Welcome Letter

Welcome! Thank you for choosing Pediatric Orthopaedic Specialists of Orange County. Your health care needs are our most important priority. Our goal is to be available and responsive to your needs. The following information is provided to introduce you to our practice and help you plan your office visit. Please let us know if you have any questions or would like additional information.

- Office hours are 8AM to 5PM Monday through Friday
- Please call (714) 633-2111 during regular office hours to schedule an appointment.
- Our office does not provide childcare supervision during appointments. No children under age 12 may be left unaccompanied in the waiting room.
- You will receive a call 48 hours prior to your appointment to confirm your appointment.
- If you are unable to keep an appointment, please call the office in advance. After hours, you may leave a message with our exchange service.
- Our specialty practice has a “No Show” fee of $25 is charged if you do not cancel 24 hours in advance, an exception will be made for an emergency. A 24 hour notice is needed so that we can offer your appointment time to another patient.
- If you are running late for an appointment, please call our office so we are aware and accommodate your arrival with our schedule.
- If you need to contact the physician after hours your call will be answered by our exchange service. The on-call physician will be notified and respond to your call.
- Please bring a photo ID to your visit as a part of our privacy/identity theft program.
- Pediatric Orthopaedic Specialists of Orange County maintains compliance with federal and state HIPPA privacy laws. If you would like health information released to yourself or another person you must sign a HIPPA release form identifying the individual to whom you want the information released.
- Co-pays are due at the time of the appointment and bills are payable within 30 days of receipt. We bill insurance on your behalf; however, the balance due is your responsibility.
- Once you are a registered patient you may communicate with Pediatric Orthopaedic Specialists of Orange County through the patient portal (does not currently provide communications by email or electronic transmission).
- Our office does not permit photography, video or audio recording in the office.
- Please be advised that we fit in patients with emergency conditions and at times find it hard to stay on schedule. Please know that we do respect your time, and we will make every effort to see you as close to your scheduled time as possible.

Thank you for choosing Pediatric Orthopaedic Specialists of Orange County. We look forward to providing you with the highest quality of services to support your health care needs. Wishing you the best of health.

Sincerely yours,

Pediatric Orthopaedic Specialists of Orange County

PEDIATRIC ORTHOPAEDIC
SPECIALISTS OF ORANGE COUNTY
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REGISTRATION

Physician/PCP_____Referred by_____

Dr.'s Address _____

Dr.'s phone:( )_____Dr.'sfax:( )_____

Nameofpatient: Last_____First_____Middle_____

Home address: Number_____City_____State_____Zip_____

Home Phone:( )_____SS#_____Cell _____

Date of birth_____Age_____Sex M F Driver's lic. _____

Employer_____Occupation_____

Employer address:_____City_____State_____Zip_____

Employer phone( ) _____

Insurance Name_____I.D#_____

Policy Holder Name _____

Is this ins. Primary? Yes ; No Is there other coverage? _____

Name ofspouse: Last_____First_____Middle_____

Date of birth_____Driver's lic.

Employer_____Occupation

Employer address:_____City_____State_____Zip

Employer phone ( ) _____

Details of injury/illness :

Date of Onset_____Explain in detail (where, when, how) _____

_____

Preferred Pharmacy Name and Address

I hereby authorize release of information necessary to file a claim with my Insurance company and assign benefits otherwise payable to: Adult and Pediatric Orthopaedic Specialists.

I understand I am financially responsible for any balance not covered by my insurance carrier.

Patient/Responsible Party Signature_____Date _____

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PATIENT HEALTH INFORMATION FORM

Name_____ Date of Birth_____ Age_____ Sex ☐ M ☐ F
Phone: Home_____ Work_____ Cell_____
Whatis yourcurrent: Height_____ Weight _____
Have you ever had, or been told you had: blood transfusions ☐ Yes No When _____
Anesthetic reaction ☐ Yes ☐ No Surgical bleeding ☐ Yes ☐ No Bleeding from aspirin ☐ Yes ☐ No

Have you been hospitalized for non-surgical reasons? Attach a list if necessary

Reason for admission	Year	Hospital	Doctor

Any prior surgeries? Attach a list if necessary

Operation	Year	Hospital	Doctor

List all prescription medications you are now taking: Attach a list if necessary

Name	Dose	How often	Name	Dose	How often
1.			4.		
2.			5.		
3.			6.		

