ORTHOHEALING
CENTER
LOS ANGELES

Steven Sampson, D.O.
Danielle Aufiero, M.D.
NON-SURGICAL ORTHOPAEDICS AND SPORTS MEDICINE

PATIENT DATA FORM

Date:_____

Name:			
Address:			
City:	**State:**	**Zip:**	
Home Ph. # ( )			
Cell Ph. # ( )			
E-mail:			
Spouse Name:			
Spouse Address: (if different)	City:	State:	No:
Emergency Contact:	**Ph. # ( )**		
Employer:	**Ph. # ( )**		

Sex: M F	****PLEASE FULLY COMPLETE REFERRING PROVIDER INFO****
INSURANCE INFO (CARRIER AND MEMBER ID#)	***Referring Doctor** Name, Address and Phone number
	If not referred by a doctor, how did you hear about us?
PHARMACY INFO	***Primary Care Doctor** Name, Address and Phone number

***PLEASE FILL OUT FORM COMPLETELY**

10780 Santa Monica Blvd.
Suite 210
Los Angeles, CA 90025

310 453 5404 Tel
310 453 2535 Fax
www.orthohealing.com

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Name:_____ Today's Date ____ /____ /____ Date of Birth ____ /____ /____

PLEASE FILL OUT THIS FORM AS COMPLETE AS POSSIBLE. IT WILL ASSIST THE DOCTORS IN DEVELOPING AN INDIVIDUALIZED PLAN OF CARE FOR YOU. THIS INFORMATION IS CONFIDENTIAL.

Medical History: (Diabetes, high blood pressure, asthma, etc) _____

Surgical History: _____

Current Medications: _____

Allergies: _____

PLEASE PROVIDE A DETAILED DESCRIPTION OF YOUR REASON FOR SEEKING TREATMENT

_____

_____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM?

PLEASE CIRCLE: ☐ SUDDEN ONSET GRADUAL ONSET ☐

☐ IMPROVING PAIN WORSENING PAIN ☐

RATE YOUR AVERAGE DISCOMFORT ON THE SCALE:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10

IS YOUR PAIN CONSTANT OR INTERMITTENT? (Circle one) Sharp ☐ Dull ☐ Achy ☐ Electric ☐

WHAT MAKES YOUR PAIN WORSE?

WHAT HELPS ALLEVIATE YOUR PAIN?

DOES THE PAIN RADIATE TO ANY OTHER PART OF YOUR BODY?

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?

☐ No other treatment ☐ Massage therapy ☐ Chiropractor

☐ Physical therapy ☐ Acupunture ☐ Other _____

☐ Epidural Spinal Injection ☐ Surgery

Medication list _____

HAVE YOU HAD ANY OF THE FOLLOWING EXAMS RECENTLY? (CIRCLE ALL THAT APPLY)

MRI ☐ X-RAY ☐ CT SCAN ☐ EMG (Nerve Test) ☐ IF SO, WHEN: _____

Please bring report of any imaging studies that you've had related to your chief complaint

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OCCUPATION:_____ HOBBIES:_____

Height_____ Weight_____

MARITAL STATUS (CIRCLE ONE):

Single ☐ Live with Partner ☐ Separated ☐ Divorced ☐ Widowed ☐

DO YOU CONSUME ALCOHOLIC BEVERAGES? (CIRCLE ONE)

Never ☐ Rarely ☐ Moderately ☐ Daily ☐

DO YOU SMOKE CIGARETTES? YES ☐ NO PACKS PER DAY_____ YEARS SMOKED: _____

ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? (CIRCLE ONE) YES ☐ NO ☐ N/A ☐

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

	YES	NO
General weakness	☐	☐
Cramping	☐	☐
Numbness	☐	☐
Short of breath	☐	☐
Weakness of muscles or joints	☐	☐
Any difficulties walking	☐	☐
Pain in the calves or buttocks If yes, is that pain relieved by rest?	☐	☐
History of falls or poor balance	☐	☐
Decreased sensation in arms or legs	☐	☐
Numbness in arms or legs	☐	☐
Psychiatric care	☐	☐
Depression	☐	☐
Chemical dependency (alcohol / drugs)	☐	☐
Hepatitis	☐	☐
Weight loss	☐	☐
Thyroid problems	☐	☐
Dizziness / fainting	☐	☐
Cancer	☐	☐
Family history of cancer:	☐	☐
Please specify:	☐	☐
Hearing loss	☐	☐

	YES	NO
Abnormal bowel movement	☐	☐
Frequent urination	☐	☐
Unable to urinate	☐	☐
High blood pressure	☐	☐
Chest pain or angina	☐	☐
Stroke	☐	☐
Heart surgery	☐	☐
Cardiovascular disease	☐	☐
Epilepsy / seizures	☐	☐
Kidney disease	☐	☐
Lung disease	☐	☐
Fevers	☐	☐
Emphysema / bronchitis	☐	☐
Gout	☐	☐
Arthritis	☐	☐
Diabetes	☐	☐
Varicose veins	☐	☐
Irritable bowel syndrome	☐	☐
Stomach ulcer	☐	☐
Disruption in sleeping habits	☐	☐

IS THERE ANY OTHER CONDITION YOU WOULD LIKE TO TELL THE DOCTOR ABOUT?

