WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

Today's Date: _____

PATIENT DEMOGRAPHICS

Patient's Legal Name: (Last, First, Initial)	**Preferred Name**:	**SSN:**
Home Address:	**City & State**:	**Zip**:
Date of Birth	**Gender** ❑ M ❑ F	**Marital Status**: ❑Single ❑Mar ❑Div ❑Sep ❑Wid	**Email**:
Best Contact Number: ❑ Cell ❑Home ❑ Work ( )	Other Contact Number: ❑ Cell ❑Home ❑ Work ( )	Other Contact Number: ❑ Cell ❑Home ❑ Work ( )
Employer:	**Occupation**:	**Work Phone#:** ( )
Primary Care Physician:	**Employment Status**: ❑ Full-Time ❑ Part-Time ❑ Retired ❑ Not Working	
Who referred you to our office? (Physician, family member, friend, etc. - Please list their name) :		

IF PATIENT IS A MINOR PLEASE COMPLETE:	PARENT: (Name/Relation)	Work#:	Cell#:
	PARENT: (Name/Relation)	Work#:	Cell#:

RESPONSIBLE PARTY/GUARANTOR (IF DIFFERENT FROM ABOVE OR THE PATIENT IS A MINOR)

Name:	Relationship:	Date of Birth:
Address:	City & State:	Zip:

INSURANCE INFORMATION

Name of **Primary** Insurance Carrier:		
Subscriber Name:	Subscriber SSN:	Subscriber DOB:
ID#:	Group#:	
Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		
Name of **Secondary** Insurance Carrier:		
Subscriber Name:	Subscriber SSN:	Subscriber DOB:
ID#:	Group#:	
Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		

Is this a work related injury? ❑ No ❑ Yes If Yes, list date of injury _____

IN CASE OF EMERGENCY CONTACT

Name of local friend or relative:	Relationship to patient:	Home phone:	Cell/Work phone :
		( )	( )

GENERAL INFORMATION

Interpreter needed? ❑ Yes❑ No	Preferred Language:	
Ethnicity: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Decline		Race: ❑American Indian/Alaska Native ❑Black/African American ❑Hawaiian/Pacific Islander ❑ White/Causasian ❑ Other_____ ❑Decline
Religion:		

Revised: 02/17/2017

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
FINANCIAL POLICIES

(updated October 2014)

Walnut Creek Orthopedics & Sports Medicine (WCOSM) has 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. We are not responsible for any changes in your insurance coverage.
I understand it is my responsibility and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

Co-payments are due at the time of service: I understand that if my insurance policy requires that I make a co-payment for office visits, I will be expected to pay that co-payment at the time of my appointment. I understand that this is a term of my health care contract.
I understand if I do not pay for my co-payment at the time of service, an additional fee of $10 to cover billing and administrative costs will be added to my bill.
The co-payment and any billing fee are due upon receipt of statement from this practice.

When verification of insurance coverage is not available: I understand that if WCOSM cannot confirm that I am covered by an accepted insurance plan, I will be expected to pay for my charges in full at the time of my visit. Once WCOSM can confirm insurance coverage, WCOSM will bill my insurance company. I understand if an insurance payment is received, WCOSM will promptly refund any money due to me.

Auto Accidents and other injuries: I understand that WCOSM does not bill third parties; nor do they accept liens. I understand I will be expected to pay my charges in full at the time of service. ***Sorry- no exceptions*.**

When the insurance company delays payment: I understand that WCOSM will bill my insurance carrier as a courtesy. If my insurance carrier does not make payment within 90 days, I am responsible the balance in full will be due and payable immediately. I understand WCOSM will send me a statement. If there is a problem or dispute over payment with my insurance carrier, you will ask me to pursue the matter with them directly. If my insurance carrier subsequently makes a payment, WCOSM will refund any money due to me.

When your insurance company denies a claim: I understand if my insurance company denies a claim, I will be billed for all services provided, in accordance with the contract of my 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 me and that information is not provided in a timely manner and instances where maximum benefits have been reached. I understand WCOSM is not able to determine my specific coverage and benefits, plan limitations or plan provisions. For this information, I should contact my insurance carrier directly.

Surgery: I understand that WCOSM will verify my insurance eligibility for surgery, but until claims are processed deductible amounts and co-insurance amounts prior to surgery cannot be determined. I further understand that surgery co-pay may be collected upfront and applied to those fees. I further understand that ANY FEES I AM QUOTED ARE ESTIMATED based on 1) anticipated surgery to be performed and 2) current information provided to this practice by my insurance carrier. I understand that this practice will obtain the necessary authorizations prior to surgery. *I further understand that prior authorization is not a guarantee of payment,* and that I

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FINANCIAL POLICIES

(updated October 2014)

am responsible for all charges not paid by my insurance carrier. This also applies if my insurance company delays payment over 90 days after billing or denial of insurance coverage. If my insurance company demands a refund of any monies paid to WCOSM, I become financially responsible for those charges.

