PEDIATRIC ORTHOPAEDIC
SPECIALISTS OF ORANGE COUNTY
POSOC

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

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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)

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_____