

UNIVERSITY ORTHOPEDICS

Welcome to University Orthopedics!

Before you come into the office for your appointment

with Dr Husain,

it is essential that you:

A)Get any Xrays taken (If required)

B)Fill out All paperwork

***Waiting to take xrays or filling out paperwork the day of your appointment will result in extremely long wait times.**

Also be sure to bring your insurance card along with a photo i.d. And be sure to have either a check, cash or credit card for your co pay, co insurance of deductible payment. They are due at the time of your appointment.

Thank you!

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In order for us to better serve you, please fill out the enclosed questionnaire and bring with you on the date of your scheduled appointment. An Orthopedic assistant will phone you before your appt date to obtain your medical history. This information is required to be seen by Dr Husain.

Appt date: _____ Time: _____ a.m./p.m.

Reminder:

Please bring:

1. Any X-Rays AND MRI films that were taken of the injured body part that you are seeing Dr Husain for.

2. Your Medical Insurance Card and Picture ID.

(Although we are contracted with most PPO insurances, we urge you to telephone the member services number on your insurance card to inquire as to our contract status with your insurance plan.)

3. Form of payment for any co-payments or deductibles due.

(Deductible and co-payments are due in full at the time of service. No exceptions. We accept checks, Cash, Visa and Master card.)

CANCELLATION POLICY

If for any reason you are unable to keep your scheduled appointment, please notify our office within a 24hr period prior to your appointment time to avoid a \$20 no show fee by calling (909) 989-4400.

Thank you,
University Orthopedics.

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(Please Print & Complete In Full)

Patient's Last Name: _____ First Name: _____ MI: _____

Patient's Date of Birth: _____ Age: _____ Sex: _____ Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone #-() _____ Cell Phone #-() _____ Fax #-() _____

Drivers License #: _____ Email Address: _____ @ _____

(Check the following that applies to the patient)

Martial Status: Single Married Divorced Widowed

Employed: Full Time Part Time Retired Unemployed

Student: Full Time Part Time Not a Student

Patient Employer: _____ Phone#-() _____ Ext: _____

Patient Employer Address, City, State, Zip Code: _____

Spouse or Parent Name (circle one) _____ DOB: _____ S.S.# _____

Spouse or Parent Employer _____ Work Phone #-() _____

Family Physician: _____ Phone # _____ Fax# _____

Emergency Contact, and Relation: _____ Phone #-() _____

Name of Doctor / Facility / Source, who referred you: _____ Phone #: _____

If not referred, how did you hear about us? _____

* REASON FOR SEEING DOCTOR/SYMPTOMS _____ DATE OF INJURY/ONSET: _____

Was injury sustained on the Job? **Y** or **N** If yes, was this filed with your employer as Worker Compensation? **Y** or **N** If yes, what is the claim #? _____ Adjustor's Name: _____

Adjustor's Phone #-() _____ Fax #-() _____

HEALTH INSURANCE INFORMATION

Patient Relationship to Subscriber: (circle one) SELF SPOUSE CHILD _____ OTHER _____

* Primary Insurance Company: _____

Policyholder Name: _____ Policyholder DOB: _____ S.S.# _____

* Secondary Insurance Company: _____

Policyholder Name: _____ Policyholder DOB: _____ S.S.# _____

CONSENT FOR TREATMENT

I, the undersigned, whose name appears above, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of Asghar Husain, MD

PATIENT SIGNATURE: _____ **DATE:** _____

(If a minor, this form must be signed by parent or legal guardian) PLEASE INDICATE OF DIFFERENT LAST NAME

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ORTHOPEDIC EXAMINATION QUESTIONNAIRE

Date: _____

Patient Name: _____ Age: _____

Occupation: _____

Height: _____ Weight: _____ Right Handed: _____ Left Handed _____

Part(s) of body injured or that you are scheduled to be seen for today: _____

DETAILS OF INJURY - Where, When, How injury occurred:

Date of injury(s): _____ if not injury, give date of onset: _____

Was injury or onset related to: **WORK:** Y N **AUTO ACCIDENT:** Y N

Other (school, sports, activity, or explain): _____

How did the injury/problem occur? _____

Any previous treatment or problems? (Include any medications prescribed)

HISTORY OF PRESENT ILLNESS:

Name of physicians who treated you: _____

Location of your pain: (e.g. low back, neck, groin, buttocks, right or left knee, calf, right or left shoulder, right or left elbow, wrist, foot pain, heel; other):

