SIERRA PACIFIC ORTHOPEDICS
The Strength of Experience.

WHEN FILLING OUT THE NEW PATIENT QUESTIONNAIRE, PLEASE PRINT CLEARLY USING BLUE OR BLACK INK ONLY. PLEASE DO NOT USE PENCIL.

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Mark A. Sison, M.D.
Connor J. Telles, M.D.
Timothy C. Watson, M.D.
Jeryl J. Wiens, M.D.

Dear: _____

Your appointment has been scheduled for:

Date: _____ / _____ / _____ ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time: _____

Consultation Check List

- ☐ New Patient questionnaire completed. If this is not completed, your appointment will be rescheduled. (Possible 4-6 weeks out)
- ☐ MRI, CT Scan, Bone Scan, X-Rays, ect. **in CD format unless only films are available**. (Your appointment will be rescheduled if you do not have these available for your consultation appointment, possibly 4-6 weeks out)
- ☐ Previous medical records pertaining to your condition. i.e. operative reports, Electromyography (EMG/Nerve) reports, Bone Density reports. (This can delay any treatment recommendations if they are not available.)
- ☐ List any and all medications. (No records of your medications could delay procedures and treatments significantly).
- ☐ If you require an interpreter, you must bring a family member over the age of 18. If you are a **workman's compensation** claimant, you must contact your adjuster to provide you with an interpreter. (Your appointment will be rescheduled if there is no one to interpret for you.)

You must arrive **30 minutes prior to your scheduled time** to insure you have sufficient time to consult with the physician. Please make sure you have all of the above available when you come in for your appointment.

Sierra Pacific Orthopedics
Spruce Campus
1270 E. Spruce Ave
Fresno, CA 93720
(559) 256-5200

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Name: _____ Today's Date: _____

Referring Doctor: _____

Mark these drawings according to where you hurt. (If the back of your neck hurts, mark the drawing on the back or the neck, ect.) If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.

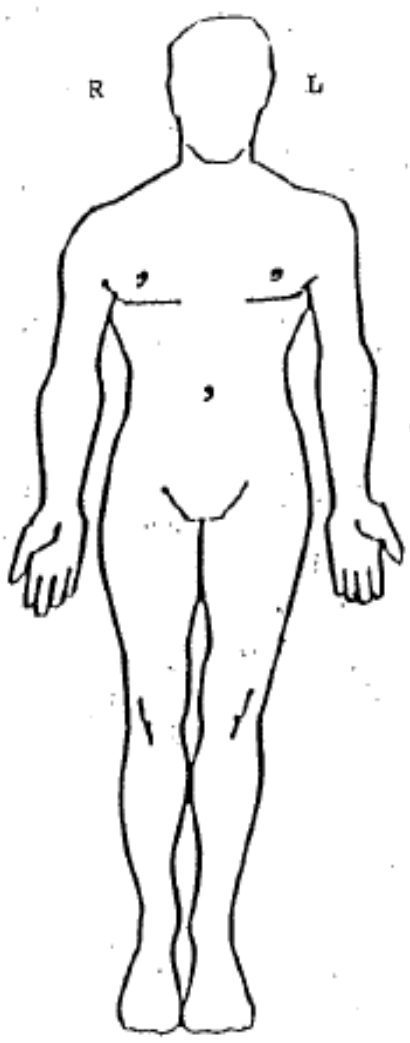
Numbness """"""""""""""""
""""""""""""""""

