Please fax completed form to Admin RN/ Pre Reg Main OR (916) 423-6002 or OPS (916) 689-7822

Today's date_____

Surgeon _____ Surgery Date _____ Diagnosis_____ Date of Injury_____

PATIENT INFORMATION

Last Name _____ Title ____ First Name _____ Middle Initial _____

Social Security No. _____ Sex _____ Ethnicity _____

Birth Date _____ Age _____ Birth State _____

Marital Status _____ Religion _____ Primary Language _____

Interpreter Needed _____ Mailing Address _____

City _____ State _____ Zip Code _____ Country of Residence _____

Street Address (if different from Mailing Address) _____

City _____ State _____ Zip Code _____ Country _____

Home Telephone No. _____ Cell Number _____

Employment Status/Retirement Date _____ Employer _____

Occupation _____ Address _____

City _____ State _____ Zip Code _____ Telephone No. _____

Primary Care Physician _____

Other Physician(s) _____

SPOUSE/GUARDIAN INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Social Security No. _____ Date of Birth _____ Same Address as Patient _____

If "No" Mailing Address _____

City _____ State _____ Zip Code _____ Telephone No. _____

Employment Status/Retirement Date _____ Employer _____

Occupation _____ Address _____

City _____ State _____ Zip Code _____ Telephone No. _____

EMERGENCY CONTACT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Relationship to Patient _____ Address _____

City _____ State _____ Zip Code _____

Home Telephone No. _____ Cell Number _____

INSURANCE INFORMATION – PRIMARY

Plan Name _____ Address _____

City _____ State _____ Zip Code _____ Authorization No. _____

Policy No. _____ Group No. _____ Group Name _____

Subscriber: Patient/Spouse/Guardian/Other _____ No. of Insurance Approved Days ____

If "Other" Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Sex _____ Employment Status/Retirement Date _____

Employer _____ Occupation _____ Address _____

City _____ State _____ Zip Code _____ Telephone No. _____

INSURANCE INFORMATION – SECONDARY

Plan Name _____ Address _____

City _____ State _____ Zip Code _____ Authorization No. _____

Policy No. _____ Group No. _____ Group Name _____

Subscriber: Patient/Spouse/Guardian/Other _____ No. of Insurance Approved Days ____

If "Other" Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Sex _____ Employment Status/Retirement Date _____

Employer _____ Occupation _____ Address _____

City _____ State _____ Zip Code _____ Telephone No. _____

CYRA Phone Interpreter No. _____ Additional Notes _____

WORKER'S COMPENSATION

PLEASE PRINT

PATIENT: Last Name _____ First _____ M.I. _____

Address _____

City _____ State _____ Zip _____

Home Phone Number ( ) _____

Marital Status: ☐ Single (1) ☐ Married (2) ☐ Divorced (3) ☐ Widowed (4)

Sex: ☐ Male (1) ☐ Female (2)

Date of birth / / Age _____

Social Security Number _____

Driver's Lic. Number _____ State _____

Message Phone Number ( ) _____

INJURY NO. 1

Date of Injury / Onset / / Date First Seen / / Condition _____

PATIENT'S EMPLOYER:

Employer Name _____ Address _____

Occupation _____ ( ) Work Phone _____ City _____ State _____ Zip _____

INSURANCE:

Worker's Compensation Insurance Carrier _____ Address _____

Policy # _____ Claim # _____ City _____ State _____ Zip _____

Group # _____ Phone ( ) _____ Treatment Authorized By _____

REFERRING SOURCE: (Who sent you to our office?) Code _____

Name _____

Facility Name or Other _____

Address _____

City _____ State _____ Zip _____ Phone _____

FAMILY PHYSICIAN: (Primary Care Physician) Code _____

Physician Name _____

Office Address _____

City _____ State _____ Zip _____ Phone _____

INJURY NO. 2

Date of Injury / Onset / / Date First Seen / / Condition _____

PATIENT'S EMPLOYER:

Employer Name _____ Address _____

Occupation _____ ( ) Work Phone _____ City _____ State _____ Zip _____

INSURANCE:

