ROSEVILLE ORTHOPEDIC
Surgery & Sports Medicine
151 N. Sunrise Ave, Suite 1005
Roseville, CA 95661
Tel: 916-782-1217
Fax: 916-782-7630
rosevilleorthopedics.com

REGISTRATION FORM

(Please Print)

Today's Date:	**Primary Care Provider:**

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status: ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former / Maiden Name):	Sex: ❑ F ❑ M	Age:	Birth Date: / /

Street address:	Social Security #:	Home Phone:
		Cell Phone:

P.O. Box:	City:	Email:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Race: ❑ Caucasian/White ❑ African American ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Other Pacific Islander ❑ Mexican ❑ Other Spanish ❑ Other:_____	Language: ❑ English ❑ Spanish ❑ Other:_____	Interpreter Needed: ❑ Yes ❑ No

PAYMENT: All charges are due at the time of services, all professional services rendered are charged to the patient.
The patient is responsible for all fees, regardless of insurance coverage.
WORKER'S COMP? ❑ YES ❑ NO MOTOR VEHICLE ACCIDENT? ❑ YES ❑ NO LITIGATION PENDING? ❑ YES ❑ NO

INSURANCE INFORMATION

(Please give your insurance card and ID to the receptionist.)

Responsible Party if Minor Patient:	Birth Date: / /	Address (if different):	Home Phone:

Guarantor Employer Name:	Guarantor Employer Address:	Guarantor Employer Phone:

Name of primary insurance:	Subscriber Name:	ID / Policy #:	Group #:

Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of Secondary Insurance:	Subscriber's Name:	ID / Policy #:	Group #:

Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone:	Work Phone:
Alternate Contact Person:	Relationship to Patient:	Home Phone:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Roseville Orthopedics & Sports Medicine** or insurance company to release any information required to process my claim(s).

_____ _____

Patient/Guardian signature *Date*

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices:*

By subscribing my name below. I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
_____	_____	_____	

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care in that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ **Phone #:** _____

Print Name: _____ **Phone #:** _____

Print Name: _____ **Phone #:** _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

_____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Work Telephone Number:

_____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Written Communication Address:

_____

____ OK to mail to address listed above

____ E-mail me at _____

Fax Communication:

_____

____ OK to fax at the number listed above

____ E-mail me at _____

Other: _____

Name of Patient (Print)	Signature	Date
_____	_____	_____

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Medical Information

Primary Care Physician: _____ Patient Name: _____

How were you referred to our office: _____

Reason for visit: _____ Date of Onset: _____

How did injury occur? _____

What treatment have you received? _____

What makes your symptoms worse, better? _____

_____

Past Medical History:

Do you have any active medical problems? Please circle or list if not present

Hypertension Diabetes High Cholesterol Hypothyroidism Rheumatoid Arthritis

Other _____

What surgeries have you had in the past and when? _____

_____

Are you allergic to anything, including medications? Please list and note reaction: _____

_____

What medications do you take? _____

_____

_____

Have you had problems with anesthesia? _____

Social History: Are you married/single?

What type of work do you do? _____

Do you smoke? Y/N If so, how much _____

Family History: Please check in appropriate location if a family member has or has had any of the following:

	Mother	Father	Sibling	Other (specify)
Heart Attack	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Rheumatoid Arthritis	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____
Problems with anesthesia	_____	_____	_____	_____

Worker's Comp Carrier _____ Claim Number _____

Adjuster's Name _____ Phone Number _____

REVIEW OF SYSTEMS

Yes (Now or within last 6 months) or No. Please explain any yes answers in the space provided at the end of the form.

