Tri-Valley Orthopedic Specialists, Inc.
Solving Musculoskeletal Problems Since 1985

In order to bill your Insurance, Please fill out the following information completely.

PLEASE PRINT AND BRING TO YOUR APPOINTMENT

1) PATIENT REGISTRATION

ACCT #: **DR.:** **APPT. DATE:**

FIRST NAME	MIDDLE	LAST	BIRTH DATE	AGE

CIRCLE ONE	SOCIAL SECURITY NO.	DRIVER'S LICENSE	
☐ MR. ☐ MS. ☐ MRS. ☐ MISS			☐ MALE ☐ FEMALE

STREET ADDRESS	CITY	STATE	ZIP	HOME PHONE

WORK PHONE	CELL PHONE	EMAIL	DATE OF ILLNESS OR INJURY

MAY LEAVE MESSAGE WITH: ❑ HOME ANSWERING MACHINE ❑ ANYONE ANSWERING HOME PHONE
❑ WORK ANSWERING MACHINE ❑ ANYONE ANSWERING WORK PHONE ❑ NO ONE

EMPLOYER NAME OR NAME OF SCHOOL	NAME OF SKILLED NURSING FACILITY

2) EMERGENCY CONTACT

NAME OF PERSON	RELATIONSHIP	HOME / CELL PHONE	WORK PHONE

3) INDIVIDUAL RESPONSIBLE FOR PAYMENT

NAME OF PERSON	SOCIAL SECURITY #	BIRTH DATE

HOME PHONE	CELL PHONE	WORK PHONE	RELATIONSHIP TO PATIENT
			☐ SELF ☐ SPOUSE ☐ PARENT OTHER_____

STREET ADDRESS	APT#	CITY	STATE	ZIP

EMPLOYER	PHONE NUMBER

4) PRIMARY INSURANCE COMPANY

Please present insurance card to the receptionist

INSURANCE COMPANY NAME	SOCIAL SECURITY #	BIRTH DATE

NAME OF INSURED	INSURANCE ID #	GROUP #

5) SECONDARY INSURANCE COMPANY

Please present insurance card to the receptionist

INSURANCE COMPANY NAME	SOCIAL SECURITY #	BIRTH DATE

NAME OF INSURED	INSURANCE ID #	GROUP #

6) WORK RELATED INJURIES ❑ YES ❑ NO

NAME OF COMPENSATION INSURANCE CARRIER	ADJUSTER AND PHONE NUMBER

CARRIER'S ADDRESS

NAME OF EMPLOYER (AT THE TIME OF INJURY)	ADJUSTER FAX NUMBER

ADDRESS	DATE OF INJURY

AUTHORIZATION GIVEN BY	NURSE CASE MANAGER	PHONE NUMBER

INDUSTRIAL CLAIM / CASE NUMBER	KAISER PHYSICIAN AND OFFICE	KAISER ID #

☐ CONSULT ONLY	☐ CONSULT AND TREAT	☐ TRANSFER CARE

SIGNATURE_____DATE_____

Tri-Valley Orthopedic Specialists, Inc.
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Name: _____ Date: _____

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Tri-Valley Orthopedic Specialist, 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. Refunds will be issued upon request. I hereby authorize this healthcare provider to release all necessary information to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature:_____

MEDICARE AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made either to me or on my behalf to Tri-Valley Orthopedic Specialists for any services furnished me by physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is complete, my signature authorizes releasing of the information to the insurer of the agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: _____

HIPAA Compliance

As mandated by the Federal Government and Office of Civil Rights, Tri-Valley Orthopedic Specialists is required to follow the **HIPAA Compliance Act to ensure patient confidentiality.** I understand that as part of my healthcare, Tri-Valley Orthopedic Specialists, Inc., maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care treatment.

I understand that this information serves as a 1) basis for planning my care and treatment; 2) means of communication with the many healthcare professionals who contribute to my care; 3) source of information for applying my diagnosis and surgical information to my bill; 4) means by which a third-party can verify that services billed were actually provided; 5) a tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right: 1) to object to the use of my health information for directory purposes: 2) to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operation – and that the organization is not required to agree to the restrictions requested: 3) to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Comments and Restrictions: _____

Detailed message regarding test results can be left on my answering machine: ❑ Yes ❑ No

_____

Signature of Patient or Legal Representative

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Medical History

Date_____

Name:_____ **Age:**_____

Have you or any member of your family been treated at Tri-Valley Orthopedics? ☐ **Yes** ☐ **No** _____

Occupation:_____ **How Long:**_____ **Employer:** _____**How Long:** _____

Name of physician who requested that you contact TVO for this appointment (telephone # and location): _____

