

Patient Registration

Approx. Date of Injury

PATIENT INFORMATION

Last Name		First Name		Middle Name		
Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Age
Home Street Address			City and State		Zip Code	
Mailing Street Address			City and State		Zip Code	
Home Phone () -		Cell Phone () -		Drivers License #	Exp Date	
Employer or School		Address			Occupation	
Emergency Contact Person				Emergency Contact's Phone () -		

RESPONSIBLE PARTY (If not Patient)

Last Name (Responsible Party)		First Name		MI	Social Security #	
Mailing Street Address			City and State		Zip Code	
Employer Name		Address			City and State	Zip Code
Cell Phone () -		Occupation			Drivers License	

SPOUSE (If not Responsible Party)

Spouse's Last Name		First Name		MI	Social Security #		
Spouse's Employer			Address			City and State	Zip Code
Cell Phone () -		Occupation			Drivers License		

PRIMARY INSURANCE

Subscriber's Name on Card		Insurance Company		Subscriber #		Group Number
Insurance Company Street Address			City	State	Zip Code	Date of Birth

SECONDARY INSURANCE

Subscriber's Name on Card		Insurance Company		Subscriber #		Group Number
Insurance Company Street Address			City	State	Zip Code	Date of Birth

REFERRING PHYSICIAN(S)

Primary Care Physician	Referring Physician
Primary Care Physician's Address	Referring Physician's Address
Primary Care Physician's Telephone Number	Referring Physician's Telephone Number

PHARMACY

Name of Pharmacy	Address or Cross Streets	Telephone Number
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INDUSTRIAL OR ON THE JOB INJURY? PLEASE CIRCLE ONE → NO YES (IF YES, PLEASE COMPLETE BELOW)

Labor & Industries Claim Number	Last Day Worked	Commercial Insurance Carrier
Date & Cause of Injury	Affected Area	Legal Case? <input type="checkbox"/> YES <input type="checkbox"/> NO

Current Problem and Medical History

Patient's Name	Today's Date
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SOCIAL HISTORY

Patient's Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation	Sports/Exercises/Hobbies
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		Highest Level of Education <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Graduate School	
Do You Smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes How Much Per Week? _____		Drink Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes How Much Per Week _____	
Have You Had Chemical Dependency? <input type="checkbox"/> No <input type="checkbox"/> Yes, when? _____		Any Intravenous Drug Use? <input type="checkbox"/> No <input type="checkbox"/> Yes, when? _____	

HISTORY OF PRESENT INJURY OR PROBLEM

1 Briefly describe your bone or joint problem and for what you would like help:

2 Injury Is your problem related to an injury? Yes No
Briefly describe how and where it occurred _____

3 Location Where is your condition/problem?
 Right Shoulder Right Knee Right Arm Right Leg
 Left Shoulder Left Knee Left Arm Left Leg
 Other _____

4 Quality Are you experiencing?
 Pain Weakness Swelling Color Change
 Numbness Tingling
 What type of pain do you have? Dull Sharp Tightness Radiating

5 Severity How strong is your pain? Light Moderate Severe
 How bothersome is the problem? Interferes with Daily Activity Keeps You Up at Night
 Stops you from attending Work, School or Sports

6 Duration How long has your problem lasted? _____ Days _____ Weeks _____ Months _____ Years

7 Timing How does your pain/problem occur? Gradual Onset Intermittent Continual
 Has the problem changed recently? Yes No
 Have you had similar problems in the past? Yes No

8 Context When does the pain/problem occur? Moving Lifting During Sports Other

9 + Factor What makes the problem better? _____

10 - Factor What makes the problem worse? _____

11 Associated Have you had any related problems? _____

12 **PREVIOUS TEST(S) OR EXAM(S):** Please list all previous tests performed for this problem

<u>TEST</u>	<u>DATE PERFORMED</u>	<u>TEST</u>	<u>DATE PERFORMED</u>
<input type="checkbox"/> MRI	_____	<input type="checkbox"/> Bone Scan	_____
<input type="checkbox"/> EMG	_____	<input type="checkbox"/> Arthrogram	_____
<input type="checkbox"/> X-ray	_____	<input type="checkbox"/> Myelogram	_____
<input type="checkbox"/> CAT Scan	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Seen Another Specialist	_____		

13 **IS YOUR INJURY/PROBLEM WORK OR JOB RELATED?** NO YES, Please Complete Below

Who is your Job Related Primary Physician?
What are the specific job duties effected by your injury or problem?

