# SPORTS AND SPINE ORTHOPEDICS

**Peter S. Borden M.D.   Christopher F. Wolf M.D.   Allyson Estess M.D.**

23456 HAWTHORNE BLVD, SUITE 200
TORRANCE CA 90505
TELEPHONE (310) 375-8700 FAX (310) 375-8776

2361 ROSECRANS AVE, SUITE #165
EL SEGUNDO, CA 90245
TELEPHONE (310) 775-2331 FAX (424) 255-4012

We hope that the following information will be helpful to you. We respect your time and would like to help make your visit as efficient as possible.

## PLEASE BRING THE FOLLOWING ITEMS TO YOUR VISIT:

- **NEW PATIENT FORMS**
  - Please complete the following registration and history forms and bring them to your visit or plan to arrive 30 minutes before your scheduled appointment time to complete these forms.
  - Printing and completing the forms prior can save you time on the day of your visit!

- **MEDICAL INFORMATION**
  - IMAGING STUDIES: You must bring a copy of any prior MRI or CT imaging studies to you visit (CD or film copy ok). Failure to bring your studies may require us to schedule an additional appointment.
  - PERTINANT MEDICAL RECORDS: Please bring any recent medical records (within past 5 years) related to the medical condition you are being treated for today
    - Operative notes from previous surgeries
    - Discharge summaries from ER visits or recent hospital stays
    - List of current medical problems and medications you currently take

- **MEDICAL INSURANCE CARD/FINANCIAL INFORMATION**
  - Please bring copies of all insurance cards.
  - We collect co-pays at the time you check in for your appointment before seeing the doctor.
  - Before your appointment, please verify that your insurance allows treatment at our office. Be aware that your insurance reimbursement may not cover the full cost of your visit. Regardless of insurance, payment remains your personal responsibility.
  - If you are being seen for a workman's compensation injury, motor vehicle accident or personal injury claim, please bring all relevant billing information including address and claim number. We do require a copy of your personal insurance care for these claims as well.

**Please note that patients under the age of 18 must be accompanied by a parent or guardian**

## LOCATIONS:

- TORRANCE LOCATION    23456 Hawthorne Blvd, Suite 200
  - We are located off of Hawthorne Blvd in the building behind the Olive Garden Restaurant. We recommend that you park in or near the structure as that parking is nearest to our building.

- EL SEGUNDO LOCATION    2361 Rosecrans Ave, Suite 165
  - We are located in the building on the north side of Rosecrans Ave near Aviation Blvd near the Paul Martin restaurant. Parking is available in one of the main garages on the inside of the campus.

# Sports and Spine Orthopaedics

## Clinical Patient Information and Medical History

(Please type or print legibly)

Name: ______________________________ Date: ______________

Age: ____________ Date of birth: ____________ Sex: □ Male □ Female

Wt ____________ HT ____________ Hand dominance: □ Right □ Left

Referring physician: ______________________ Primary care physician (if any): ______________________

Chief complaint: (what are you here for today?) ______________________ Date of injury: ____________

Where did the injury occur? □ Work □ Other Have you been treated for this problem by another doctor? □ Yes □ No

Prior treatments: □ None □ Bracing □ Pain medications □ Injections □ Chiropractic □ Surgery □ Other

Medical history: (please check previous or current conditions)

| | | | | |
|---|---|---|---|---|
| □ None | □ Anemia | □ COPD/lung disease | □ High blood pressure | □ Prostate |
| | □ Arthritis | □ Depression | □ High cholesterol | □ Stomach ulcers/reflux |
| | □ Asthma | □ Diabetes | □ HIV/AIDS | □ Seizures |
| | □ Blood clots/DVT | □ Heart disease | □ Liver disease | □ Thyroid disease |
| | □ Cancer | □ Hepatitis | □ Osteoporosis | □ Vascular disease |

□ Other (please list) ______________________________

Previous surgeries: (list type of surgery, right or left side, year, where, by whom, etc)

1. ______________________________
2. ______________________________
3. ______________________________

Current medications: (list medication and dosage, if known)

1. ____________________ 4. ____________________
2. ____________________ 5. ____________________
3. ____________________ 6. ____________________

Known allergies: (list allergy and reaction) ______________________________

Social history: Marital status: □ Single □ Married □ Divorced □ Widowed

Occupation: ______________________ Hobbies: ______________________

Do you smoke? □ Yes □ No Packs/day? ________ Do you drink alcohol? □ No □ Rare □ Social □ Daily

Family history: (check all that apply) □ Heart disease □ Diabetes □ Bleeding disorders □ Other ______________

