Office Policies:

Please read the following carefully

Take a proactive role in your health. Patients are responsible for their health, by signing below you agree to enter a partnership to help achieve the best possible treatment options. Our physicians will make recommendations regarding certain health screenings during your exam appropriate for your diagnosis. It is the patient's responsibility to assist in following through with physician orders such as additional imaging, physical therapy, or surgical clearances.

Medication Refills: OC Sports and Orthopaedics requires that you inform our office at least 48-72 hours prior to needing a medication refill. Our surgeons are not in the office 5 days a week, therefore, we require time to coordinate medication refills.

Disability Form Policy: Blank forms will not be accepted, all personal information must be filled in.
-Our staff strives to fill out forms in a timely manner, turnaround time will be 5 business days.
-Forms cannot be completed for delinquent accounts; all outstanding balances must be paid PRIOR to form completion.
-A fee of $20 will be charged for the completion of disability forms.

Dictated Letters: Letters prepared for third parties (employers, airlines, gyms etc.) will be charged $30. Turnaround time for these letters is a minimum of 5 business days.

Privacy Preferences:

1. List any individuals whom we may share your personal information with; we will not discuss patient information with anyone not listed.

   _____

2. May we leave personal health information on a voicemail? __ Yes ___No

The Medical Board of CA requires every office to notify patients of the following:

Pursuant to Assembly Bill (AB) 1278, physicians will soon be required to provide a notice to their patients regarding the Open Payments database (Database), which is managed by the U.S. Centers for Medicare & Medicaid Services, or CMS.
"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

_____	_____	_____
Patient Name	**Patient** or Guardian **Signature**	Date

Financial Policy:

Thank you for choosing us as part of your healthcare team. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. We make every effort to keep our fees reasonable.

Fees are based on the complexity of your visit and our contract agreement with your insurance. Payment in full is required at the time of your visit and can be made with cash, Visa, Mastercard, Amex or Discover.

Insurance copayments are due at the time of service. If you are unable to pay your copayment at your visit, your appointment will need to be rescheduled.

Not all services are a covered benefit in all policies. It is very important that you understand the provisions of your individual policy. Insurance companies select the services that will cover, therefore, we cannot guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility.

Please Note: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and considered insurance fraud.

Required at check in:

1. Verify personal contact information
2. Present a current and valid picture ID
3. Payment of today's visit
4. Payment of any outstanding balance.

We will verify your coverage at each visit. If we are unable to do so, you will be considered self-pay and will be responsible for the cost of your visit and any services rendered.

Returned Checks: Non-sufficient fund checks are subject to a $25 fee (in addition to fees from your bank)

Insurance Information:

Primary Insurance Name:	**Secondary Insurance Name:**

Statement of Insurance Eligibility:

Many individuals use health insurance to pay a portion of their health services. We require that each individual pay for their health services with health plan benefits. We require that each individual paying for their health services with health plan benefits sign this form declaring eligibility as well as acknowledging that they are still responsible for payment of their health services should they be found ineligible for any reason.

"*I certify and declare that I am eligible for health plan benefit coverage as demonstrated by my presenting of my health ID care and that I have chosen OC Sports & Orthopaedics to provide health services to me. Furthermore, I certify and declare that if I am found ineligible for health plan coverage, I will be financially responsible for all costs incurred during the delivery of health services and agree to pay these charges to OC Sports & Orthopaedics. If I do not have health insurance, I agree to pay in full for the services rendered on the day I receive them unless a payment plan has been previously agreed upon.*"

Patient Name _____ **Patient** or Guardian **Signature** _____ Date _____

27725 Santa Margarita Pkwy., Ste. 100 Mission Viejo, CA 92691
31920 Del Obispo, Ste. 170 San Juan Capistrano, CA 92675
1211 W. La Palma, Ste 602, Anaheim, CA 92801

Registration Form:

Patient Name: _____ **DOB:** _____ **Sex:** _____

Street Address: _____ **City:** _____

State: _____ **Zip:** _____ **Social Security (must list last 4 to verify insurance benefits)** _____

Marital Status: Single Married Divorced Widowed

Email:_____ **Phone:** _____

Employer: _____ **Occupation:**_____

If Minor, Legal Guardian Name: _____ **Phone:** _____

Emergency Contact: _____ **Relationship:**_____

Emergency Contact Phone Number: _____

How did you hear about our clinic? Family Friend Physician Online Search Health Insurance Other_____

Preferred Pharmacy: _____ **Pharmacy Phone #:**_____

Pharmacy City: _____ **Pharmacy Street:** _____

Primary Care Doctor:_____: **City** _____

Primary Care Phone #:_____

Health History

Drug Allergies: List all medications and reactions

Medication:	**Reaction:**
_____	_____
_____	_____
_____	_____

Medications: List all medications you are currently taking and dosage/frequency

Medication:	**Dosage/frequency:**	**Medication:**	**Dosage/frequency:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prior Surgeries and dates:

Procedure:	**Date:**	**Procedure:**	**Date:**
_____	_____	_____	_____
_____	_____	_____	_____

On Average, how many days a week do you exercise for 30 minutes or more? _____

Please indicate if you have any history of the following:

Smoking_____ Frequency & Quantity_____ When did you quit? _____

Alcohol consumption: _____ Frequency & Quantity:_____

Sleep Apnea_____ COPD____ Congestive Heart Failure____ Asthma_____ Emphysema _____

Anemia____ Blood clots____ DVT_____ Thyroid Disease_____ Aids_____

Liver Disease (Jaundice, hepatitis)_____ Diabetes_____ Type_____

Arthritis_____ Osteoporosis_____ Hypertension_____ Cancer____Type & Treatment_____

Heart Attack_____ When?_____ Heart Murmur_____ Pacemaker_____ How long?_____