Severity of your pain: Mark the point on the line between **0 (least)** and **10 (worst)** which best describes how severe current pain is:

1 2 3 4 5 6 7 8 9 10

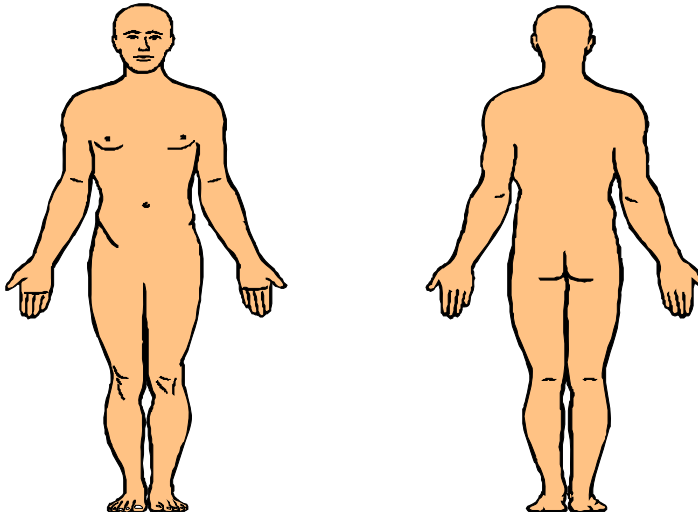
Character of the pain (e.g. Dull, sharp, achy, burning, throbbing, cramping, shooting, incapacitating, prickly, stabbing, other):

When do you feel the pain and for how long does it last: (Morning, afternoon, evening, increases over day, bending, climbing, squatting. Is the pain constant? How long does the pain last? _____

Associated Symptoms: (e.g. swelling, locking, giving way, tenderness, fatigue, bruising, tingling, numbness radiating pain)

What makes your symptoms better: (e.g. rest, heat, cold, elevation, physical therapy, braces, injections, special positioning, medications?)

PAIN DRAWING: Place X's at the location(s) of your worst pain using the diagram below:



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ILLNESSES: (Please circle **Yes** or **No** if you have any of the following medical problems)

High blood pressure	Y N	Diabetes	Y N	Heart trouble	Y N
Respiratory problems	Y N	Stroke	Y N	Cancer	Y N
Bleeding problems	Y N	HIV/AIDS	Y N		
Pulmonary embolism	Y N	Blood clot	Y N		
Gastrointestinal problems	Y N	Other Problems:	_____		

Past hospitalizations/surgeries/injuries and approximate dates: _____

Allergies: (Please circle those that apply) **NONE**

Contrast dye Sulfa Penicillin Local anesthetics Latex Iodine Shellfish
Other: _____

CURRENT MEDICATIONS: **NONE ()**

Medication Name	Dosage	Frequency

FAMILY HISTORY: (Please list any family history medical problems: (I.e. heart disease, stroke, diabetes cancer))

Father: _____ Mother: _____
 Siblings: _____ Other: _____

SOCIAL HISTORY: (Please circle all those that apply)

Marital Status:	Single	Married	Separated	Widowed	Divorced	Partner
Tobacco use:	Never	Pack per day:	How many years:	Quit/When:		
Alcohol use:	Never	Rarely	Moderate	Daily Amount:		
Drug use:	Never	Type and frequency:				

Please circle one: Highest level of education:

High School College Trade School Graduate School Professional School

REVIEW OF SYSTEMS: (Please circle **YES** or **NO** if you have any of the following problems)

