ORTHOKRISTY
BONE AND JOINT CENTER

Patient Registration Form

Patient Information

Date of Appointment:

Patient's First Name		Middle Name	Last Name (as it appears on insurance card of ID)		
Sex	Race/Ethnicity	Marital Status	Date of Birth (Age)	Social Security Number	
Patient's Address			City	State	Zip
Home Phone		Mobile Phone	Email Address		
Referred by		Primary Care Physician	Primary Care Physician Phone		
Pharmacy		Pharmacy Phone	Pharmacy Address		

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone		
Employer/School Address		City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured Employer/School	
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number
Insured's Address		City	State	Zip
Insured's Social Security Number		Insured's Birthdate	

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured Employer/School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient
Address		City	State	Zip

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying OrthoKristy Bone and Joint Center of any changes made to my contact information and/or insurance.

_____ _____

Signature of Patient of Authorized Guardian Date

ORTHOKRISTY
BONE AND JOINT CENTER

Name: _____	Gender: _____	Age: _____	Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____
_____
_____
_____
_____

When did the problem begin? _____
_____
_____

Where is the problem located?

☐ Left-side ☐ Right-side ☐ Both

What event or incident is this problem related to?

☐ Work Accident ☐ Car Accident ☐ Other: _____

Pain Assessment

Indicate your level of pain on a scale of 1 - 10.
(10 = worst pain imaginable)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Check the symptoms that best describe your problem.

☐ Stiffness ☐ Pain ☐ Instability
☐ Swelling ☐ Numbness ☐ Other: _____

Are your symptoms getting…

☐ Better Gradually ☐ Better Rapidly
☐ Worse Gradually ☐ Worse Rapidly

What **improves** your symptoms?

☐ Rest ☐ Ice ☐ Heat
☐ Motrin/Aleve ☐ Other: _____

What makes your symptoms **worse**?

☐ Activity ☐ Cold ☐ Other: _____

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name	Start Date	Dosage	Frequency

Have you or are you planning to apply for disability?

☐ Yes ☐ No

Is there a lawsuit or litigation pending in relation to your pain?

☐ Yes ☐ No

Please describe any previous treatment and care you have received for this problem. _____
_____
_____
_____

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No

# of years_____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No

Types:_____ # times/week _____

How much alcohol to you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How oftern to you exercise?

times/week _____

Hospitalizations & Surgeries

_____
Reason Date

_____
Reason Date

_____
Reason Date

Allergies

Are you allergic to any of the following?

☐ Latex ☐ Antibiotics ☐ Adhesive Tape
☐ Aspirin ☐ Sulfa ☐ Barbituates
☐ Codeine ☐ Iodine ☐ Local Anesthetics

Do you have any other allergies?

_____
Name Reaction

_____
Name Reaction

_____
Name Reaction

ORTHOKRISTY
BONE AND JOINT CENTER

Name: _____ Gender: _____ Age: _____ Date of Appointment: _____

Current Medical Conditions

Have you ever had any of the following? *(Please check all that apply.)*

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Ear Problems
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis (A, B, or C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Skin Disorder
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease

Family History

Has anyone in your family ever had any of the following conditions?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis (A, B, or C)
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Migraines
- ☐ Psychiatric Disorders
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorder

Women Only

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Have you experienced any of the following?

	Yes	No	In Past
Frequent or severe headaches	☐	☐	☐
Dizzy spells or blackouts	☐	☐	☐
Diarrhea	☐	☐	☐
Blood in stool	☐	☐	☐
Chest pain	☐	☐	☐
Weight loss	☐	☐	☐
Easy Bruising	☐	☐	☐
Bleeding issues	☐	☐	☐
Cancer	☐	☐	☐
Bowel Control issues	☐	☐	☐

Other Notes

_____

_____

_____

_____

_____

FINANCIAL POLICY

PATIENTS WITH INSURANCE

Although we bill your insurance company/medical group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your health pan/medical group, we may contact you for assistance. If your health plan/medical group denies coverage for any reason, you will be responsible for that payment.

PATIENTS WITHOUT INSURANCE

Our fees cannot always be determined in advance, since they depend on actual services provided. If you would like an estimated total amount before being seen, please ask the front desk personnel. Please note that this is only an estimated amount and the actual charge totals may vary from this estimate. Payment for all services is due at the time of service.

CO-PAY POLICY

It is your obligation to be familiar with our insurance co-payment and/or deductible amounts. Your co-pay amount must be paid at the time of your visit.

NO-SHOW POLICY

The office requires twenty-four (24) hour notice of cancellation for scheduled appointments. In the event that we are not notified twenty-four (24) hours prior to your appointment, you will be charged a $40.00 "No-Show" fee.

DELINQUENT ACCOUNTS

Interest of 1.67% will be applied every month for any past due accounts (20.03% annually)

RETURNED CHECKS

There will be a $25.00 service fee for returned checks.

OTHER FEES

There is a nominal charge of $25.00 for each form/report (i.e. Disability forms, FMLA, etc.) that requires completion by the physician.

For your convenience, we accept cash, MasterCard, Visa, debit cards, and personal checks.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information, which may have a bearing on the determination, and/or payment of my claim. I request that payment is made directly to OrthoKristy Bone and Joint Center Inc. and I acknowledge that I am responsible for payment if this assignment is not honored. I understand I am responsible for all co-payment, coinsurance, and deductible that I may have with my insurance. I further understand that I have been provided a service and it is my responsibility to know my own insurance coverage and be aware of services that may or may not be covered. I have read and understand the above policies, and I agree to comply with them. I attest that all information is true and accurate to the best of my knowledge.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY: _____

DATE: _____/_____/_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues if liability and damages upon written request by the neutral arbitrator.

The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summery judgment or summery adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05: however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provision**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived for forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____
Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held to be invalid or unenforceable, the remaining provisions shall remain in full force and shall not be effected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY USSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____ By: _____ _____
Physician's or Authorized Representative's Signature (Date) Patient's or Patient's Representative Signature (Date)

Charissa "Kristy" Farris, MD
2516 Samaritan Drive Suite B
San Jose, CA 95124

_____ By: _____
Print of Stamp Name of Physician, Medical Group, or Association Name Print Patient's Name

_____
(If Representative, Print Name and Relationships to Patient)

HIPPA Notice of Privacy Practices

OrthoKristy
Bone and Joint Center
2516 Samaritan Drive Suite B, San Jose, CA 95124
(408) 356-3777

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by our physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate yoru physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you or your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by law, Public Health issues as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made with Your Consent Authorization or Opportunity to object unless required by law.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

2. **Your Rights**

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administration action or proceedings:; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your personal health information. This means that you may ask us not to use of disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. Your then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us be alternative means or at an alternative location. Your have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaints. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practice with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient's Signature: _____

Patient's Printed Name: _____

Date: _____