NEW PATIENT REGISTRATION FORMS FOR OSS ORTHOPAEDICS, PAIN MANAGEMENT, IMAGING

IMPORTANT

OSS ossburbank.com

After booking your office appointment, here is your checklist for appointment day:

- [ ] **Health Insurance Card(s)**
if using *PPO, Medicare, POS, HMO*
It's your job to understand your health insurance.


Primary Insurance

If Applicable

Secondary Insurance

- [ ] Copy of **Authorization #**
and letter (digital or paper) if using HMO

Providence
Axminser Medical Group
Facey Medical Group

- [ ] **Credit Card Payment** if applicable.
You may need to handle a fee at check in.
Read the consents in this packet to learn more.

- [ ] **Valid Photo ID**

- [ ] **X-Ray** & Reports if taken in
last 3 months specific to body part

- [ ] **List of Medications**
Bring list and TAKE PICTURES of the medications as a back up.


The list of medications is very important so provider makes the right medical decisions about your treatment.

- [ ] **CT Scan and/or MRI Image(s) & Reports**
if taken in **last 12 months**
specific to body part

- [ ] **Completed Registration Forms**
in this packet.

- [ ] **Wear** loose fitting **gym** or **street clothing** so easier for you to be examined.

- [ ] **Arrive 15 minutes before appointment time at OSS** Orthopaedics, Pain Management & Imaging office. Cancel? Call or text 1 busines day before.

Եթե դժվարանում եք անգլերեն հասկանալ: խնդրում ենք ձեզ հետ բերել ձեր թարգմանիչը: Շնորհակալություն!

Si tiene difilcutad entendiendo 'o' leendo Ingles por favor de trear un traductor

Burbank | Main Office
Pacific Ave & Hollywood Way
3413 W Pacific Ave, #100
Burbank, CA 91505
T: (818) 841-3936
F: (818) 841-5974

- Dr. Yuri Falkinstein
- Dr. Chrystina Jeter
- Dr. Mark Mikhael
- Dr. Ray Raven, III
- Dr. Shahan Yacoubian
- Dr. Stephan Yacoubian
- Dr. Jeffrey Korchek
- Dr. Richard Feldman
- Dr. Michael Moses
- Orthopaedic PAs
- MRI, CT Scan, Bone Density Scan (DEXA)

Glendale Office
1300 S. Central Ave
Glendale, CA 91204
T: (818) 841-3936
F: (818) 841-5974

- Dr. Chrystina Jeter
- Dr. Michael Moses

Still have a **question?**

Ready to Email Your **Completed Forms?**

Email us! info@ossburbank.com

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

ORTHOPAEDIC SURGERY SPECIALISTS & AFFILIATED ASSOCIATES
Print or Stamp Name of Physician, Medical Group, or Associate Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

By: _____
(if Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.
(01-16)

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PATIENT PERSONAL FORM

Kindly use Black Ink

GENERAL

Patient Name (Last Name, First Name, M.I.) | Today's Date (MM/DD/YY)

Social Security # | Driver's License / State Issued | Gender: Male ☐ Female ☐ | Date of Birth (MM/DD/YY)

Email Address (Tip! Email will get you access to our OSS Patient Portal) | Name of Spouse / Partner

Home Address (Please include Street Number, Street Name, City, State, Zip Code

Primary Telephone (1st # to reach you) Cell ☐ Home ☐ Work ☐ | Secondary Telephone Cell ☐ Home ☐ Work ☐

Emergency Contact, Your Relationship, & Primary Telephone

EMPLOYMENT

Employer & Job Title

Is this a work related injury? Yes ☐ No ☐ | Work Comp Insurance Carrier & Claim #

If yes, has your employer been notified? Yes ☐ No ☐ | Claim Adjuster & Telephone

PHARMACY (Tip! We can refill your Rx faster if you provide us this information)

Pharmacy Name, Address & Telephone

MEDICAL REFERRALS

Who referred you to our practice?

☐ Doctor ☐ Relative ☐ Friend ☐ Internet ☐ Hosptial ☐ Insurance Company Name

LEGAL

Is there a legal case or lawsuit involved with this injury? ☐ Yes ☐ No | Attorney or Liability Representative Name and Telephone

Is an attorney, liability carrier, or auto insusrance invovled in payment? ☐ Yes ☐ No

PRIMARY INSURANCE

Insurance Company Name	I.D. / Policy Number	Group Number
Insured Name	Insured Social Security #	Insured Date of Birth (MM/DD/YY)
Subscriber of the Health Insurance & Relationship	Subscriber Social Security #	Subscriber Date of Birth (MM/DD/YYYY)

SECONDARY INSURANCE

Insurance Company Name	I.D. / Policy Number	Group Number
Insured Name	Insured Social Security #	Insured Date of Birth (MM/DD/YY)
Subscriber of the Health Insurance & Relationship	Subscriber Social Security #	Subscriber Date of Birth (MM/DD/YYYY)

AUTHORIZATION

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize examination and all services deemed medically necessary. I authorize the release of all medical information necessary to process my claim. I agree to assume financial responsbility for ALL services provided.

