Corona-Temecula Orthopaedic Associates
MEDICAL GROUP

341 Magnolia Avenue, Suite 101
Corona, CA 92879
(951) 735-6060
www.CTOAMG.com

28078 Baxter Road, Suite 330/340
Murrieta, CA 92563
(951) 677-2157
Fax (951) 735-4510

Provider you will be seeing:

Physician
- ☐ Baum, Bradley L.
- ☐ Luna, Mario
- ☐ Rouhe, Richard L.
- ☐ Tooma, Ghassan S.
- ☐ Locke, John S.
- ☐ Roghani, Reza
- ☐ Starry, Amy
- ☐ Wallace, G. Carleton

Physician Assistant
- ☐ Demetrio Quismorio, Jr.
- ☐ Nicholas Alonzo
- ☐ Liela Neria
- ☐ Steven Hinojos

PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME (Last, First, Middle Initial)	SSN#	BIRTHDATE	SEX ☐ *MALE* ☐ *FEMALE*
PRIMARY ADDRESS		EMERGENCY CONTACT NAME	
CITY, STATE, ZIP		BIRTHDATE	Relationship to Patient
EMAIL ADDRESS		PHONE	☐ *HOME* ☐ *CELL* ☐ *OTHER*
PHONE	☐ *HOME* ☐ *CELL* ☐ *OTHER*	EMPLOYER	
PHONE	☐ *HOME* ☐ *CELL* ☐ *OTHER*	ADDRESS	
MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Widowed		CITY, STATE, ZIP	
PRIMARY CARE PHYSICIAN		WORK PHONE	
PHARMACY NAME		PHARMACY PHONE	

RESPONSIBLE PARTY / SUBSCRIBER INFORMATION (If different than above)

NAME (Last, First, Middle Initial)	SSN#	BIRTHDATE	SEX ☐ *MALE* ☐ *FEMALE*
PRIMARY ADDRESS		SECOND CONTACT BILLING ADDRESS (If applicable)	
CITY, STATE, ZIP		CITY, STATE, ZIP	
PRIMARY CARE PHYSICIAN		RELATIONSHIP TO PATIENT	
PHONE		CITY, STATE, ZIP	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF PRIMARY INSURED MEMBER	DATE OF BIRTH	GROUP #	
ADDRESS OF INSURANCE COMPANY		CO-PAY AMT	DEDUCTIBLE
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If applicable)

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF PRIMARY INSURED MEMBER	DATE OF BIRTH	GROUP #	
ADDRESS OF INSURANCE COMPANY		CO-PAY AMT	DEDUCTIBLE
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

OPTIONAL

RACE: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Latino/Hispanic ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Multiple ☐ Refuse to Report

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Refuse to to report

LANGUAGE: ☐ English ☐ Spanish ☐ Other (Please specify):

WORK-RELATED INJURY ONLY

DATE OF ACCIDENT	BODY PART	EMPLOYER NAME	
EMPLOYER CONTACT NAME	EMPLOYER CONTACT #		
W/C INSURANCE CO NAME	CLAIM #	PHONE #	

I hereby assign the insurance benefits to which I am entitled, directly to CORONA-TEMECULA ORTHOPAEDIC ASSOCIATES (CTOA), a medical group. I understand that I am financially responsible for all charges regardless of insurance verification benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. I hereby authorize treatment by CORONA ORTHOPAEDIC ASSOCIATES MEDICAL GROUP, INC. A Photostat of this authorization is accepted with the same authority as original.

SIGNATURE OF PATIENT/GUARDIAN ____________________ DATE ____________

This agreement will remain valid from this day forward to include all future services relating to the above patient, or until changes in the above information are required. It is the patient's responsibility to notify CTOA of any changes in information.