List all herbal/non prescription medications you are taking: Attach a list if necessary

1.	4.
2.	5.
3.	6.

Do you take vitamins? ☐ Yes ☐ No What? _____
Do you drink milk ☐ Yes ☐ No # Glasses/Day _____
Take calcium ☐ Yes ☐ No Dose _____ #/Day _____
Do you have allergies to:
Medications: list _____
Foods: list _____ Tape ☐ Yes ☐ No
Metal/Jewelry ☐ Yes ☐ No Iodine ☐ Yes ☐ No Latex ☐ Yes ☐ No
Do you have: Dermatitis ☐ Yes ☐ No Eczema ☐ Yes ☐ No

Family History:

	If living		If deceased	
	Age	Health	Age	Cause
Mother				
Father				
Siblings				
Children				
Spouse				

In your blood family, is there a history of:

Cancer	☐ Yes ☐ No	TB	☐ Yes ☐ No	Muscle disease	☐ Yes ☐ No
Heartattack	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	Suicide	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bleeding	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Bone disease	☐ Yes ☐ No	Congenitaldeformity	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Blood Clots	☐ Yes ☐ No		

Personal History:

☐ Married ☐ Single ☐ Divorced ☐ Widowed Living Situation: House__ Apt.____ Other _____

Occupation _____

Alcohol use: ☐ Yes ☐ No How much/Day_____ Tobacco use: ☐ Yes ☐ No

Recreational drug use? ☐ Yes ☐ NoList _____

Industrial health hazards exposure: ☐ Yes ☐ No List_____ HIV/AIDS: ☐ Yes ☐ No

Health Review:

Have you had a dexa bone density scan? ☐ Yes ☐ No When? _____

Haveyouhadafallinthepastyear? ☐ Yes ☐ No Howmany _____

Unexplainedfevers: ☐ Yes ☐ No Unexplainedweightloss: ☐ Yes ☐ No Cancer: ☐ Yes ☐ No

Have you had any of the following health problems? Check all that apply:

Head, Eyes, Ears, Nose, Throat:

Eye injury	☐ Yes ☐ No	Deafness	☐ Yes ☐ No	Hay fever	☐ Yes ☐ No
Nosebleeds	☐ Yes ☐ No	Hoarseness	☐ Yes ☐ No	Wear glasses	☐ Yes ☐ No
Earache	☐ Yes ☐ No	Double vision	☐ Yes ☐ No	Gland enlargement	☐ Yes ☐ No
Headache	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No	Ear ringing	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Seizures	☐ Yes ☐ No		

Cardiovascular:

Angina	☐ Yes ☐ No	Fast heart	☐ Yes ☐ No	Varicose veins	☐ Yes ☐ No
Phlebitis	☐ Yes ☐ No	Chest pain	☐ Yes ☐ No	Short of breath	☐ Yes ☐ No
Jumping heart	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Ankle swelling	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No	Heart failure	☐ Yes ☐ No
High bloodpressure	☐ Yes ☐ No			Pulmonary embolism	☐ Yes ☐ No
Passingoutwithexercise	☐ Yes ☐ No			Chest pain with exercise	☐ Yes ☐ No

Pulmonary:

Cough	☐ Yes ☐ No	Pleurisy	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Cough blood	☐ Yes ☐ No	Wheezing	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Night sweats	☐ Yes ☐ No

Gastrointestinal:

Gallstones	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Heartburn	☐ Yes ☐ No	Stomach pain	☐ Yes ☐ No	Colitis	☐ Yes ☐ No
Ulcer	☐ Yes ☐ No	Appetite change	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Vomit blood	☐ Yes ☐ No	Blood instool	☐ Yes ☐ No	Black stool	☐ Yes ☐ No
Pain swallowing	☐ Yes ; ☐ No	Hiatal hernia	☐ Yes ☐ No		

Gynecologic:

Fibroids	☐ Yes ☐ No	Ovarian cyst	☐ Yes ☐ No	Irregular periods	☐ Yes ☐ No

Last menstrual period _____ #Pregnancies _____ Last pap smear _____

Hysterectomy? ☐ Yes ☐ No At what age _____ Do you take hormones ☐ Yes ☐ No

Genitourinary:

Kidney disease	☐ Yes ☐ No	Kidneyinfection	☐ Yes ☐ No	Bladderinfection	☐ Yes ☐ No
Blood inurine	☐ Yes ☐ No	Wetting	☐ Yes ☐ No	Stones	☐ Yes ☐ No
Poor stream	☐ Yes ☐ No	Pain on urination	☐ Yes ☐ No	Kidney failure	☐ Yes ☐ No
Venereal disease	☐ Yes ☐ No	Explain	_____		

Skin/ breast:

Rashes	☐ Yes ☐ No	Skincolorchanges	☐ Yes ☐ No	Skinulcers	☐ Yes ☐ No
Lumps	☐ Yes ☐ No	Psoriasis	☐ Yes ☐ No		
Scars	☐ Yes ☐ No	Where?	_____		

Hematologic/Lymphatic/Endocrine:

Anemia	☐ Yes ☐ No	Easy bleeding	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Thyroid disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Blood disease	☐ Yes ☐ No
Muscle weakness	☐ Yes ☐ No	Easy bruising	☐ Yes ☐ No	Easy fractures	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Thirst	☐ Yes ☐ No	Enlarged glands	☐ Yes ☐ No

Psychological:

Depression	☐ Yes ☐ No	Mood swings	☐ Yes ☐ No	Tearfulness	☐ Yes ☐ No
Poor sleeping	☐ Yes ☐ No	Angry outbursts	☐ Yes ☐ No	Hallucinations	☐ Yes ☐ No
Tiredness	☐ Yes ☐ No	Addiction history	☐ Yes ☐ No		

Neurologic:

Seizures	☐ Yes ☐ No	Weakness	☐ Yes ☐ No	Memory loss	☐ Yes ☐ No
Incoordination	☐ Yes ☐ No	Falling	☐ Yes ☐ No	Speech slurring	☐ Yes ☐ No
Vision changes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Tremors	☐ Yes ☐ No
Tinglinghandsorfeet	☐ Yes ☐ No	Difficulty swallowing	☐ Yes ☐ No	TIA	☐ Yes ☐ No

Do you have any other health problems that you are aware of?

Please explain _____

_____

Signature _____ Date _____

Dr's Weinert, Rosenfeld, Dobyns, Aminian, Lalonde, Schlechter, Davis and Misaghi
1310 W. Stewart Dr. Suite 508, Orange, CA 92868 Tel: (714) 633-2111 Fax: (844) 387-7625 25982
Pala Dr. Suite 230, Mission Viejo, CA 92691 Tel: (949) 600-8800 Fax: (844) 374-4221
4980 Barranca Parkway, Suite 220, Irvine CA 92604

Insurance Eligibility Certification HMO/PPO/POS

IherebyattestthatIamaneligiblememberofacontractedhealthplanasnotedbelow.Iagree,that shoulditbedeterminedthat Iamineligibleorservicesaredeniedto meunderthehealthplannoted below, that I will be responsible for payment to:

Adult and Pediatric Orthopaedic Specialist

Health Plan _____

Plan ID _____

Name of Subscriber _____

Social Security Number _____

Name of Patient _____

Social Security Number _____

Relationship toSubscriber _____

I authorize release of my medical history and documentation directly to my insurance company for the purpose of payment for medical service and that the payment(s) be made directly to: ADULT AND PEDIATRIC ORTHOPAEDIC SPECIALISTS.

Signature _____ Date _____

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ADULT AND PEDIATRIC ORTHOPAEDIC SPECIALISTS

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plananddirect my treatmentandfollow-upamongthe multiple healthcareproviderswho may be involved in that treatment directly and indirectly.
- Obtain payment for services.
- Conduct normal health care operations.

I have received, read and understand your"Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at 714-633-2111 at any time to obtain a current copy of the"Notice of Privacy Practices".

IunderstandthatImayrequestinwritingthatyourestricthowmyprivateinformationisusedordisclosed to carry out treatment, payment or health care operations.

Patient Name _____

Patient Representative _____

Signature_____Date _____

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OUR PRIVACY PROMISE TO YOU, OUR PATIENTS

YOUR INFORMATION IS IMPORTANT AND CONFIDENTIAL. OUR POLICIES REQUIRE THAT YOUR INFORMATION BE HELD IN COMPLETE CONFIDENCE.

