Orthopaedic Specialty Institute
Medical Group of Orange County

_____, **your appointment with Dr. Shepard is scheduled for:**

□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday

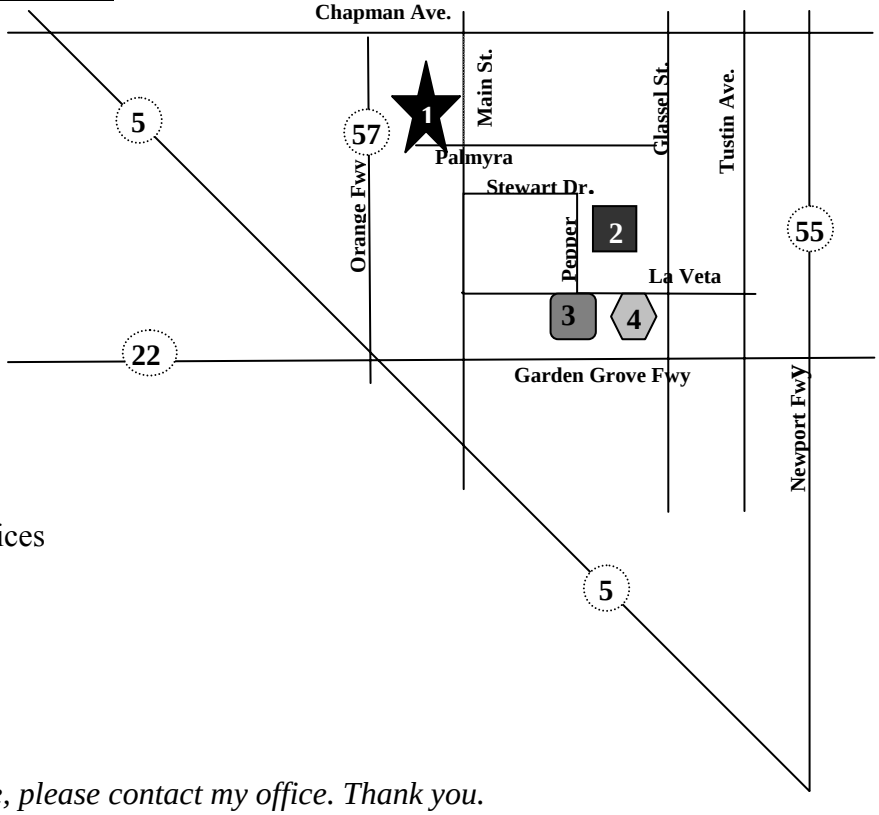
DATE: _____ TIME: _____

****Kindly give 24 hour notice of cancellation****

Please remember to bring:

- ✓ Any forms sent by my office to be filled out at home
- ✓ **Insurance Cards and/or Claim Forms**
- ✓ *****<u>X-rays, MRI films, CT Scan, etc. relating to injury</u>***- otherwise appt will be rescheduled.**
- ✓ **For female shoulder patients: please bring or wear a tank, halter, or bathing suit top**
- ✓ **For hip, knee and ankle patients: please bring or wear a pair of shorts**
- ✓ **Patients with injuries to the back or neck will be evaluated in a gown**

<u>Orthopaedic Specialty Institute</u>
<u>Michael Shepard, M.D.</u>
<u>280 S. Main Street, Suite 200</u>
<u>Orange, CA 92868</u>
<u>(714) 937-2148</u>



2 St. Joseph Hospital

3 St. Joseph Pavilion

4 Orange Surgical Services

If you need further assistance, please contact my office. Thank you.

