Registration Form

PLEASE PRINT CLEARLY Date: _____ / _____ / _____

Patient Name: _____
(Last, First)

Home Address: _____
Street City State Zip

Home Phone: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

Email Address: _____

Date of Birth: _____ / _____ / _____ SS#: _____ Sex: ☐ Male ☐ Female

Occupation: _____ Employer Name: _____

Emergency Contact: _____ Emergency Contact Phone: (_____) _____ - _____

Relation to you: _____

Preferred Pharmacy Name: _____ Street: _____

City: _____ Phone: (_____) _____ - _____

Primary Insurance: _____ ☐ **PPO** ☐ **POS**

Insurance Phone: (_____) _____ - _____ Group #: _____ ID#: _____

Effective Date: _____ / _____ / _____ Coverage Code: _____

Subscriber Name (if not patient): _____

DOB: _____ SS#: _____

Secondary Insurance: _____ ☐ **PPO** ☐ **POS**

Insurance Phone: (_____) _____ - _____ Group #: _____ ID#: _____

Effective Date: _____ / _____ / _____ Coverage Code: _____

Subscriber Name: _____

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Physician Information

Patient Name: _____ Date: _____ / _____ / _____

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION SO THAT WE MAY KEEP THEM INFORMED OF YOUR PROGRESS.

INTERNIST/PRIMARY CARE PHYSICIAN

Name: _____

Address: _____

Phone: (_____) _____ - _____ *Fax: (_____) _____ - _____

ATTORNEY INFORMATION (IF APPLICABLE)

Name: _____

Address: _____

Phone: (_____) _____ - _____ *Fax: (_____) _____ - _____

WORKER'S COMPENSATION INFORMATION (IF APPLICABLE)

Name: _____

Address: _____

Adjustor: _____ Phone: (_____) _____ - _____

Claim #: _____ Date of Injury: _____

PLEASE USE THE BACK OF THIS PAGE FOR ANY ADDITIONAL PHYSICIAN INFORMATION

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Patient Name_____ Age_____ Today's Date ____ /____ /____
(Last, First)

Date of Birth: ____ / ____ / ____ Height: _____ Weight: _____ Sex: M____ F____

- Left-handed / Right-handed / Ambidextrous (CIRCLE)
- Occupation:_____
- Primary Care Physician: _____
- Who referred you to us? _____

List **ALL MEDICATIONS AND SUPPLEMENTS** you are currently taking: ☐ **NONE**

_____

Please list **ALL DRUG ALLERGIES,** including allergies to iodine or latex: ☐ **NONE**

Do you smoke? Y / N Packs per day _____ Number of years _____

Do you drink? Y / N How much / how often? _____

PAST MEDICAL HISTORY:

Which medical problems you have been treated for in the past: ☐ **NONE**

seizures / stroke	Y / N	ulcer / stomach bleed	Y / N	cancer	Y / N
angina / heart attack	Y / N	thyroid disorder	Y / N	psoriasis / rash	Y / N
high blood pressure	Y / N	drug / alcohol abuse	Y / N	diabetes	Y / N
asthma	Y / N	blood clots / PE	Y / N	hepatitis / jaundice	Y / N
emphysema / bronchitis	Y / N	bleeding disorder	Y / N	difficulty voiding	Y / N
kidney / bladder infection	Y / N	steroid treatment	Y / N	HIV / AIDS	Y / N
Rheumatoid arthritis	Y / N	osteoporosis	Y / N	Other _____	

Please list all previous surgical procedures and hospitalizations: ☐ **NONE**

_____

Do you or a family member have a history of blood clots (DVT) or pulmonary embolism (PE)? ☐ **NONE**

ARE YOU PREGNANT? YES / NO **PLEASE TELL OUR STAFF/X-RAY TECH IF YOU ARE/MIGHT BE PREGNANT**

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WHAT IS YOUR CHIEF COMPLAINT TODAY?

- Which part of the body? SHOULDER KNEE OTHER _____
- Which side is involved? LEFT RIGHT BOTH
- How long has the current problem affected you?_____
- Briefly describe how your current problem started and current symptoms:

_____

_____

_____

- Which sports/hobbies have been affected by current problem?

_____

- Have you had any PAST injuries to THE AFFECTED area? Please describe or ☐ **NONE**

_____

_____

- Have you been treated by another physician for the CURRENT problem? YES NO (**CIRCLE**)

  If NO proceed to next section / If YES please enter the following information:

DOCTOR'S NAME	**TYPE OF DOCTOR** (physical therapist, chiropractor, orthopedic, etc)	**TREATMENT GIVEN** (meds, physical therapy, tests, etc)
1.		
2.		
3.		