MEDICAL HEALTH COVERAGE

Financial Responsibility

- Insurance billing by Corona Orthopaedic Medical Group is provided as a courtesy.
- Any charges not covered by health care benefits are the patient's responsibility.
- It is my responsibility to notify the office of any changes in my health care coverage.
- In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.
- I am responsible for the entire bill, or balance of the bill, as determined by the office, and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Authorization of Release of Information

I authorize the release of medical or any other information to the health Care Financing Administration, my insurance carrier(s) or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Corona Orthopaedic Medical Group. A copy of this authorization will be sent to the health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file.

My insurance remains the same from my last visit. ☐ Yes ☐ No

OR

My new insurance is: ______________________________

Primary Care Physician: ______________________________

New Medical Group: ______________________________

I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

____
Patient/Insured Name (Please Print)

______________________________ ______________
Patient/Insured's Signature Date

PATIENT HISTORY

Date: ______________ Who sent you to our office? ______________________________

Patient's Name: ______________________________ SSN: ________________ Sex: ☐ M ☐ F

Date of Birth: Age: ☐ Right-handed ☐ Left-handed Height: Weight:

CHIEF COMPLAINT

Reason for your visit: ______________________________ Date of Injury: ______________

Did you have an injury? Explain: ______________________ Where? ______________

Current problem is the result of: (Check all that apply) ☐ Car accident ☐ Work Accident ☐ Other: ________

Is there a third-party insurer involved: ☐ Yes ☐ No Name of auto insurance: ______________________

Auto insurance name & address: ______________________________

Have you had X-rays? ☐ Yes ☐ No Where: Date:

CURRENT MEDICAL PROBLEMS (CHECK ALL THAT APPLY)

- ☐ Diabetes
  - ☐ Adult Onset ☐ Juvenile Onset ☐ Insulin Dependent
- ☐ High Blood Pressure
- ☐ Cholesterol Problems
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blackouts/Fainting
- ☐ Bleeding Disorder
- ☐ Cancer ______________________
- ☐ COPD
- ☐ Depression
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis ______________________
- ☐ Hormone Replacement Therapy
- ☐ Lung Disease
- ☐ Kidney Problems
- ☐ Obesity
- ☐ Numbness & Tingling
- ☐ Psychological Problems ______________________
- ☐ Repeated Infections
- ☐ Seasonal Allergies
- ☐ Thyroid Disease
- ☐ **Other** ______________________
- ☐ **No Pertinent Past Medical History**

FAMILY HISTORY

List drug ALLERGIES: ____

Allergy to LATEX? ☐ Yes ☐ No

Has any **blood relative** had any of the following? Please enter relationship.

- ☐ Arthritis ______________________
- ☐ Anemia ______________________
- ☐ Leukemia ______________________
- ☐ Bleeding disorder ______________________
- ☐ Repeated infections ______________________
- ☐ Crippling infections ______________________
- ☐ Chronic lung disease ______________________
- ☐ Tuberculosis ______________________
- ☐ Heart Disease ______________________
- ☐ Hypertension ______________________
- ☐ Kidney disease ______________________
- ☐ Asthma ______________________
- ☐ Allergies ______________________
- ☐ Mental Illness ______________________
- ☐ Migraines ______________________
- ☐ Diabetes ______________________
- ☐ Gout ______________________
- ☐ Cancers ______________________
- ☐ Ulcers ______________________
- ☐ Thyroid problems ______________________
- ☐ Obesity ______________________

Patient's Initials: __________ **---Please complete 2nd page ---►**

SOCIAL HISTORY

☐ Employed (Occupation: ________________________) ☐ Work in home ☐ Student ☐ Daycare ☐ Retired

☐ Single ☐ Married ☐ Divorced ☐ Widowed Children: ☐ No ☐ Yes #________

Do you live alone? ☐ Yes ☐ No If NO, who do you live with? ☐ Spouse ☐ Children ☐ Parents ☐ Other _____

Exercise: ☐ Daily ☐ 1-3 times/week ☐ 4-6 times/week ☐ Inactive

What type of exercise? ____

Special Interests or Hobbies: ____

Eating habits: ☐ Good ☐ Fair ☐ Poor Explain: ____

History of substance abuse: ☐ Yes ☐ No If YES, explain: ____

Smoke Currently ☐ No ☐ Yes If YES, how many a day: ______________ For how many years? ___________

