Platinum Orthopaedics

11190 Warner Avenue, Suites 300, 305, & 310
Fountain Valley, CA 92708

710 N. Euclid Street, Suite 201
Anaheim, CA 92801

TEL 714-241-7000
FAX 714-241-7003

Patient Last Name (Family Name) | Patient *First Name (Given Name)*

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Patient Middle Initial

PATIENT OR RESPONSIBLE PARTY INFORMATION

☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other (specify): _____

Last Name (Insurance Subscriber) | *First Name (Insurance Subscriber)*

Street Address

City | *ZIP Code* | *State*

Cell Phone Number | *email address (please write clearly)*

☐ M ☐ F
Sex | *Date of Birth (MM/DD/YYY)* | *Marital Status* | *Social Security Number*

Driver's License or ID # | *Occupation*

Employer | *Employer Phone Number*

Employer | *Employer Phone Number*

Insurance Company | *Insurance Subscriber Number* | *Group Number*

Emergency Contact Name | *Relationship to you* | *Emergency Contact Phone Number*

I HEREBY AUTHORIZE MY INSURANCE CCOMPANY TO MAKE PAYMENTS DIRECTLY TO THE PHYSICIAN/PROVIDER FOR ALL MEDICAL EXPENSE BENEFITS OTHERWISE PAYABLE TO ME FOR PROFESSIONAL SERVICES RENDERED. I UNDDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSRANCE BENEFITS.

Signature | *Name* | *Date*

What is the main problem you are coming in for today? _____

How did it start? Was there an injury? (please give dates if possible) _____

On a scale of 1 to 10 (10 being the worst) what is your pain level? _____

Where is your pain located? _____

What is the quality of your pain? (sharp, dull, achy, etc.) _____

How long have you had this problem? _____

What is the timing of your problem (constant, occasional, mornings, night, etc.) _____

Is there anything that makes it worse? _____

Is there anything that makes it better? _____

Past Medical History: (Please list ALL current medical conditions such as hypertension, cardiac disease, kidney disease, diabetes, asthma, ulcers, etc.)

_____

_____

_____

List All Surgeries and Hospitalizations with dates

_____

_____

_____

_____

_____

List All Medications and Dosages

_____

_____

_____

_____

_____

List All Allergies

_____

_____

_____

_____

_____

_____

_____

_____

Family History: Are there any diseases that run in your family? _____

Have you or anyone in your immediate family had a blood clot, deep venous thrombosis (DVT), or pulmonary embolism (PE)? _____

Have you ever had a major infection or history of MRSA? _____

Do you smoke? ___ How many cigarettes per day? ___ Do you use any recreational drugs? _____

Do you drink alcohol? _____ How many drinks per week? _____

Current employment status: (circle one) Employed Not Employed Disabled

Patient signature _____ Date _____

REVIEW OF SYSTEMS

Please circle any problems you currently have or have had in the past.

GENERAL
fatigue fever night sweats chills weight gain or loss other: _____

MUSCULOSKELETAL
Joint or muscle pain swelling stiffness weakness instability other: _____

EYES
loss of vision double vision eye redness

EARS / NOSE / MOUTH THROAT
hearing loss ringing in ears dizziness sinus infections frequent bloody nose dry mouth
mouth sores sore throat hoarseness other: _____

CARDIOVASCULAR
chest pain irregular heartbeat palpations leg swelling other: _____

RESPIRATORY
shortness of breath difficulty breathing chronic cough coughing up blood other: _____

GENITOURINARY
painful urination blood in urine increased frequency loss of bladder control
heavy or irregular periods other: _____

SKIN
rash color change abnormal moles nail changes other: _____

NEUROLOGIC
headache dizziness numbness tingling weakness seizure fainting other: _____

PSYCHIATRIC
anxiety depression insomnia memory loss other: _____

ENDOCRINE
appetite change increased thirst increased urination heat or cold intolerance other: _____

HEMATOLOGIC
easy bruising prolonged bleeding enlarged lymph nodes other: _____

ALLERGIC and IMMUNOLOGIC
hives seasonal or environmental allergies exposure to HIV other: _____

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 (open)? 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 (open)? 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 list all injured body parts: _____

_____

_____

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

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WAIVER OF LIABILITY

PATIENT NAME:_____

Platinum Orthopaedics works with your insurance and will bill your insurance on your behalf.

