CALIFORNIA ORTHOPAEDIC INSTITUTE
MEDICAL ASSOCIATES, Inc.

(PLEASE PRINT & COMPLETE ALL QUESTIONS)

PATIENT INFORMATION

DATE	ACCOUNT TYPE	DR. NO.	ACCOUNT NO.	PREFERRED LANGUAGE

PATIENT'S NAME LAST	FIRST	MIDDLE	GENDER ❑ MALE ❑ FEMALE

HOME / MAILING ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	SOCIAL SECURITY #	DRIVER LIC #	MARITAL STATUS ❑ S ❑ M ❑ W ❑ D ❑ SEP

PHONE # HOME	WORK	CELL	EMAIL ADDRESS

EMPLOYER	OCCUPATION (INDICATE IF A STUDENT)

RESPONSIBLE PARTY ❑ SELF ❑ OTHER	IF OTHER: NAME	ADDRESS

PHONE	RELATIONSHIP

EMERGENCY CONTACT NAME	**PHONE**	**RELATIONSHIP**

REFERRING MD	**REFERRED BY, OTHER THAN MD**

INSURANCE INFORMATION (OFFICE USE ONLY)

MEDICARE ❑	MEDICARE NUMBER #	MEDI-CAL ❑	MEDI-CAL NUMBER #

NAME OF INSURANCE COMPANY (PRIMARY)	SECONDARY / SUPPLEMENTAL INSURANCE COMPANY

STREET ADDRESS	STREET ADDRESS

CITY, STATE & ZIP CODE	CITY, STATE & ZIP CODE

GIVE NAME OF POLICY HOLDER	GIVE NAME OF POLICY HOLDER

GROUP / POLICY NO.	SUBSCRIBER / I.D. NO.	GROUP / POLICY NO.	SUBSCRIBER / I.D. NO.

❑ ACCIDENT ❑ AUTO/VEHICLE ❑ JOB RELATED ❑ OTHER, Explain	DATE OF INJURY

PLEASE SIGN THE FOLLOWING FORM

I hereby authorize California Orthopaedic Institute Medical Associates, Inc., to furnish to my insurance company or to a designated attorney, all information which the insurance company or attorney may request. I hereby assign to the above referenced physicians all monies to which I am entitled and/or surgical expense relative to the services rendered by either of them. It is understood that any money received from the above-named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible. WHETHER MY INSURANCE COMPANY PAYS OR NOT, for all costs incurred by me. I further agree that in the event of non-payment, I will bear the cost of collection and/or Court cost and reasonable legal fees should such court action be required. I agree that a photocopy of this authorization shall be as valid as the original.

Insured or Guardian Signature

Patient's Signature

California Orthopaedic INSTITUTE

American Board of Orthopaedic Surgery

NOTICE OF DISCLOSURE

L. Randall Mohler, M.D.
Drew A. Peterson, M.D.
Michael H. Quinn, D.P.M.
Jeffrey E. Schultz, M.D.
William Tontz Jr., M.D.
Steven Tradonsky, M.D.

Dear Patient:

Under California Business and Professions Code 654.2, the physicians of California Orthopaedic Institute are required to inform you that they have a financial interest in Mission Valley Heights Surgery Center (MVHSC).

Should you require outpatient surgery, it is possible that your surgery would be scheduled at MVHSC. By signature below, you are confirming that you have read and understand this notice of disclosure.

You may opt to have your surgery performed at a different outpatient facility. An alternative will be discussed with you upon your request.

Sincerely,

L. Randall Mohler, M.D.

William L. Tontz, Jr., M.D.

Michael H. Quinn, D.P.M.

Jeffrey E. Schultz, M.D.

Drew A. Peterson, M.D.

Steven Tradonsky, M.D.

_____ _____

Patient's Signature Date

7485 Mission Valley Road, Suite 104, San Diego, California 92108 • (619) 291-8930 • fax: (619) 291-8491

California Orthopaedic INSTITUTE

ZERO TOLERANCE POLICY

NOTICE TO OUR PATIENTS

American Board of Orthopaedic Surgery

L. Randall Mohler, M.D.

Drew A. Peterson, M.D.