Medical History Continued

PAST MEDICAL HISTORY

1 **ANY PAST SURGERIES OR HOSPITALIZATIONS?** **NO** **YES**, Please List Below

Type of Surgery/Hospitalizations	Date	Surgeon/Physican	Was it Helpful?
1			<input type="checkbox"/> Yes <input type="checkbox"/> No
2			<input type="checkbox"/> Yes <input type="checkbox"/> No
3			<input type="checkbox"/> Yes <input type="checkbox"/> No
4			<input type="checkbox"/> Yes <input type="checkbox"/> No

2 **MEDICATIONS THAT YOU TAKE**

List All Medications Taken for this Problem:

1	4
2	5
3	6

List All Other Prescription or Nonprescription Medications

1	5
2	6
3	7
4	8

3 **LIST ANY ALLERGIES** to Any Medications or Substances

Type of Reaction

4 **BLOOD & INFECTION HISTORY**

Do you now or have you recently taken "blood thinning" medication"? (Coumadin, Aspirin)

Yes No

Have you ever had any problems with previous surgeries with excessive bleeding, clots or infections?

Yes No

FAMILY MEDICAL HISTORY

Have you, your mother, father, or siblings ever had treatment for?

	Yourself? (Please Circle)		Family Member? (Please Circle)			Yourself? (Please Circle)		Family Member? (Please Circle)	
Asthma	Yes	No	Yes	No	Pneumonia	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Seizures	Yes	No	Yes	No
Heart Problems	Yes	No	Yes	No	Thyroid Gland Problem	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No	Tuberculosis	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Lung Disease	Yes	No	Yes	No
Liver Disease/Hepatitis	Yes	No	Yes	No	Digestive Disorders	Yes	No	Yes	No
Anxiety or Depression	Yes	No	Yes	No	<u>Other Illnesses</u>				
Sexually Transmitted Disease	Yes	No	Yes	No		Yes	No	Yes	No
Bone or Joint Problems	Yes	No	Yes	No		Yes	No	Yes	No

Do you have any other concerns?

Patient's Signature X	Today's Date
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Peter T. Simonian, MD X	Today's Date
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A MEMBER OF SAINTÉ FOUNDATION MEDICAL GROUP & PART OF SAINTÉ HEALTH FOUNDATION

Patient Agreement of Financial Responsibility

Simonian Sports Medicine Clinic ("SSMC") is committed to providing quality care and service to all our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient, and sign and date below. Should you have any questions regarding the SSMC policies, please bring them to our attention before you sign this agreement.

_____ **Consent to Medical Services:** By signing this agreement, you consent to and authorize the performance of all treatment, surgeries, and medical services rendered by Simonian Sports Medicine Clinic and any other medical professionals at SSMC.

_____ **Insurance Information:** You are responsible for making sure we have all the current and accurate insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you and/or denial of coverage by your insurance company. We ask that you update and verify your insurance information in our file at each visit, as well as whenever there may be a change or update to your insurance coverage.

_____ **Agreement to Pay for Medical Services:** You understand and agree that you are personally and fully responsible for all charges for the services provided by SSMC, which include without limitation all medical and health-related services such as visits, consultations, routine examinations, testing, treatment and surgeries. You further understand and agree that it is your responsibility to know if your insurance has any deductible, co-payment requirement, co-insurance, out-of-network terms, limits, prior authorization requirements, or any other type of benefit limitation for the services you receive, and you agree to comply with all requirements of your insurance and agree to make payment in full to SSMC for any amount billed by SSMC that may not be covered or paid by your insurance.

_____ **Non-Covered Services:** We will do our best to confirm your insurance coverage before any medical services are provided to you, but it is ultimately your responsibility to know your benefits and to pay your bill from SSMC, including without limitation any co-payments, co-insurance, and deductibles. Our confirmation of insurance benefits and coverage is not a guarantee of payment from your insurance. Any service performed by SSMC that is not covered by your insurance is your sole responsibility to pay.

_____ **Referrals:** You understand and agree that it is your responsibility to know if your insurance requires a referral from your primary care physician (or requires some other authorization), and that it is up to you to obtain the referral or authorization. You further understand and agree that without this referral or authorization, your insurance may not pay for any services from SSMC and you will then be personally and fully responsible to pay SSMC for all services rendered.

_____ **Self-Pay:** If you do not have health insurance, are on an insurance plan we are not contracted with, or if we are unable to confirm your coverage at the time of service, we may collect an estimated payment from you before you are seen by a doctor. There may be additional charges depending on the services provided by SSMC, for which you may receive a bill that exceeds the estimated payment you make. You agree to be personally and fully responsible for all charges for the services provided by SSMC if you are not insured.