Orthopaedic Specialty Institute
Medical Group of Orange County

Patient Registration

PATIENT INFORMATION (Please Print)

Name: _____ **Sex:** ☐ Male ☐ Female

Address: _____ **Date of Birth:** _____ **Age:** _____

_____ **Social Security #:** _____

City, State, Zip: _____ **Driver's License/ID #:** _____

Marital Status: ☐ Married ☐ Single ☐ Divorced **Email address:** _____

Primary Phone: _____ ☐ Home ☐ Work ☐ Cell ☐ Other: _____

Alternate Phone: _____ ☐ Home ☐ Work ☐ Cell ☐ Other: _____

Who referred you to us/How did you hear about us? _____

Primary Physician: _____ **Employer:** _____

Address: _____ **Address:** _____

Phone: _____ **Phone:** _____

Race: _____ **Ethnicity:** ☐ Hispanic or Latino

Language: _____ ☐ Not Hispanic or Latino

☐ Unknown / Not Reported

Date of injury or onset of symptoms: _____ **Was this an injury?** ☐ Yes ☐ No

Where did your injury occur? ☐ Work ☐ Auto ☐ Home ☐ School ☐ Other: _____

GUARANTOR RESPONSIBLE PARTY ☐ **Patient** ☐ **Other:** **Relationship:**

Name: _____ **Employer:** _____

Address: _____ **Phone:** _____

_____ **Social Security #:** _____

City, State, Zip: _____ **Date of Birth:** _____

PRIMARY INSURANCE **Insured Party:** ☐ **Patient** ☐ **Guarantor** ☐ **Other:**

Relationship to Patient: _____ **Social Security #:** _____

Insurance Carrier: _____ **Date of Birth:** _____

Claims Address: _____ **Insured ID/Cert #:** _____

City, State, Zip: _____ **Phone:** _____

SECONDARY INSURANCE **Insured Party:** ☐ **Patient** ☐ **Guarantor** ☐ **Other:**

Relationship to Patient: _____ **Social Security #:** _____

Insurance Carrier: _____ **Date of Birth:** _____

Claims Address: _____ **Insured ID/Cert #:** _____

City, State, Zip: _____ **Phone:** _____

EMERGENCY CONTACT

Name: _____ **Address:** _____

Relationship: _____ **Phone:** _____

I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original.

Photo identification and insurance cards must be presented at the time of service to enable OSI to submit claims to your insurance carrier. Should identification and insurance cards not be presented, you will become a cash patient with payment in full due at the time of service.

This agreement will remain valid from this day forward to include all future services relating to the above patient. *Rev 04/12*

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

Michael F. Shepard, M.D.
Orthopaedic Specialty Institute

MEDICAL HISTORY DATE: _____

NOTE: PLEASE TRY TO ANSWER EVERY QUESTION TO THE BEST OF YOUR ABILITY.
EVERYTHING IS KEPT CONFIDENTIAL.

PATIENT NAME: _____ DATE OF BIRTH: _____

CHIEF COMPLAINT_____
PLEASE DESCRIBE THE RECENT EVENTS OF THIS CURRENT ORTHOPAEDIC PROBLEM. HOW LONG HAS IT BEEN A PROBLEM? WHAT MAKES IS WORSE? WHAT MAKES IT BETTER?

_____
_____
_____
_____

ONSET DATE _____

DO YOU WEAR GLASSES/CONTACTS/NONE (PLEASE CIRCLE)

NAME OF THE PHYSICIAN WHO REFERRED YOU TO US _____
DRUG ALLERGIES _____

CURRENT MEDICATIONS: PLEASE LIST ASLL CURRENT MEDICATIONS. IF UNSURE, CALL OR MAIL ACCURATE LIST AS SOON AS POSSIBLE.

	MEDICATION	DOSE	FREQUENCY
1.			
2.			
3.			
4.			
5.			

PAST SURGERIES: LIST PAST SURGERIES IN CHRONOLOGICAL ORDER:

	TYPE OF SURGERY	YEAR
1.		
2.		
3.		
4.		
5.		

Michael F. Shepard, M.D.
Orthopaedic Specialty Institute

PATIENT NAME _____ **DATE**_____

FAMILY MEDICAL HISTORY: List medical illness affecting your immediate family

	Disease	Family Member		Disease	Family Member
1.			4.		
2.			5.		
3.			6.		