X

Signature of Patient or Responsible Party *Date*

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MEDICAL QUESTIONNAIRE

KINDLY USE BLACK INK

GENERAL

Name *Last Name* *First Name* *M.I.*				Today's Date (MM/DD/YYYY) / /
Gender ☐ Male ☐ Female	Height	Weight	Age	Which is your dominant hand? ☐ Left ☐ Right
Referring Doctor & Phone			Primary Care Doctor & Phone	

Have you been discharged from an inpatient facility in the past 30 days? If yes:

What was your date of discharge?

Were any of your medications changed?

CURRENT PROBLEM

What part of your body are you being seen for today? Which side? (if applicable) ☐ Left ☐ Right

What is the goal of your appointment today?

☐ Pain Management ☐ Better Function ☐ Better Appearance ☐ Return to Work ☐ Return to Play ☐ Other: _____

How did the problem develop?

When did the problem start: ☐ Over Time (Duration:_____) ☐ Injury (Date of Injury: _____)

Is this work related? ☐ Yes ☐ No

On a scale of 0-10 (0=no pain, 10= worst possible pain) what is your level of pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have: ☐ Numbness? ☐ Tingling? If yes, where:

Have you noticed any weakenss? ☐ Yes ☐ No If yes, explain:

What other symptoms do you have?

Do your symptoms limit your ability to work? ☐ Yes ☐ No If yes, explain:

Do your symptoms affect your activities of daily living? ☐ Yes ☐ No If yes, explain:

Do your symptoms keep you awake at night? ☐ Yes ☐ No

What treatments have you tried? ☐ Injection ☐ Physical Therapy ☐ Chiropractic ☐ Medication:_____ ☐ Other: _____

Have any treatments helped? ☐ Yes ☐ No Please explain:

How many street blocks can you walk?

Do you use a walking device? ☐ Cane ☐ Crutches ☐ Walker ☐ Wheel Chair ☐ Not Applicable; Don't use a walking device

Describe how you use stairs: ☐ Place one foot per step ☐ Place both feet on step before proceeding to next ☐ Not Applicable; Don't use stairs

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MEDICAL QUESTIONNAIRE

KINDLY USE BLACK INK

MEDICAL HISTORY: LIST ALL

Medical problems:

Medications:

Supplements:

Surgeries:

Drug allergies (include reaction):

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed **Name:**

Hobbies / Interests: **Occupation:**

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If "Yes": How often did you have a drink containing alcohol in the past year?

☐ Never (0 point) ☐ Monthly or less (1 point) ☐ 2 to 4 times a month (2 points)

☐ 2 to 3 times a week (3 points) ☐ 4 or more times a week (4 points)

If "Yes": How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 drinks (0 point) ☐ 3 or 4 drinks (1 point) ☐ 5 or 6 drinks (2 points)

☐ 7 to 9 drinks (3 points) ☐ 10 or more drinks (4 points)

If "Yes": How often did you have 6 or more drinks on one occasion in the past year?

☐ Never (0 point) ☐ Less than monthly (1 point) ☐ Monthly (2 points)

☐ WeekIt (3 points) ☐ Daily or almost daily (4 points)

Do you use tobacco products? ☐ No ☐ Yes **If yes, how many packs per day?**

Do you use recreational drugs? ☐ No ☐ Yes **Describe:**

IF YOU ARE 65 OR OLDER

Do you have an advance care plan or surrogate decision maker?

Have you fallen in the last 12 months? ☐ No ☐ Yes **If "Yes": How many times?** **Were you injured?**

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (print) _____ **Signature**_____ **Date**____/____/____

USE BLACK INK

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MEDICAL QUESTIONNAIRE

KINDLY USE BLACK INK

HEALTH REVIEW (Do you have any of the following?)