SYSTEM			SYSTEM		
GENERAL			EYES		
Unwanted weight loss	**Yes**	**No**	Recent visual changes	**Yes**	**No**
Fevers	**Yes**	**No**	Pain in eyes	**Yes**	**No**
Chills	**Yes**	**No**	Dryness	**Yes**	**No**
Night Sweats	**Yes**	**No**	Light intolerance	**Yes**	**No**
EARS, NOSE, THROAT			CARDIOVASCULAR		
Hearing loss	**Yes**	**No**	Irregular heart beat	**Yes**	**No**
Ringing	**Yes**	**No**	Chest pain	**Yes**	**No**
Frequent nose bleed	**Yes**	**No**	Swollen ankles	**Yes**	**No**
Sore throat	**Yes**	**No**	Short of breath when lying down	**Yes**	**No**
Hoarseness	**Yes**	**No**	Passing out	**Yes**	**No**
RESPIRATORY			GASTROINTESTINAL		
Cough yellow or green Sputum	**Yes**	**No**	Vomit blood	**Yes**	**No**
Cough up blood	**Yes**	**No**	Blood in stool	**Yes**	**No**
Shortness of breath	**Yes**	**No**	Black stools	**Yes**	**No**
Pain with breathing	**Yes**	**No**	Frequent nausea	**Yes**	**No**
GENITOURINARY			Loss of appetite	**Yes**	**No**
Pain on urination	**Yes**	**No**	Diarrhea	**Yes**	**No**
Blood in urine	**Yes**	**No**	SKIN		
Urinating too often	**Yes**	**No**	Rashes	**Yes**	**No**
Incontinence	**Yes**	**No**	Non healing wounds	**Yes**	**No**
NEUROLOGIC			Boils	**Yes**	**No**
Seizures	**Yes**	**No**	Dry skin	**Yes**	**No**
Fainting	**Yes**	**No**	PSYCHIATRIC		
Dizziness	**Yes**	**No**	Depression	**Yes**	**No**
Loss of coordination	**Yes**	**No**	Anxiety	**Yes**	**No**
Weakness	**Yes**	**No**	High stress level	**Yes**	**No**
Numbness	**Yes**	**No**	Mood swings	**Yes**	**No**
Tingling	**Yes**	**No**	Poor concentration	**Yes**	**No**
MUSCULOSKELETAL			ENDOCRINE		
Joint stiffness	**Yes**	**No**	Excessive thirst	**Yes**	**No**
Joint pain	**Yes**	**No**	Fatigue	**Yes**	**No**
Bone pain	**Yes**	**No**	Feel too hot	**Yes**	**No**
Multiple broken bones	**Yes**	**No**	Feel too cold	**Yes**	**No**
Weakness	**Yes**	**No**	Dry skin	**Yes**	**No**
Joint swelling	**Yes**	**No**	Slow wound healing	**Yes**	**No**
HEMATOLOGIC/LYMPHATIC			ALLERGIC/IMMUNOLOGIC		
Easy bruising	**Yes**	**No**	Frequent infections	**Yes**	**No**
Easy or prolonged bleeding	**Yes**	**No**	Chronic infections	**Yes**	**No**
Swollen glands	**Yes**	**No**	Slow wound healing	**Yes**	**No**
Swelling in limbs	**Yes**	**No**	Frequent sneezing	**Yes**	**No**
Blood clots	**Yes**	**No**	Chronic runny nose	**Yes**	**No**

Please explain any "yes" answers here:

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Financial Policy

Thank you for choosing our group for your orthopedic treatment. Any pain can cause an inconvenience in your life. This can be stressful, and so can the financial piece, we can relieve some stress and move toward a healthier life overall. Below is our financial policy.
The purpose of this form allows Roseville Orthopedic Surgery and Sports Medicine to treat you, bill any insurance you may have, share information with other health care offices and facilities, and to collect on your account.

REGARDING INSURANCE: Our office participates with many managed care insurance companies and with Medicare. Should your insurance coverage be with one or more of these companies, we will bill your insurance company along the guidelines of our contract. However, co-payments, co-insurance, deductibles, and non-covered services that have not been paid, are the responsibility of the patient and payment is expected at the time services are rendered. You are responsible for any balance not covered by insurance (examples: denied services, or services not covered by your plan). If this is not paid timely, we have a collection service that will take over your account. This additional service costs more money, for both of us, your portion is approx $20. We require payment when due to keep everyone's expenses to a minimum. If payment arrangements or general payment questions are needed, please contact our billing office at (209) 579-5628, Monday through Friday from 8:00am to 5:00pm.

