SHASTA ORTHOPAEDICS & SPORTS MEDICINE PATIENT REGISTRATION **Chart No.** _____

PLEASE PRINT & COMPLETE ALL PORTIONS

Today's Date Mo. _____ Day _____ Year_____

PRIMARY CARE PHYSICIAN:_____
PART OF BODY TO BE TREATED: _____

HAVE YOU EVER BEEN TREATED BY ONE OF OUR DOCTORS ☐ Yes ☐ No

REFERRED BY: _____
Physician, Attorney, Other

☐ SMOKER ☐ NON-SMOKER

DOCTOR: _____

PATIENT NAME: _____ SEX: _____ DATE OF BIRTH: _____ AGE: _____

MAILING ADDRESS: _____
Street or Box Number City State Zip

HOME TELEPHONE _____

SOCIAL SECURITY #: _____ E-MAIL: _____

MARITAL STATUS: (check one) ☐ Married ☐ Unmarried ☐ Separated ☐ _____

PATIENT'S EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS:_____
Street or Box Number City State Zip

EMPLOYER'S PHONE: _____

PRIMARY INSURANCE _____ POLICY or GROUP NO. _____ I.D. NO. _____

PRIMARY INSURANCE ADDRESS: _____
Street or Box Number City State Zip

SUBSCRIBER NAME:_____ DATE OF BIRTH _____

SECONDARY INSURANCE _____ POLICY or GROUP NO. _____ I.D. NO. _____

SECONDARY INSURANCE ADDRESS: _____
Street or Box Number City State Zip

SUBSCRIBER NAME:_____ DATE OF BIRTH _____

GUARANTOR/GUARDIAN_____ DATE OF BIRTH _____ OCCUPATION: _____

GUARANTOR/GUARDIAN EMPLOYER: _____ EMPLOYER'S PHONE: _____

ADDRESS: _____
Street or Box Number City State Zip

GUARANTOR/GUARDIAN ADDRESS IF DIFFERENT FROM PATIENT'S ABOVE:

_____
Street or Box Number City State Zip

PHONE: _____

INJURY: ☐ Yes ☐ No If yes, complete the following:

HOW DID IT HAPPEN? _____

DATE OF INJURY: _____ WHERE? _____

Did injury occur on-the-job? ☐ Yes ☐ No Claim No: _____ Adjuster Name: _____

EMPLOYER AT TIME OF INJURY: _____

EMPLOYER'S WORKER'S COMPENSATION INSURANCE CARRIER: _____

ADDRESS COMPENSATION INSURANCE CARRIER: _____
Street or Box Number City State Zip

IN CASE OF EMERGENCY CONTACT: _____ Relationship_____

_____
Street or Box Number City State Zip

Telephone: _____

SHASTA ORTHOPAEDICS & SPORTS MEDICINE
1255 Liberty St., Redding CA 96001 Phone: (530) 246-2467 Fax: (530) 245-5632

Paul E. Schwartz, MD	John C. Lange, MD	J. David Schillen, MD	Stephen Ferraro, Jr., MD	Farzad Sabet, MD
Tony Chang, MD	Eric Jenkinson, MD	Jason Nowak, DPM	Troy Miles, MD	Kimberly Page, MD
Terry Pelayo, PA-C	Steve Doll, PA-C	Brain Davis, PA-C	Lance Lollar, DC	Theresa Unruh, PA-C
Jennifer Olds, FNP	Marisa Mackenzie, PA-C	Michelle Murillo, PA-C		

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Shasta Orthopaedics & Sports Medicine, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

PATIENT NOTIFICATION DISCLOSURE OF PHYSICIAN OWNERSHIP

You have the right to choose any health care facility and provider you desire. As such, it is necessary that we disclose the following information to you. Other health care providers of which our doctors have a financial interest in are as follows:

Apogee Outpatient Surgery Center: Paul E. Schwartz, M.D., John C. Lange, M.D., Stephen P. Ferraro, Jr., M.D., J. David Schillen, M.D. Farzad H. Sabet, M.D., Troy A. Miles, MD

Liberty Physical Therapy & Sports Performance and Shasta Orthopaedics MRI: Paul E. Schwartz, M.D., John C. Lange, M.D., Stephen P. Ferraro, Jr., M.D., J. David Schillen, M.D., Farzad H. Sabet, M.D., Tony Chang, M.D., Eric Jenkinson, M.D., Troy A. Miles, MD

A listing of alternative providers can be found on the internet, in the telephone book, or by contacting North Valley Medical Association at (530) 247-0293. You can also discuss options with your health care provider.

You will not be treated differently by your physician if you choose a healthcare facility or provider other than those referenced above.

If you have any questions concerning this notice, please feel free to ask for additional information from your physician or any representative of Shasta Orthopaedics & Sports Medicine.

If you are uncomfortable with your physician's relationship with the healthcare facilities or providers referenced above, and prefer to have your health care services provided elsewhere, we will be happy to honor your request. Please do not hesitate to tell us if you wish to have your health care services provided elsewhere.

SHASTA ORTHOPAEDICS & SPORTS MEDICINE FINANCIAL POLICIES

The Service We Provide
Our physicians, doctors, physician assistants, therapists and technical staff provide professional medical and radiology services as well as supplies required by your orthopedic medical needs. The bill from Shasta Orthopaedics & Sports Medicine is for these services ***only***. Services provided by the hospital, surgery center, laboratory, pathologist, anesthesiologist, medical equipment supplier, and in some instances your assistant surgeon will be billed separately from our services. Consistent with our Privacy Practices we will give your billing information to these providers. Please direct any questions you have about these services to the appropriate provider's office. Our staff can assist you if you need to contact these providers.

We will bill your insurance company for the services we render. To provide excellent service it is necessary that we have accurate information about you, your employer and your insurance. We will ask you to complete health questionnaires and consent for use and disclosure of information. We will also need to take copies of your insurance card(s). These items will be necessary for your treatment and to receive payment for our services. Please, notify us immediately when there are changes to the information you have provided.

Medicare
Shasta Orthopaedics and Liberty Physical Therapy are Medicare Participating Providers. As a Participating Provider we will bill Medicare directly for you and will honor Medicare's "allowance". We will also bill your secondary insurance if you have provided us with the information. You will be required to pay only the amount Medicare determines to be your responsibility that is not paid by your secondary insurance. We will send you a statement that will detail all charge and payment activity.

Medi-Cal/Partnership Healthplan
Shasta Orthopaedics and Liberty Physical Therapy participate in the Medi-Cal Program. As a Medi-Cal Provider we will bill Medi-Cal directly and accept Medi-Cal's "allowance". You will be responsible to pay only the amount determined by Medi-Cal to be your "Share Of Cost". To comply with the Medi-Cal program requirements it is necessary that your share of cost be paid at the time the service is rendered.

PPO, Indemnity Insurance and HMO Plan
Shasta Orthopaedics and Liberty Physical Therapy are participating providers for many insurance plans. To ensure that your insurance benefits are maximized we will verify eligibility and estimate benefits of your insurance from the information you provide us. Prior to your surgery we will notify you of the eligibility and benefit results. Any deductible, co-payment and co-insurance amounts are to be paid prior to your surgery. These amounts are estimated during the eligibility and benefit verification process. Actual benefits can only be determined when your insurance company processes your bill. You will be promptly refunded in the event you have over paid; conversely you are obligated to pay any balance. We will send you a statement that details all charge and payment activity. Should your insurance company not pay within sixty days of your surgery, we may seek payment from you. Please assist us by communicating with your insurance company to ensure that their financial obligation is met.

