HANNON

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____

Address: _____ Age: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Social Sec. # _____

Female: _____ Male: _____ email: _____

Marital Status: Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Employer _____ Phone _____

Employer Address: _____

Employer City: _____ State: _____ Zip _____

SPOUSE INFORMATION or RESPONSIBLE PARTY FOR BILLS (if different from patient)

Name: _____ Date of Birth: _____

Address: _____ Relationship: _____ Age: _____

City: _____ State: _____ Zip: _____ Female: _____ Male: _____

Home Phone: _____ Work Phone: _____

Social Security Number: _____

Employer: _____

Employer Address: _____

IN CASE OF EMERGENCY NOTIFY

Name: _____ Phone Number: _____

Relationship: _____

ADDITIONAL INFORMATION

Referred to us by: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Pharmacy: Name, address and phone number of pharmacy you would like medications to be called in to:

_____

Primary Insurance Co. (Co-Pay Amt.$ _____)	Secondary Insurance Co. (Co-Pay Amt.$ _____)
Insurance Name: _____	Insurance Name: _____
Address: _____	Address: _____
Policy or ID Number: _____	Policy or ID Number: _____
Group Number: _____	Group Number: _____
Main Policy Holder: _____	Main Policy Holder: _____
Relationship to Patient: _____	Relationship to Patient: _____

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HISTORY FORM—NEW PATIENT

PATIENT NAME_____ TODAY'S DATE _____

Who referred you to this office?_____ Internist/Family MD_____

CHIEF COMPLAINT

1) What is the main reason for your visit today?_____ Right / Left / Both

HISTORY OF PRESENT ILLNESS

Age_____ Height _____ Weight_____ Right/Left Handed_____ Occupation_____

1) What is the date your symptoms started/were injured?_____

_____

2) Explain Injury:_____

3) Was this a work related accident? ☐ Yes ☐ No
If yes, are you still working? ☐ Yes ☐ No
If yes, are you working? ☐ Full ☐ Light duty

4) Was this an auto accident? ☐ Yes ☐ No
If so, were you driving? ☐ Yes ☐ No
Did airbags inflate? ☐ Yes ☐ No

5) Recreational or athletic injury? ☐ Yes ☐ No

6) Accident or in your home? ☐ Yes ☐ No

7) On a scale of 1 (least) to 10 (greatest), what is your pain today? 1 2 3 4 5 6 7 8 9 10

8) Describe symptoms you are having (check all that apply):

☐ Aching ☐ Gives way ☐ Sharp ☐ Stabbing ☐ Wakes you up ☐ Clicking ☐ Locking
☐ Snapping ☐ Throbbing ☐ Weakness ☐ Dull ☐ Numbness ☐ Sore ☐ Tingling

9) How long does problem last? ☐ Constant ☐ Comes and goes ☐ Other:_____

10) Does anything make it better? ☐ Yes ☐ No Explain:_____
(eg: ice, rest, standing, sitting, meds. etc.)

11) Does anything make worse? ☐ Yes ☐ No Explain:_____
(eg: standing, sitting, bending, lifting, etc.)

12) Does it radiate anywhere? ☐ Yes ☐ No If so, where:_____

13) List any other doctors you have seen for this problem:

_____

14) List any previous tests, procedures, treatments (injections, physical therapy, medications) for this problem:
Physical therapy:_____# of visits per week X _____weeks/months
Injections: How many?_____ Date of last injection___/___/___Type of injection _____
Medications you have tried:_____
Chiropractic/Acupuncture:_____# of visits

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MEDICATIONS

Are you sensitive to any allergic to any medications ☐ Yes ☐ No

If yes, please mark all that apply: ☐ Penicillin ☐ Keflex ☐ Aspirin ☐ Codeine ☐ Tetracycline
☐ Erythromycin ☐ Valium ☐ Demerol ☐ Barbitrates ☐ Epinephrine
☐ Iodine ☐ Latex ☐ Naproxen ☐ Other _____

Are you currently taking: Any cortisone-type medication (e.g. Prednisone)? ☐ Yes ☐ No
Any blood thinning medication (e,g, Coumadin, Warfarin, ASA, Plavix, etc.) ☐ Yes ☐ No
Family member ever had major adverse reaction to anesthesia? ☐ Yes ☐ No
If yes, Explain_____

Please list all the medications you are currently taking and the dosages:

_____
_____
_____
_____
_____

PAST MEDICAL HISTORY

Serious Childhood Illnesses:_____
Adult Illnesses: List and document hospital stays if any_____

_____

Surgeries: List date, procedure, surgeon, and hospital_____

_____

Major accidents/injuries with dates: _____

_____

FAMILY HISTORY

Father: Age if alive_____ Age/Death and cause_____
Mother: Age if alive_____ Age/Death and cause_____
Siblings: Age/health status_____
Children: Age/health status_____
Family Disease: (Hypertension, Diabetes, Tuberculosis, Gout, Cancer, etc.) _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If you, how much? _____ How long? _____
If no, did you ever smoke? ☐ Yes ☐ No If you, how much? _____ How long? _____ Year quit_____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____ How often?_____
Do you take drugs? ☐ Yes ☐ No If yes, what drugs?_____
How often?_____
Have you been addicted?_____ Detoxed? _____