Pins & Needles °°°°°°°°°°°°
°°°°°°°°°°°°

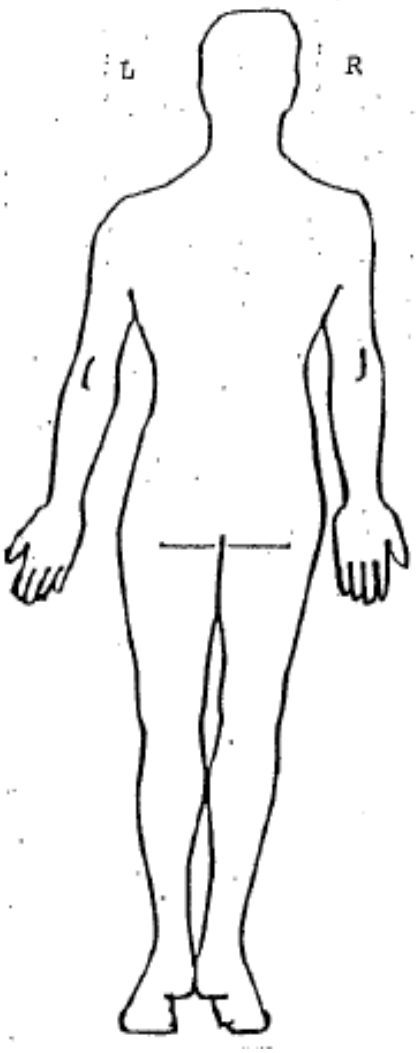
Burning xxxxxxxxxx
xxxxxxxxxx

Stabbing ////////////
////////////

Aches ^^^^^^^
^^^^^^^



Front View



Back View

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Back and Neck History Form

Instructions: This form has been designed to help the doctor focus in on the pertinent facts regarding your problems and initial visit to this office. Please complete sections II and III only if you had an on the job injury or were involved in a motor vehicle accident. All patients need to complete sections **I** and **IV** through **VI**.

Section I – General Information (For all patients)

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex: M F
Who referred you to our office? _____
Who is your family doctor? _____
In your own words, please describe what your problem is and what you hope to get from this visit. You may use the back of this sheet if necessary.

_____

_____

When did your problem begin or how long have you had it? _____
How did your problem begin? _____

_____

_____

What is, or was, your occupation? _____ Retired ☐
Have you ever had a disability rating before, and if so, why and how much? _____

Are there any other family members with disabilities or compensations injuries? _____
What is the name of the attorney involved with your present medical problem? _____
Have you ever had back or neck surgery before? If so, describe below.

Date	Type of Surgery and Doctor	Result		
		Helped	Made Worse	No Change
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐

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Name: _____ Date of Birth: _____

Section II – Work Injury (Fill out this section only if your problem is work related (on the job injury).

Date of first injury: _____ Other dates of injury (if any): _____
Employer: _____
Name of Primary Treating Physician: _____
What functions does your job require you to do? _____
_____
Are you working now? If not, what was the last day you worked? _____
How long have you been at this job? _____
Have you had an industrial claim before? If so, please explain: _____
_____
_____
Please list previous employers, dates of employment, and job descriptions.
_____
_____
_____
_____
If you were to get better in the next few weeks, would your employer let you return to work?
☐ Yes ☐ No

Section III – Motor Vehicle Accident (Fill out this section only if your problem relates to a motor vehicle accident.)

Please describe the accident and note whether you were the driver, passenger, wearing a seat belt, speed of vehicle involved, and other information you think is important.
_____
_____
_____
_____

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Name: _____ Date of Birth: _____

Section IV (For all patients)

Are you having problems with your bowels or bladder; for example, loss of control? If so, please describe: _____

Have you ever had problems with your neck or back in the past? If so, please explain: _____

_____

Check how the following activities affect your discomfort.

	Increase	Decrease	No Effect
Driving	☐	☐	☐
Turning your head	☐	☐	☐
Lying Down	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Getting upset or tension	☐	☐	☐
Straining at a bowel movement	☐	☐	☐
Medications, such as aspirin or Tylenol	☐	☐	☐

Check the joint areas below if you have weakness in any of these areas. (R=Right; L=Left)

Shoulder	☐ R	☐ L	Hip	☐ R	☐ L	Knee	☐ R	☐ L
Ankle	☐ R	☐ L	Elbow	☐ R	☐ L	Big Toe	☐ R	☐ L
Wrist	☐ R	☐ L	Thumb	☐ R	☐ L	Other Toes	☐ R	☐ L
Fingers	☐ R	☐ L						

Describe this weakness, if any: _____

Which of the following describes the reason for the weakness?