Worker's Compensation Insurance Carrier _____ Address _____

Policy # _____ Claim # _____ City _____ State _____ Zip _____

Group # _____ Phone ( ) _____ Treatment Authorized By _____

REFERRING SOURCE: (Who sent you to our office?) Code _____

Name _____

Facility Name or Other _____

Address _____

City _____ State _____ Zip _____ Phone _____

FAMILY PHYSICIAN: (Primary Care Physician) Code _____

Physician Name _____

Office Address _____

City _____ State _____ Zip _____ Phone _____

INJURY NO. 3 Date of Injury / Onset / / Date First Seen / / Condition _____

PATIENT'S EMPLOYER:

Employer Name _____ Address _____

Occupation _____ ( ) Work Phone _____ City _____ State _____ Zip _____

INSURANCE:

Worker's Compensation Insurance Carrier _____ Address _____

Policy # _____ Claim # _____ City _____ State _____ Zip _____

Group # _____ Phone ( ) _____ Treatment Authorized By _____

REFERRING SOURCE: (Who sent you to our office?) Code _____

Name _____

Facility Name or Other _____

Address _____

City _____ State _____ Zip _____ Phone _____

FAMILY PHYSICIAN: (Primary Care Physician) Code _____

Physician Name _____

Office Address _____

City _____ State _____ Zip _____ Phone _____

AUTHORIZATION:

I request the payment of any authorized insurance benefits to be made to any physician affiliated with PHC Administration, Inc. for any services provided to me by any physician affiliated with PHC Administration, Inc. I authorize any holder of medical information about me be released to any insurance intermediaries and carriers in compliance with the terms of the confidentiality of Medical Information Act of 1980, Section 50, of the California Civil Code.

I understand that I or my account guarantor is responsible to pay, within 30 days, the amount billed on any service denied as noncovered by my insurance policy. I hereby permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient Signature of Parent or Guardian

_____ _____

Date Date

NOTES: _____

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS | PLEASE DO NOT USE THIS COLUMN

2. **EMPLOYER NAME** | Case No.

3. Address No. and Street City Zip | Industry

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.) | County

5. **PATIENT NAME** (first name, middle initial, last name) | 6. Sex Male Female | 7. Date of Birth Mo. Day Yr. | Age

8. Address: No. and Street City Zip | 9. Telephone number ( ) | Hazard

10. Occupation (Specific job title) | 11. Social Security Number - - | Disease

12. Injured at: No. and Street City County | Hospitalization

13. Date and hour of injury or onset of illness Mo. Day Yr. Hour _____ a.m. _____ p.m. | 14. Date last worked Mo. Day Yr. | Occupation

15. Date and hour of first examination or treatment Mo. Day Yr. Hour _____ a.m. _____ p.m. | 16. Have you (or your office) previously treated patient? Yes No | Return Date/Code

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination

B. X-ray and laboratory results (State if non or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? Yes No
ICD-9 Code ___ ___ ___ - ___ ___

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? Yes No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? Yes No If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location Date admitted Mo. Day Yr. Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? Yes No
If "no", date when patient can return to: Regular work ___/___/___
Modified work ___/___/___ Specify restrictions _____

Doctor's Signature _____ CA License Number _____

Doctor Name and Degree (please type) _____ IRS Number _____

Address _____ Telephone Number (_____)_____

FORM 5021 (Rev. 4)
1992

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

HIPPA 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 or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physicians, our office staff and others outside of our office that our 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 activities, employee review activities, training of medical students, licensing, 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 waiting 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.

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, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 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 this 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

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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 for the purposes of treatment, payment or healthcare operations. 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.

Your physician is not required to agree to a restriction that you may request. If physician believes it is not in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right use another Healthcare Professional.

You have the right to request to receive confidential communications 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 may have the right to have your physician amend 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 a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in the notice.

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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____ Date_____

1. NAME: _____

2. DATE OF INJURY: _____ TODAY'S DATE _____

3. **MAIN PROBLEM:** Please describe problem that requires evaluation today. _____

_____

_____

4. **HISTORY OF PRESENT PROBLEM:** How did this problem start or happen? _____

_____

_____

_____

_____

5. **PAST HISTORY:**

A. Any previous problems in this same area? Please descirbe (include dates). _____

_____

B. Please describe any fractures or all other injuries you may have had. _____

_____

_____

C. Do you have any family history or serious diseases? (Heart disease, diabetes, cancer, arthritic problems, birth defects, etc.)? Please describe.

