

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

Orange. Irvine. Mission Viejo

www.posocortho.com



REGISTRATION

Physician/PCP _____ Referred by _____

Dr.'s Address _____

Dr.'s phone:() _____ Dr.'sfax:() _____

Name of patient: Last _____ First _____ Middle _____

Home address: Number _____ City _____ State _____ Zip _____

Home Phone:() _____ SS# _____ Cell _____

Date of birth _____ Age _____ Sex M F Driver's lic. _____

Employer _____ Occupation _____

Employer address: _____ City _____ State _____ Zip _____

Employer phone () _____

Insurance Name _____ I.D# _____

Policy Holder Name _____

Is this ins. Primary Yes No Is there other coverage? _____

Name of spouse: Last _____ First _____ Middle _____

Date of birth _____ Driver's lic. _____

Employer _____ Occupation _____

Employer address: _____ City _____ State _____ Zip _____

Employer phone () _____

Details of injury/illness :

Date of Onset _____ Explain in detail (where, when, how) _____

Preferred Pharmacy Name and Address

I hereby authorize release of information necessary to file a claim with my Insurance company and assign benefits otherwise payable to: Adult and Pediatric Orthopaedic Specialists.

I understand I am financially responsible for any balance not covered by my insurance carrier.

Patient/Responsible Party Signature _____ Date _____

PATIENT HEALTH INFORMATION FORM

Name _____ Date of Birth _____ Age _____ Sex M F

Phone: Home _____ Work _____ Cell _____

What is your current: Height _____ Weight _____

Have you ever had, or been told you had: blood transfusion Yes No When _____

Anesthetic reaction Yes No Surgical bleeding Yes No Bleeding from aspirin Yes No

Have you been hospitalized for non-surgical reasons? Attach a list if necessary

Reason for admission	Year	Hospital	Doctor

Any prior surgeries? Attach a list if necessary

Operation	Year	Hospital	Doctor

List all prescription medications you are now taking: Attach a list if necessary

Name	Dose	How often	Name	Dose	How often
1. _____			4. _____		
2. _____			5. _____		
3. _____			6. _____		

List all herbal/non prescription medications you are taking: Attach a list if necessary

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Do you take vitamins? Yes No What? _____

Do you drink milk Yes No # Glasses/Day _____

Take calcium Yes No Dose _____ #/Day _____

Do you have allergies to:

Medications: list _____

Foods: list _____ Tape Yes No

Metal/Jewelry Yes No

Iodine Yes No

Latex Yes No

Do you have: Dermatitis Yes No

Eczema Yes No

Family History:

	If living		If deceased	
	Age	Health	Age	Cause
Mother				
Father				
Siblings				
Children				
Spouse				

In your blood family, is there a history of:

- | | | | | | |
|--------------|--|----------------|--|----------------------|--|
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | TB | <input type="checkbox"/> Yes <input type="checkbox"/> No | Muscle disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bone disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital deformity | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Clots | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Personal History:

- Married Single Divorced Widowed Living Situation: House ___ Apt. ___ Other ___
- Occupation _____
- Alcohol use Yes No How much/Day _____ Tobacco use Yes No
- Recreational drug use Yes No List _____
- Industrial health hazards exposure Yes No List _____ HIV/AIDS Yes No

Health Review:

- Have you had a dexta bone density scan? Yes No When? _____
- Have you had a fall in the past year? Yes No How many _____
- Unexplained fevers Yes No Unexplained weight loss Yes No Cancer Yes No
- Have you had any of the following health problems? Check all that apply:

Head, Eyes, Ears, Nose, Throat:

- | | | | | | |
|-------------|--|---------------|--|-------------------|--|
| Eye injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | Deafness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nose bleeds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hoarseness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Wear glasses | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ear ache | <input type="checkbox"/> Yes <input type="checkbox"/> No | Double vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gland enlargement | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headache | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear ringing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Cardiovascular:

- | | | | | | |
|---------------------------|--|--------------------------|--|-----------------|--|
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fast heart | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose veins | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Phlebitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Short of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Jumping heart | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ankle swelling | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart failure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pulmonary embolism | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Passing out with exercise | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest pain with exercise | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Pulmonary:

Cough Yes No Pleurisy Yes No Emphysema Yes No
Cough blood Yes No Wheezing Yes No Asthma Yes No
Pneumonia Yes No Tuberculosis Yes No Night sweats Yes No

Gastrointestinal:

Gallstones Yes No Liver disease Yes No Hepatitis Yes No
Heartburn Yes No Stomach pain Yes No Colitis Yes No
Ulcer Yes No Appetite change Yes No Jaundice Yes No
Vomit blood Yes No Blood instool Yes No Black stool Yes No
Pain swallowing Yes No Hiatal hernia Yes No

Gynecologic:

Fibroids Yes No Ovarian cyst Yes No Irregular periods Yes No
Last menstrual period _____ #Pregnancies _____ Last papsmear _____
Hysterectomy? Yes No At what age _____ Do you take hormones Yes No

Genitourinary:

Kidney disease Yes No Kidneyinfection Yes No Bladderinfection Yes No
Blood inurine Yes No Wetting Yes No Stones Yes No
Poor stream Yes No Pain on urination Yes No Kidney failure Yes No
Venereal disease Yes No Explain _____

Skin/ breast:

Rashes Yes No Skin color change Yes No Skin ulcers Yes No
Lumps Yes No Psoriasis Yes No
Scars Yes No Where? _____

Hematologic/Lymphatic/Endocrine:

Anemia Yes No Easy bleeding Yes No Osteoporosis Yes No
Thyroid disease Yes No Diabetes Yes No Blood disease Yes No
Muscle weakness Yes No Easy bruising Yes No Easy fractures Yes No
Gout Yes No Thirst Yes No Enlarged glands Yes No

Psychological:

Depression Yes No Mood swings Yes No Tearfulness Yes No
Poor sleeping Yes No Angry outbursts Yes No Hallucinations Yes No
Tiredness Yes No Addiction history Yes No

Neurologic:

Seizures Yes No Weakness Yes No Memory loss Yes No
Incoordination Yes No Falling Yes No Speech slurring Yes No
Vision changes Yes No Stroke Yes No Tremors Yes No
Tingling hands or feet Yes No Difficulty swallowing Yes No TIA Yes No

Do you have any other health problems that you are aware of?

Please explain _____

Signature _____ Date _____



Dr's Weinert, Rosenfeld, Dobyms, 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

Insurance Eligibility Certification HMO/PPO/POS

I hereby attest that I am an eligible member of a contracted health plan as noted below. I agree, that should it be determined that I am not eligible or services are denied to me under the health plan noted below, that I will be responsible for payment to:

Adult and Pediatric Orthopaedic Specialist

Health Plan _____

Plan ID _____

Name of Subscriber _____

Social Security Number _____

Name of Patient _____

Social Security Number _____

Relationship to Subscriber _____

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

Signature _____

Date _____



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ADULT AND PEDIATRIC ORTHOPAEDIC SPECIALISTS

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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for services.
- Conduct normal health care operations.

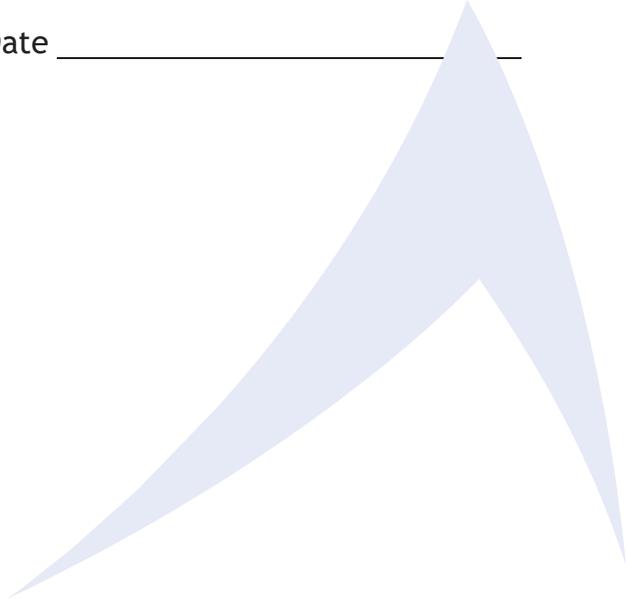
I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this 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 health care operations.

Patient Name _____

Patient Representative _____

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.

Authorization to leave messages

I give my permission for the staff of Adult and Pediatric Orthopaedic Specialist to leave messages on my telephone answering machine or with a family member such as information regarding medication, surgery, appointments and healthcare.

Signature of Patient _____ Date _____

Patient Name - Please Print _____

Family Member's Name _____

Family Member's Name _____

I do not give my permission for the staff of Adult and Pediatric Orthopaedic Specialist to leave message on my telephone answering machine or with a family member such as information regarding medication, surgery, appointments and health care.

Signature of Patient _____ Date _____

Patient Name - Please Print _____



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)



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

Patient or Responsible Party:

Signature _____ Date _____