GENERAL			***GASTROINTESTINAL***		
Have you been in good general health most of your life	☐ No	☐ Yes	Vomiting blood or food	☐ No	☐ Yes
Any allergies, including medication	☐ No	☐ Yes	Gallbladder disease	☐ No	☐ Yes
Any recent weight gain	☐ No	☐ Yes	Liver trouble	☐ No	☐ Yes
SKIN			Hepatitis	☐ No	☐ Yes
Skin Disease	☐ No	☐ Yes	Painful bowel movements	☐ No	☐ Yes
Jaundice	☐ No	☐ Yes	Black stools	☐ No	☐ Yes
Hives, eczema or rash	☐ No	☐ Yes	Hemorrhoids or piles	☐ No	☐ Yes
Frequent infections or boils	☐ No	☐ Yes	Recent changes in bowel habits	☐ No	☐ Yes
Abnormal pigmentation	☐ No	☐ Yes	Heartburn or indigestion	☐ No	☐ Yes
HEAD, EYES, EARS, NOSE, THROAT			***GENITOURINARY***		
Eye diseases or injury	☐ No	☐ Yes	Loss of urine	☐ No	☐ Yes
Wear glasses	☐ No	☐ Yes	Frequent urination	☐ No	☐ Yes
Double vision	☐ No	☐ Yes	Night time urinating	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Blood in urine	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes	Kidney trouble / Kidney stones	☐ No	☐ Yes
Itching eyes or nose	☐ No	☐ Yes	***LOCOMOTOR - MUSCULOSKELETAL***		
Sneezing or runny nose	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes
Nosebleeds	☐ No	☐ Yes	Varicose veins	☐ No	☐ Yes
Chronic sinus trouble	☐ No	☐ Yes	Weakness of muscles or joints	☐ No	☐ Yes
Ear disease	☐ No	☐ Yes	Difficulty walking	☐ No	☐ Yes
Impaired hearing	☐ No	☐ Yes	Pain in calves or buttocks on walking, relieved by rest	☐ No	☐ Yes
Dizziness or transient episodes of unconsciousness	☐ No	☐ Yes	***NEURO - PSYCHIATRIC***		
RESPIRATORY			Ever had psychiatric care	☐ No	☐ Yes
URI (cold) now	☐ No	☐ Yes	Ever been advised to see a psychiatrist	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes	Fainting spells	☐ No	☐ Yes
Chronic of frequent cough	☐ No	☐ Yes	Convulsions	☐ No	☐ Yes
Asthma or wheezing	☐ No	☐ Yes	Paralysis	☐ No	☐ Yes
Difficulty breathing	☐ No	☐ Yes	***ENDOCRINE***		
CARDIOVASCULAR			Diabetes	☐ No	☐ Yes
Chest pain or angina pectoris	☐ No	☐ Yes	Thyroid disease	☐ No	☐ Yes
Shortness of breath with walking or lying down	☐ No	☐ Yes	Hormone therapy	☐ No	☐ Yes
Heart trouble or heart attacks	☐ No	☐ Yes	Any change in hat or glove size	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Any change in hair growth	☐ No	☐ Yes
Swelling of hands, feet or ankles	☐ No	☐ Yes	Become colder than before or skin become dryer	☐ No	☐ Yes
Heart murmur	☐ No	☐ Yes	***HEMATOLOGICAL***		
NECK			Slow to heal after cuts	☐ No	☐ Yes
Stiffness	☐ No	☐ Yes	Blood disease	☐ No	☐ Yes
Enlarged glands	☐ No	☐ Yes	Anemia	☐ No	☐ Yes
			History of blood clots	☐ No	☐ Yes
			Bleeding problems	☐ No	☐ Yes

FAMILY'S HEALTH REVIEW (Has any blood relative ever had any of the following?)

Cancer	☐ No	☐ Yes	Convulsions	☐ No	☐ Yes
Tuberculosis	☐ No	☐ Yes	Suicide	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Mental illness	☐ No	☐ Yes
Heart trouble	☐ No	☐ Yes	Bleeding tendency	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Gout or other arthritis	☐ No	☐ Yes
Stroke	☐ No	☐ Yes	Hereditary defects	☐ No	☐ Yes

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (print)_____ **Signature**_____ **Date**____/____/____

HIPAA PRIVACY PREFERENCES

Please select the level of privacy you would like Orthopaedic Surgery Specialists (OSS) to observe concerning your information (appointment information, test results, procedure results, etc.)

☐ OSS may only discuss my information with me, directly.

If we are not able to reach you directly, may we provide you with your information via messages?

