16311 Ventura Blvd.
Suite 1150
Encino, CA 91436
Phone: (818) 477-0787
Fax: (818) 477-0677

LA BONE AND JOINT INSTITUTE

PLEASE COMPLETE THE FORM IN ITS ENTIRETY

History of Present Illness

Name: _____ **Date:** _____

Have you been discharged from an inpatient facility in the past 30 days? If yes: _____

Date of Discharge: _____ **Any medication changes?** _____

_____

What part of your body are you being seen for today? _____

If there is pain, where is it (be specific)? _____

What is the goal of your appointment today?

___Pain Management ___Better Function ___Return to Work ___Return to Play Other:_____

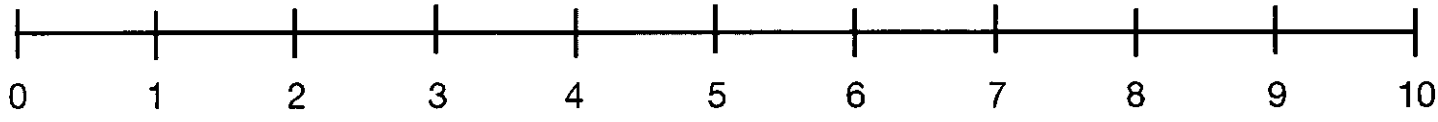
When did this problem start? _____

How did this problem start? Any Injuries? _____

_____

Is this work related? ___Yes ___No

On a scale 0-10 (0 = no pain; 10 = worst pain you can imagine) what is your level of pain?



How would you describe the pain? ___Sharp ___Stabbing ___Dull ___Throbbing ___Electrical ___Burning

___Crushing Other: _____ Does it radiate? If yes, where? _____

Do you have any of the following? ___Swelling ___Numbness ___Tingling ___Weakness

Location(s): _____

Do you have a history of back pain or problems? _____

Do your symptoms affect your ability to work? ___Yes ___No **If yes explain:** _____

_____

Do your symptoms affect your activities of daily living? ___Yes ___No **If yes explain:** _____

_____

Do your symptoms wake you up at night? ___Yes ___No

What makes your symptoms worse? _____

_____

What makes your symptoms better? _____

_____

What treatments have you tried? ___Physical Therapy ___Ice ___Injection (__Steroid __Other) Date: _____

___Medication: _____ ___Other: _____

How many minutes or street blocks can you walk? _____

Can you complete a trip to the grocery store? ___Yes ___No

Can you put your own socks and shoes on? ___Yes ___No

Describe how you use stairs: ___Place one foot per step ____Place both feet on step before proceeding to next

___Use banister ___Not applicable; don't use stairs

Do you limp? _____

Do you use a walking device? ___None ___Cane ___Crutches ___Walker ___Wheel Chair

How often and when? _____

PLEASE USE THE SPACE BELOW TO EXPLAIN OR TELL THE DOCTOR ABOUT YOUR PROBLEM NOT COVERED IN THE FORM ABOVE

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PLEASE COMPLETE THE FORM IN ITS ENTIRETY

Health Questionnaire

Date Completed_____

Name: _____ **Marital Status:** S/ M/ D/ W

Age: _____ **Sex:** M/ F **Race/Ethnicity:** _____

Employer:_____ **Occupation:** _____ **Retired:** Yes / No

Height: _____ **Weight:** _____**Birthdate:** _____ **Dominant Hand:** L/ R

Primary Care Physician Information: _____

Hobbies:_____

Allergies: Please list all allergies and reactions (latex, medications & etc.) or indicate none

_____

Current Medications: List all medications including non-prescribed or indicate none

_____

_____

Tobacco: (please circle one): Never Smoked Former Smoker as of_____

Current Smoker # of Packs Per Day _____ Other Tobacco Use _____

Alcohol: (please circle one): None, Recovering Alcoholic, Drinking Daily/ Weekly if so, # Of Drinks per Week _____

Substance/ Drug Abuse: (please circle one): Yes / No Prior History of_____

Past Surgeries / Medical Problems / Illnesses/ Accidents and Hospitalizations: Please include dates for each occurrence

_____

_____

_____

Family History: Please circle

Father: Age _____ Living / Deceased * Allergies * Cancer * Autoimmune * Diabetes * Heart disease * Stroke * Bleeding Disorders

Mother: Age_____ Living / Deceased * Allergies * Cancer * Autoimmune * Diabetes * Heart disease * Stroke * Bleeding Disorders

