Orange County Orthopedic Specialists

John P. Kelly, M.D.
11190 Warner Avenue, Suite 300 Fountain Valley, CA 92708
(714) 241-7000 Fax (714) 241-7003

WORKER'S COMPENSATION PATIENT REGISTRATION INFORMATION

Patient Personal Information

Patient Name _____ Sex _____M _____F
Date of Birth _____Social Security # _____ Driver's License # _____
Address _____ City _____ State _____ Zip _____
Marital Status _____Single _____Married _____Divorced _____Widowed
Approximate height _____ Approximate weight _____
Spouse's Name _____ Home phone #_____ Cell phone #_____
Reasons for today's visit: _____
_____

Employer Information

Is light duty or modified work available? ____Yes ____No____Don't know
Employer _____ Occupation_____
Address _____ City _____ State _____ Zip _____
Work # ( ) _____-_____ Extension _____ Your Supervisor _____
Spouse's Employer _____ Phone # ( ) _____
Street Address _____City_____ State_____Zip_____

Insurance Information

Date of Injury _____ Claim # _____
Worker's Comp Ins. Co. _____
Address _____ City _____ State _____ Zip _____
Claim Adjuster's Name _____ Email Address _____
Phone # ( )_____-_____ Fax # ( )_____-_____

Patient Referral Information

Who may we thank for referring you? _____
Primary Care Doctor _____ Phone # ( ) _____-_____
Address _____ City _____ State _____ Zip _____
Have you been seen by one of our physicians before? _____No _____ Yes When? _____

Emergency contact information

Name of person **NOT** living with you _____Relationship_____
Address _____ City _____ State _____ Zip _____
Phone # ( ) _____-_____ Work # ( ) _____-_____

Patient/Responsible Party Signature _____ Date_____

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WORKER'S COMPENSATION PATIENT QUESTIONNAIRE

THE FOLLOWING INFORMATION CONCERNS YOUR HEALTH AND BACKGROUND. ALTHOUGH SOME OF THE QUESTIONS MAY NOT APPEAR TO APPLY TO YOUR PRESENT INJURY, THE INFORMATION MAY HELP THE DOCTOR DIAGNOSE YOUR CONDITION.

PLEASE FILL IN THE FORM AS COMPLETELY AS POSSIBLE. NOTIFY OUR STAFF IF YOU HAVE ANY QUESTIONS. THEY WILL BE GLAD TO HELP YOU. THANK YOU IN ADVANCE FOR YOUR TIME AND EFFORT.

Date of Injury _____Time of Injury_____ Date Injury Reported _____

Did you have a pre-employment physical examination? No _____ Yes _____

Were there any work restrictions based on that exam? No _____ Yes _____ If yes, Please explain:

_____

List all parts of the body injured: _____

_____

Describe how the injury happened: (When did the injury occur? What were you doing when the accident occurred? Did the accident happen as a result of a fall? Was the accident due to the use of certain equipment? etc.)

_____

_____

_____

Did your symptoms develop during the course of your employment and not due to a specific trauma? If so, when did you first notice symptoms? How does your job relate to the onset of these symptoms?

_____

_____

_____

What kind of pain or discomfort did you initially experience at the time of injury? _____

_____

Did you report the accident at the time of injury _____No _____Yes-to whom? _____

Were there any witnesses to the accident? _____No _____Yes-to who? _____

CURRENT COMPLAINTS

Describe your current symptoms in detail (What part of the body hurts? Describe the level of pain: mild, slight, moderate, severe. Does the pain radiate into another part of the body?).

_____

_____

How often do you experience pain? _____

What makes the pain worse? _____

What makes the pain better? _____

_____

HISTORY OF INITIAL MEDICAL TREATMENT

Were you provided with medical treatment immediately after the accident? If so, where? _____

_____

Did your employer refer you to this facility or did you self-seek medical treatment? _____

What type of treatment was provided? (X-rays, medication, therapy, etc.)_____

_____

HISTORY OF TREATMENT TO PRESENT TIME

Have you participated in a physical therapy program? If so, who was the referring physician?

_____

How often? _____ How long? _____

Are you currently still participating in a therapy/chiropractic program? _____Yes _____No

Has therapy helped or does it seem to be helping? _____Yes _____No

Since the time of your first medical care, have you been referred to any other physicians or specialist?

_____No _____Yes If so, explain course of treatment provided by physician:

_____

_____

_____

Have you undergone any special tests (MRI, CT scan, EMG/nerve conduction tests)? If so, where and when? Indicate the part of the body where the test was performed.)

