PACIFICA
ORTHOPEDICS
MEDICAL & SURGICAL CENTER

In Huntington Beach:
18800 Delaware Street, Suite 1100
Huntington Beach, CA 92648
Phone 714-841-5333 800-540-3077
Fax 714-841-5303
www.pacificaortho.com
E-mail appt@pacificaortho.com

In Riverside:
11130 Magnolia Avenue, Suite B
Riverside, CA 92505

In San Bernardino:
201 E. Airport Drive
San Bernardino, CA 92408

Private Patients

Date_____

Patient Info

NAME(Last)_____(First)_____S.S.#_____
STREET ADDRESS_____(City)_____
(State)_____(Zip)_____
PHONE:(Home)_____(Cell)_____
DATE OF BIRTH_____AGE_____ GENDER: M F
MARITAL STATUS: S M D W **EMAIL ADDRESS**:_____

Parent or Legal Guardian (Make Copy of I.D.)

NAME (Last)_____(First)_____
STREET ADDRESS_____(City)_____
(State)_____(Zip)_____
PHONE:(Home)_____(Cell)_____
DATE OF BIRTH_____AGE_____ GENDER: M F

Emergency Contacts: Persons to be contacted in case of an emergency. Please list two contacts.

1. **NAME**_____**RELATIONSHIP**_____

   ADDRESS:_____**PHONE:**_____

2. **NAME**_____**RELATIONSHIP**_____

   ADDRESS:_____**PHONE:**_____

Primary Care Physician

ADDRESS_____PHONE_____
FAX_____

Complete date below and attach copies of both sides of your insurance and prescription cards.

INSURANCE Co. NAME_____MEMBER BENEFITS PHONE #_____
ADDRESS (To Send Claims)_____(City)_____
(State)_____(Zip)_____
I.D. #_____GROUP #_____
INSURED'S NAME (Policy Holder/Responsible Party)_____
INSURED's S.S.#_____INSURED'S BIRTH DATE_____
RELATIONSHIP INSURED Child Spouse Other

Secondary Insurance Co. Name

INSURANCE Co. NAME_____MEMBER BENEFITS PHONE#_____
ADDRESS_____(City)_____
(State)_____(Zip)_____
I.D. #_____GROUP #_____
INSURED'S NAME (Policy Holder/Responsible Party)_____
INSURED's S.S.#_____INSURED'S BIRTH DATE_____
RELATIONSHIP TO INSURED Child Spouse Other

Please let us know who referred you or how you found Pacifica Orthopedics:

☐**Physician Referral:**_____
☐**Insurance Website:**_____
☐**Internet**
☐**OTHER:**_____
☐**Friend/Relative:**_____
☐**Flyer/Mailer**
☐**Hospital/ER:**_____

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PATIENT NAME:_____PHONE:_____
S.S. #_____

CHIEF COMPLAINT (Where do you hurt?):_____
_____

HISTORY OF CURRENT COMPLAINT/INJURY(How did you injure yourself?):_____
_____
_____

PREVIOUS TREATMENT:_____
_____
_____

PREVIOUS INJURIES:_____
_____

DO YOU HAVE, OR HAVE YOU HAD IN THE PAST ANY OF THE FOLLOWING? ***PLEASE CIRCLE:***

ALCOHOLISM	**Y**	**N**	**GOUT**	**Y**	**N**
ANEMIA	**Y**	**N**	**HEART TROUBLE**	**Y**	**N**
ARTHRITIS	**Y**	**N**	**HIGH BLOOD PRESSURE**	**Y**	**N**
EDEMA (SWELLING)	**Y**	**N**	**KIDNEY DISEASE**	**Y**	**N**
BLEEDING DISORDER	**Y**	**N**	**LIVER DISEACANCER**	**Y**	**N**
CANCER	**Y**	**N**	**MENTAL ILLNESS**	**Y**	**N**
DIABETES	**Y**	**N**	**MIGRANE HEADACHES**	**Y**	**N**
EMPHYSEMA	**Y**	**N**	**STOMACH ULCERS**	**Y**	**N**
EPILEPSY	**Y**	**N**	**STROKE**	**Y**	**N**
GLAUCOMA	**Y**	**N**	**TUBERCULOSIS**	**Y**	**N**
BREATHING DISORDER	**Y**	**N**	**DRUG ADDICTION**	**Y**	**N**

OTHER: _____
_____

FAMILY HEALTH
HISTORY:_____
_____

SOCIAL HISTORY:
TOBACCO:_____ **EXERCISE:_____**
ALCOHOL:_____ **OCCUPATION:_____**

SERIOUS BURNS (DESCRIBLE)_____
_____
WHEN?_____

WOUNDS (DESCRIBE)_____
_____
WHEN?_____

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Surgeries

APPENDIX_____ WHEN_____
GALL BLADDER_____ WHEN_____
HERNIA_____ WHEN_____
HYSTERECTOMY_____ WHEN_____
STOMACH_____ WHEN_____
TONSILS_____ WHEN_____

OTHER :_____

PRESENT MEDICATIONS:_____
_____

PRESENT ALLERGIES:_____
_____

Welcome to Pacifica Orthopedics Medical Corporation, Inc. We are committed to serving your health care needs with dedication, professionalism and compassion. Your understanding of our financial policy is important to our professional relationship. Please be advised of the following:

Office Policy and Payment Terms

Payment of co-payments, anticipated co-insurance, and deductibles will be collected in full and is due at the time services are rendered. For your convenience, Pacifica Orthopedics accepts Visa, MasterCard, Cash, and Check. It is the responsibility of the patient/member to verify that our office is affiliated with their Insurance carrier of PPO. As well, it is the responsibility of the patient/member to understand their benefits and any plan restrictions or plan limitations. Please contact your Insurance carrier directly for questions regarding your benefit limitations. Patients not confirming prior authorization procedures per their policy and/or requesting services when authorization has been denied or has not been obtained will be billed as a private pay account. We will provide you with an itemized statement of services or insurance claim form upon request. As a courtesy, Pacifica Orthopedics does provide insurance billing services. However, accounts not resolved within ninety days (90) from the date services were rendered, may be referred to any outside collection agency.

I, the undersigned, do understand and agree to the above office policy and understand my participation and financial responsibility.

_____ _____
Patient or Legal Guardian Signature Date

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Assignment of Insurance Benefits and Private Insurance Waiver

1. I hereby authorize payment directly to Pacifica Orthopedics Medical Group, Inc., of benefits due to me for services rendered. I also hereby authorize Pacifica Orthopedics Medical Group, Inc., to furnish information to my Insurance carrier as necessary to secure payment of benefits, and hereby assign to Pacifica Orthopedics Medical Group, Inc., any and all payments for services rendered.

2. I further agree that a photocopy of this agreement shall be as valid as the original.

3. I understand in the event any check or credit card payment is not honored by my bank or financial institution that I will be charged a service fee of **$25.00**, and I will be responsible to make immediate restitution to my account balance. I understand that subsequent visits may be on a cash basis only.

4. I understand that if my Insurance carrier refuses to pay and/or process my claims or denies toauthorize medical treatment for services rendered, that I will be financially responsible for the charges incurred at this facility.

Patient or Legal Guardian Name:_____

Signature:_____ Date: _____

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Payment Responsibility Form

Dear Patient:

Pacifica Orthopedics is committed to providing you with the best possible care. Your understanding of our financial policy is important to our professional relationship. Please be advised of the following:

Any co-payments, deductibles, co-insurance, non-covered services or amounts in excess of your policy's lifetime maximum are **due and payable at time of service.** Professional services are charged to the patient. As a courtesy to you, we will complete necessary forms to help expedite insurance carrier payments, however, the patient is ultimately responsible for all fees, regardless of insurance coverage.
_____ (initial)

Authorizations: Patients not confirming prior authorization procedures per their policy and/or requesting services when authorization has been denied or has not been obtained will be billed as a private pay account.
_____ (initial)

Referrals: In the course of providing care, your doctor may refer you to facilities or other physicians that are out of your coverage network. Because all policies and networks are different, it is the responsibility of the patient to determine whether or not the referred physicians/facilities are within their coverage network and how that affects their personal financial responsibility. Our front office can assist in determining network coverage if time allows.
_____ (initial)

Collection Measures: Accounts not resolved within sixty (60) days may be referred to an outside agency for further follow up.

My signature below acknowledges that I understand my financial responsibility.

Patient or Legal Guardian Signature: _____

Print Name: _____

Date: _____

Tel. No. (714) 841-5333 Fax No. (714) 541-5303

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NOTICE OF PRIVACY PRACTICES

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.

Pacifica Orthopedics Medical Corporation has always kept your health information secure and confidential. A new Law requires for us to continue maintaining your privacy, to give you this notice and to follow the terms of this office.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associate, such as a billing service.

We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletter or other information.

We may also want to call and remind you about your appointments. If you are not home, we may leave information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

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You have the right to k now of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for your copies.

You have the right to request an amendment or change to your health information. Give us a request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

Complaints about your privacy rights or how Pacifica Orthopedics Medical Corporation has handled your health information should be directed to Dr. Emile P. Wakim, M.D. calling (714) 841-5333

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHA, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of signature, I provide Pacifica Orthopedics with my authorization and consent to use and disclose my protected health care information for the purpose of treatment and payment and health care operations as described in the Privacy Notice.

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Treatment Consent

I hereby agree to any and all medical examinations, diagnostic and therapeutic recommendations as ordered or viewed as medically necessary per the Doctors and Associates at Pacifica Orthopedics.

Patient or Legal Guardian Signature: _____
Date:_____

General Permission for Release of Medical Records

I _____ am hereby authorizing Pacifica Orthopedics Medical Group, Inc., direct access to my medical records, history's laboratory results, etc., if available, per this request. I understand the medical confidentiality still prevails for both parties. I am also authorizing Pacifica Orthopedics Medical Group, Inc, to provide release of necessary documentation to my Insurance Adjustor, and/or Attorney if applicable.

Patient or Legal Guardian Signature: _____
Date: _____

Notice of Privacy Practices

I have received a copy of Pacifica Orthopedics Medical Corp. Notice of Privacy Practices.

_____
Patients Name (Print)

_____
Patient or Legal Guardian Signature