SYSTEM REVIEW: Please circle if you have / had any of these conditions

- **General**: * Healthy * Ill * Recent Weight Gain _____ LBS, Loss _____ LBS
- **Heart/ Circulation**: * Normal * High Blood pressure * Heart Attack * Heart Failure * Angina/Chest Pain
  * Arrhythmia/Irregular Heart Beat * Poor Circulation * Edema * Swelling of Hands/Feet
  * Shortness of Breath When Lying Flat
- **Lungs**: * Normal * Asthma * Chronic Lung Disease * Blood Clots In Lung * Pneumonia * Difficulty Breathing
- **Gastrointestinal**: * Normal * Reflux * Peptic Ulcer * Liver Disease * Vomiting * Constipation * Diarrhea
  * Gallbladder Disease
- **Urinary Tract**: * Normal * Bladder Infection * Prostate Enlargement * Frequent Urination * Kidney Stones
  * Kidney Failure
- **Endocrine:** * Normal * Diabetes * Thyroid Abnormality * Other_____
- **Hematologic**: * Normal * Blood Clots * Transfusion – Your own Blood , OR Donor Blood
  * Abnormal Bleeding Tendencies
- **Neurologic**: * Normal * Stroke * Seizures * M.S * Parkinson's disease * Depression * Tremors
  * Weakness/Paralysis * Fainting Spells * Numbness/Tingling
- **Muscles & Joints**: * Normal * Osteoarthritis * Rheumatoid * Lupus * Fibromyalgia * Gout
- **Head & Neck:** * Normal * Headaches * Sinus Problems * Hearing Loss * Visual Loss
- **Skin:** * Normal * Cancer * Psoriasis * Eczema * Rashes * Boils/Abscess * Jaundice
- **Infectious Disease:** * None * Hepatitis A/ B/ C * HIV * Tuberculosis * Fever/Chills
- **Cancer:** * None * Yes , TYPE : _____
- **Bones:** * Normal * Osteoporosis * Joint/Bone Infection (Osteomyelitis)
  * Fracture, if yes , which bones _____

Pharmacy Information: Please provide your pharmacy information if available:

Pharmacy Name_____

Address (Cross Street and/or City) _____

Phone number _____

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Demographics and Intake

Today's Date: ___/___/_____

General

Last Name: _____ First Name: _____ Middle Initial: ____

Social Security Number: _____-___-_____ Driver License #: _____ State Issued: _____

Gender (Circle one): Male / Female Date of Birth: ___ / ___ / _____

Marital Status: _____ Spouse/Partner: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ Secondary Phone #: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Race and Ethnicity

☐ Black or African-American
☐ American Indian or native Alaskan
☐ Hispanic or Latino
☐ White
☐ Multiple races

Asian
☐ Multiple Asian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Indian
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other

Pacific Islander
☐ Multiple Pacific Islander
☐ Hawaiian
☐ Guamanian
☐ Samoan
☐ Other Pacific Islander

Employment/Legal

Employer: _____ Occupation: _____ Retired: Yes / No

Is this a work related injury (circle one): Yes / No

Is there a legal case or lawsuit involved with this injury (circle one): Yes / No

If YES to either of the above, please see receptionist at front desk for additional paperwork and forms.

Referrals

Who referred you to our practice? Name: _____

☐ Doctor ☐ Relative ☐ Friend ☐ Insurance Company ☐ Hospital ☐ Internet

If a doctor please provide Address: _____

Phone: _____ Fax: _____

Primary Insurance

Insurance Company Name: _____ ID/Policy #: _____ Group #: _____

Insured Name: _____ Insured SSN: _____-___-_____ Insured DOB: ___/___/_____

Subscriber of the Health Insurance: _____ Relationship to the Insured: _____

Subscriber SSN: _____-___-_____ Subscriber DOB: ___/___/_____

Secondary Insurance

Insurance Company Name: _____ ID/Policy #: _____ Group #: _____

Insured Name: _____ Insured SSN: _____-___-_____ Insured DOB: ___/___/_____

Subscriber of the Health Insurance: _____ Relationship to the Insured: _____

Subscriber SSN: _____-___-_____ Subscriber DOB: ___/___/_____

Authorization

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize examination and all services deemed medically necessary. I authorize the release of all medical information as necessary to process my claim. I agreed to assume financial responsibility for ALL services provided.

_____ ___/___/_____

Signature of Patient or Responsible Party Date

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HIPAA Privacy Preferences and Signature

Please complete the following form for how you would like LA Bone and Joint Institute to communicate or disclose your protective medical information such as appointment information, test results, procedures, etc.

☐ LA Bone and Joint Institute may only discuss my information directly with me.

If we are not able to reach directly, may be provided you with your information via voicemail or email*? If yes please complete the following.

_____	_____	_____	_____
Home	Cell	Work	Other

_____
email address

*Although our email is secure within our practice, emails sent outside of our practice will be unencrypted.

Is there anyone that you would like to allow us to speak to about your information if they inquire about it? This can be anyone (family member, friend, caretaker, etc.) that might accompany you to an appointment, help you with your forms, call to make or check an appointment for you, or pick anything up for you from our office. If someone does come to us on your behalf but the name is not listed below, we will not be able to see share anything with them regarding the protected health information.

LA Bone and Joint Institute may shar my information with the following individuals.

Name	**Relationship to Patient**
_____	_____
_____	_____

In addition to the above form, I have received and carefully reviewed a copy of the Notice of Privacy Practices for LA Bone and Joint Institute.

