ROSEVILLE ORTHOPEDIC
Surgery & Sports Medicine

151 N. Sunrise Ave, Suite 1005
Roseville, CA 95661
Tel: 916-782-1217
Fax: 916-782-7630
rosevilleorthopedics.com

Dear New Patient,

We are pleased to welcome you to Roseville Orthopedic Surgery & Sports Medicine. We are very proud to have been serving the community with a tradition of excellence for over 50 years. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner. As a result, we can offer you a proactive and expeditious recovery from your orthopedic problems.

Roseville Orthopedic Surgery & Sports Medicine is an independent group affiliated with Sutter Medical Foundation. Our shared electronic medical record allows us to receive patient results quickly and efficiently through our direct link with Sutter Medical Foundation services. This is an important resource for patients and referring providers, and we encourage you to take full advantage of My Health Online through the Sutter website. Likewise, www.rosevilleorthopedics.com has much of the information and details you may be seeking for your consultation with us. We encourage you to visit our website for general information, driving directions, and biographies of our surgeons.

In addition to your relevant imaging studies and medication lists, you will need to bring your current insurance card and a photo ID with you for your first appointment. We have also attached registration and medical history forms that need to be completed prior to arrival. All co-pays and past due balances are expected at time of service, unless prior arrangements have been made with our billing department.

To facilitate new patient registration, we ask that you arrive prior your scheduled check in time. We take your time and other commitments seriously, and strive to stay on schedule. As a courtesy to our other patients that are affected by delays, you may be asked to reschedule your appointment if you are more than 15 minutes late. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to reschedule or stay to be seen, and we will do our best to keep you informed of how long of a delay you may experience.

Providing the highest quality of professional care to our patients is very important to us. We encourage feedback and any suggestions on how we can make your time here with us comfortable. Welcome, and thank you for choosing our practice.

Sincerely,

The Doctors and Staff of Roseville Orthopedic Surgery and Sports Medicine

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices:*

By subscribing my name below. I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
_____	_____	_____	

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care in that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ **Phone #:** _____

Print Name: _____ **Phone #:** _____

Print Name: _____ **Phone #:** _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

_____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Work Telephone Number:

_____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Written Communication Address:

_____

____ OK to mail to address listed above

____ E-mail me at_____

Fax Communication:

_____

____ OK to fax at the number listed above

____ E-mail me at_____

Other:_____

Name of Patient (Print)	Signature	Date
_____	_____	_____

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Medical Information

Primary Care Physician: Patient Name:

How were you referred to our office:

Reason for visit: Date of Onset:

How did injury occur?

What treatment have you received?

What makes your symptoms worse, better?

Past Medical History:

Do you have any active medical problems? Please circle or list if not present

Hypertension Diabetes High Cholesterol Hypothyroidism Rheumatoid Arthritis

Other _____

What surgeries have you had in the past and when? _____

_____

Are you allergic to anything, including medications? Please list and note reaction: _____

_____

What medications do you take? _____

_____

_____

Have you had problems with anesthesia? _____

Social History: Are you married/single?

What type of work do you do? _____

Do you smoke? Y/N If so, how much _____

Family History: Please check in appropriate location if a family member has or has had any of the following:

	Mother	Father	Sibling	Other (specify)
Heart Attack				
Stroke				
Diabetes				
Rheumatoid Arthritis				
Bleeding Disorder				
Problems with anesthesia				

Worker's Comp Carrier Claim Number

Adjuster's Name Phone Number

REVIEW OF SYSTEMS

Yes (Now or within last 6 months) or No. Please explain any yes answers in the space provided at the end of the form.

SYSTEM		
GENERAL		
Unwanted weight loss	**Yes**	**No**
Fevers	**Yes**	**No**
Chills	**Yes**	**No**
Night Sweats	**Yes**	**No**
EARS, NOSE, THROAT		
Hearing loss	**Yes**	**No**
Ringing	**Yes**	**No**
Frequent nose bleed	**Yes**	**No**
Sore throat	**Yes**	**No**
Hoarseness	**Yes**	**No**
RESPIRATORY		
Cough yellow or green Sputum	**Yes**	**No**
Cough up blood	**Yes**	**No**
Shortness of breath	**Yes**	**No**
Pain with breathing	**Yes**	**No**
GENITOURINARY		
Pain on urination	**Yes**	**No**
Blood in urine	**Yes**	**No**
Urinating too often	**Yes**	**No**
Incontinence	**Yes**	**No**
NEUROLOGIC		
Seizures	**Yes**	**No**
Fainting	**Yes**	**No**
Dizziness	**Yes**	**No**
Loss of coordination	**Yes**	**No**
Weakness	**Yes**	**No**
Numbness	**Yes**	**No**
Tingling	**Yes**	**No**
MUSCULOSKELETAL		
Joint stiffness	**Yes**	**No**
Joint pain	**Yes**	**No**
Bone pain	**Yes**	**No**
Multiple broken bones	**Yes**	**No**
Weakness	**Yes**	**No**
Joint swelling	**Yes**	**No**
HEMATOLOGIC/LYMPHATIC		
Easy bruising	**Yes**	**No**
Easy or prolonged bleeding	**Yes**	**No**
Swollen glands	**Yes**	**No**
Swelling in limbs	**Yes**	**No**
Blood clots	**Yes**	**No**