_____

_____

OCCUPATIONAL HISTORY AND JOB DESCRIPTION

Employer at time of injury _____

Job title _____ Work hours _____ How many days a week? _____

General description of job duties at time of injury _____

PLEASE NOTE THE FOLLOWING INFORMATION PERTAINING TO THE SPECIFIC JOB REQUIREMENTS AT THE TIME OF INJURY

In a typical 8-hour day, how often were you required to perform the following?

	NEVER	OCCASIONALY	FREQUENTLY	CONSTANTLY
SIT	_____	_____	_____	_____
STAND	_____	_____	_____	_____
WALK	_____	_____	_____	_____
WALKING ON UNEVEN GROUND	_____	_____	_____	_____
BENDING	_____	_____	_____	_____
SQUATTING	_____	_____	_____	_____
CLIMBING	_____	_____	_____	_____
KNEELING	_____	_____	_____	_____
CRAWLING	_____	_____	_____	_____
REACHING ABOVE SHOULDER	_____	_____	_____	_____
REACHING AT SHOULDER LEVEL	_____	_____	_____	_____
REACHING BELOW SHOULDER	_____	_____	_____	_____
PUSHING	_____	_____	_____	_____
You were required to lift:				
Up to 10 pounds	_____	_____	_____	_____
11 to 20 pounds	_____	_____	_____	_____
21 to 50 pounds	_____	_____	_____	_____
51 to 75 pounds	_____	_____	_____	_____
76 to 100 pounds	_____	_____	_____	_____
You were required to carry:				
Up to 10 pounds	_____	_____	_____	_____
11 to 20 pounds	_____	_____	_____	_____
21 to 50 pounds	_____	_____	_____	_____
51 to 75 pounds	_____	_____	_____	_____
76 to 100 pounds	_____	_____	_____	_____

Repetive use of hands required?	_____Right	_____Left	_____Both
Fine manipulation?	_____Right	_____Left	_____Both
Simple grasping?	_____Right	_____Left	_____Both
Forceful gripping?	_____Right	_____Left	_____Both
Repetitive movement of feet?	_____Right	_____Left	_____Both

List types of machines, tools, equipment used. _____

List vehicles or moving equipment operated. _____

Are you presently working for same employer where you were injured? _____Yes _____No

If not, when did you leave employer? _____ Why? _____

Have you been advised to remain off work? If so, by whom? _____

If you have been off work, how long have you been off? _____

Are you currently performing modified work duties? If so, what are your restrictions? _____

_____

_____

If you have a new employer, who is your new employer? _____

When did you begin new employment? _____ What is your job title? _____

Full time _____ Part time _____ Any restrictions? _____

What are your physical duties at the new job? _____

_____

Did you have a concurrent employer at the time of the injury? _____No _____Yes. If so, write the name of the employer, length of employment, job title, physical duties, and hours worked:

_____

_____

PREVIOUS EMPLOYERS: List all employers for the past five years prior to this injury. How long did you work there? What kind of work did you perform?

_____

_____

PAST MEDICAL HISTORY

Have you ever had a previous injury to currently injured body part? _____No _____Yes If so, when and where did this injury occur? _____

_____

What treatment was provided for this injury? _____

_____

Did your symptoms completely resolve? If not, what symptoms continued to persist? _____

_____

List any previous work-related injuries sustained in the past with any employer. _____

_____

_____

List any previous injuries sustained on a non-industrial basis (home, school, motor vehicle accidents, etc.) _____

_____

_____

_____

List any previous surgeries or hospitalizations. _____

_____

List any major illnesses or medical conditions. _____

_____

Do you currently use any orthotics or assistive devices. _____

_____

Do you have any allergies to food or medication? _____

SOCIAL AND FAMILY HISTORY

Marital Status: _____Single _____Married _____Divorced _____Widowed

How many children? _____ _____brothers _____ sisters

Father: alive/ deceased _____ Familial diseases_____

Mother: alive/ deceased _____ Familial diseases_____

Do you smoke? If so, how much? _____

Do you drink alcoholic beverages? If so, how often? _____

List any hobbies, recreational activities, sports, and if you have discontinued any of these activities due to your current injury. _____

_____

_____ _____

Patient Signature Date

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COMPLETE ONLY IF YOUR CONDITION IS DUE TO AN ACCIDENT OR WORK RELATED INJURY

PATIENT NAME: _____

Was this accident work related? _____Yes _____No

If yes, is the claim outstanding? If not, when was it closed? _____

_____

Did your condition occur as the result of an accidental injury? _____Yes _____No

Was there a third party responsible? _____Yes _____No

If yes, is the claim outstanding? If not, when was it closed? _____

Were you previously treated for this condition? _____Yes _____No

Please provide the following information:

Date and time of accident: _____

Location of accident: _____

Explanation of how accident happened and injuries sustained: _____

_____

_____

This office does not accept third party insurance. Please indicate the name(s) of your insurance company that will be responsible for this incident. You will be responsible for all balance(s) due after your insurance is paid and /or if your claim is denied.