_____

If you would like a letter sent to your family/primary care physician, please provide *name and location:* _____

_____

Describe the problem and the DATE your symptoms began: Side affected ☐ **Left** ☐ **Right** ☐ **Both**

_____

_____ **DATE SYMPTOMS BEGAN:** _____

Cause of problem? ☐ **Car accident** ☐ **Work injury** ☐ **Sports injury** ☐ **Home** ☐ **Other**_____

Who has given you treatment for this condition and what treatment did you receive? _____

_____

Have any tests been done? ☐ **X-rays** ☐ **CT scan** ☐ **MRI** ☐ **EMG** ☐ **NCT** ☐ **Other:** _____

Have you had, or do you presently suffer from:

1. Seizures	☐ Yes	☐ No	12. Thyroid Disorder	☐ Yes	☐ No	23. Reaction to Anesthesia	☐ Yes	☐ No
2. Stroke	☐ Yes	☐ No	13. Depression	☐ Yes	☐ No	If yes, Reaction? _____		
3. Cardiac/Heart problems	☐ Yes	☐ No	14. Anxiety	☐ Yes	☐ No	24. Smoke Cigarettes	☐ Yes	☐ No
4. High Blood Pressure	☐ Yes	☐ No	15. Blood Clots / Phlebitis	☐ Yes	☐ No	If yes? Amount _____		
5. Respiratory problems	☐ Yes	☐ No	16. Bleeding Disorder	☐ Yes	☐ No	25. Drink Alcohol?	☐ Yes	☐ No
6. Cancer	☐ Yes	☐ No	17. Difficulty Urinating	☐ Yes	☐ No	If yes? Amount _____		
If yes, Site_____			18. Kidney / Bladder Infection	☐ Yes	☐ No	26. Recreational Drugs?	☐ Yes	☐ No
7. Diabetes	☐ Yes	☐ No	19. Psoriasis / Skin rash	☐ Yes	☐ No	If yes, Name: _____		
8. HIV	☐ Yes	☐ No	20. Have you had Cortisone?	☐ Yes	☐ No	If yes, frequency:_____		
9. Hepatitis / Jaundice	☐ Yes	☐ No	If yes, Site:_____					
10. GERD	☐ Yes	☐ No	21. Chemical Dependency	☐ Yes	☐ No			
11. Ulcer / GI problems	☐ Yes	☐ No	22. Alcoholism	☐ Yes	☐ No			

List any other medical problems not mentioned above: _____

Please list ALL MEDICATIONS (prescription and non-prescription) that you are presently taking: _____

_____

List ALL ALLERGIES: _____

List all past surgery (include dates of possible): _____

_____

Any illnesses / medical conditions that "run" in your family? _____

Patient Signature: _____**Physician Signature:** _____

Physician use only (B/P_____ HR_____ Resp _____)

PATIENT-Please complete information in square to the right and below!

PHARMACY – NAME / ADDRESS_____

❑ **Male** ❑ **Female**

Height:_____**Weight:**_____

❑ **Right-Handed** ❑ **Left-Handed**

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Alexandra M. Burgar, M.D.
Roger D. Dainer, D.O.
Gregory Horner, M.D.
David J. Jupina, M.D.
Ian A. Stine, M.D.
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fax 925-463-0473

Business Office
tel 925-469-0939
fax 925-469-0165

Rehab Therapy
tel 866-623-7600
fax 925-463-0473

ACCIDENT QUESTIONNAIRE

Patient's Name:_____ **Date:**_____

Insured Person:_____

SS# of Insured Person:_____

1. **Is today's visit the result of an accident?** ☐ Yes ☐ No
2. **If so, where and on what date did the injury occur?**
3. **How did the accident happen?**
4. **Is today's visit the result of an work injury?** ☐ Yes ☐ No
5. **Is today's visit the result of an auto accident?** ☐ Yes ☐ No
6. **Was another party involved in the accident who you believe to be liable?** ☐ Yes ☐ No

_____ _____

Signature of Insured Person **Date**

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DISCLOSURE LETTER

Effective October 1, 2005

Dear Patient:

During the course of your treatment, you may be referred to a Tri-Valley Orthopedic Specialist service and/or facility. It is our duty to inform you that one or more of our physicians may have a financial interest in a facility or service associated with your orthopedic care. You have the option to choose any organization you wish in obtaining the necessary services which we request and order for you.

Your physician would be more than happy to discuss your options and answer any questions you might have. Potential sources of Information concerning alternatives can either be obtained from the Yellow Pages or the county medical association which can be reached at 510-654-5383.

Sincerely,

The Physicians at Tri-Valley Orthopedic Specialists, Inc.

_____ _____

Patient Signature **Date**