☐ Pain ☐ Actual loss of muscle, or muscles ability to move a joint

What has been your most significant life stressor(s)? _____

_____

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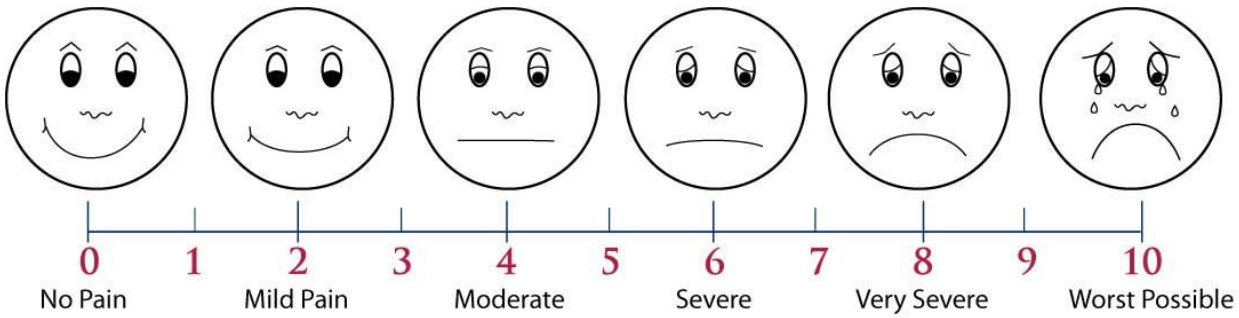
Name: _____ Date of Birth: _____

With a total of all of your pain adding up to 100%, what percentage of your pain is:

Neck	_____%
Arm	_____%
Mid Back	_____%
Low Back	_____%
Leg	_____%
Total	100% (Cannot add up to more than 100%)

Are you right or left handed: ☐ Right ☐ Left

Please use the Pain Guidelines below to express, by number, 1-10, the amount of pain you are feeling in the areas listed below (back, neck, ect.) (Check box; R=Right; L=Left)



Neck	_____	☐ R	☐ L	Upper Back	_____	☐ R	☐ L
Shoulder	_____	☐ R	☐ L	Lower Back	_____	☐ R	☐ L
Forearms	_____	☐ R	☐ L	Thighs	_____	☐ R	☐ L
Upper Arms	_____	☐ R	☐ L	Buttocks	_____	☐ R	☐ L
Hands	_____	☐ R	☐ L	Calves	_____	☐ R	☐ L
Feet	_____	☐ R	☐ L				

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Name: _____ Date of Birth: _____

Which of these tests have been performed?

Regular spine x-rays	Date: _____	Nuclear Bone Scan	Date: _____
CT Scan	Date: _____	MRI Scan	Date: _____
Discogram	Date: _____	Myelogram	Date: _____
EMG/Nerve Conduction	Date: _____	Nerve Blocks	Date: _____
Bone Density	Date: _____	PET Scan	Date: _____

What treatments have you tried so far for your problem?

	Not Tried	Helped	Made Worse	No Change
Muscle relaxants	☐	☐	☐	☐
Strong pain medications (narcotics)	☐	☐	☐	☐
Aspirin type medications	☐	☐	☐	☐
Anti-depression medications	☐	☐	☐	☐
Electrical stimulation	☐	☐	☐	☐
Physical therapy	☐	☐	☐	☐
Chiropractic treatment	☐	☐	☐	☐
Massage therapy	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Surgery	☐	☐	☐	☐
Back exercises	☐	☐	☐	☐
Hot packs	☐	☐	☐	☐
Ultrasound	☐	☐	☐	☐
Ice	☐	☐	☐	☐
TENS unit for home use	☐	☐	☐	☐
Traction	☐	☐	☐	☐
Bedrest	☐	☐	☐	☐
Biofeedback	☐	☐	☐	☐
Local (trigger point) injections	☐	☐	☐	☐
Epidural injections	☐	☐	☐	☐
Facet injections	☐	☐	☐	☐
Percutaneous rhizotomy	☐	☐	☐	☐
Osteopathic treatment	☐	☐	☐	☐
Gravity inversion	☐	☐	☐	☐
Manipulation	☐	☐	☐	☐
Vertebroplasty/Kypholasty	☐	☐	☐	☐

Other (Please describe): _____

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Name: _____ Date of Birth: _____

Section V – Past Medical History (For all patients)

Please list all unusual childhood illnesses you have had? _____
_____
_____

Do you have a history of the following medical problems? (Please check all that apply)