Review of systems: (Check any positives)

| | | | |
|---|---|---|---|
| *General* | □ Fatigue | □ Weight loss /gain | □ Fever /chills |
| *Heart* | □ Shortness of breath | □ Chest pain | □ Palpitations |
| *Lungs* | □ Productive cough | □ Wheezing | □ Coughing up blood |
| *GI* | □ Heartburn | □ Abdominal pain | □ Nausea/vomiting |
| *Urinary/reproductive* | □ Blood in urine | □ Incontinence | □ Sexual dysfunction |
| *Skin* | □ Skin lesions | □ Psoriasis | □ Chronic rash |
| *Neurological* | □ Seizures | □ Migraines | □ History of stroke |
| *Musculoskeletal* | □ Joint pain | □ Joint swelling | □ Muscle pain |
| *Psychiatric* | □ Depression | □ Anxiety | □ Mood swings |
| *Hematologic* | □ Easy bruising | □ Easy bleeding | |

______________________________

Patient Signature Date

# Sports and Spine Orthopaedics

## Patient Demographic and Insurance Information

(Please type or print legibly)

**Chart #**________________ **Physician**____________________ **Date**____________

Patient name (LAST)______________________(FIRST)________________(MIDDLE)__________
Social Security #_______________________Drivers License#__________________ State__________
Date of Birth:______________ Age:__________ Sex ☐M ☐F Marital Status: ☐S ☐M ☐D ☐W
Address:_______________________________City:_______________ State:__________ Zip:__________
Mailing Address: ☐Same as above
Address:_______________________________City:_______________ State:__________ Zip:__________
Home Phone:_____________________________ Business Phone:______________________________
Cell Phone:______________________________ Email: _____________________________________
Emergency Contact:_______________________Relationship:______________ Phone: ______________
Address:_______________________________City:_______________ State:__________ Zip:__________

Date of Injury:__________________________ If not injury, when did pain begin_________________
Reason for Visit:_________________________ Body part:_________________ ☐R ☐L
How did you hear about our office? ☐Website ☐Social media ☐Magazine ☐Emergency room/urgent care
☐Primary care doctor ☐Current patient ☐Other____________________

Insurance
Primary:_______________________________ Secondary:_______________________________
Name of Insured: ________________________ Name of Insured:__________________________
SS#___________________________________ SS#:____________________________________
Date of Birth:___________________________ Date of Birth:_____________________________
Relationship: ☐Self ☐Spouse ☐Other Relationship: ☐Self ☐Spouse ☐Other

*Is this is a workman's compensation/personal injury claim?* ☐Yes ☐No *If yes, please complete below*
Insurance Company:__________________________________ Date of Injury:_________________
Adjuster's Name:____________________________________ Claim #:______________________
Phone:_________________________________ Fax:_______________________________________

If Patient is a Minor or a Student
School Name, Address and Phone:__________________________________________________
Father's Name:________________________________________Date of Birth:__________________
Address:_______________________________City:_______________ State:__________ Zip:__________
Employer:____________________________________________Phone:_______________________
Mother's Name:________________________________________Date of Birth:__________________
Address:_______________________________City:_______________ State:__________ Zip:__________
Employer:____________________________________________Phone:_______________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize Sports and Spine Orthopaedics or insurance company to release any information required to process my claims, determine the benefits payable fir related equipment or services to the organization, the Health Care financing administration. A copy of this authorization will be send to the Health Care financing Administration, my insurance company or other entity if requested. I, the above listed, authorize and direct the above listed insurance company to pay by check, made out and mailed to Sports and Spine Orthopaedics c/o Peter S. Borden MD 23456 Hawthorne Blvd, Suite 200 Torrance CA 90505. If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct the above mentioned insurance company to make the check to me and mail it as follows: Sports and Spine Orthopaedics c/o Peter S. Borden MD 23456 Hawthorne Blvd, Suite 200 Torrance CA 90505.

If the patient is less than 18 years of age, guarantor must sign.

Signature of Financially Responsible Party:_____________________________________________
Relationship to Patient:_____________________________________ Date:__________________

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# Medication Treatment Contract

The purpose of this agreement is to prevent any misunderstanding about the ordering and filling of certain medications that may be required for the management of pain. This contract will also help comply with the laws regarding pharmaceuticals. I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines.

I agree to use only one pharmacy to have prescriptions filled. I choose to use the following pharmacy for all my prescriptions:

Name of pharmacy:______________________________

Address:______________________________

Phone:______________________________

These are the terms of the medication contract:

1. If I change my pharmacy for any reason, I agree to notify my doctor with the new address and phone number prior to filling any prescriptions.
2. I will use one physician to provide medication for me. I understand that if I seek a prescription for narcotic medications from another provider or facility, this will break my contract and this office will no longer prescribe my medication.
3. I will safeguard medication from loss or theft. Lost or stolen medication will not be replaced.
4. I agree that refills for pain medication will be made only at office visits or refill requests placed with my pharmacy.
5. Refills will not be given during weekends or evenings.
6. This office will not provide early refills.
7. If a long-term medication regimen is needed to control your pain, we will help transition your care to your primary care physician for long-term medication management.
8. I agree that I will use my medicine at the prescribed rates and that use of my medicine at a greater rate will result in my being without medication for a period of time.
9. I will not sell, share or trade my medication. I will not use any illegal controlled substances.

I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescription of medications, and I authorize my doctor to provide this information to any person or facility he/she deems appropriate or necessary.