Constitutional:		Ears/nose/mouth/throat:		Eyes:	
Good general health	Y N	Hearing loss/ringing	Y N	Wears glasses/contacts	Y N
Recent weight change	Y N	Sinus problems	Y N	Blurred/double vision	Y N
Night sweats/fever	Y N	Nose bleeds	Y N	Eye disease or injury	Y N
Fatigue	Y N	Sore throat/voice change	Y N	Glaucoma	Y N
Cardiovascular:		Respiratory:		Gastrointestinal:	
Chest pain	Y N	Shortness of breath	Y N	Nausea/vomiting	Y N
Palpitations	Y N	Cough	Y N	Abdominal pain	Y N
Heart trouble	Y N	Wheezing/Asthma	Y N	Rectal bleeding	Y N
Swelling hands/feet	Y N	Coughing up blood	Y N	Bowel problems	Y N
Musculoskeletal:		Neurological:		Integumentary(skin-breast):	
Muscle pain or cramps	Y N	Frequent headaches	Y N	Change in hair or nails	Y N
Stiffness/swelling joints	Y N	Paralysis or tremors	Y N	Rashes or itching	Y N
Joint pain	Y N	Convulsions/seizures	Y N	Breast lump	Y N
Trouble walking	Y N	Numbness/tingling	Y N	Breast pain or discharge	Y N
Endocrine:		Hematologic/Lymphatic:		Allergic/Immunologic:	
Excessive thirst/urination	Y N	Bruise easily	Y N	Food allergies	Y N
Thyroid disease	Y N	Slow to heal	Y N	Aspirin allergies	Y N
Hormone problems	Y N	Enlarged glands	Y N	Antibiotic allergies	Y N
Genitourinary-Male Only		Genitourinary-Female Only		Psychiatric:	
Blood in urine	Y N	Blood in urine	Y N	Insomnia	Y N
Kidney stone	Y N	Kidney stones	Y N	Confusion/memory loss	Y N
				Depression	Y N

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NOTICE OF PRIVACY POLICIES AND PRACTICES FOR UNIVERSITY ORTHOPEDICS

Dear Patient:

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

INTRODUCTION

At University Orthopedics, we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by and required by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit University Orthopedics; a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services were actually provided.
- An education tool for medical health providers
- A source for medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and/or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure it's accuracy, determine what entities have access to your health information and make informed decisions when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

University Orthopedics is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means/locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies practices will be applied to all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example: results of

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laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment.

Your health plan may request and receive information on dates of service, the services provided, the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations.

Your health information may be used as necessary to support the day-to-day activities and management of University Orthopedics. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates.

In some instances, we have contracted separate entities to provide services for us. These “associates” require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these “business associates” might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with Family.

Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives or any other person that is involved in your care that you have authorized to receive this information. Please inform us when you do not wish a family member or other individual to have authorization to receive your information.

Research/Teaching/Training.

We may use your information for the purpose of research, teaching and training.

Healthcare Oversight.

Federal Law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public Health Reporting.

Your health information may be disclosed to public health agencies as required by law.

Law Enforcement

Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations and to comply with the government mandated reporting.

Appointment reminders

We may use your information to remind you about your upcoming appointments.

Typically, these are left by phone and may be left as a message on your answering machine. If you don't approve of this method, you must inform us in writing.

Other uses and disclosures

Disclosure of your health information or its use for any purpose other than those listed above requires your specific authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of University Orthopedics, please contact:

Leslie Fletcher

University Orthopedics

7777B Milliken Avenue, Suite #330 Rancho Cucamonga CA 91730

(909) 989-4400

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CONSENT FOR TREATMENT

I, the undersigned, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of Asghar Husain, M.D.

Patient Signature _____ Date _____
(If a minor, must be signed by legal parent or guardian)

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I, hereby authorize Asghar Husain, M.D., to release any information acquired in the course of my examination and/or treatment to Social Security Administration & Health Care Financing Administration or its intermediaries or carriers, any information needed for Medicare or other insurance claims. I permit a copy of this authorization to be used in place of the original and I request payment of medical insurance benefits to either myself or to the party who accepts assignment. This is a lifetime authorization. I agree to pay in full for all medical services rendered by the above doctor. If I fail to pay charges, I agree to pay the cost of collection and including reasonable attorney fees.

Patient Signature _____ Date _____
(If a minor, must be signed by legal parent or guardian)

AUTHORIZATION FOR RELEASE OF INFORMATION

I give the office of Dr Asghar Husain the authorization to release any and all medical information in regards to my care to: _____.

I understand that if a hospital or physician or family member or spouse calls for any information and the name is not listed above, the office will be unable to release any information.

Patient Signature _____ Date _____
(If a minor, must be signed by legal parent or guardian)

UNIVERSITY ORTHOPEDICS NOTICE OF PRIVACY POLICIES

I _____ (print name) have received and read the University Orthopedics Notice of Privacy Policies and Practices. (If receiving paperwork in hand or online the privacy policy is on a separate page)

Patient Signature _____ Date _____
(If a minor, must be signed by legal parent or guardian)

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There is a \$25 fee for any appointments that are not cancelled within 24 hours prior to your appointment.

These are considered “no shows.”

Please sign below to indicate you have read our \$25 fee no show policy.

Thank you.

Signed _____

Date _____