Name: Date:
DOB: Sex:

Patient Information

Home Phone: Cell Phone: Business Phone:	Driver's License SSN: Email:	**Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Race ☐ American Indigenous ☐ Asian ☐ Black/ African American ☐ Native Hawaiian ☐ White ☐ Unknown	**Ethnicity** ☐ Non-Hispanic Origin ☐ Hispanic Origin	**Preferred Language** ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Vietnamese ☐ Other:_____

Patient Address Information

Physical Address Street:	City:	State:	Zip:
Mailing Address (if any) Box:	City:	State:	Zip:

Primary Care Information

Primary Care Physician:	Address:	Phone:
Who referred you to our practice?		

Pharmacy Information

Pharmacy Name:	Pharmacy Address:	Pharmacy Phone:

Employment Information

Employer Name: Congress Orthopaedic	Occupation:	Employer Address:
City:	State:	Zip Code:

Private Medical Insurance Information

Primary Insurance:	Effective Date:	Policy ID:	Group ID:
Subscriber Name:	DOB:	Relationship: ☐ Self ☐ Spouse	☐ Parent ☐ Other
Secondary Insurance:	Effective Date:	Policy ID:	Group ID:
Subscriber Name:	DOB:	Relationship: ☐ Self ☐ Spouse	☐ Parent ☐ Other

Workers Comp or Personal Injury Information

Were you injured on the job? ☐ Yes ☐ No		Did you file a Workers Compensation claim? ☐ Yes ☐ No
Industrial Carrier:		Name of Claim Examiner:
Claim Number:	Injury Date:	Phone Number:
Were you injured at home? ☐ Yes ☐ No Were you involved in an Auto Accident? ☐ Yes ☐ No Were you injured at school? ☐ Yes ☐ No Injured area of the body: _____		Did you file a homeowners claims? ☐ Yes ☐ No Did you file an Auto claims? ☐ Yes ☐ No Did you file a School Accident claim? ☐ Yes ☐ No Did you receive treatment for this injury? ☐ Yes ☐ No
Briefly describe your treatment to date:		

Emergency Contact Information

Contact Name:	Contact Relationship:	Contact Phone:

Name: Date:
DOB: Sex:

PHYSICIAN OWNERSHIP DISCLOSURE NOTICE:

The Shareholders of Congress Orthopaedic Associates: Richard C. Diehl, MD, Gregory J. Adamson, MD, James A. Shankwiler, MD, Michael J. Fraipont, MD, William M. Costigan, MD, Todd B. Dietrick, MD, Kenneth R. Sabbag, MD, Thomas G. Harris, MD, Roy F. Ashford, MD, Gary M. Moscarello, MD, John T. Quigley, MD, Rishi Garg, MD, Joe Y. B. Lee, MD, Timothy J. Jackson, MD, Steven D. Lin, MD, Kevork N. Hindoyan, MD, James A. O'Dowd, MD; hold ownership in Congress Medical Surgical Center. This Outpatient Surgery Center/Extended Stay Facility, is located at 800 S Raymond Ave, Pasadena, CA 91105. In addition they hold ownership interest in Senate Surgical Distribution, LLC, a Company which sells implantable medical devices to the hospital or ambulatory surgery center to which you may be referred. If you have been referred for surgery it is possible that in connection with your surgery your physician will order one or more implantable devices which will be provided by Senate Surgical Distribution, LLC.

Please note that you have the right to obtain medical devices or hospital or ambulatory surgery services from any provider of your choosing unless your ability to choose the providers of such services is limited by the terms of your health insurance coverage.

AUTHORIZATION TO PAY PHYSICIAN/ ASSIGNMENT BENEFITS

I, the undersigned, have insurance coverage with _____ Insurance Company(ies) and assign directly to Congress Orthopaedic Associates, all medical and surgical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize use of this signature on all my insurance claim submissions.