1) _____

2) _____

_____ _____

Patient Signature Date

Orange County Orthopedic Specialists
Patient Partnership Plan

Dear Patient,

Welcome! 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 your health" we ask you to help us in the following ways:

Keep Follow-up Appointments and Reschedule Missed 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 or her a chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my doctor will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs or Other Tests
I understand that my doctor's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my doctor's office within the time specified, I will call the office for my results.

Inform My Doctor if I Decide NOT to Follow His or Her Recommended Treatment Plan. I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, even asking me to return to the office within a certain period of time. 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 follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

NOTIFICATION TO CONSUMERS

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE
MEDICAL BOARD OF CALIFORNIA
(800) 633-2322
WWW.MBC.CA.GOV

PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY THE
PHYSICIAN ASSISTANT COMMITTEE
(916) 561-8780
WWW.PAC.CA.GOV

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 any further information about your health or condition, please ask.

Patient Signature_____

For Office Use Only:

Account # _____ Witness: _____ Date: _____

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WAIVER OF LIABILITY

Patient Name: _____

Orange County Orthopedic Specialists participates with your insurance plan and will bill your insurance on your behalf.

However, I understand and agree that I am responsible for payment of all services if they are not paid or covered by my insurance.

_____ _____

Signature Date

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Orange County Orthopedic Specialists
11190 Warner Ave., Suite 300
Fountain Valley, CA 92708
(714) 241-7000

I (**Print Name**) _____ understand that as part of my health care, Orange County Orthopedic Specialists originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Orange County Orthopedic Specialists is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Orange County Orthopedic Specialists reserves the right to change its notice and practices, and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Orange County Orthopedic Specialists change its notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____
_____
_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept / decline the terms of this consent.

_____
Patient's Signature

_____
Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on_____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

NOTICE OF INFORMATION PRACTICES FOR ORANGE COUNTY ORTHOPEDIC SPECIALISTS

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

INTRODUCTION
At Orange County Orthopedic Specialists, we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD / HEALTH INFORMATION
Each time you visit Orange County Orthopedic Specialists, a record of your visit is made. Typically, this record contains information about your visit, including your examination, diagnosis, test results, treatment, as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as:

- a basis for planning your care and treatment,
- a means of communication with other health professionals involved in your care,
- a legal document outlining and describing the care you received,
- a tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided,
- an education tool for medical health providers,
- a source for medical research,
- a basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards,
- a source of data for planning and / or marketing,
- a tool that we can reference to ensure the highest quality of care and patient satisfaction.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS
You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information,
- the right to receive confidential communications concerning your medical condition and treatment,
- the right to inspect and copy your protected health information,
- the right to amend or submit corrections to your protected health information,
- the right to receive an accounting of how and to whom your protected health information has been disclosed,
- the right to receive a printed copy of this notice.

OUR RESPONSIBILITIES
Orange County Orthopedic Specialists is required to:

- maintain the privacy of your health information,
- provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- abide by the terms of this notice,
- notify you if we are unable to agree to a requested restriction,
- accommodate reasonable requests you may have regarding communication of health information via alternative means or at alternative locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice at your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.
We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. **Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.**
We will use your information for payment. **Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.**

We will use your information for regular health operations. **Your health information may be used as necessary to support the day-to-day activities and management of Orange County Orthopedic Specialists. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.**

Business Associates. In some instances, we have contracted separate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services, and computer software/hardware provider.
Communication with family. Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.
Healthcare Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee, if there are circumstances that require us to do so
Research / Teaching / Training. We may use your information for the purpose of research, teaching, and training.
Public health reporting. Your health information may be disclosed to public health agencies, as required by law.
Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
Appointment reminders. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are made by telephone, or a brief, non-specific message may be left on your answering machine. If you don't approve of these methods, or, if you prefer alternative methods, please inform the practice.
Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM
If you have complaints or questions, or would like additional information regarding this notice or the privacy practices of Orange County Orthopedic Specialists, please contact:

ATTN: Privacy Officer
Orange County Orthopedic Specialists
11190 Warner Ave, Suite 300
Fountain Valley, CA 92708
714-241-7000

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C., 20201