_____ Height _____ Weight

SOCIAL HISTORY: Check and fill in blanks

_____ Married _____ Single _____ Divorced _____ Live Alone _____ # Children _____Pets
_____ Alcohol _____ Occasional _____ Daily _____ Heavy
_____ Tobacco _____Years Used _____Packs per day _____Drugs

GENERAL HISTORY: Please fill out and check all that apply.

General
_____ 1.Weight Change
_____ 2.Fever or Chills
_____ 3. Night Sweats
_____ 4.Urinary Frequency
_____ 5.Bleeding
_____ 6.Lumps or Masses
_____ 7.Dizziness or Fainting
_____ 8.Itching or Rash
_____ 9.Diabetes Mellitus
_____ 10.Thyroid Problem
_____ 11.Cancer

Gastrointestinal
_____ 1. Dysphagia (difficulty swallowing)
_____ 2. Nausea & Vomiting
_____ 3. Jaundice
_____ 4. Hepatitis

Cardiovascular
_____ 1. Heart dx/Pain
_____ 2. Hypertension
_____ 3. Mitral Valve Prolapse
_____ 4. Thrombophlebitis

Genitourinary
_____ 1. Urinary Infections
_____ 2. Incontinence
_____ 3. Venereal Disease
_____ 4. Menopause

Neurological
_____ 1. Seizures
_____ 2. Paralysis
_____ 3. Numbness
_____ 4. Weakness

Ear-Nose-Throat-Eye
_____ 1. Visual Change
_____ 2. Hearing Change
_____ 3. Tinnitus
_____ 4. Dentures
_____ 5. Bleeding Gums
_____ 6. Hoarseness

Respiratory
_____ 1. Cough/Sputum
_____ 2. Rheumatic Fever
_____ 3. Tuberculosis
_____ 4. Pleurisy/Pneumonia
_____ 5. Shortness of Breath
_____ 6. Asthma

Musculoskeletal
_____ 1. Backache
_____ 2. Joint Pain
_____ 3. Joint Swelling

Breast
_____ 1. Lumps, Pain, Nipple Discharge

Orthopaedic Specialty Institute
Medical Group of Orange County

Accident/Injury Information Form

Name: _____ Doctor: _____

To help us process your insurance claim quickly and efficiently please provide us with your accident/injury details:

When did your accident/injury occur? _____
_____
_____

Where did your accident/injury occur? _____
_____
_____

How did your accident/injury occur? _____
_____
_____

Signature: _____ Date: _____

Thank you for your assistance.

280 S. Main Street - Suite 200 - Orange, CA 92868 – Tel. (714) 634-4567

Effective Date: 3/5/10

Notice of Privacy Practices

Orthopaedic Specialty Institute
280 S. Main #200, Orange Ca. 92868

Privacy Officer:
Maria Taylor
Assistant Office Manager
(714) 937-2182

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law, all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign in sheet. We may require that you sign in when you arrive at our office. We may call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We will not sell your personal information. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

20. Fundraising. We may contact you directly for fundraising activities in which the practice chooses to participate, such as Arthritis Foundation events or other charity organizations. Your information will not be disclosed to outside agencies for fundraising purposes.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice available in our reception area, and will offer you a copy at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:
Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Orthopaedic Specialty Institute
Medical Group of Orange County

Acknowledgement of Receipt of Notice of Privacy Practices and Notices to Consumers

Orthopaedic Specialty Institute

I hereby acknowledge that I received a copy of the medical practice's Notice of Privacy Practices as well as Consumer Notices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices and/or Consumer updates at each appointment.

NOTICE TO CONSUMERS

PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY

THE PHYSICIAN ASSISTANT COMMITTEE

(916) 561-8780

WWW.PAC.CA.GOV

NOTICE TO CONSUMERS

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA

(800) 633-2322

WWW.MBC.CA.GOV

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate

Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____