: ____

Employer Address: ________________________________ City_____________ State____ Zip___________

INSURANCE INFORMATION

Insurance Name:__________________________________ I.D. #:________________ Group #: _________

Name of Subscriber: ______________________ Date of Birth: _____________ SS#: _____-____-_______

Relationship to Patient: ____

I hereby attest that I am 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 ORTHOPAEDICS SPECIALISTS**.
I authorize release of my medical history and documentation directly to my insurance company for the purpose of payment for medical services and that the payment(s) be made directly to: **ADULT AND PEDIATRIC ORTHOPAEDIC SPECIALISTS**.

Signature of parent, legal guardian or responsible party requesting care.

Signature____ Date__________________________

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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)

Date of Injury/Onset of Symptoms: _____/_____/_____

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 THAT YOUR INFORMATION BE HELD IN COMPLETE CONFIDENCE.

I understand that, under the 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 uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may 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: ____

PEDIATRIC ORTHOPAEDIC
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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

Email Use — 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 Email For — 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.

Creating a Message — In the "Subject" line of the email, please include general topic of your message (i.e., prescription, appointment, medical advice, billing question).
In the body of the message, please include the patient's name and date of birth. This information is necessary to verify your identity and make sure we pull the correct medical file.

Content of the 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 In Medical Record — 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.

I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of Email as one form of communication with the office.

Email Address:______________________________

______________________________ ____________________
Signature of Patient, Parent or Personal Representative — Date

____
Relationship (if other than patient)

PEDIATRIC ORTHOPAEDIC
SPECIALISTS OF ORANGE COUNTY
POSOC

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.

Patient or Responsible Party:

Signature____ Date____________________