

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE PATIENT REGISTRATION FORM

(Please Print)

Date _____

Referring Physician: _____ PCP: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____
 Mr. Miss Marital status (circle one)
 Mrs. Ms. Single / Mar / Div / Sep / Wid
 Dr.

Is this your legal name? Yes No
 If not, what is your legal name? _____ (Former name): _____ Birth date: ____/____/____ Age: _____ Sex: M F

Street address: _____ City: _____ State / Zip Code: _____

Phone number: _____ () _____ Other contact number: Cell ____ Work ____ Social Security #: _____ () _____

Occupation: _____ Employer: _____ Address: _____ Employer phone no.: _____ () _____

IF PATIENT IS A MINOR PLEASE COMPLETE:
 Father: _____ Work# _____ Cell# _____
 Mother: _____ Work# _____ Cell# _____

Other family members seen here: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Birth date: ____/____/____ Address (if different): _____ Home phone no.: _____ () _____

Is this person a patient here? Yes No

Occupation: _____ Employer: _____ Employer address: _____ Employer phone no.: _____ () _____

Is this patient covered by insurance? Yes No

Name of primary insurance: _____

Subscriber's name: _____ Subscriber's S.S. no.: _____ Birth date: ____/____/____ Policy no.: _____ Group no.: _____ Co-payment: _____ \$

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): _____

Subscriber's name: _____ Subscriber's S.S. no.: _____ Birth date: ____/____/____ Policy no.: _____ Group no.: _____ Co-payment: _____ \$

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative: _____ Relationship to patient: _____ Home phone no.: _____ Work phone no.: _____ () _____ () _____

REASON FOR VISIT

Chief Complaint: _____ Body Part: _____ Right: _____ Left: _____

Related to: Employment ____ Date of Injury: ____/____/____ Other ____ Date of Incident: ____/____/____

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

Name _____

Date _____

CHIEF COMPLAINT: (Please present complaints in patient's own words.)

DATE OF ONSET/INJURY: _____

CAUSE: (If injury, please explain.)

- X-rays or MRI's brought to today's appointment.
- X-rays or MRI's exist but not brought to today's appointment.
- No previous imaging done.

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
PATIENT CONSENT FORM

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Patient's Name

A. PERMISSION TO GIVE MY HEALTH RELATED INFORMATION TO SPOUSE/SIBLING/CHILD/FRIEND/ETC:

I, _____ hereby authorize Walnut Creek Orthopedics & Sports Medicine and/or William B. Workman, M.D. to disclose the following protected health/billing information to :

_____ (name/relationship) contact # _____

_____ (name/relationship) contact # _____

PATIENT SIGNATURE

DATE

PARENT/GUARDIAN NAME/SIGNATURE

DATE

B. PARTY RESPONSIBLE FOR PAYMENT*:

Assignment and Release: I hereby assign my insurance benefits to be paid directly to Walnut Creek Orthopedics & Sports Medicine and/or William B. Workman, M.D. I am financially responsible for non-covered services, which may include non-durable goods such as splints, supports and other supplies not covered under my personal insurance. I also authorize the medical providers to release any information required to process my claims for payment.

PATIENT SIGNATURE

DATE

PARENT/GUARDIAN NAME/SIGNATURE

DATE

***Statements will be sent to patient or Parent/Guardian unless otherwise specified here:**

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
PATIENT CONSENT FORM

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Patient's Name

C. PERMISSION TO TREAT A MINOR: (if applicable)

I give permission to have my son/daughter receive the necessary medical treatment as prescribed by the medical providers of Walnut Creek Orthopedics & Sports Medicine.

PARENT/GUARDIAN NAME/SIGNATURE

DATE

RELATIONSHIP TO MINOR

D. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:

I acknowledge that I have been provided an opportunity to review the NOTICE OF PRIVACY PRACTICES for Walnut Creek Orthopedics & Sports Medicine.

PATIENT SIGNATURE

DATE

PARENT/GUARDIAN NAME/SIGNATURE

DATE

E. PERMISSION TO LEAVE VERBAL DIAGNOSTIC STUDY RESULTS:

I give permission to have Walnut Creek Orthopedics & Sports Medicine leave MRI or diagnostic results on my voicemail at the phone numbers I have listed in the event that I cannot be reached.

