SOUTHERN CALIFORNIA
SPINE & JOINT
INSTITUTE

Patient Information

First & Last Name: _____ Birth Date: _____

SSN: _____ Sex: Male Female Marital Status:_____

Primary Phone #: _____ Alternative Phone #: _____

Mailing Address: _____

City:_____ State: _____ Zip Code: _____

Email: _____

Race: ☐American Indian ☐Asian ☐African American/Black ☐Hispanic Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other: _____

Preferred language: _____

Emergency Contact

Emergency Contact Name: _____ Relationship: _____

Phone #: _____

Employment Status

☐ Employed ☐Unemployed ☐ Retired ☐ Other: _____

Employer / Job Title: _____

Is your pain related to an automobile accident? ☐ No ☐ Yes – please explain: _____

Is your pain related to a worker's comp injury? ☐ No ☐ Yes – please explain: _____

Insurance Information

Primary Insurance Carrier (Blue Cross, Blue Shield, Tricare…)**:** _____

Insurance Type: PPO HMO Medicare Other: _____

Subscribers Name (if someone other than yourself): _____

Subscribers Date of Birth: _____ **SSN of Subscriber** (Tricare only): _____

Secondary Insurance Carrier (Blue Cross, Blue Shield, Tricare…)**:** _____

Insurance Type: PPO HMO Medicare Other: _____

Subscribers Name (if someone other than yourself): _____

Subscribers Date of Birth: _____ **SSN of Subscriber** (Tricare only): _____

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Patient Associations

How did you find us? Friend, relative, neighbor, online…

Name or Website: _____

Primary Care Doctor

First and Last Name: _____

City: _____ Phone #: _____

Referring Physician – Please list MD, not PA or NP

First and Last Name: _____

City: _____ Phone #: _____

Financial Responsibility Disclosure

This office's policy is to collect the co-payments, co-insurance amounts and deductibles the day of the appointment.

The co-payment made at the front desk is for the visit only for the time you spend with the doctor. If you have any procedures performed during your visit to our office or on a separate occasion, the procedure may not be covered in the co-payment made at the front desk. In other words, the amount you pay during your visit may not be all you owe. Your financial responsibility will be determined before and/or after your insurance company has received a bill for all services rendered, processed and paid your claim.

I acknowledge that the insurance card and information provided each visit is the correct and current information. I understand that it is my responsibility to inform your office if a change of insurance coverage occurs. **In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge.** Payment is due upon receipt of a statement from our office. If your treatment requires surgery, or a procedure performed in the office or surgery center, we will bill your health plan for all services provided in the office and/or surgery center. You understand that these fees are separate than surgical assists, facility anesthesia fees, and lab or pathology fees.

Uninsured /Cash Pay Patients: As a private pay patient you will be asked to make payment the day of your appointment. It is important that you ask about the cost of care or services that your physician is recommending prior to the services rendered.

Assignment of Benefits: I authorize my insurance company and/or my healthcare contract with my employer (collectively, the "INSURANCE COMPANY") to direct all payments for all professional and medical benefits under my current policy as payment for services rendered directly to PROVIDER(s) providing services or their designated associates or assignee(s) (collectively "PROVIDERS"). I assign, whether signing as patient or patient's agent, all rights and benefits under my contract with my INSURANCE COMPANY, to any and all PROVIDERS. I give express right to PROVIDERS to obtain the insurance and benefits policy booklet, and ALL policy information from INSURANCE

COMPANY, employer or any of their associates/agents. I also provide express consent and give full rights to PROVIDERS to appeal on my behalf to INSURANCE COMPANY or my employer or any of their associates/agents for any reason I also authorize the release of any information pertinent to my case to any insurance company, adjuster, attorney or other party(s) involved in this case. I authorize PROVIDERS to initiate complaint(s) to the Insurance Commissioner or any other agency for any reason on my behalf. The assignment further permits PROVIDERS to obtain from INSURANCE COMPANY and employer or any of their agents or associates all information necessary for the determination of benefits allowed under the contract and permits the direct disclosure to PROVIDERS of all information including benefits provided including benefits & payments made on my behalf, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered. The assignment shall allow PROVIDERS to take all action necessary to obtain the benefits I have, in good faith, been promised by INSURANCE COMPANY and/or employer on my behalf. All benefits are to be paid directly to PROVIDERS and mailed directly to Southern California Spine & Joint Institute. A photocopy of this assignment shall be considered as effective and valid as the original. This is retroactive for any services Southern California Spine & Joint Institute has provided me. I understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary, cosmetic or excluded. I agree to be responsible for payment of all such services rendered to the patient.