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REVIEW OF SYSTEMS
Please circle those that apply or check the "none" box

GENERAL
Fever, Night Sweats
Marked Weight gain/loss
None ☐

HEAD, EYES, EARS, NOSE
Frequent headaches
Neck pain/stiffness
Glaucoma
Blurring/vision
Dizziness
Hearing problems
Sinus problems
None ☐

CHEST/RESPIRATORY
Asthma
Sputum production from cough
Cough up blood
Chronic cough
Positive TB skin test
Abnormal Chest X-ray
None ☐

CARDIAC
High Blood Pressure
History of Heart attack
Chest Pain
Rapid/Abnormal Pulse
Ankle Swelling
None ☐

VASCULAR
Previous phlebitis
Leg cramps on exercise
Varicose veins
Poor circulation
None ☐

GASTROINTESTINAL
Ulcers/gastritis
Severe/frequent abdominal pain
Tarry/Black bowel movements
Yellow/Jaundice
Vomit blood, Hepatitis
None ☐

GYNECOLOGICAL/WOMEN
Pregnant now?_____
Abnormal / irregular period
Date last period_____
Age periods stopped
None ☐

MUSCULOSKELETAL
General joint pain/arthritis
Joint swelling
Spinal pain
None ☐

ENDOCRINE
Diabetes
Thyroid abnormality
Gout
Osteoporosis
None ☐

NEUROLOGICAL
Fainting
Convulsions
Dizziness
Shakiness/trembling
Diffuse muscle weakness
Tingling in extremities
None ☐

URINARY
Kidney Stones
Blood in your urine
Frequent /Painful urination
Recurrent Kidney/Bladder infections
None ☐

PSYCHIATRIC
Psychiatric Hospitalization
Depression
Frequent Mood Swings
History of substance abuse
None ☐

OTHER
AIDS/HIV
Positive for HIV? No O
Yes O When _____

I attest that the above information is true and correct to the best of my knowledge and recollection.

_____ _____

Signature of Patient or Legal Representative Date

HANNON

FINANCIAL POLICY

We are dedicated to providing the best care for our patients and we want you to completely understand our financial policies. Please read below and sign at the bottom and don't hesitate to let us know if you have any questions.

1. **INSURANCE** - Your insurance policy is a contract between you and your insurance company. As a courtesy, we will help you receive maximum benefits by promptly filing your claim and supplying information as required by the insurance company. In order for your claim to be filed in a timely manner we require that you provide patient and insurance information at each visit. We participate in most PPO insurance plans as well as Medicare. If you are not insured by a plan we accept, do not have a current insurance card, or do not have any health insurance, payment in full is expected at each visit. It is the patient's responsibility to notify us of any changes with their insurance information. If your insurance carrier reimburses you directly for our services, we expect you to send or bring the signed insurance check and Explanation of Benefits (EOB) to our office within 7 days.

2. **COPAYS**- All copayments must be paid at the time of service.

3. **DEDUCTIBLES AND CO-INSURANCE**-Your estimated deductible and coinsurance amount is due at the time of service. Your deductible is the amount you must pay out-of-pocket for services before your insurance company will begin to pay. Coinsurance is a cosharing agreement between you and your insurance company which provides that your insurance will cover a set percentage of the covered costs after the deductible has been paid. If you have a high deductible plan, be prepared to pay for your services in full on the date of service. After your insurance has paid, any remaining patient responsibility will be billed to you. If our original estimate was too high, you will be refunded your overpayment in a timely manner. Please be advised that we cannot waive deductibles, coinsurances or copays that are required by your insurance.

4. **FORMS OF PAYMENT**- We accept all major credit cards, debit cards, cash, and checks.

5. **OUTSTANDING BALANCES**- Statements are sent out monthly, and we ask that balances due be paid when you receive your statement or at your next appointment, whichever is sooner. Balances not paid within 90 days will be turned over to an outside collection agency, unless prior payment arrangements have been made.

_____ _____

Patient's Signature Date

HANNON

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATJON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures:

Treatment: Your health information may be used by our staff members or disclosed to other health care professional is for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by our staff members.

Payment: Your health information may be used to seek payment from your health plans, from other sources of cover age such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities of Hannon Orthopedics. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosure require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requiresyour specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit and written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Appointment reminders: Your health information may be used by our staff to send you appointment reminders.

HANNON

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request instructions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Hannon Orthopedics imaging Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office manager.

Complaints

If you would like to submit a comment or compliant about our privacy practices, you can do so by sending a letter outlining your concerns to:

HIPPA Compliance Department
8670 Wilshire Boulevard, Suite 101
Beverly Hills, CA 90211

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

_____ _____

Signature Date

HANNON

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)

1. **Authorization**

I authorize Hannon Orthopedics (healthcare provider) to use and disclose the protected health information described below to the following person(s) _____(individual seeking the information).

2. **Effective Period**

This authorization for release of information covers the period of healthcare from the below dates:
_____ to _____ or ☐ all past , present, and future periods.

3. **Extent of Authorization**

☐ I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse)

☐ I authorize the release of my complete health record with the exception of the following:

- ☐ Mental healthcare records
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify)_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effective until date listed in item (2) above, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the and the insurer has the right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Printed name of patient/guardian	Signature of patient/guardian	Date