PATIENT SIGNATURE

DATE

PARENT/GUARDIAN NAME/SIGNATURE

DATE

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

FINANCIAL POLICIES

(updated February 2009)

We have adopted the following financial policies to simplify the billing process and help secure reimbursement for medical services provided to you.

Please bring your insurance card to the office every visit: You must bring your insurance card on your first visit, as well as any time your coverage changes in any way. If you do not have a current insurance card we appreciate and expect payment at the time of service. Always be sure to tell us right away when you obtain new insurance coverage, updated information or a new insurance card. ***It is your responsibility to determine that we are contracted providers before you are seen.*** We are not responsible for any changes in your insurance coverage.

Please update your address, telephone numbers, and employer information: Please call the billing department at **(925)944-0334** if your contact information changes prior to your next appointment.

Co-payments are due at the time of service: If your insurance policy requires you to pay a co-payment for office visits, you will be asked to pay that co-payment at the time of your appointment. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. ***If you do not pay for your co-payment at the time of service, we must add an additional fee of \$10 to cover our billing and administrative costs.*** The co-payment and any billing fee are due upon receipt of statement from us.

If we are unable to verify your insurance coverage, you will be asked to pay for our charges at the time of service: If we cannot confirm that you are covered by an insurance plan that we accept, you will be expected to pay our charges in full at the time of your visit. Upon receipt of confirmed insurance coverage, we will bill your insurance company. When we receive an insurance payment, we will promptly refund any money due to you.

Auto Accidents and other injuries: We do not bill third parties. We do not accept liens. If you do not have commercial insurance, you must inform the front office staff. You will be expected to pay our charges in full at the time of service. *Sorry- no exceptions.*

When your insurance company delays payment: If you have commercial insurance, we will bill your insurance carrier as a courtesy to you. If your insurance carrier does not make payment within 90 days, the balance of our full charges will be due and payable immediately from you. We will send you a statement. If there is a problem or dispute over payment with your insurance carrier, we will ask you to pursue the matter with them directly. If your insurance carrier subsequently makes a payment, we will promptly refund any money due to you.

When your insurance company denies a claim: If your insurance company denies a claim, you will be billed for all services provided, in accordance with our contract with your insurance company. This may include, but is not limited to, denials due to eligibility, out of network services, when the insurance carrier has requested information from the patient and that information is not provided in a timely manner and instances where maximum benefits have been reached. We are not able to determine your specific coverage and benefits, plan limitations or plan provisions. For this information, you should contact your insurance carrier directly. We must emphasize that as a health care provider our relationship is with you and not the insurance company.

Workers' Compensation cases: If you have a workers' compensation case, you need to bring all of your insurance information with you to your appointment. You cannot be seen without prior authorization and we will ask you to reschedule your appointment if your treatment is not authorized.

**WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
FINANCIAL POLICIES**

(updated February 2009)

Medical Records: There is a charge of \$15.00-\$25.00 for reproduction of your medical record, depending on the size of the record. This charge includes the transfer of records to an attorney, other physicians, and other medical facilities.

Medical Forms: There is a \$25.00 charge for the completion of forms (other than California State Disability Forms). This fee is due in advance.

Payment Options: For your convenience, we accept Visa and Mastercard.

Missed Appointments and Cancellations: If you must cancel or reschedule your appointment, please notify us no less than 48 hours in advance. Please be courteous and remember that the appointment time reserved for you can be used by another patient. Cancellations with less than 48 hours notice and No Shows will be billed a \$50 service fee.

Delinquent Accounts: It is your responsibility to keep your account and contact information current. All charges are due in full at the time of service, or upon your receipt of a statement from us. We assume receipt by you of all statements we send to you at the most recent address you provide to us. We assume you accept all charges as accurate unless you contact us promptly upon receipt of a statement to dispute them. Statements returned to us due to the expiration of a postal forwarding order, or as undeliverable for any reason will be assumed accurate. Charges on account outstanding over 90 days may be submitted to an outside collection agency and any applicable fees from the agency will be added to your balance due.