_____

Please sign below to confirm that the information presented in this questionnaire is accurate

Patient Name: _____ Date: _____

Signature: _____

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Cancellation/No Show Policy

Dear Patient,

In order to promote timely office visits and enhance patient care, there will be a cancellation and a no show fee. If you need to reschedule or cancel your appointment, please do so at least 24 hours prior to your appointment time. If a follow up appointment is not canceled or rescheduled 24 hours in advance, you will be charged a fee.

Consults/Follow-ups:	$100
Injections/PRP:	$250
BMC / MFat:	$500
Bio-Recovery Lab:	$150

Thank you for your cooperation.

Sincerely,

The Orthohealing Center.

I have read the cancellation policy and understand that I am responsible for any charges made to me for not cancelling or rescheduling an appointment 24 hours prior to the scheduled time.

_____ _____

Patient Name (Please Print) Date

_____

Patient Signature

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BRACING POLICY AND GUIDELINES

Dear Orthohealing patient,

Please read the following policy and guidelines regarding the distribution of braces at the Orthohealing center.

- Absolutely no brace can be returned once worn, even if only for a few minutes. We cannot distribute a used brace to another patient, nor can we return it to the manufacturer. Once the brace has left the office with you, it cannot be returned and no refunds will be issued.

I have read and understand the above.

_____
Patient Name

_____
Patient Signature

_____
Date

Communication

☐ Yes, please send any emails regarding Orthohealing Center news, products, and services

☐ No, I do not wish to receive any emails on Orthohealing Center news, products, or services

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Data Biologics

In our ongoing efforts to advance the field of cell therapy, it's critical that we document patient progress with simple questionnaires. This will help us quantify benefits of our treatments and advance protocols.

This will involve less than 5 minutes of your time completing baseline questions before your treatment. The survey must be completed prior to your procedure. It is important to understand that our doctors cannot treat you without completing this baseline information beforehand.

You will receive 5 minute surveys to complete at 2 weeks, 6 weeks, 3 months, 6 months, 12 months, and 24 months to help us track your progress. All of your information will remain anonymous and no 3rd party is provided your contact information.

Please sign below that you acknowledge that Orthohealing cannot perform your treatment without completing this data and that you accept our policy to optimize care.

I have read and understand the above

_____
Patient Name

_____ _____
Patient Signature Date

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Authorization to Release Medical Information

Patient's Name: _____

Date of Birth: _____/_____/_____

I request the following Information:

X____Imaging Diagnostic tests: ☑ MRI ☑ X-Ray ☑ EMG ☑ CT

X____History

X____Records

X____Procedure/OP Notes

To be released to: The Orthohealing Center

Steven Sampson, D.O., Danielle Aufiero M.D.
10780 Santa Monica Blvd Suite 210 Los Angeles, CA 90025
Phone (310)453-5404
FAX (310) 453-2535 ATTN: _____

Patient Signature: _____ Date: _____

Requesting from: _____ (name of Doctor or Facility)

Fax number _____ Phone number_____

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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 Orthohealing Center (healthcare provider) to use and disclose the protected health information described below to the follow 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 o 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 health 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 was obtained as a condition of obtaining insurance coverage and the insurer has a legal 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	Patient/Guardian Signature	Date

If all categories declined above, please check below

□ Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Privacy Practices for the Orthohealing Center.

_____	_____	_____
Printed Name of Patient/Guardian	Patient/Guardian Signature	Date

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health Information (PHI) to carry out treatment payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also' describes your rights to access and control your protected health Information. "Protected health Information" is Information about you, including demographic Information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health Information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health Information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities Include, but are not limited to, quality assessment, employee review, training· of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-In sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the wailing room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of Interest to you.

We may use or disclose your protected health Information In the following situations without your authorization. These situations include: as required by law, public health Issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, Inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon ·your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to Investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law, You may revoke the authorization, at any time, In writing, except to the extent that your physician or the physician's practice has taken an action In reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to Inspect and copy your protected health Information (fees may apply) -under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasoable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health Informat10□ restricted by law, information that Is related to medical research In which you have agreed to participate, Information □hose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health Information -This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health Information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications -You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
You have the right to request an amendment to your protected health Information -If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures -You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.
You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS
You may complain to us or to the Secretary of Health and Human Services If you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Office of Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza -Room 322
San Francisco, CA 94102

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health Information. We are also required to abide by the terms of the notice currently In effect. If you have any question□ In reference to this form, please ask to speak with our HIPAA Compliance Officer In person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

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Credit Card Authorization
Orthohealing Center

By signing this form, you give **Orthohealing Center** permission to keep your payment information on file. Verbal or written permission must be given prior to any transaction using the payment information contained herein.

I _____ authorize **Orthohealing Center** to keep my payment information on file.
Full Name

Cardholder Name: _____

Card Number: _____ Expiration Date: _____ , _____

CVV (3-digit number on back of card Visa/MC, 4 digits on front of AMEX: _____

Billing Address of the Card: _____

City, State: _____ Billing Zip Code: _____

Please identify if your card is one of the following: Debit Card ☐ Credit Card ☐

I authorize the above-named business to keep the credit card indicated in this authorization form according to the terms outlined above. This credit card authorization is valid for the terms specified only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form.

Signature of the Card Holder: _____

Signature Date: _____

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