_____ _____ _____
Signature Printed Name Date

PATIENT CONSENT

I agree that Congress Orthopaedic Associates may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____ _____
Signature Printed Name Date

MEDICAL AUTHORIZATION:

I request that payment of authorized medical benefits be made on my behalf to Congress Orthopaedic Associates for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim or other health insurances as indicated in item 9 of the CMS1500 form or elsewhere on other approved claim forms or electronically submitted claims. My signature authorizes releasing information to the insurer or agency shown. In Medicare assigned cases, the physicians or supplier agree(s) to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based on the charge determination of the Medicare carrier.

My signature acknowledges that the information provided hereto is true and that I have understood all disclosures to the best of my knowledge.

_____ _____ _____
Beneficiary Signature **Beneficiary Printed Name** **Date**

Name: Date:
DOB: Sex:

CONGRESS MEDICAL ASSOCIATES, INC
ORTHOPAEDIC SURGEONS

Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions. If you need further information about any of these policies, please ask to speak with one of our billing specialists at (626) 795-7035.

How May I Pay?
We accept payment by cash, check, Visa, Mastercard, American Express and Discover.

Do I Need A Referral?
If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physican. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be re-scheduled.

What is My Financial Responsibilty for Services?
Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If you have:	You are responsible for:	Our staff will:
HMO, PPO, POS, EPO plans with which we have contract.	**If the services you receive are covered by the plan:** All applicable co-pay and deductibles are requested at the time of service. **If the service you receive are not covered by the plan:** Payment in full is requested at the time of service.	Call your insurance company ahead of time to determine copays, deductibles and non-covered services for you. File an insurance claim on your behalf.
HMO- which we are not-contracted	Payment in full for office visits, x-rays, injections and other changes at the time of service.	Provide you with all the necessary information for you to submit these services to your insurance.
Out of Network or Indemnity Plans	Payment of any out-of network co-insurance, deductible and co-pays.	Call your insurance company ahead of time to determine out-of network benefits, co-pays, deductibles and non-covered services. We will file an insurance claim on your behalf.

Name: Date:
DOB: Sex:

If you have:	You are responsible for:	Our staff will:
Medicare	If you have regular Medicare and have not yet met your $203.00 deductible, we will ask that it be paid at the time of service. Also any services not covered by the Medicare program will be collected at the time of service. **If you have Medicare as your primary insurance and also have secondary insurance or Medicare** No payment is necessary at the time of service. **If you have Medicare as your primary insurance but do not have a secondary insurance:** Your 20% co-insurance will be collected at the time of service.	File the claim on your behalf as well as any claims to your secondary insurance.
Medi-cal	If Medi-cal is your primary insurance you are responsible to pay for services at the time of service, we are not contracted with Med-ical. If Medi-cal is your secondary insurance you are requested to pay the 20% co-insurance at the time of service.	We will work with you to settle your account. Please ask to speak to one of our billing representatives.
No Insurance:	Payment is due at the time of service	We will work with you to settle your account. Please ask to speak to one of our billing representatives.

If your physician recommends surgery, you will need to speak to the appropriate surgical scheduler. They will be able to answer specific questions about the surgery scheduling process and discuss any paperwork that is needed. Our Pre-certification department will verify benefits and request prior authorization from your insurance. In addition to these services one of our billing specialists will be contacting you to go over any financial responsibility prior to surgery.

What if my child needs to see the physician?
A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined above.

The undersigned agrees to pay for all services rendered if insurance does not pay. The undersigned also agrees to pay court costs and a reasonable attorney fee in the event legal action is required to enforce this agreement.

I authorize my Insurance benefits be paid directly to Congress Medical Associates, Inc.

I authorize Congress Medical Associates, Inc. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____ _____ _____

Date: **Signature** **Print Name**

Name: Date:
DOB: Sex:

NOTICE OF PRIVACY PRACTICES

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

This medical practice is required and permitted to make uses and disclosures of an individual's personal health information for purposes of treatment, payment and health operations. It is necessary to share specific and appropriate levels of confidential information about an individual, for example: when submitting claims to insurance companies, retaining records in our office concerning the individual's treatment, or the sharing of information between staff members to process paperwork related to office operations.

