Valley Hand & Orthopaedics

GEORGE W. BALFOUR, M.D.
ELI T. ZIV, M.D.
JENNIEFER KHO, M.D.

DR. ZIV NEW PATIENT QUESTIONNAIRE

(Yes these forms can be a pain, but thank you for your time and accuracy)

Date:_____ NAME: Mr./Mrs./Ms./Dr. _____

MALE / FEMALE AGE:_____ NICKNAME:_____

PRIMARY DOCTOR:_____WHO REFERRED YOU?_____

OCCUPATION:_____

WHAT PROBLEM/ BODY PART ARE YOU BEING SEEN FOR?_____
_____ RIGHT / LEFT/ BOTH

DID THIS PROBLEM: __START GRADUALLY __START SUDDENLY___AN INJURY

IF NOT AN INJURY, WHEN DID IT START/ HOW LONG HAS IT BEEN A PROBLEM?_____

IF AN INJURY, HOW DID IT HAPPEN? _____

WHERE AND WHEN DID IT HAPPEN? _____

DO YOU HAVE: ____PAIN ____A SWELLING OR BUMP ____NUMBNESS
OTHER SYMPTOMS: _____

IF YOU HAVE PAIN, RATE IT FROM 1-10: ____/10

IF YOU HAVE PAIN, IS IT WORSE:
____WITH USE ____WITH GRIPPING ____AT REST ____DAYTIME _____AT NIGHT

IF YOU HAVE PAIN, HOW OFTEN?_____

IF HAVING NUMBNESS, DO FINGERS FALL ASLEEP?__YES ___ NO
IS IT WORSE:
___ WITH USE ____ AT REST ____ DRIVING A CAR ____DAYTIME ____AT NIGHT

IF YOU HAVE A BUMP OR SWELLING, IS IT:
____GETTING BIGGER ____GETTING SMALLER _____NOT CHANGING

ANY TREATMENT SO FAR FOR THIS PROBLEM?: ____YES ____NO
IF YES, WHAT:_____

ANY MEDICATION TAKEN SO FAR FOR THIS PROBLEM?: ____YES ____NO

IF YES, WHAT/ HOW LONG:_____

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PAST MEDICAL HISTORY (list any of your current or former health conditions):

_____
_____
_____

LIST ANY SURGERIES OR PROCEDURES IN THE PAST:

_____
_____
_____

ORTHOPAEDIC HISTORY (especially any prior problems with the body part being seen for today):

_____

HAVE YOU SEEN DR ZIV FOR THIS PROBLEM? ____YES ____NO _____DATE

CURRENT MEDICATIONS YOU ARE TAKING:_____
_____
_____
_____

ANY ALLERGIES TO MEDICATION:_____
_____

DO YOU HAVE ANY HISTORY OF (PLEASE CIRCLE):

HEARTBURN	HIGH BLOOD PRESSURE	ASTHMA	CHEST PAIN
ULCER	BLEEDING PROBLEMS	COPD	ARRYTHMIA
THYROID	SHORTNESS OF BREATH	CANCER	HEPATITIS B/C
DIABETES	EMOTIONAL PROBLEMS	HIV	SEIZURES
ARTHRITIS	KIDNEY DISEASE	GOUT	CHRONIC PAIN

ANY <u>FAMILY</u> HISTORY OF ORTHOPAEDIC OR ANESTHESIA PROBLEMS?

___YES ___ NO IF YES THEN WHAT?_____

DO YOU SMOKE? __YES __NO
DRINK ALCOHOL? __YES __NO ___#DRINKS A WEEK

ANY CURRENT/PRIOR ISSUES WITH DRUG/ALCOHOL ABUSE? ___YES ___NO
CURRENT/PRIOR ISSUES WITH PRESCRIPTION DRUG ABUSE? ___YES ___NO

ANY OTHER CONCERNS THE DOCTOR SHOULD KNOW ABOUT?