_____ **Returned Checks:** We charge a \$25.00 fee for any returned checks.

_____ **No Show Policy:** If you are unable to make your appointment, we ask that you cancel your appointment at least 24 hours before the date of the appointment.

_____ **Minors:** For all services rendered to minor patients, the parent, guardian, and/or responsible party will be required to sign this agreement and agrees to be fully responsible for all payments due to SSMC for all medical services that are provided by SSMC.

_____ **Delinquent Accounts:** Your account may be sent to a collection agency if the balance is over 90 days old, and partial or no payment has been made towards the balance.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

_____ **Contact:** If you have any questions regarding your bill, please contact the SSMC billing office at (559) 228-4220.

I have read this Patient Agreement of Financial Responsibility and agree to be bound by its terms. I also understand that SSMC has the right to amend this agreement at any time.

Patient Signature: _____ Date: ____/____/____

Printed Name of Patient: _____

Printed Name of Responsible Party: _____

Relationship to Patient: _____

***Note: Simonian Sports Medicine Clinic is a part of
Santé Foundation Medical Group (SFMG).
All billing statements regarding charges incurred by any services
provided by our physicians will come from and be processed by SFMG.***



**Notice of Privacy Practices and
CCR 1355.4 Compliance**

By my signature below, I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Simonian Sports Medicine Clinic. I also understand that Medical doctors are licensed and regulated by the Medical Board of California. The Medical Board may be reached by phone at (800) 633-2322 or email at www.mbc.ca.gov.

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Notice to Patients

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov, email: licensecheck@mbc.ca.gov, or call (800) 633-2322.



Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority



NOTICE OF PRIVACY PRACTICES

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 to carry out treatment, payment or other health care operations and for other purposes that are permitted or required by law. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be effective for all protected health information that we maintain. Upon your request we will provide you with a copy of our revised notice by calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

I. Permitted Uses and Disclosures of Protected Health Information

- **Treatment:** Your physician will use or disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g. a specialist or a laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.
- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include activities that your health plan may undertake before it approves or pays for health care services that we recommend for you. These activities include: determining eligibility, reviewing services for medical necessity, and utilization review activities.
- **Health Care Operations:** We may use or disclose your protected health information to support the business activities of our office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the front desk where you will be asked to sign your name and indicate your physician, we may call you by name in the waiting room when your physician is ready to see you, or we may use your information as necessary, to contact you to remind you of an appointment, and leave voicemail messages on your phone or message with person answering your phone.

II. Uses and Disclosures Based on Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization unless otherwise permitted or required by law as described below. You may revoke an authorization, at any time, in writing, except to the extent we have relied on the use or disclosure of protected health information indicated in the authorization.

III. Permitted Uses and Disclosures Without Your Authorization or Opportunity to Object

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your protected health information for public health activities and purposes, such as contagious disease reporting,

investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs and medical devices.

Communicable Diseases: We may disclose protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Healthy Oversight: We may be required to disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil right laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to a subpoena or administrative tribunal (to the extent such disclosure is expressly authorized).

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. For example, to provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened somewhere else.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes or to determine the cause of death; to a funeral director, as authorized by law, to aid in burial; or to organizations that handle organ and tissue donations.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: We may use or disclose your protected health information to prevent a serious threat to health or safety.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Business Associates: We may disclose your protected health information to third party "business associates" who perform health care operations for us and who agree to keep your health information private.

Required Uses and Disclosures: Under the law, we must 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 the requirements of Section 164.500 et. seq.

IV. Patient Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to request access or a copy of your protected health information. You may request access and/or a copy of your medical information maintained in our records, including medical and billing records. Your request must be in writing. Following is our fee schedule for copying medical records:

Patient Request: \$15-\$30 per copy of record, depending on chart size

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We do not have to agree to the request, however if we do, we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. You may request a restriction by completing a "Restriction Request Form" available at the front desk. You will receive a response in writing within seven (7) days of receiving your request.

Your physician may deny the restriction request if he/she believes it is in your best interest to permit the use and disclosure of your protected health information.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of

contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office manager.

You have the right to request an amendment to your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us from which we may prepare a rebuttal. We will provide you with a copy of any such rebuttal. Please fill out an "Amendment Request Form" available at the front desk if you would like to request that an amendment be made to your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations or pursuant to a valid authorization as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Central California Health Information Exchange. We participate in the Central California Health Information Exchange (the "Exchange"), which is an electronic health record that is shared with other health care providers who participate in the Exchange and, in other certain limited circumstances, with other health care providers who are not Exchange participants, such as a specialist to whom you have been referred. Your electronic health record may also be available electronically for health care providers to access when it is determined that you require emergent care.