☐ OSS may leave voice messages containing my information at the following phone number(s):

_____ (home) _____ (cell) _____ (work) _____ (other)

☐ OSS may send unencrypted emails from the physician and his staff to the following e-mail address:

_____
(e-mail address)

Is there anybody else that you would like to allow us to speak to about your information if they inquire about you? This should be anyone (family member, friend, caretaker, etc.) that might ever come into an appointment with you, help you with your forms, call to make or check on an appointment for you, or pick anything up for you from our office. **If someone does come to us on your behalf but their name is not listed below, we will not be able to share anything with them regarding any of your information.**

☐ OSS may share my information with the following individuals:

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

Those listed above **must answer the following security question before any information is shared:

What is the patient's birthday? _____

Under the requirements of HIPAA we are not allowed to give information to anyone other than the patient without the patient's written consent. Signing this form will only give consent to release appointment information, test results, and procedure results to the designated person(s) above. This consent form will not allow the doctor to release any other information to this person. You may revoke this consent in writing except where we have already made disclosures on your prior consent.

_____ (print patient's name) _____ (sign patient's name) _____ (date)

Orthopaedic Surgery Specialists Burbank

OSS Financial Contract & Consents
General & Office Appointments

Directions: Please read the OSS Financial Contract & Consents document and sign. By signing, you acknowledge all of the OSS General & Office Appointment policies even if it does not currently apply to you.

Are you using?	At check in, please handle:	Important Requirements & Responsibilities
PPO, POS, or EPO* *as your primary insurance*	Can include a co-payment (co-pay), a deposit of $120 if deductible is not met (which would include the co-pay and deposit, 1st appt only) and/or outstanding balance.	**It's your job to understand your health insurance.** Topics to ask your insurance include: office visits, injections, casting, bracing, xrays, ultrasound, MRI, CT, and Bone Density Scan (DEXA). Understanding your coverage holds true if your insurance is in-network or out-of-network.
Medicare		
Only 1 insurance and it's Medicare	Can include a deposit of up to $120 if your annual deductible is not met.	
2 insurances, Medicare is one of them	No deposit or payment is required in advance.	
HMO Insurance* with Axminster or Facey Medical Group *as your primary insurance*	Can include a co-payment (co-pay), co-insurance, and/or outstanding balance	**It's your job to understand your health insurance.** You'll need an **authorization number** from your referring provider. If you received this number in a letter, **please bring a copy of the letter** to the office appointment. Otherwise, OSS will get the details for the authorization before you see the provider.
Workers Compensation	Not Applicable	You filed a claim through your employer and now have an open workers comp claim. OSS will need the **open claim number.** In addition, you'll need to have a **copy of the letter from your workers compensation adjuster that says you are authorized for care at OSS** and your adjuster has sent (emailed) your **medical records** to OSS in advance.
Self-Pay *no insurance*	See Next Page for Prices	**You'll need to pay the amount before** you receive services.

We do not take third-party liability coverage insurance like *auto insurance, personal liability, property insurance, liens, travel insurance or out of the country insurance, etc.* If you would like to use one of these, then ask OSS to be self-pay and then you can be responsible for submitting your medical bills to the third party insurance.

***Using insurance?** After your appointment, OSS will submit the claim to your health insurance company for services rendered at your appointment. **If your insurance company denies any portion of your claim** (meaning the insurance does not pay OSS for the services you have already received), **<u>you are still financially responsible.</u>** OSS works diligently with your health insurance to ensure the services you received are reimbursed accordingly. Once the Explanation of Benefits ("EOB") from your insurance company has been reviewed, you are welcome to discuss your concerns with the OSS Billing Department. Go to ossburbank.com for contact information.

I will have these cards out and ready at every OSS office appointment at check in:

Health Insurance Card(s)
if using PPO, HMO, or Medicare insurance

Valid Picture ID

Initial _____

Orthopaedic Surgery Specialists Burbank

OSS Financial Contract & Consents
General & Office Appointments

Changes to your insurance, identification, mailing address, email or phone number?
PLEASE LET US KNOW. Why? Could lead you to getting additional bills.

I will use credit card to to handle any expected fees and outstanding balances at each OSS office appointment. If patient is under the age of 18, I understand that I am responsible to handle the payment for the minor.