- ☐ High blood pressure
- ☐ Sugar diabetes
- ☐ Thyroid (low/high)
- ☐ Heart problems
- ☐ Stomach ulcers
- ☐ Blood problems
- ☐ Vein problems
- ☐ Liver problems
- ☐ Kidney problems
- ☐ Lung problems
- ☐ Eye problems
- ☐ Gout
- ☐ Arthritis
- ☐ Bladder problems
- ☐ Prostate problems
- ☐ Blood clot problems
- ☐ Asthma
- ☐ Stroke/TIA
- ☐ Nerve problems
- ☐ Skin problems
- ☐ Recurrent infections
- ☐ Chronic pain
- ☐ Headaches
- ☐ Anxiety
- ☐ Cancer
- ☐ Other _____

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Name: _____ Date of Birth: _____

If you have been hospitalized in the last five years, please explain: _____

_____

Are you, or have you ever been, under the care of a psychiatrist/psychologist? ☐ Yes ☐ No

If yes, please explain and name of treater: _____

Please check all that apply:

☐ Depression ☐ Bipolar disorder ☐ Schizophrenia
☐ Dysthymia ☐ Anxiety ☐ Suicidal

List all previous non back surgeries and dates: _____

_____

Are you allergic to anything? If so, please list, and describe your reactive symptoms: _____

_____

Please list all of your current medications. Please include the strength and dosage. You may use the back of this paper, if necessary.

_____
_____
_____
_____
_____
_____
_____

What illnesses, including psychiatric, do your parents have, if any, or what illnesses tend to run in your family? _____

What is your ethnic background / religion? _____

How much alcohol do you drink on average in a day? ☐ None
Beer _____ bottles Wine _____ glasses Liquor _____ drinks

Do you smoke? ☐ Yes ☐ No if yes, _____ packs per day for _____ years.

Do you use other nicotine products? ☐ Yes ☐ No

If yes, please explain: _____

Do you use any recreational drugs? Please list them: _____

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed # of children: _____

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Name: _____ Date of Birth: _____

How much schooling did you complete?

Grade school	_____ years	High school	_____ years
Technical school	_____ years	College	_____ years

Present means of support (financial): _____

Section VI – Review of Systems (For all patients)

Constitutional

1. Yes ☐ No ☐ Have you lost weight in the last year? How many pounds? _____
2. Yes ☐ No ☐ Have you gained weight in the last year? How many pounds? _____
3. Yes ☐ No ☐ Have you had unexplained chills or fevers in the past month?
4. Yes ☐ No ☐ Do you have trouble sleeping?
5. Yes ☐ No ☐ Are you tired most of the time?

HEENT

6. Yes ☐ No ☐ Are you having vision problems, aside from wearing corrective glasses?
7. Yes ☐ No ☐ Are you having hearing problems?
8. Yes ☐ No ☐ Are you frequently bothered with nosebleeds?
9. Yes ☐ No ☐ Has your voice been persistently hoarse in the past year?
10. Yes ☐ No ☐ Have you had bleeding gums often in the past year?

Neurological

11. Yes ☐ No ☐ Do you have problems with dizziness?
12. Yes ☐ No ☐ Do you frequently feel nervous or upset?
13. Yes ☐ No ☐ Do you often feel discouraged or depressed?
14. Yes ☐ No ☐ Are you subject to fainting or blackout spells?
15. Yes ☐ No ☐ Do you have seizures?
16. Yes ☐ No ☐ Are you often bothered with bad headaches?

Musculoskeletal

17. Yes ☐ No ☐ Do you have frequent swelling, inflammation, or stiffness in any joints?

Immunological

18. Yes ☐ No ☐ Do you have frequent skin rashes?

Respiratory

19. Yes ☐ No ☐ Are you troubled with a chronic cough?
20. Yes ☐ No ☐ Do you regularly cough up much sputum?
21. Yes ☐ No ☐ Have you coughed up blood in the past year?
22. Yes ☐ No ☐ Do you have problems with shortness of breath?

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Name: _____ Date of Birth: _____

Cardiovascular

23. Yes ☐ No ☐ Do you have problems with chest pain?
24. Yes ☐ No ☐ Do you have chest pressure or tightness when excited?
25. Yes ☐ No ☐ Do you have chest pressure of tightness with walking or working?
26. Yes ☐ No ☐ Does your heart often pound or race?
27. Yes ☐ No ☐ Are your feet or legs unusually swollen by the end of the day?