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

_____ _____

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 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 the 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 physician 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 and Other Tests
I understand that my physician's goal is to report my lab and test results 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 for my test 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, or 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 ASSTANTS ARE LICENSED AND REGULATED BY THE
PHYSICIAN ASSISTANT COMMITTEE
(916) 561-8760
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 more information about your health or condition, please ask.

_____ _____
Patient Signature Date

PLATINUM ORTHOPAEDICS

Receipt of Notice of Privacy Practices

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

I hereby acknowledge that I received a copy of this medical practice's **Notice of Privacy Practices.** I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

☐ El padre o tutor del paciente menor de edad

☐ Tutor o curador de un paciente incompetente

NOTICE OF PRIVACY PRACTICES
PLATINUM ORTHOPAEDICS

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Health Information

This medical practice collects medical and related identifiable patient information (such as billing information, claims information, referral and health plan information) and stores it in a chart, in administrative or billing files, and on a computer. The medical record is the property of this medical practice, but the information in the medical record is accessible to the patient. This information is considered "protected health information" (PHI) under the HIPAA Privacy Rule. The law permits us to use or disclose health information for the following purposes without the patient's written authorization:

1.Treatment. We use medical information to provide medical care. We disclose medical information to our employees and others who are involved in providing the care our patients need. For example, we may share medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription, or a laboratory that performs a test. We may also disclose medical information to members of patients' families or others who can help them-when they are sick or injured, or following the patient's death.

2.Payment. We use and disclose PHI to obtain payment for the services we provide. For example, we give health plans the information they require for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to our patients.

3.Health Care Operations. We may use and disclose PHI to operate this medical practice e. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get health plans to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs, and business planning and management. We may also share PHI with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of this PHI. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, health care clearinghouse, or one of their business associates, California law prohibits all recipients of health care information from further disclosing it except as specifically required or permitted by law.

a. We may also share PHI with other health care providers, health care clearinghouses, or health plans that have a relationship with our patients when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

b. We may also share PHI with the other health care providers, health care clearinghouses, and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities that collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind our patients about

appointments. If the patient is not home, we may leave this information on the patient's answering machine or in a message left with the person answering the phone.

5. Sign-in Sheet. We may use and disclose medical information about our patients by having them sign in when they arrive at our office. We may also call out their names when we are ready to see them.

6. Notification and Communication with Family. We may disclose our patients' health information to notify or assist in notifying a family member, personal representative or another person responsible for their care about their location or general condition in the event of their death, unless a patient had instructed us otherwise. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with our patient's care or helps pay for care. If our patient is able and available to agree or object, we will give the patient the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over the patient's objection if we believe it is necessary to respond to the emergency circumstances. If our patient is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient's family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact our patients to encourage them to purchase or use products or services related to their treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to them. We may similarly describe products or services provided by this practice and tell our patients which health plans we participate in. We may receive financial compensation to talk with our patients face-to-face, to provide them with small promotional gifts, or to cover our cost of reminding them to take and refill medication or otherwise communicate about a drug or biologic that is currently prescribed for the patient, but only if the patient either:
(1) has a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise the patient about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) the patient is a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while the patient has a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) the patient's right to opt-out of future remunerated communications by calling the communicator's toil-free number. We will not otherwise use or disclose PHI for marketing purposes or accept any payment for other marketing g communications without the patient's prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity our patients authorize, and we will stop any future marketing activity to the extent the patient revokes that authorization.

8. Sale of Health Information. We will not sell our patients' health information without their prior written authorization. The authorization will disclose that we will receive compensation for PHI if the patient authorizes us to sell it, and we will stop any future sales of information to the extent that the patient revokes that authorization.