If you need surgery, we advise you to know and understand your insurance coverage. We will pre-approve the surgery with your carrier, however, it's not a guarantee the service will be fully paid. We may require you to pay a deposit, deductible or co-payment prior to surgery.

PRIVATE PAY: At the time of scheduling your office visit, you will be required to make a $150-$350 deposit depending on the nature of your appointment. The deposit will be applied towards your first visit. If you need to make payment arrangements, please contact our billing office. If you are able to pay in full at the time of service, you will receive a 10% discount.

NO SHOWS: Please be advised that if you do not show up for your appointment you will be charged $50 for No Show Appointment. This fee will not be covered by your insurance company and will be your sole responsibility. Please bear in mind this is only being done to better serve our patients by improving access to appointment times often taken by patients who have scheduled appointment and failed to utilize them.

We require a 24 hour notice in advance if you need to change your appointment to not be charged.

FORMS COMPLETION: It is our office policy to charge any request for correspondence such as letters of medical necessity and disability forms. The form fee is $25 for each form to be completed. If you require a CD of your x-ray the cost is $5. We require that you pick up your forms upon completion, you will receive a call from us.

Please sign below to indicate that you have read, understand and agree with the above statements.

Patient/Parent signature _____ Date _____

Our medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

DME

We will collect a deposit that will be applied to your co-insurance. We will bill your insurance for your DME product.

Based on your insurance coverage, your DME could be applied towards your deductible or not be a covered benefit.

We would bill you based on the determination of your benefit coverage plan.

Patient/Parent Signature_____ Date _____

Medicare Patient Signature Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, or its intermediaries or carriers, or billing agent of this physician or supplier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request that payment under Medicare be made either to me or Roseville Orthopedic Surgery & Sports Medicine on any bills for services furnished me by that physician.

Patient Signature_____ Date _____

Assignment of Benefits

I hereby authorize that payment of the amount due me in my pending insurance claim be made directly to: Roseville Orthopedic Surgery & Sports Medicine. Payment is authorized upon your receipt of an itemized statement of services.

Patient Signature_____ Date _____

Records Release Authorization

I hereby authorize Roseville Orthopedic Surgery & Sports Medicine to release to my referring physician, insurance company, or legal guardian, any information, including diagnosis and records of treatment, concerning my medical history and orthopedic care.

Patient Signature_____ Date _____

ROSEVILLE ORTHOPEDIC SURGERY and SPORTS MEDICINE

CREDIT CARD AUTHORIZATION AGREEMENT

Roseville Orthopedic Surgery and Sports Medicine has implemented a new credit card policy. Like many other practices and medical offices, we have adopted a similar policy. We kindly request our patients' guardian/guarantor for a credit card which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service. At registration and/or check-in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notify us of the balance due, if any. The information will be held securely until your insurance has paid its portion of the claim and notified us of any additional amount owed by the patient. At that time, **we will bill the credit card up to $500.00 maximum per month. If the balance owing is more than $500.00, this will be billed the following month unless the patient contacts our billing office and would like the entire balance applied to the credit card in one month.** This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. If you have questions about the card-on-file payment method, please tell us. Any CC charges will be sent by email as a notification.

By signing below, I authorize Roseville Orthopedic Surgery and Sports Medicine to keep my signature and my credit card information securely on file in my account. I authorize Roseville Orthopedics to charge my credit card for any outstanding balances when due, including prior open balances from 2023 and before.

Visa ☐ MasterCard ☐ Discover ☐

Name on Card (Print): _____ **MRN#** _____

Cardholder Relationship to Patient: _____

Last Four Digits of Credit Card Number: _____ Exp. Date: ___/____

Email: _____

Please fill out the information below for any person(s) you authorize this credit card for:

Patient Full Name (Print): _____ DOB: ___/___/____

Credit Card Holder's Signature: _____ Date: _____

For any questions about the credit card or other billing questions, **please call our billing office at (888) 461-7001.**

PJ completed: _____ **No prior PJ patient:** _____ **Date:** _____