V. Complaints

If you believe we have not properly protected your privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights, you may contact our Corporate Privacy Officer, Juan Carlo Muro at (559) 228-5479 or by e-mail at JCMuro@santehealth.net. You may also send a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights as follows:

U.S. Department of Health and Human Services
Office for Civil Rights
Attn: Regional Manager
50 United Nations Plaza, Room 322
San Francisco, CA 94102
1-415-437-8310

Simonian Sports Medicine Clinic will ensure that you will not be penalized nor will the care you receive at our facilities be impacted if you file a complaint.

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



Notice of Open Payments Database

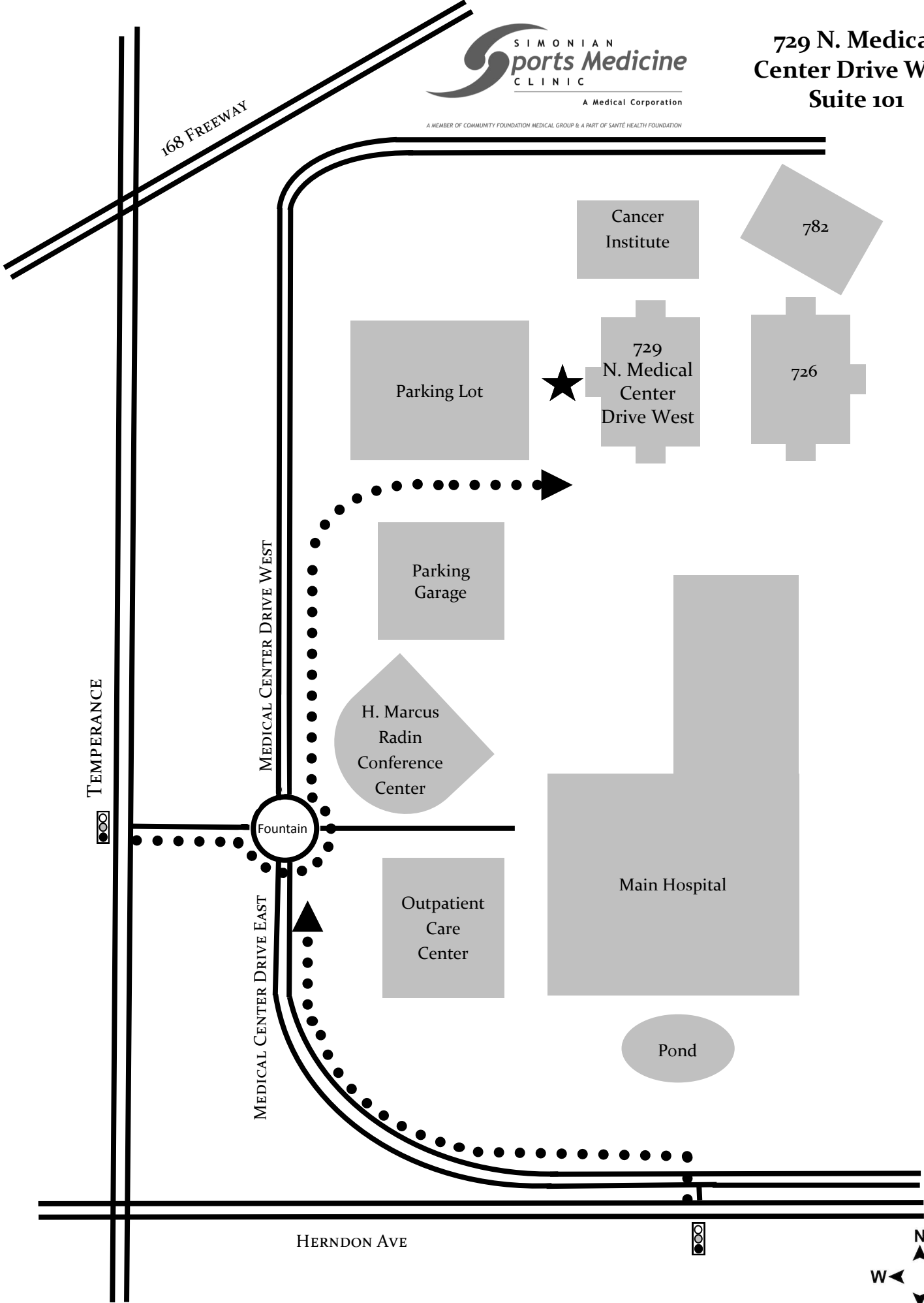
The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority



Clovis Community Medical Center Campus

TEMPERANCE

HERNDON AVE