9. Required by Law. As required by law, we will use and disclose our patients' health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose our patients' health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform our patients or their personal representative promptly unless in our best professional judgment, we believe the notification would place a patient at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose our patients' health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose our patients' health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about our patients in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify them of the request and they have not objected, or if their objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose out patients' health information to a law

enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose our patients' health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose our patients' health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose our patients' health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if the patient has agreed to the disclosure on behalf of themselves or their dependent.

18. Specialized Government Functions. We may disclose our patients' health information for military or national security purposes or to correctional institutions or law enforcement officers that have the patient in their lawful custody.

19.Workers'.Compensation. We may disclose our patients' health information as necessary to comply with workers' compensation laws.
For example, to the extent our patients' care is covered by workers' compensation, we will make periodic reports to their employer about their conditions. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20.Change of Ownership. In the event that this medical practice is sold or merged with another organization, our patients' health information/record will become the property of the new owner, although our patients will maintain the right to request that copies of their health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify our patients as required by law.
If they have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Other disclosures specified in our Notice of Privacy Practices. We may disclose our patients' health information as otherwise described in our Notice of Privacy Practices.

B. When this Medical Practice May Not Use or Disclose Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies individual patients without their written authorization. If a patient authorizes this medical practice to use or disclose health information for another purpose, the patient may revoke the authorization in writing at any time.

C. Our Patients' Health Information Rights

1. Right to Request Special Privacy Protections. Our patients have the right to request restrictions on certain uses and disclosures of their health information by a written request specifying what information they want to limit, and what limitations on our use or disclosure of that information they wish to have imposed. If our patients tell us not to disclose information to their commercial health plan concerning health care items or services for which they paid for in full out-of - pocket, we will abide by their request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify our patients of our decision.

2. Right to Request Confidential Communications. Our patients have the right to request that they receive their health information in a specific way or at a specific location. For example, they may ask that we send information to a particular email account or to their work address. We will comply with all reasonable requests submitted in writing which specify how or where our patients wish to receive these communications.

3. Right to Inspect and Copy. Our patients have the right to inspect and copy their health information, with limited exceptions. To access their medical information, our patients must submit a written request detailing what information they want access to, whether they want to inspect it or get a copy of it, and if they want a copy, their preferred form and format. We will provide copies in the requested form and format if it is readily producible, or we will provide our patients with an alternative format they find acceptable, or if we can't agree and we maintain the record in an electronic format, their choice of

a readable electronic or hardcopy format. We will also send a copy to any other person our patients designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny our patients' request under limited circumstances. If we deny a request to access a child's records or the records of an incapacitated adult because we believe allowing access would be reasonably likely to cause substantial harm to the patient, the guardian or legal representative will have a right to appeal our decision. If we deny a patient's request to access their psychotherapy notes, our patients will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement Our patients have a right to request that we amend their health information if they believe it is incorrect or incomplete. Our patients must make a request to amend in writing, and include the reasons they believe the information is inaccurate or incomplete. We are not required to change our patients' health information, and will provide them with information about this medical practice's denial and how they can disagree with the denial. We may deny their request if we do not have the information, if we did not create the information (unless the person or entity that created the information Is no longer available to make the amendment}, if they would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny a request, our patients may submit a written statement of their disagreement with that decision, and we may, in turn, prepare a written rebuttal. Our patients also have the right to request that we add to their record a statement of up to 250 words concerning anything in the record they believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5.Right to an Accounting of Disclosures. Our patients have a right to receive an accounting of disclosures of their health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to them or pursuant to their written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to Impede their activities.

6.Right to Paper Copy of Notice of Privacy Practices. Our patients have a right to notice of our legal duties and privacy practices with respect to their health information, including a right to a paper copy of this Notice of Privacy Practices, even if they have previously requested its receipt by email. If we have a website, we must post our current Notice of Privacy Practices on our website.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles our patients' health information should be directed to our Privacy Officer listed below:

ATTN: Privacy Officer
Platinum Orthopaedics
11190 Warner Ave, Suite 300
Fountain Valley, CA 92708
TEL 714-241-7000 FAX 714-241-7003

If our patients are not satisfied with the manner in which this office handles a complaint, they may submit a formal complaint to:
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103