- DIAGNOSTIC TESTS: if you have had any of the following tests, **please enter the following information or CIRCLE <u>NO TESTS</u>**

TEST	**DATE**	**IMAGING CENTER NAME**	**ORDERING PHYSICIAN**
X-Rays			
MRI			
EMG (nerve test)			
CT Scan			

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- INJECTIONS: if you have had any injections for the CURRENT problem **please provide the following information or CIRCLE** **NO INJECTIONS**

Type of Injection (cortisone, lubricating)	**DATE (Appx)**	**Name of doctor who performed injection**	**Did the injection help? For how long?**
1.			
2.			
3.			

- SURGERY: If you have had surgery on this part of the body **please provide the following information or CIRCLE** **NO PRIOR SURGERY**

What procedure was performed?	**DATE (Appx)**	**Name of Surgeon**	**Did the surgery provide relief?**
1.			
2.			
3.			

CURRENT REVIEW OF SYSTEMS: Do you currently have any of these symptoms? ☐ **NONE**

depression / anxiety	Y / N	night sweats	Y / N
weight gain / loss	Y / N	chest pain	Y / N
irregular heartbeat	Y / N	poor circulation	Y / N
bloody urine / inability to urinate	Y / N	bleeding problems	Y / N
frequent headaches	Y / N	shortness of breath	Y / N
previous transfusions	Y / N	persistent cough	Y / N
vision loss / glaucoma	Y / N	muscle aches	Y / N
wheezing	Y / N	loss of hearing	Y / N
joint pain	Y / N	stomach pain	Y / N
diarrhea	Y / N	vomiting	Y / N
rash	Y / N	other: _____	

_____ _____
Patient Signature **Date**

_____ _____
Physician Signature **Date**

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Patient Contact Information Release Consent

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or alternative means of communication PHI, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner:

- **Home Phone # _____**
- Y / N OK to leave message with detailed information
- Y / N Leave message with call back number only

- **Work Phone # _____**
- Y / N OK to leave message with detailed information
- Y / N Leave message with call back number only

- **Cell Phone # _____**
- Y / N OK to leave message with detailed information
- Y / N Leave message with call back number only

- **Email Address _____**
- Y / N OK to leave email with detailed information

- **Work Phone # _____**
- Y / N OK to leave message with detailed information
- Y / N Leave message with call back number only

I hereby consent to the release of Protected Health Information to the following individuals. I understand this authorization will be in effect until which time it is revoked.

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

Printed Name _____ Signature _____Date:_____

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MILLSTEIN ORTHOPEDICS FINANCIAL POLICY

Thank you for choosing Millstein Orthopedics. We are committed to the success of your treatment and care. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes, such as address, name, and insurance information. Please read and sign the policy. A copy will be provided to you upon request.

Insurance: Our office is contracted with several commercial insurance companies including Medicare, Blue Cross and Aetna. Co-payments, coinsurance, deductibles, and non-covered services are the responsibility of the patient and payment is expected at the time services are rendered. Dr. Millstein is not contracted with Cigna, Healthnet, United Healthcare or Medi-cal (if medi-cal is secondary you will be billed for your coinsurance after Medicare remits payment for your treatment). We will submit your claims as a courtesy and assist you in any way we reasonably can to help get your claims paid either in or out-of-network. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. All other payments are expected within 30 days of receipt of our billing statement. If you do not have insurance, payment is due in full at the time of service. If you do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. A driver's license is also required with proof of insurance. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. We do not accept any HMO plans.

Workers' Compensation or Automobile Accidents: In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Nonpayment and Outstanding Balances: Balances over 60 days delinquent will be charged to the credit card we have on file. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that Dr. Millstein has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered and all costs of collection including, but not limited to, interest due at 18% APR, all court costs and attorney fees, and a collection fee will be added to the outstanding balance.

Payment Plans: There are situations when making a payment can be a financial hardship. If you are in need of special payment arrangements, please advise us prior to your visit. Co-pays are exempt. Your insurance requires you to pay your co-pay and deductible at the time services are rendered. Please feel free to contact our billing service, ML Medical Billing, at 877-388-0040 to discuss these arrangements.

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SIGNATURES PLEASE:

I. La Peer Surgery Center

We wish to inform you that Eric S. Millstein, MD has a significant beneficial interest in the La peer Surgery Center health care facility. We feel these facilities offer competent and qualified medical services and procedures. However, you have the absolute right to use any alternative facility of your choice. You are not obligated to use any facility recommended by Dr. Millstein. He will be happy to recommend and discuss other facilities that provide the same medical services or procedures. If you have any questions in regard to this information please do not hesitate to ask Dr. Millstein directly.
I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENT AND ANY QUESTIONS I HAVE WITH THE ABOVE MATTER HAVE BEEN ANSWERED.

SIGNED: _____ _____
Patient Signature **Date**

II. HIPAA

In compliance with Federal and State law regulations, this is to confirm that I have reviewed and been offered a copy of the Notice of Privacy Policies (HIPAA forms).

SIGNED: _____ _____
Patient Signature **Date**

III. Financial Policy

I certify that I have read, understood, and agree to the terms outlined on the Millstein Orthopedics Financial Policy, located on page 8 of this document.

SIGNED: _____ _____
Patient Signature **Date**

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