Quit smoking: ☐ This year ☐ 1 year ago ☐ 5 years ago ☐ Longer: _______

Drink Alcohol: ☐ No ☐ Yes If YES, how much per day: ____

MEDICATIONS – PLEASE LIST CURRENT MEDICATIONS

Medication	**Strength**	**Reason for Medication**

SURGICAL HISTORY – PLEASE LIST ANY PAST SURGERIES

Surgery	**Year**

Do you have an advanced directive, durable power of attorney for health care or living will? ☐ Yes ☐ No

If yes, may we have a copy for our records? ☐ Yes ☐ No

Any additional information: ____

____

____

____

____

Patient/Parent Signature ________________________________ ***Date***________________

Reviewed by: ________________________________ Date________________

NOTICE OF PRIVACY PRACTICES
Corona-Temecula Orthopaedic Associates
Privacy Officer: Terrie Sepulveda, DOO
(951) 735-6060

Effective Date: 09/23/2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re- disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our

health professionals will use their best judgment in communication with your family and others.

Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. If you are currently an enrollee of a health plan, we may receive payment for communications to you in conjunction with our provision, coordination, or management of your health care and related services, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care, but only to the extent these communications describe: 1) a provider's participation in the health plan's network, 2) the extent of your covered benefits, or 3) concerning the availability of more cost-effective pharmaceuticals. We will not accept any payment for other marketing communications without your prior written authorization unless you have a chronic and seriously debilitating or life-threatening condition, we will tell you who is paying us, and we will also tell you how to stop these communications if you prefer not to receive them. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization, and we will disclose whether we receive any payments for any marketing activity you authorize.

Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

Fundraising. We may use or disclose your demographic information and the dates that you received treatment in order to contact you for fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Individual Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional. If your written request clearly, conspicuously and specifically asks us to send you or some other person or entity an electronic copy of your medical record, and we do not deny the request as discussed above, we will send a copy of the electronic health record as you requested, and will charge you no more than what it cost us to respond to your request.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

4. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
5. You have a right to a paper or electronic copy of this Notice of Privacy Practices, even if you have previously received one.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Physicians Duties:

Our physicians have a duty to maintain the privacy of PHI, and to provide patients with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individual following a breach of unsecured PHI. Our physicians are required to abide by the terms of this notice of privacy practices currently in effect.

E. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website: www.CTOAMG.com.

F. Complaints Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX	(415) 437-8310	90 7th Street, Suite 4-100 San Francisco, CA 94103
Office for Civil Rights	(415) 437-8311 (TDD)	OCRMail@hhs.gov
U.S. Department of Health & Human Services	(415) 437-8329 FAX	

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf . You will not be penalized for filing a complaint.

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the current Notice of Privacy Practices and understand a current Notice of Privacy Practices is available at my appointments and at www.CTOAMG.com.

Patient Name: ______________________________ Date of Birth: ______________

Signature: ______________________________

Relationship to Patient if not "Self": ____________________

Date: ____________________

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

____

Instructions for Communicating Personal Health Information (PHI)

Please indicate which of the following numbers and/or email address we should use to communicate with you regarding appointment reminders, lab results, etc. Only list the phone number, or numbers, you want us to call. Please specify if a message can be left on voicemail or with a designated person.

Home ______________________________ Message: *Yes / No*

Work ______________________________ Message: *Yes / No*

Cell ______________________________ Message: *Yes / No*

Other ______________________________ Message: *Yes / No*

Email ______________________________ Message: *Yes / No*

Please note: Emailing medically sensitive information can result in privacy breaches out of our control. Please initial here to indicate you understand the risks. ________

My Personal Health Information may be communicated to:

____

____

____

Do not communicate my Personal Health Information to:

____

____

____

Initials: ________

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of receipt of Notice of Privacy Practices but was unable to do so as documented below:

Date: ________________

Reason: ____

____

Employee Initials: ________