If my INSURANCE COMPANY sends payments to me, I understand that I will endorse and send all funds to PROVIDERS and mail to 38860 SKY CANYON DR MURRIETA Bldg A, Murrieta, CA 92563 within 72 hours of receipt or there may be a late fee and an additional collections fees. I also understand that my insurance policy is a contract between INSURANCE COMPANY and me. If my insurance company does not pay my claim within 30 days after it is received, I agree to remit payment to PROVIDERS within 1 week of receiving the bill, and contact INSURANCE COMPANY regarding this settlement with PROVIDERS will assist me in processing my claim; however, I am ultimately responsible for payment of my account. This is a direct assignment of my rights and benefits under this policy. 1. I will remit the check(s) that are sent to me by my insurance to the address written above. 2. I am responsible for co-payments, deductibles, coinsurance or other amounts I am required to pay under my benefit plan. 3. I am voluntarily choosing on behalf of myself or the patient named above to get services from this provider.

I have read and agreed to the form "FINANCIAL RESPONSIBILITY DISCLOSURE & ASSIGNMENT OF BENEFITS"

_____ _____

Print Patient Name Date

_____

Signature of Patient of Patient Representative

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Designation for Release of Medical Information

Introduction

It is the physicians′ responsibility to ensure that the physician-patient relationship is confidential. As required by the Health Portability and Accountability Act (HIPAA), you have the right to designate a person to act on your behalf with respect to your personal health information (PHI). This allows physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization.

Please note the following points:

- The designation is valid until you cancel it in writing.
- If you designate no one, Southern California Spine & Joint Institute will **not** release information to any family member or friend or legal representative.

Designation Statement

I, _____, designate the following person to be able to speak to a physician/staff member at Southern California Spine & Joint Institute, should it be necessary, on my behalf. I hereby give permission to Southern California Spine & Joint Institute, through its physicians and staff, to release to my designee the following information:

- ☐ **Make, change, or confirm appointments.**
- ☐ **Sign a release of information form to request a release of my records and/or copies.**
- ☐ **Speak with a physician regarding the coordination of my care.**
- ☐ **Speak with the office staff / billing department regarding billing and/or payments.**
- ☐ **Other: _____**
- ☐ **All of the above**

Name of Designated Person: _____
(First and Last Name)

Relationship to Patient: _____ Phone Number: _____
(son, daughter, spouse…)

_____ _____
Patient Signature Date

I decline to designate another person to speak with my physician or clinical staff.

_____ _____
Patient Signature Date

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Patient Partnership Plan

Dear patient,

Welcome to our practice!

We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health", we ask you to help us in the following:

Scheduling Visits with my Primary Care Provider
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and person/family history and I will need to complete these recommended health screenings. **These health screenings are tests that can help detect life-threatening disease and conditions.** If I visit my doctor only for treatment of immediate problems and do not arrange regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and discuss health screenings.

Keep Appointments and/or Call Office to Cancel/Reschedule Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him/her the chance to check my condition and response to treatment. During a follow up appointment, my doctor might order tests, refer to a specialist, prescribe medication, or even discover/treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect/treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible. **If I do not call to cancel or reschedule my appointment within 24 hours of my scheduled appointment, I will be charged a $30.00 no show/cancellation fee.**

Call the Office When I Do Not Hear the Results of Tests or Treatments Ordered
I understand that my physician's goal is to report my test results and treatments ordered to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office to make an appointment to get the results.

Inform My Doctor if I Decide Not to Follow His/Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he/she feels is best for my health. This may include referring to a specialist, order lab/tests, or asking me to return to the office within a certain period. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to following his/her recommendations so that he/she may fully inform me of any risks associated with my decision to delay/refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____

Patient Signature Date