Other purposes listed below are either permitted or required to use or disclose confidential information without the individual's written authorization:

a) Uses and disclosures for public health activities
b) Reporting about victims of abuse, neglect or domestic violence
c) Disclosures for health oversight activities
d) Disclosures for judicial and administrative proceedings
e) Disclosures for law enforcement purposes
f) Uses and disclosures about decedents
g) Uses and disclosures for cadaveric organ, eye or tissue donation purposes
h) Disclosures to avert a serious threat to health or safety
i) Uses and disclosures for special government functions
j) Electronic access to medication history

Other uses and disclosures will be made only with the individual's written authorization and that the individual may revoke such authorization. This office also may contact individuals and may leave messages to provide appointment reminders or information regarding treatment.

The federal government has granted patients several new rights under the privacy regulations. These are as follows:

a) The right to request restrictions on certain uses and disclosures, for example: an individual may request that this office not leave messages with other family members or on a home voice-mail system regarding certain treatment.
Please note that the practice is not required to agree to all requested restrictions.
b) The right to receive confidential communications, for example: on a home voice-mail system
c) The right to inspect and copy protected health information, for example: clinical records, billing records or other records used to make decisions regarding your care and treatment.
d) The right to amend protected health information, for example: an individual may request information be amended in your records if he/she feels it is incorrect.
e) The right to receive an accounting of disclosures of protected health information, for example: disclosures permitted or required by the office to be made in the ordering of a needed medical test.
f) The right of an individual's receiving notice electronically to obtain in a paper copy of that notice.

This practice is also required to abide by the terms of this notice and we reserve the right to change the terms of this notice and make new notive provisions effective for all confidential information we maintain. Any revised notices will be given to you at this office and a request for your signature on acknowledgment form will be requested.

Individuals may complain to the practice and to the Secretary of the Department of Health and Human Services if they believe their privacy rights have been violated and without retaliation from this practice.

For further information you may contact:

Veronica Camarena
Administrator
Congress Orthopaedic Associates, Inc
800 S. Raymond Avenue
Pasadena, CA 91105
Phone: (626) 795-8051

ACKNOWLEDGEMENT OF NOTICE
I acknowledge receipt of
Congress Orthopaedic Associates
Notice of Privacy Practices

_____	_____	_____
Patients Name	Patients Signature	Date

Name: Date:
DOB:

PATIENT INTAKE & HISTORY

1.) Patient Name: **Height_____Weight _____** ☐ **Right- Handed** ☐**Left-Handed**

2.) Do you smoke: ☐ Yes ☐ No How many per day?_____ How long?_____ When did you stop?_____

3.) Do you drink alcohol? ☐ Yes ☐ No Socially? ☐ Yes ☐ No Daily? ☐ Yes ☐ No How much?_____

4.) Name of primary doctor:_____ Last seen:_____
5.) Please list current medications:

6.) Have you had surgery in the past? ☐ Yes ☑ No If yes, how many?_____

Surgery 1:_____ Surgery 2:_____

_____ _____

Surgery 3:_____ Surgery 4;_____

_____ _____

7.) Please list any Medication & Food Allergies *(If you do not have any allergies, please write, NONE):*

_____

_____

_____

_____

Review of Systems

Check all that apply:

SKIN: ☐ Rashes ☐ Eczema ☐ Psoriasis ☐ Cancer Other: _____
EARS/NOSE/THROAT: ☐ Painful swallowing ☐ Sore Throat ☐ Nose Bleeds ☐ Sinusitis ☐ Loss of smell ☐ Cancer
VISION: ☐ Blurred vision ☐ Eye-pain ☐Redness ☐ Glasses ☐ Dryness
CARDIAC/HEART: ☐ Palpitations ☐ Chest Pains ☐ Swollen Ankles ☐ Hypertension ☐ Rheumatic Fever
LUNGS/RESPIRATORY: ☐ Lung Disease ☐ Emphysema ☐ Asthma ☐ Wheezing ☐ Shortness of Breath ☐ Chronic Cough
GASTROINTESTINAL: ☐ Ulcers ☐ Weight Loss ☐ Abdominal Pain ☐ Blood in Stools ☐ Bowel Problems ☐ Liver Disease
BLADDER/KIDNEY: ☐ Frequent Urination ☐ Painful Urination ☐ Blood in Urine ☐ Kidney Problems
☐ Other:_____
MUSCULOSKELETAL: ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Gout
CONDITIONS: ☐ Diabetes ☐ History of Cancer ☐ Sickle Cell
ANESTHESIA: ☐ Previous Anesthesia Problems? (Explain):_____
FAMILY HISTORY: ☐ Heart Disease ☐ Tuberculosis ☐ Diabetes ☐ Cancer

Name: Date:
DOB:

PATIENT INTAKE & HISTORY

Chief Complaint "What is hurting/reason for visit":

History of Present Illness " Describe how you were hurt/injured":

Date of Present Illness/ Injury:_____

PLEASE CHECK ALL BOXES THAT APPLY

Location of present condition:

□ Neck	□ Collar Bone	□ Shoulder	□ Arm	□ Elbow
□ Forearm	□ Wrist	□ Hand	□ Finger	□ Thumb
□ Upper Back	□ Lower Back	□ Pelvis	□ Hip	□ Thigh
□ Knee	□ Leg	□ Ankle	□ Foot	□ Toe

Quality of pain "What does the pain feel like":

□ Dull	□ Sharp	□ Throbbing	□ Pulsating	□ Aching
□ Localized	□ Radiating			

Severity of pain "How painful":

□ Minor □ Moderate □ Severe

Pain Level: Please check your level of pain on a scale of 1 (mild) to 10 (severe)

□1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Context "Is your pain_____":

□Improving □Worsening □ The Same □ Recurrent

Modifying Factors:

"What makes it feel better?"

□ Rest	□ Ice	□ Heat	□ Elevation	□ Medication
□ Tylenol	□ Aleve	□ Motrin	□ Ibuprofen	

"What makes it feel worse?"

□ Ice □ Heat □ Activity □ Movement

Associated signs and symptoms "What do you feel/see?":

□ Bruising □Numbness □ Tingling □ Redness □ Swelling

Timing "When does it hurt":

□ Day	□ Night	□ Exercise	□ Certain Movements
□ Sitting	□ Walking	□ Standing in One Spot	

Duration "How long have you experienced your symptoms":

□ Constant □ Intermittent □ ( ) Days □ ( ) Weeks □ ( ) Months □ ( ) Years

Name: Date:
DOB:

PLEASE CHECK ALL BOXES AND ANSWER ALL QUESTIONS THAT APPLY

Past Medical History

1.) When was your **last flu shot**? Provide at minimum **month and year**:_____ ☐ N/A

2.) For patients, ages **65 years and older**, when was your **last pneumonia injection**? Provide a **year**: _____☐ N/A

3.) For patients, ages **50-75 years**, when was your **last colonoscopy**? Provide a **year**:_____ ☐ N/A

FOLLOWING QUESTIONS APPLY ONLY TO FEMALE PATIENTS:

4.) For **women**, ages **51-74**, when was your **last mammogram**; provide a **year:**_____ ☐ N/A

5.) For **women**, ages **21-64**, have you been **screened for cervical cancer**? Provide a **year:**_____ ☐ N/A

Do you have the following:

☐ NONE APPLICABLE ☐ High Blood Pressure ☐ Heart Attack ☐ Hypothyroidism ☐ Diabetes
☐ Stroke ☐ Cancer ☐ Other:_____

Past Surgical History

☐ NONE APPLICABLE ☐ (List Here)_____

Highest level of education

☐ Middle School ☐ High School ☐ College ☐ Graduate Program ☐ Other:_____

Current Occupation:

_____ ☐ Retired ☐ Unemployed ☐ Medical Disability

Family History

☐ NONE APPLICABLE ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Other:_____

_____ _____

Signature Date

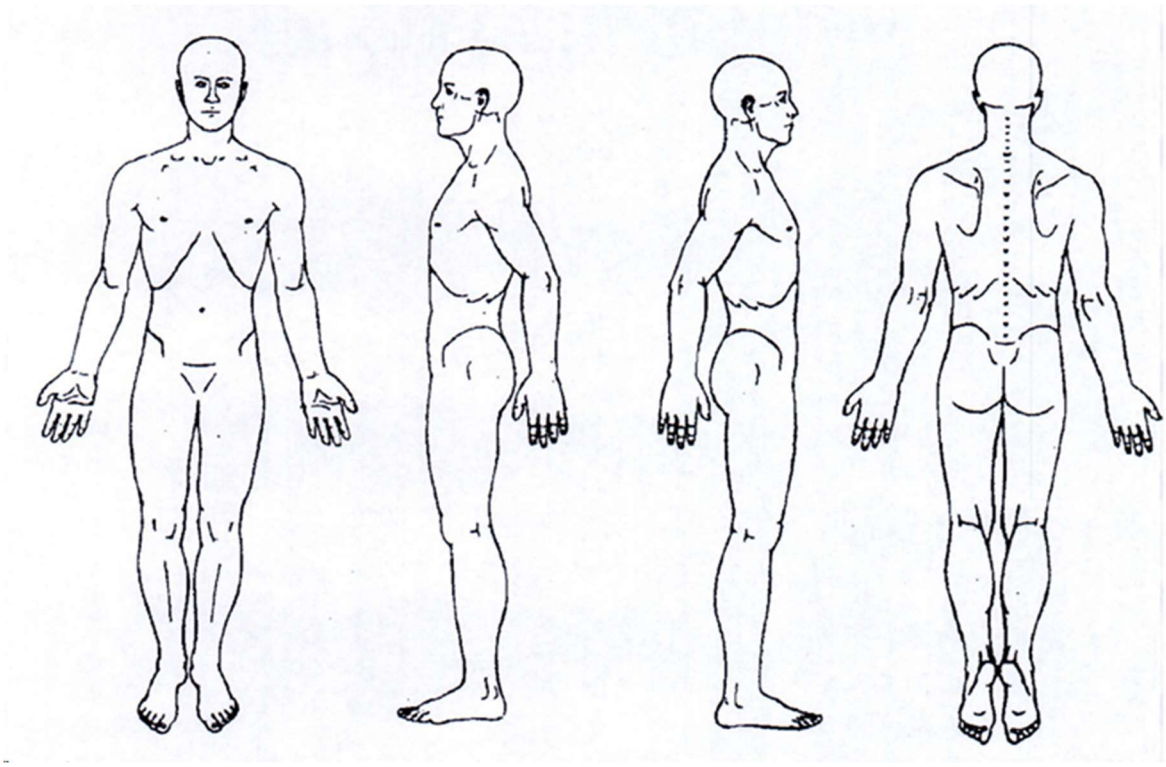
Name: Date:
DOB:

Pain Assessment

Name: **Date:**

1. ☐ Initial Visit ☐ Follow-up Visit

2. Please mark or shade the areas of your body where you feel pain on the diagrams below.



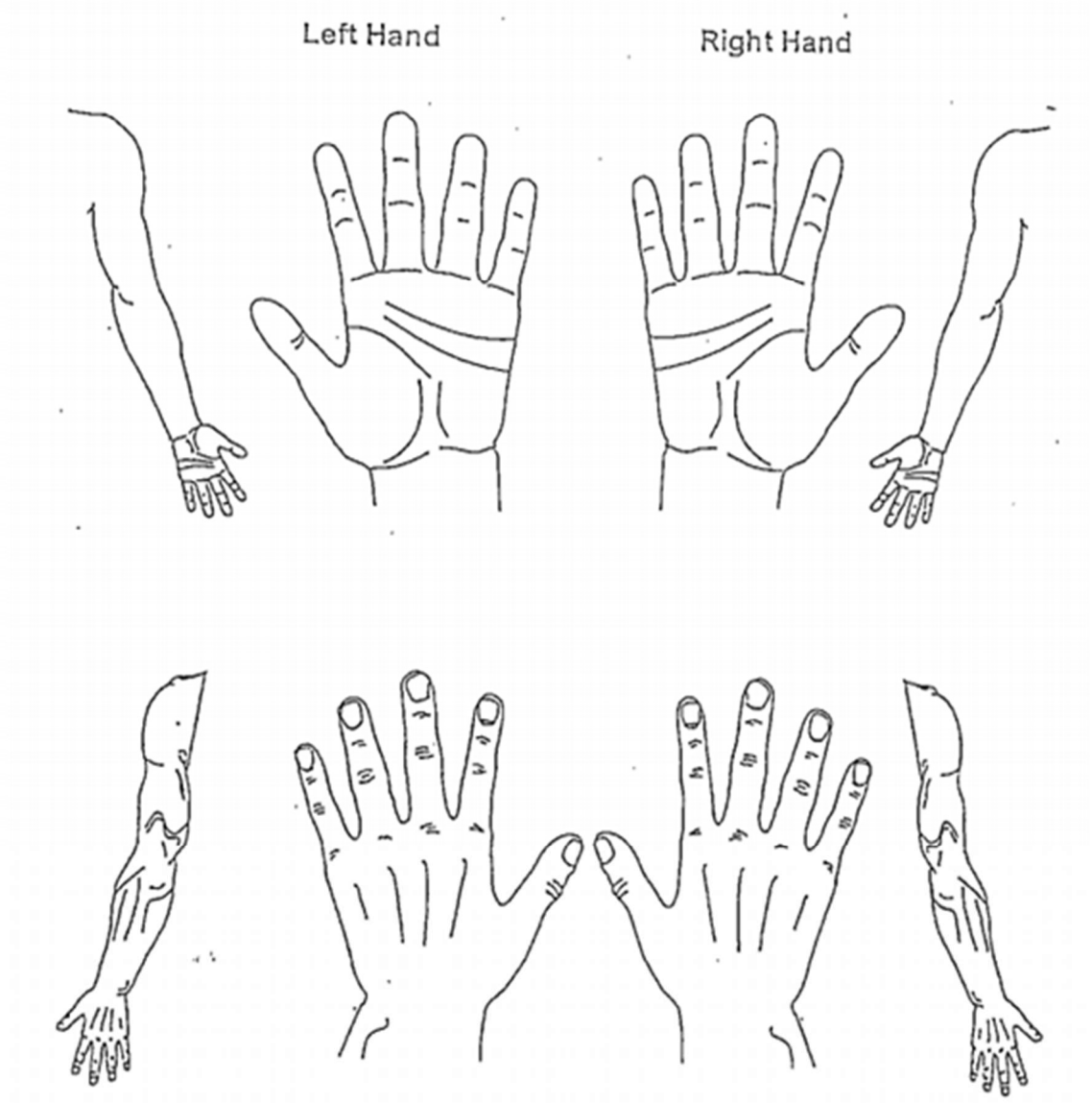
3. Next to each area marked above, please note the intensity of pain.

No Pain	Minimal		Tolerable, but hinders activites		High - 50% of activities impaired		Extreme - most activities impaited		Unbearable
0	1	2	3	4	5	6	7	8	9

_____

Patient Signature

Name: Date:
DOB:



1. Rate your symptoms on a scale 1-10.

minimal 1 2 3 4 5 6 7 8 9 10 severe

2. Shade the areas where you are feeling pain (Achy, Sharp, Dull)

3. Draw lines to the areas you are experiencing numbness

4. Draw dots to the areas you are experiencing tingling