Self-Pay Prices. To be handled at Check in

In Office for Orthoapedics or Pain Management: Evaluate & Treat Condition (Injury / Pain)	1st Appointment with Provider	May include: Xray, Minor Procedure, Splint, Non Waterproof Cast, Brace (up to $25)	$350
	Follow Up Appointment with Same Provider for Same Condition	May include: Xray, Minor Procedure, Splint, Non Waterproof Cast, Brace (up to $25)	$100
In Office Care for Physical Therapy, Hand Therapy, or Chiropractic	1st Appointment with Evaluation	This appointment is typically 45 to 50 minutes.	$150
	Follow Up Appointment for Same Condition	This appointment is typically 45 to 50 minutes.	$100
MRI	Includes the imaging needed for one body part + the reading by the radiologist. No contrast. *Does not include the provider follow up appointment for imaging results.*		$400
CT Scan	Includes the imaging needed for one body part + the reading by the radiologist. No contrast. *Does not include the provider follow up appointment for imaging results.*		$280
Bone Density DEXA Scan	Includes the imaging of 2 body parts + the DEXA report. *Does not include the provider follow up appointment for imaging results.*		$60

*You may be responsible to pay an additional amount at check out if you received services (e.g., waterproof cast, bone setting) beyond what is included above.

After my appointment, I understand that I am responsible for the following:

To pay my outstanding balance in full within 15 business days after I get a bill (in mail or electronically) from OSS. *You'll get the bill typically 45 days later - once OSS has submitted the claim to your health insurance.*

To pay OSS the outstanding balance if my insurer sent me the check (may apply to out of network insurers).

If I get a call or letter from **OSS Billing**, then it's my responsibility to call OSS Billing within **3 business days.**

If I get an inquiry from my **insurance in regards to services I received from OSS,** it is my responsibility to respond **within 5 business days.** If not, I will be fully responsible for the claim.

Initial _____

Orthopaedic Surgery Specialists Burbank

OSS Financial Contract & Consents
General & Office Appointments

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my insurance carrier, including Medicare to pay directly to my physician, Orthopaedic Surgery Specialists & Affiliated Associates, for services rendered for me. I hereby authorize my physician to release information from my medical records necessary to bill my insurance carrier for these services. A photocopy of my signature on this form is to be considered as valid as the original. If the insurance sends you, the patient, the check, you would then issue a check to OSS for the same amount. If the check is made out to OSS but mailed to you, then you can give to OSS. **Mailing Address:** Orthopaedic Surgery Specialists (CA MSK MSO), 1310 S. Central Ave, Glendale, CA 91204

Signature: _____. Date: _____

NOTICE OF PRIVACY PRACTICES: PATIENT ACKNOWLEDGEMENT FORM.

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information (PHI) about our patients.

Federal regulations require that we give our patients or their authorized representative access to our Notice before signing this acknowledgment. Let us know if you have any questions about your rights or our privacy practices.

- If the question is about orthopaedics or pain management, email to melissap@ossburbank.com or send a letter to:

  Privacy Officer/Melissa Pereda
  OSS, Orthopaedic Surgery Specialists, 3413 W. Pacific Ave, Suite 100, Burbank, CA 91505.

- If the question is about physical or hand therapy, email to mandy@ossphysicaltherapy.com or send a letter to:

  Privacy Officer/Amanda Gonzales
  Orthopaedic Surgery Specialists, 3413 W. Pacific Ave, Suite 200, Burbank, CA 91505.

By signing this form, you are only acknowledging that you have been provided access to our Notice
Available at ossburbank.com. Click Resources > Click Forms (Registration). You'll find the document there.

Patient or Authorized Representative Name (print): _____

Signature: _____. Date: _____

OFFICE APPOINTMENTS

I agree that I will follow these rules if I need to cancel an appointment or if there are special rules that apply for a specific OSS Department.

Orthopaedic or Pain Management

- **Cancel.** Call us 24 hours before (1 business day).

MRI, CT Scan, Bone Density DEXA

- **Arrive 20 minutes before** your appointment. **You must cancel 1 business day (24 hours) in advance to avoid a cancellation fee.**
- **Cancel.** Call us at least 24 hours before. (1 business day).

Therapy include physical therapy, hand therapy or chiropractic:

- **Arrive 15 minutes before** your appointment.
- **Cancel.** Call or text us 24 hours before. (1 business day).

Initial _____

BRACE, SPLINT, CAST (Durable Medical Equipment) & MEDICATIONS

A provider will prescribe a brace if s/he determines the body part needs more support. A brace or cast may be given as part of the short term recovery. OSS rules:

- OSS does not accept returns or exchanges for braces or splints.
- OSS offers waterproof casts at an additional cost to you.

I allow OSS to access my medication history from my pharmac(ies).

Initial _____

I agree to all of the rules in the OSS Financial Contract & Consents for General & Office Appointments

Your Printed: _____

Patient Name: _____

Signature Name: _____. Date: _____