Michael H. Quinn, D.P.M.

Jeffrey E. Schultz, M.D.

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Steven Tradonsky, M.D.

For the safety of our patients and staff, the California Orthopaedic Institute has a ZERO TOLERANCE POLICY for any threatening or abusive behavior, verbal or physical, against anyone in this facility or on its grounds.

Such behavior will result in the immediate termination of the Provider-Patient relationship.

We appreciate your cooperation with this policy.

Sincerely,

Physicians and Staff

_____ _____

PRINTED NAME **SIGNATURE**

_____

DATE

7485 Mission Valley Road, Suite 104A, San Diego, California 92108 • (619) 291-8930 • fax: (619) 291-8491

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to view and/or request a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures prior to signing this consent. I understand that the organization reserves the right to change their notice and practices, and prior to implementation will post and make available, the revised notice at physical practice site(s). I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____

I have read and understand the ***Notice of Privacy Practices***.

_____	_____
Signature of Patient or Legal Representative	Witness
_____	_____
Date	Notice Effective Date

California Orthopaedic INSTITUTE

FINANCIAL POLICY

Dear Patient:

Our office will be happy to bill your primary and secondary insurance carrier as a courtesy if the proper information has been provided.

If you do not have insurance, payment is due at the time of service. If you are a Medi-cal patient and do not bave your eligibility card, you will be considered a "cash" patient and will be responsible for the balance due.

Several insurance companies have a "co-payment" that the patient is responsible for at the time of service. The office will bill the insurance company for the difference and you will not receive a statement. We will bill you for any services that are not covered. Please let the office know if you participate in this type of insurance plan or if you are required to have a referral authorization.

If you feel that your insurance company has not responded to your claim, or if you question the amount covered, please contact your insurance company. It is your responsibility to follow-up on claims submitted. We will be happy to assist you if necessary.

To our HMO and EPO patients: *Please read and sign the following liability statement.*
I, _____ will assume full financial liability for any non-covered benefit or service denied by my Health Plan. Example: Medical equipment, elective surgeries, etc.

_____ _____

Date ***Signature***

Release of Information/Assignment of Benefits

I hereby authorize California Orthopaedic Institute to furnish to my insurance company or to a designated attorney, all information which the insurance company or attorney may request. I hereby assign to the above-referenced physicians all monies to which I am entitled and/or surgical expense relative to the services rendered by either of them. It is understood that any money received from the above-named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible, WHETHER MY INSURANCE COMPANY PAYS OR NOT, for all charges incurred by me. I further agree that in the event of non-payment, I will bear the cost of collection and/or Court cost and reasonable legal fees should such court action be required. I agree that a photocopy of this authorization shall be as valid as the original.

_____ _____

Insured or Guardian Signature Patient's Signature

Date:

California Orthopaedic
INSTITUTE
IMAGING CENTER

ICAMRL
Intersocietal Commission for the Accreditation of Magnetic Resonance Laboratories
Accredited Magnetic Resonance Facility

Dear Patient,

We are required, by law, to disclose the following:

(1) California Orthopaedic Institute (COI) has ownership in the MRI facility on these premises Located in suite 101.

(2) You may obtain ancillary services (MRI) from another facility of your choosing and Below are 5 options.

(3) Other facilities and their location may be obtained from your insurance company.

Please note that COI obtains authorization for your MRI prior to your scan here at our facility. We cannot guarantee that the other facilities are connected with your insurance company.

If you choose another option, please contact your insurance company for assistance.

Other Options:

Open Air MRI – (800) 948-1998
Imaging Healthcare Specialists – 5th & Upas – (619) 295-9729
Imaging Healthcare Specialists – Alvarado Court – (619) 229-2299
Sharp & Children's MRI Center – 7901 Frost Street – (858) 939-4550
Regents MRI – 4130 La Jolla Village Drive, #101 – (858) 200-3300

We are pleased to provide the MRI service as requested by your physician. If you have questions regarding this information, please ask your doctor or the medical assistant.

L. Randall Mohler, M.D.
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Patient Name _____ Signature _____ Date _____

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