Authorization to leave messages

I give my permission for the staff of Adult and Pediatric Orthopaedic Specialist to leave messages on my telephoneanswering machine orwithafamily member such as informationregarding medication, surgery, appointments and healthcare.

SignatureofPatient _____ Date _____

Patient Name - Please Print _____

Family Member's Name _____

Family Member's Name _____

I do not give my permission for the staff of Adult and Pediatric Orthopaedic Specialist to leave message on mytelephone answering machine orwithafamily member suchasinformationregarding medication, surgery, appointments and health care.

SignatureofPatient _____ Date _____

Patient Name - Please Print _____

PEDIATRIC ORTHOPAEDIC
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Consent for Electronic Mail ("Email") Use

APOS ("Office") offers patient the opportunity to communicate by Email for non-urgent matters. This form provides the guidelines regarding Email communications, and documents your consent.

IN CASE OF A MEDICAL EMERGENCY, DO NOT USE E-MAIL. CALL 911

Email Use

Email communications should be between the office and an adult patient 18 years of age or older, or the parent or guardian of a minor.

Do Not Use Email For

Do not use Email for communicating sensitive medical information such as sexually transmitted diseases, HIV, hepatitis, substance abuse, mental health or presence of malignancy. Do not use Email to request records. Please call your office.

Privacy, Security & Confidentiality

Although the office has implemented reasonable technical safeguards, the office cannot and does not guarantee the privacy, security or confidentiality of any Email messages sent or received over the Internet. There is a potential that Email sent or received over the Internet can be intercepted, altered, forwarded, and / or read by others. The office is not responsible for Email messages that are lost due to technical failure during composition, transmission, or storage.
The office will not forward Emails to independent third parties without your prior written consent, except as authorized or required by law. If any of this is a concern to you, you should not communicate with the office through Email.

Creating a Message

In the "Subject" line of the email, please include general topic of your message (i.e., prescription, appointment, medical advice, billing question).
In the body of the message, please include the patient's name and date of birth. This information is necessary to verify your identity and make sure we pull the correct medical file.

Content of the Message

Email should only be used for non-sensitive and non-urgent issues. Email communications are appropriate for the following type of transactions:

- Appointment scheduling
- Prescriptions / refills
- General medical advice after an initial face-to-face visit
- Lab/Test Results
- Referrals
- Attachments such as: physical education excuse note, etc.

Response Time

Although APOS will endeavor to read and respond within 24 hours to any Email, we cannot guarantee that any particular Email will be responded to within any particular period of time. If you have not received a response within 3 days, please call our office.

Documentation In Medical Record

Email communications regarding treatment will be documented in your medical record by placing a copy of the message in your file.

Ending Email Relationship

You may discontinue using Email as a means of communication by sending an email or letter to the office.

I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of Email as one form of communication with the office.

Email Address: _____

_____ _____
Signature of Patient, Parent or Personal Representative Date

_____
Relationship (if other than patient)

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PATIENT CONSENT AND WAIVER FORM

I,_____, understand that I am, or will be, responsible for all of the charges associated with my appointment today, as well as any subsequent appointments relating to the testing, x-rays, diagnosis, and all treatment, including, but not limited to the following items:

1. **ALL DURABLE MEDICAL EQUIPMENT, IF NOT COVERED BY INSURANCE PLAN.**

2. **NO REFERRAL AT TIME OF VISIT:** If you wish to be seen today, but did not bring a referral with you, nor do you have a valid referral already here in the office, you will be responsible for all charges.

3. **NO INSURANCE:** You will be responsible for all charges associated with all visits.

4. **MISSED APPOINTMENTS:** Appointments are confirmed prior to your appointment date. If an appointment is cancelled up to 24 hours prior, you will not be charged. If you fail to show up for your confirmed appointment, you will be charged $25.00.

5. **CHANGES IN INSURANCE:** All co-pays and fees are due in full at the time of service.

6. **DELINQUENT ACCOUNTS:** In the event that your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing costs and processing fees.

7.

8. **I authorize** my physician to access my medication history.

Patient or Responsible Party:

Signature_____Date_____