Gastrointestinal

28. Yes ☐ No ☐ Are you often troubled by stomach discomfort, indigestion, or heartburn?
29. Yes ☐ No ☐ Have you recently noted blood in your stool?
30. Yes ☐ No ☐ Have you had a recent change in bowel habits?
31. Yes ☐ No ☐ Are you bothered by itching around the rectum?

Genitourinary

32. Yes ☐ No ☐ Have you had a recent change in bladder habits?
33. Yes ☐ No ☐ How many times do you get up at night and empty your bladder? _____ times.
34. Yes ☐ No ☐ Do you have burning or pain when empting your bladder?
35. Yes ☐ No ☐ Do you have problems starting to empty your bladder?
36. Yes ☐ No ☐ Have you seen blood in your urine?
37. Yes ☐ No ☐ Have you noted any stones in your urine?
38. Yes ☐ No ☐ Do you have problems emptying your bladder completely?

Hematological

39. Yes ☐ No ☐ Do you bleed excessively when cut?

Reproductive

40. Yes ☐ No ☐ Do you have difficulties in your sex life?
41. Yes ☐ No ☐ Women only: Is your menstrual cycle regular?
42. Yes ☐ No ☐ Women only: If you have reached menopause, do you still have any bleeding?
43. Yes ☐ No ☐ Women only: Are you pregnant? Date of last menstrual cycle? _____
44. Yes ☐ No ☐ Women only: Have you taken birth control pills in the last 2 weeks?
45. Yes ☐ No ☐ Women only: Do you notice a change in back discomfort with your menstrual cycle?

Metabolic/Endocrine

46. Yes ☐ No ☐ Do you have generalized weakness?

Please explain any "Yes" answers: _____

_____

_____

_____

_____

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Surgery/Injection Screening Form:

Name: _____ DOB: _____

Do you see a cardiologist? Yes ____ No ____ Dr's. Name: _____

OR

Have you seen a cardiologist in the last 5 years? Yes ____ No ____

Dr. Name: _____ Town: _____

Do you have a Pacemaker or Implanted Defibrillator? Yes ____ No ____

Do you have a cardiac stent? Yes ____ No ____ When and where was it placed?

_____

Who is your primary care physician? Dr's. Name: _____

Has your primary care Dr. done any cardiac testing? Yes ____ No ____

Have you been hospitalized in the past 3 months? Yes ____ No ____ Where: _____

Do you have a history of MRSA (STAPH) Infection? Yes ____ No ____

Do you see any other physicians or medical specialists? Yes ____ No ____

Name: _____

Town: _____ Specialty: _____

I, _____, authorize any of the above mentioned physicians and medical facilities to release any of my medical records, upon request, to:

_____

Patient signature: _____ Date: _____

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ACCIDENT / INJURY INFORMATION

Patient Name: _____ Date: _____
Reason for today's appointment: _____
Affected body area(s) _____ ☐ Left ☐ Right ☐ Both
Is the problem related to an accident or injury of any kind? ☐ Yes ☐ No
If yes, please complete the following information:
What is the date of injury? _____ When did the symptoms occur? _____
(Please give approximate date)
How did the injury occur? _____
_____
Where did the injury occur? _____
_____
Have you been treated for this condition before? ☐ Yes ☐ No
Name of treating physician _____
Did you have x-rays taken? ☐ Yes ☐ No If yes, where? _____
Are you presently taking medications? ☐ Yes ☐ No If yes, please list: _____
_____

Is this injury work related: ☐ Yes ☐ No If yes, has it been reported to your employer? ☐ Yes ☐ No
Employer contact: _____ Phone #: _____
Is this an accepted workers compensation care? ☐ Yes ☐ No
Has a first report of injury been done? ☐ Yes ☐ No If yes, by which physician? _____
Insurance name: _____ Claim #: _____
Address: _____

Is this injury related to an auto accident? ☐ Yes ☐ No
If yes, is there auto insurance with medical coverage (med pay)? ☐ Yes ☐ No
Insurance name: _____ Claim #: _____
Address: _____
Contact person: _____ Phone #: _____