_____

_____

_____

D. Please describe any previous surgeries of any kind which you may have had. _____

_____

_____

E. Please describe any hospitalizations you may have had, excluding, the above surgeries. _____

_____

_____

F. Please describe any medication you are allergic to and the reactions you have to them. _____

_____

G. Please list any medications you take currently. _____

_____

H. Do you smoke? _____ How Much? _____

I. Do you drink alcohol? _____ How Much? _____

J. Do you take illegal drugs? _____ How Much? _____

6. **REVIEW OF SYSTEMS:** Please circle appropriate responses and list information in the space provided at the end of the review of systems.

A. RESPIRATORY: Do you have: Asthma, TB, wheezing, history of pneumonia, other? _____

B CARDIOVASCULAR: Do you have a history of: Hypertension, myocardial infarction, irregular heartbeat, other? _____

_____

C. GASTROINTESTIONAL: Do you have a history of: Nausea, vomiting, ulcers indigestion, rectal bleeding, hepatitis, weight loss, other? _____

D. Genitourinary: have you had: Kidney stones, syphillis, gonorrhea, changes in urinary habits, other? _____

_____

females: pregnancies _____ live births _____ miscarriages or abortions _____

E. ENDOCRINE: Do you have a history of: Diabetes, thyroid disease, other? _____

F. NEUROMUSCULAR: Do you have a history of fractures, congenital anomalies, arthritic conditions, other? _____

_____

G. PSYCHOLOGICAL: Do you have a history of psychiatric disease or treatment: YES NO

H. NEUROLOGICAL: Do you have a history of: siezures, epilepsy, tumors, other? _____

I. Describe any of the above: _____

_____

_____

_____

7. **OCCUPATION:** _____ how long: _____

Amount of time off work due to injury _____

8. VITAL SIGNS

Height: _____ Race: _____

Weight _____ Dominant Hand: _____

Age: _____ Sex: _____

THE ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

NAME: _____

DATE: _____

Capital Orthopedics
ORTHOPEDIC SURGERY & SPORTS INJURIES

Diplomates
American Board of Orthopedic Surgery

Fellows
American Academy of Orthopedic Surgery

Qualified Medical Examiners
State of California

CAPITAL ORTHOPEDICS
ORTHOPEDIC SURGERY & SPORTS MEDICINE

PATIENT ACKNOWLEDGEMENT

Patient Name:_____

- My signature constitutes assignment of benefits for services performed by the providers of Capital Orthopedics and/or Dr. Daniel D'Amico; a photocopy of this assignment is considered as valid as the original. Capital Orthopedics and/or Dr. Daniel D'Amico may release information that may be necessary to secure payment from my insurance. I understand that I am financially responsible for claims that are denied or delayed by my insurance and that co-pays and/or deductibles are due at the time of service.

- Workers' Compensation: I understand that the providers of Capital Orthopedics and/or Dr. Daniel D'Amico provide treatment and reporting in compliance with the State of California Labor Code.

- I understand that I or my account guarantor is responsible to pay, within 30 days, the amount billed on any service denied as noncovered by my insurance policy. I hereby permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient

Date:_____

Signature of Parent or Guardian

Date:_____

Harry A. Khasigian, M.D. ◆ (916) 525-0620 ◆ (916) 525-0639 Fax
7551 Timberlake Way, Suite 200 ◆ Sacramento, CA 95823 ◆ www.capitalspineandortho.com

Harry A. Khasigian, M.D. ~ Daniel M. D'Amico, M.D.

Orthopedic Surgery & Sports Injuries

7551 Timberlake Way, Suite 200
Sacramento, CA 95823
Phone (916)525-0620 ~ Fax (916)525-0639

RELEASE OF MEDICAL RECORDS/INFORMATION

I hereby authorize Harry A. Khasigian, M.D. / Daniel M. D'Amico, M.D. to release copies of my medical records or requested medical information as specified below.

Request release of the the following medical information:

( ) Full medical record
( ) Specified medical record information as follows: _____

_____

Release to:

Practice/Facility Name: _____

Provider Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

I understand I have the right to receive a copy of this authorization.

Signed: _____ **Dated:** _____

If not signed by the patient, please indicate relationship:

( ) Parent or guardian of minor patient (if minor could not have consented to the care)
( ) Guardian or convervator of an incompetent patient

If required, Treating Physician:

Signed: _____ Dated: _____