SYSTEM		
EYES		
Recent visual changes	**Yes**	**No**
Pain in eyes	**Yes**	**No**
Dryness	**Yes**	**No**
Light intolerance	**Yes**	**No**
CARDIOVASCULAR		
Irregular heart beat	**Yes**	**No**
Chest pain	**Yes**	**No**
Swollen ankles	**Yes**	**No**
Short of breath when lying down	**Yes**	**No**
Passing out	**Yes**	**No**
GASTROINTESTINAL		
Vomit blood	**Yes**	**No**
Blood in stool	**Yes**	**No**
Black stools	**Yes**	**No**
Frequent nausea	**Yes**	**No**
Loss of appetite	**Yes**	**No**
Diarrhea	**Yes**	**No**
SKIN		
Rashes	**Yes**	**No**
Non healing wounds	**Yes**	**No**
Boils	**Yes**	**No**
Dry skin	**Yes**	**No**
PSYCHIATRIC		
Depression	**Yes**	**No**
Anxiety	**Yes**	**No**
High stress level	**Yes**	**No**
Mood swings	**Yes**	**No**
Poor concentration	**Yes**	**No**
ENDOCRINE		
Excessive thirst	**Yes**	**No**
Fatigue	**Yes**	**No**
Feel too hot	**Yes**	**No**
Feel too cold	**Yes**	**No**
Dry skin	**Yes**	**No**
Slow wound healing	**Yes**	**No**
ALLERGIC/IMMUNOLOGIC		
Frequent infections	**Yes**	**No**
Chronic infections	**Yes**	**No**
Slow wound healing	**Yes**	**No**
Frequent sneezing	**Yes**	**No**
Chronic runny nose	**Yes**	**No**

Please explain any "yes" answers here:

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Financial Policy

Thank you for choosing our group for your orthopedic treatment. Any pain can cause an inconvenience in your life. This can be stressful, and so can the financial piece, we can relieve some stress and move toward a healthier life overall. Below is our financial policy.
The purpose of this form allows Roseville Orthopedic Surgery and Sports Medicine to treat you, bill any insurance you may have, share information with other health care offices and facilities, and to collect on your account.

REGARDING INSURANCE: Our office participates with many managed care insurance companies and with Medicare. Should your insurance coverage be with one or more of these companies, we will bill your insurance company along the guidelines of our contract. However, co-payments, co-insurance, deductibles, and non-covered services that have not been paid, are the responsibility of the patient and payment is expected at the time services are rendered. You are responsible for any balance not covered by insurance (examples: denied services, or services not covered by your plan). If this is not paid timely, we have a collection service that will take over your account. This additional service costs more money, for both of us, your portion is approx $20. We require payment when due to keep everyone's expenses to a minimum. If payment arrangements or general billing questions are needed please contact our billing office at (916)782-1217, Monday through Friday from 8:00am to 3:30pm, and follow the prompts for billing.
If you need surgery, we advise you to know and understand your insurance coverage. We will pre-approve the surgery with your carrier, however, it's not a guarantee the service will be fully paid. We may require you to pay a deposit, deductible or co-payment prior to surgery.

PRIVATE PAY: At time of scheduling your office visit you will be required to make a $150 deposit. If you cancel your scheduled office visit you will only be refunded $75 of your deposit. The deposit of $150 will be applied towards your first visit, if you need to make payment arrangements please contact our billing office. If you are able to pay in full at the time of service you will receive a 20% discount.

NO SHOWS: Please be advised that if you do not show up for your appointment you will be charged $50 for No Show Appointment. This fee will not be covered by your insurance company and will be your sole responsibility. Please bear in mind this is only being done to better serve our patients by improving access to appointment times often taken by patients who have scheduled appointment and failed to utilize them.

We require a 24 hour notice in advance if you need to change your appointment to not be charged.

FORMS COMPLETION: It is our office policy to charge any request for correspondence such as letters of medical necessity and disability forms. The form fee is $25 for each form to be completed. If you require a CD of your x-ray the cost is $20. We require that you pick up your forms upon completion, you will receive a call from us.

Please sign below to indicate that you have read, understand and agree with the above statements.

Patient/Parent signature _____ Date _____