______________________________ ______________________________

Patient Name Date Signed

______________________________

Patient Signature

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# Letter of No Accident/Injury

______________________ ______________________

Print Patient Name Date of Birth

I hereby state with my signature that I was not involved in any auto accident, slip, fall, or work injury. My treatment is in no way associated with any 3rd party, and no other party is responsible or liable for the cost of my treatment.

Please process and pay all claims immediately.

______________________ ______________________

Patient Signature Date

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## Notice of Privacy Practices and Patient Consent Form

The Notice of Privacy Practices for Sports and Spine Orthopaedics, provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Portability and Accountability Act of 1996.

How Sports and Spine Orthopaedics can use your information:

We at Sports and Spine Orthopaedics can use and give your information to anyone who is part of taking care of you. This includes different doctors, nurses and therapists. We can also give out information to Medicare or any insurance company, or individual who may be responsible for paying for your care.

We use medical information about you to provide you services. We may use your information to find ways to improve how we can take care of you. Some state or federal laws require us to report certain diseases, abuse and crimes. We may also share information to find programs or services that might help you get better or stay better.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations, including appointment reminders by postcard or messages on an answering machine.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent

You have the following rights:

- To read your records and have copies made. Requests to review and receive copies should be made in writing to Sports and Spine Orthopaedics. If it is a billing record, please contact our billing department. You will get the records to you in 30 to 60 days, depending on where they are stored.
- To ask us to correct information that we have created including encounter notes and billing statements. This request must also be made in writing and sent to our Privacy Officer along with the reason(s) that support your request.
- To know who has seen your information if we have shared it for reasons other than to take care of you and to get paid. This request can also be made by contacting the Privacy Officer.
- To complain to Sports and Spine Orthopaedics through the Manager or the Department of Health and Human Services if you believe we have not followed the law and the Notice of Privacy Practices.

This consent allows the practice to disclose my medical information to the following people:

☐ Please do not disclose my health information to anyone

Name________________________________________ Relationship_______________
Name________________________________________ Relationship_______________
Name________________________________________ Relationship_______________

________________________________________ _______________________
Patient Name Date Signed

________________________________________
Patient Signature

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## Patient Financial Agreement

Dear Patient or Guardian:

Our goal is to provide you with the best medical care available. A clear understanding of our financial arrangements is essential for a successful doctor/patient relationship.

We are contracted with most PPO insurance plans. We do not accept any HMO, IPA, Medi-Cal, and Cal Optima.

Our office will verify insurance eligibility, however we cannot be held responsible for information received when verifying insurance benefits since it is not a guarantee of payment or eligibility. Please call your insurance for detailed information regarding your plan. **Ultimately, your insurance is an agreement between you and your insurance company.**

Please do not ask for discounts, waiving your co-payment or insurance only as this violates our contracts with your insurance.

If you do not have insurance, you will be expected to pay for your services at the time they are rendered. We accept cash, check, MasterCard, American Express, Visa, and Discover.

Charges for your treatment will be billed to your insurance company. However, if your insurance company has not paid their portion of the charges within 60 days, the account may revert to your responsibility.

Returned checks will be charged a $25.00 fee and you will no longer be able to write checks for services in the office.

**We are Out of Network with the following insurance companies: (Obamacare), Covered California, Affordable Care, and Healthnet.**

We are happy to bill all charges to your out of network insurance company on your behalf. Since we are out of network, payments from your insurance will more than likely come directly to you for services provided to you by our physicians.

Please forward those payments and the explanation of benefits to us as soon as you receive them so that we can apply the payment to your account in a timely manner.

If you have any questions, please contact our Billing Department at 310-375-8700 and someone will assist you with your questions.

My signature below indicates that I have read and understand the above statements.

Patient Name ____________________ Date Signed ____________________

Patient Signature ____________________

## SPORTS AND SPINE ORTHOPEDICS

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# Waiver of Responsibility

I understand that if I am unable to obtain the proper referral/authorization from my primary care physician for my insurance, and/or in the event my workman's compensation/automobile or personal liability insurance defaults, I will be financially responsible for the services performed by Sports and Spine Orthopaedics in full. Our financial policy is as follows:

We collect (payments & co-payments) at time of services are rendered. PLEASE BRING ALL INSURANCE CARDS at the time of your visit. If it is a workman's compensation, motor vehicle accident or personal injury claim, please have the correct insurance information, including name, address, and claim/file numbers. We require having your personal health insurance information on file, and if needed, a referral/authorization from your primary care physician for the visit. If you have any questions regarding this policy, please call our billing department at 310.375.8700.

I authorize release of any information concerning my health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I also authorize release of all medical records from my previous treating physicians to my physician in this practice and for the physician in this practice to any other physician for the purpose of evaluation and treatment.

It is my responsibility to notify Sports and Spine Orthopaedics of any changes to my insurance coverage. I understand that by signing this form I am accepting financial responsibility as explained above. I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of my privacy rights.

______________________________  ____________________

Patient Name  Date Signed

______________________________

Patient Signature