Worker's Compensation Insurance
Shasta Orthopaedics and Liberty Physical Therapy accept Worker's Compensation. It is necessary that you provide us accurate information about you, your injury, your employer and your Workers Compensation carrier. Prior to your service we will obtain your claim number and pre-authorization from your Workers Compensation carrier. You will not receive a bill for these services unless your claim is denied as "not work related". In these instances your private insurance company should pay for Shasta Orthopaedics & Sports Medicine's services.

Uninsured
You are personally responsible for to pay for our services if you do not have insurance. Full payment is required prior to your service. Any arrangement for payment must be established prior to service.

Third Party & Liens
Shasta Orthopaedics and Liberty Physical Therapy ***do not*** accept Third Party or Lien Claims. You will be personally responsible to pay for your medical services out of pocket. Full payment is required prior to your service. As a courtesy we will provide you a claim form for you to submit to your Third Party Payer to assist you in recovering any reimbursement due to you.

Forms Completion Fee
Shasta Orthopaedics and Liberty Physical Therapy patients in some instances may require insurance or disability forms to be completed by us. Shasta Orthopaedics has a form completion fee of $5.00 per page; a double sided page is considered two pages, with a minimum charge of $15.00. All forms shall be completed within seven (7) business days of receipt of your payment. In the event medical record copies are required any applicable record copy fees will be charged in addition to the form completion fee.

Canceled or Missed Appointments
Shasta Orthopaedics and Liberty Physical Therapy are committed to providing care to all of our patients in a timely manner. To assist us, we ask that you make every effort to keep your scheduled appointment and contact us as soon as possible when you are unable to do so. Appointments canceled or missed without notice are subject to a Canceled or Missed Appointment fee which will not be billed to your insurance and will be your personal responsibility to pay. The following are appointment types and notice requirements that must be met to avoid a Canceled or "No-Show" Appointment Charge:

Appointment Type	Notice Required	Cancelled or "No Show" Appointment Charge
Office Visits/Consultation	1 full business day	$35.00
EMG/NCS Studies	3 full business day	$150.00
Injections and Surgeries	5 full business day	$150.00
Physical Therapy Initial Evaluation	1 full business day	$40.00
Physical Therapy Follow up Treatment	1 full business day	$25.00
MRI or Arthrogram	1 full business day	$150.00

Non-Sufficient Funds, Canceled or Return Checks
Shasta Orthopaedics and Liberty Physical Therapy will assess a fee of $25.00 for each non-sufficient fund transaction, canceled, or returned check.

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

Patients must consent to having their medication history viewable by SOSM clinicians as a condition of treatment.

By signature of this form **I consent** for my healthcare provider(s) at Shasta Orthopaedics to download my electronic medication history from all healthcare providers as is necessary for my care and treatment. Initials: _____

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your health information is important to us at Shasta Orthopaedics & Sports Medicine. A *Notice of Privacy Practices* booklet is available to review upon your request. This notice explains the federal HIPAA Privacy Rule which is designed to help protect the privacy of your health information. It also details how we may legally use your medical or health information. Your signature on this form acknowledges that you were offered a copy of the Notice of Privacy Practices. If you have any questions about the HIPPA Privacy Rule please contact Gary Whiteaker at (530) 246-2467.

My signature acknowledges that I have read and agree to the following:

- Notice of Privacy Practices
- Release of Health Information and Assignment of Insurance Benefits
- Terms of the Shasta Orthopaedics & Sports Medicine Financial Policy
- Disclosure of Physician Ownership - *I do not object to having my health care services provided by any of the health care providers of which the physicians of Shasta Orthopaedics & Sports Medicine have a financial interest as referenced above. I understand I have the right to choose and can select a different provider at any time.*

I agree that a photocopy of this agreement shall be as valid as the original.

_____

Signature of Patient or Legal Guardian if Patient is a Minor **Date**

_____

Name of Patient or Legal Guardian (Print)

_____

Name of Authorized Representative (Print) **Relationship**