Workers' Compensation cases: If I have a workers' compensation case, I understand that I will need to bring all of my insurance information with me to my appointment. I understand I cannot be seen without prior authorization and will be asked to reschedule my appointment if my treatment is not authorized.

Medical Records: I understand there is a charge of $15.00-$25.00 for reproduction of my 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: I understand 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 and American Express. I understand that WCOSM may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for WCOSM to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

Missed Appointments and Cancellations: If you must cancel or reschedule your appointment, please notify us no less than 2 business days in advance. Please be courteous and remember that the appointment time reserved for you can be used by another patient.

I understand that cancellations with less than 2 business days notice and No Shows will be billed a $50 service fee.

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.

I understand a service fee of $25.00 will be added to my balance for all returned checks. I understand this needs to be cleared on my account prior to my next visit.

Delinquent Accounts: I understand charges are due in full at the time of service, or upon receipt of a statement from this practice. I assume receipt of all statements sent to me at the most recent address I have given. I accept all charges as accurate unless I contact WCOSM promptly upon receipt of a statement to dispute them. Statements returned to WCOSM due to the expiration of a postal forwarding order, or as undeliverable for any reason will be assumed accurate.

I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be marked as "Final Notice" and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts. I understand it is my responsibility to keep my account and contact information current.

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FINANCIAL POLICIES
(updated October 2014)

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

I hereby authorize Walnut Creek Orthopedics & Sports Medicine and Bay Area Surgical Specialists, Inc. to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

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 Walnut Creek Orthopedics & Sports Medicine, Bay Area Surgical Specialists, Inc. or any of the providers or staff responsible for my insurance coverage, or for decisions made by my insurance company.

I, the patient or the patient's representative, understand that all medical doctors at Walnut Creek Orthopedics & Sports Medicine are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.

_____
Patient Name (Please print)

_____ _____
Parent/Guardian Name, if applicable (Please print) **Relationship to Patient**

X_____ _____
Patient or Guardian Signature **Date**

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
PATIENT CONSENT FORM

_____
Patient's Name (Please Print)

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

I hereby authorize Walnut Creek Orthopedics & Sports Medicine and Bay Area Surgical Specialists providers and it's medical staff to disclose my protected health/billing information to:

Name:_____ Relationship_____ Contact# _____

Name:_____ Relationship_____ Contact# _____

Name:_____ Relationship_____ Contact# _____

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.

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.

I hereby grant permissions, acknowledge, and agree to statements noted above:

Patient/Patient's Agent Signature: **X**_____ Date: _____

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 SIGNATURE **DATE**

William B. Workman, MD **Nancy E. Rolnik, MD**

PATIENT INJURY FORM

Name _____ **Today's Date** _____

DOB _____ **Age** _____ **Sex** ____

Sports/Activities _____ **Occupation** _____

Area to be examined today? _____

☐ Left ☐ Right ☐ Both

When did you first notice this problem? (specify date if possible) _____

Describe your injury/problem and cause (if known): _____

_____

_____

_____

Have you treated with another physician for this problem? ☐ Yes ☐ No

Past/Current Treatment for this problem:

☐ Physical Therapy ☐ Chiropractor ☐ Massage ☐ Acupuncture ☐ NSAIDS

☐ Herbals - please list_____

☐ Other _____

Have you had any of the following tests or procedures related to this problem in the past 6-12 months?

☐ CT ☐ MRI ☐ x-ray ☐ surgery ☐ injections **If yes, where/when?** _____

_____

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

I. RELATIONS:

Relation	Age (if living)	If deceased, cause of death	Age at death
Father			
Mother			
Brother(s)			
Sister(s)			
Spouse			
Children			

II. ILLNESSES:

Have you, or any family members, 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 you have had and your age at the time:

_____

III. OPERATIONS:

Have you had any surgical treatments or operations? YES ____ NO ____
If yes, list/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. SOCIAL HISTORY:

- Do you smoke? *YES ____ NO _____ If quit, when? _____
  * If yes, how many packs per day? ____
- Do you use smokeless tobacco? (chewing tobacco,snuff,etc) YES _____ NO _____ If quit, when? _____
- 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 any other drug allergies you have & the reaction you experience_____

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

VIII. What medications do you take on a regular basis? (please list prescription and over the counter)

Name of Medication/Supplement:	**Strength:**	**Frequency/Instructions:** **(once a day, 3x a day, at night, etc)**
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		
11)		
12)		

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.

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

What is your current weight? _____ What is your Height: _____