_____	_____	_____
Patient's Name	Patient Signature	Date

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Office Policies

LA Bone and Joint Institute is committed to personalized and high quality medical and orthopedic care. To keep our commitment to excellent care and service, we ask that you review our policies. Kindly sign and date to confirm the understanding will follow our practice's policies.

Financial Policy

We appreciate your trust in us and we want to thank you for being responsible in managing the financial element of your care. If you have any questions based on the information below, please discuss them with our staff before you see our providers.

Our doctors are contracted with many Preferred Provider Organization (PPO) health insurance plans. We accept patients who are "In Network" and "Out of Network." Note: Even if your health plan indicates that you have "out of network" benefits, please consult our staff so we can verify your authorized benefits. We welcome Medicare, Worker's Compensation plans, and patients who pay by cash (self-pay).

We accept cash, check, visa and master card.
The adult accompanying a minor is responsible for payment of all services rendered to minor patients.
Please update our staff with a change of address and or telephone number any time if change occurs.

If you have a health plan that we accept, please present your health plan card and proof of identity (e.g. driver's license) at each visit. Note: Some health plans issue a pharmacy card to. We only accept your medical health plan card.

Update our staff with a change of insurance **anytime** a change occurs.

Expect that we will bill your health plan if you are covered by one the plans that we except. Be prepared to pay the copayment or coinsurance at the time of service. When we contract with insurance companies, these agreements state we cannot charge you (the patient) other than co-pays, deductibles and items deemed by the carrier as billable charges to the patient. If we later receive a check from the insurer, we will refund any overpayment to you.

A prepayment of your deductible and coinsurance will be required for your portion of our fees based on our contracted allowable rate for scheduled surgical procedures. Any balance remaining, after your health insurer pays, is your responsibility. Payment is due upon receipt of a statement from our office.

Respond promptly to your insurance company to provide any information that it may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming overdue and payable, in full, immediately.

Be aware that all health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. We recommend you read your insurance policy to determine your benefits.

When you were charged a "global" fee for surgery or office care of a fracture, laceration, excision of an ingrown toenail, etc., the fee not only includes the service on the day it is performed, but includes routine follow-up care as well. The global period ranges from 10-90 days depending on the procedure and your health plan. X-rays and supplies (such as casting or dressing materials, splints, braces, etc.) are not included in the global fee and a charge will be made for these items.

If you are out of network, we will bill your insurance company. Insurance companies typically pay out of network fees directly to the insured. If your insurance company pays our office directly and the total amount paid (out of pocket + insurance payment) is more than the amount of billed, you will receive a refund within 30 days of payment.

Fracture Care (Broken Bones)

Health plans have created a series of numeric codes to be used by doctors when treating patients. Insurance companies mandate that your doctor use these codes. There are special codes for patients with fractures.

If you are being treated for a fracture you may encounter these "codes" on your Explanation of Benefits Statement (EOB). They may often times be referred to as "office surgery" or "office procedure." Many patients are alarmed when they see "surgery" on their bill, when they know that they have not had surgery. This is simply how your insurance company has elected to process and label insurance claims.

Fracture care codes have a 90-day global period. A 90-day global period is a period of 90 days after procedure which entitles you to 90 days of follow-up care. This means that your physician is paid only the first time they see you for your fracture (broken bone). This fee covers your care for the next 90 days. Moreover, this fee does NOT cover any repeat x-rays, supplies (braces, casts), or new complaints. These are billed separately.

Oftentimes your physician will examine you, interpret your x-rays, consider different treatment plans, and determine which is best for you. This may involve a manipulation of the fracture with possible splinting or casting, and careful continued observation. Whatever the treatment rendered, the fracture care code will cover the cost of all your follow-up visits for 90 days (excluding repeat x-rays, cast/splints).

I have read and understand the above financial policy and I agree to abide by its terms.

Patient's Name	Patient or Responsible Party Signature	Date

Assignment of Benefits and Authorization to Release Information

I hereby authorize my insurance carrier, including Medicare, to pay directly to my physician, Shahin S. Rad, M.D., for services rendered to me. I hereby authorize my physician to release information from my medical records necessary to bill my insurance carrier for these services. A photocopy of my signature on this form is to be considered as valid as the original.

Patient's Name	Patient or Responsible Party Signature	Date

Narcotic (Pain) Prescription Policy

Our doctors prescribe narcotic medications only in cases of acute injury and after surgery for period of no more than 6 weeks. If you require long-term pain control, you will be referred to your primary care physician or to a pain management specialist.

Our office requires 48 hours to process narcotic prescription refills. Please contact us or your pharmacy so you will not run out of medication while waiting for a prescription be processed. Prescriptions will only be refilled between 8:30 AM - 4:30 PM, Monday through Friday.

I have read and I understand the above Narcotic (Pain) Prescription Policy and I agree to abide by its terms.

Patient's Name	Patient or Responsible Party Signature	Date