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Patient Information

Today's Date_____ **Date of Birth_____/_____/_____**

Patient: Last Name_____First Name_____M_____

Address_____City_____State_____Zip_____

Email_____

Home Phone_____Work Phone_____Cell_____

Driver's License #_____Social Security_____

Emergency Contact Name_____Phone#_____

Employer/School_____

Spouse/Parent's Name_____

Subscriber Policy Information:
Or attach a copy of insurance card(s) front and back

Insurance Name_____
Primary Policy Holder: Relationship to Patient _Self _Spouse _Parent/Guardian
Last Name_____First Name_____ __Male __Female
Address_____City_____State_____Zip_____
Phone_____Social Security_____Date of Birth____

Secondary Policy Information:
Insurance Name_____
Primary Policy Holder: Relationship to Patient _Self _Spouse _Parent/Guardian
Last Name_____First Name_____ __Male __Female
Address_____City_____State_____Zip_____
Phone_____Social Security_____Date of Birth____

Guarantor (The Guarantor is the person responsible for co-pays, deductibles and services not covered by insurance when applicable and only if it's someone NOT listed above.)
Last Name_____First name_____
Address_____City_____State_____Zip_____
Home Phone_____Date of Birth_____

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Office Policy

(Please read each policy and write your initials and today's date.)

Release of X-Rays: Federal and State Laws require that this office keep all X-rays performed in our office as part of the patient's medical records. We do not release original X-rays. If you would like a copy of your X-ray(s), we will be happy to do so at a cost of $15 per CD.

Please note that our office may require a minimum of one week to process your films. This cannot be done same day.

_____ _____
Initials **Date**

Appointments: We request that every patient call and make an appointment before coming in to the office. In case of an emergency, please call first before coming in. We appreciate a 24-hour notice for canceling follow-ups, and at least one hour notice for canceling an appointment due to illness or other problems. A $25 fee will be billed for missed appointments without notifications: missed appointments without proper notice would mean that future appointments will no longer be available.

_____ _____
Initials **Date**

Disability Forms: There is a $20 fee for our office to complete disability forms (excluding FMLA) and more extensive forms may require additional charges.

_____ _____
Initials **Date**

PPO Patients: Over the last few years the majority of PPO insurance plans have high out of pocket deductibles, ranging from several hundred to several thousand dollars. With such a plan, the insurance does not pay anything toward your care until the deductible has been met. If this is the case, we may ask you to pay the estimated total cost of the office visit at the time of your visit.

_____ _____
Initials **Date**

HMO Patients: (Healthcare Partners, Regal, Facey, Motion Picture, Lakeside, Providence, Preferred IPA, UCLA, Blue Shield Promise):
You must have authorization/a referral from your Primary Care Physician before we can see you. You are responsible for obtaining this authorization and for any charges that are excluded by your insurance. In addition: Your co-pay must be paid at the time of your visit. Also note that HMO plans do not cover items like braces (DME) and may severely limit where you can go for services like physical therapy, X-rays and surgery centers.

_____ _____
Initials **Date**

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HIPAA

Use and Disclosure of your protected Health Information

Your protected health information will be used by Dr. Ziv or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health may be used or disclosed. You may request and receive a copy of the notice any time.

You may request a restriction on the use or disclosure of your protected health information. Dr. Ziv may or may not agree to restrict the use or disclosure of your protected health information. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right Change Privacy Practices

Dr. Ziv (Valley Hand & Orthopaedics) reserves the right to modify practices outlined in the notice.

Disclosure to Specified Individuals

I give my permission for my protected health information to be disclosed for the purposes of communication results, findings and care decision to my family members and others listed below.

Name:_____
Name:_____

I have reviewed this consent form and give my permission to Dr. Ziv to use and disclose my health information in accordance with it.

_____ _____
Initials **Date**

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Authorization and Assignment Form

By signing this form you are voluntarily giving your general consent for Dr. Ziv to examine, evaluate and treat your orthopaedic condition. This also covers X-rays, ultrasound, injections and minor procedures. If it is determined that you will require a more involved procedure, you will be asked to sign a more specific informed consent.

_____ _____
Patient Signature **Date**

_____ _____
Parent/Legal Guardian Signature (If applicable) **Date**

I hereby authorize Dr. Ziv (Valley Hand & Orthopaedics), to provide my insurance company and/or my employer the information they require to complete my claim.

I also authorize my insurance company to pay Dr. Ziv directly for my surgical/medical benefits. I understand that I am financially responsible for the charges not covered by this authorization.

_____ _____
Patient or Subscriber Signature **Date**

Welcome to my practice. Thank you for your understanding and cooperation. I look forward to providing you with excellent care.

Eli Ziv, MD