Returned or "Bounced" Checks: We pass along our banks' service charge to you for any checks that are returned for non-payment for any reason. A service fee of \$25.00 will be added to your balance for all returned checks.

I have read and understand the Financial Policies of Walnut Creek Orthopedics & Sports Medicine. I also understand that no guarantee has been made to me about my insurance coverage. I do not hold William B. Workman, MD any of the providers or staff responsible for my insurance coverage, or for decisions made by my insurance company.

Patient Name (Please print)

Parent/Guardian Name, if applicable (Please print)

Relationship to Patient

Patient or Guardian Signature

Date

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

MEDICAL HISTORY FORM

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Patient Name: _____

Date: _____

I. RELATIONS:

Relation	Age (if living)	If deceased, cause of death	Age at death
Father			
Mother			
Brothers			
Sisters			
Spouse			
Children			

II. ILLNESSES:

Have you or your relations had any of the following? (Specify if you or your relation)

ILLNESS	YES	NO	WHO	ILLNESS	YES	NO	WHO
Rheumatic Fever				Hepatitis			
Glaucoma				Asthma			
Epilepsy				Kidney Stone			
Cancer				Gout			
Heart Disease				Sickle Cell Anemia			
Tuberculosis				Diabetes			
High Blood Pressure				Allergies			

List any serious illnesses and your age at the time you had them:

III. OPERATIONS:

Have you had any surgical treatments or operations? YES ____ NO ____

If yes, describe and give your age at which they occurred: _____

IV. INJURIES:

Have you had any serious accidents or injuries? YES ____ NO ____

If yes, describe and give your age at which they occurred: _____

V. FEMALES ONLY:

Are you or could you be pregnant? YES ____ NO ____

VI. Do you smoke? YES ____ NO ____ If yes, how many packs per day? ____

Do you drink alcoholic beverages? NO ____ Occasionally ____ Weekly ____ Daily ____

VII. MEDICATION REACTIONS:

Have you had any reactions, allergies, or bad effects from any of the following?

	YES	NO		YES	NO
Cortisone Injection			Novocaine		
Penicillin			Aspirin		
Other antibiotics			Morphine		
Codeine			Other Drugs		

Please list other drug allergies _____

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

MEDICAL HISTORY FORM

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Patient Name: _____

Date: _____

VIII. Do you take any of the following medicines or drugs regularly?

	YES		YES
Digitalis (for heart)		Insulin	
Anticoagulants (blood thinner)		Cortisone	
Diuretics (to remove fluid)		Sleeping Pills	
Drugs to lower high blood pressure		Tranquilizers	
Thyroid		Aspirin	

Current Medications (Please list dosage and frequency): _____

IX. Have you ever had or do you currently have any of the following? (Check only those which pertain to you.)

	Frequent Headaches		Vomiting of blood
	Frequent or severe dizziness		Vomiting of material resembling coffee grounds
	Fainting or blackouts		Frequent vomiting
	Impaired Hearing		Recurring burning in stomach
	Worn/wear a hearing aid		Yellow jaundice
	Hay fever		Frequent diarrhea
	Frequent nose bleeds		Frequent constipation
	Impaired vision not corrected by glasses		Red blood in bowel movement
	Worn/wear glasses		Black, tarry bowel movements
	Pain or difficulty in swallowing		Hemorrhoids (piles or rectal disease)
	Frequent hoarseness		Hernia
	Lived with anyone with tuberculosis		Blood in urine
	Frequent sweating at night		Frequent or painful urination
	Chronic cough		Trouble starting or stopping urine
	Coughed up blood		Urinate more than once at night
	Severe or recurrent chest pain		Prostate trouble
	Pneumonia		Disabling back pain
	High blood pressure		Worn a back brace
	Heart murmur		Foot trouble
	Shortness of breath on climbing stairs		Trick or locked knee
	Pressure or tightness in chest		Painful or trick shoulder or elbow
	Pain or cramps in legs with walking		Blood disorder
	Irregular heart beat		Tendency to bleed
	Varicose veins		Skin cancer
	Phlebitis		Claustrophobia
	Recent change in appetite		Allergies to shellfish and/or iodine

X. DIET

Are you on any special diet? YES ____ NO ____ If yes, what kind? _____

What is your present weight? _____ and Height? _____