Is there a third party responsible for payment? ☐ Yes ☐ No
Is there litigation involved? ☐ Yes ☐ No
Attorney name: _____ Phone #: _____

Patient Signature: _____ Date: _____

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NEW PATIENT REGISTRATION

PLEASE PRINT Date _____

Patient _____
Last Name First Name Middle Initial

DOB _____ Age _____ Male _____ Female _____ Home Phone _____
Address _____ Cell Phone _____
City _____ County _____ State _____ Zip _____
Marital Status ___ Married ___ Single ___ Divorced ___ Widowed Social Security # _____
Driver's License # _____ Email Address _____
Patient Employed By _____ Occupation _____
Business Address _____
City _____ State _____ Zip _____ Business Phone _____
Emergency Contact _____ Relationship _____ Phone Number _____
Preferred Pharmacy: _____ Cross Streets: _____
Preferred Reminder Contact Method (choose all that apply): ____ Phone ____ Email ____ Text (Cell)
Race: _____ Ethnicity: Hispanic / Not Hispanic Preferred Language: _____

Responsible Party (if different from above) _____ Relationship _____
Address _____ ____ Birthdate _____
City _____ State _____ Zip _____ Home Phone _____
Social Security # _____ Driver's License # _____
Employer _____
Business Address _____
City _____ State _____ Zip _____ Business Phone _____

Spouse of Other Parent/Guardian Information (Please circle one)
Name _____ Home Phone _____
Employer _____ Business Phone _____

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 present insurance cards to front desk)
Name of Insurance Company _____ Policy Holder's Name _____
Policy Holder's DOB _____ Employer _____
Billing Address _____
Policy Number _____ Group Number _____
Name of Secondary Insurance _____ Policy Number _____ DOB _____
Billing Address _____ Employer _____
Policy Number _____ Group Number _____
Worker's Comp Carrier _____ Claim Number _____
Date of Injury _____ Adjuster's Name _____ Phone # _____

Referring Physician of Person _____
Business Address _____
City _____ State _____ Zip _____ Business Phone _____
Family Physician _____
Business Address _____
City _____ State _____ Zip _____ Business Phone _____

HIPAA Omnibus Notice of Privacy Practices

Revised 2013

Sierra Pacific Orthopedics

1270 E. Spruce

Fresno, CA 93720

(559) 256-5200

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of

your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

HIPAA COMPLIANCE OFFICERS: Annette Hopkins, Chris Johnston, Jodie Keller, Laurie Harland
PHONE: (559) 256-5200

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

SIERRA PACIFIC ORTHOPEDICS
The Strength of Experience.

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Sierra Pacific Orthopedics' Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Type or Print) Date

Signature

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Financial Policy

Welcome to Sierra Pacific Orthopedics. We would like to take this time to acquaint you with the financial policies of our group. Our goal is to provide you with the highest quality care possible. In order to maintain our goal, we have highly trained staff available to help answer questions that you may have regarding your treatment, insurance or billing issues. Please do not hesitate to ask for assistance.

Our office contracts with most Preferred Provider Organizations (PPOs) as well as many Health Maintenance Organizations (HMOs). You must verify that Sierra Pacific Orthopedics is contracted with your health plan. If your health care expenses are covered by one of these plans, we require that you pay all deductible, co-pay and co-insurance amounts at the time of service. We will bill your plan for the remaining balance. If we do not contract with your plan, we require payment in full at the time of service. Please remember medical services are rendered directly to each patient at their request, therefore, each patient is responsible to us for payment.

By signing below, you acknowledge that Sierra Pacific Orthopedics is NOT a Medi-Cal Provider, and you hereby confirm that you (or the patient, if you are signing as a responsible party) are not a Medi-Cal patient. You further acknowledge that failure to provide accurate insurance information or information about your Medi-Cal status could be considered fraudulent and could carry civil and criminal penalties. Additionally, this could result in our office terminating the professional relationship with the patient and/or billing you as a private pay patient.

A copy of your insurance card is required at each visit. It is your responsibility to notify Sierra Pacific Orthopedics of any changes in your coverage status. This information will be kept in your medical file.

Charges billed to your insurance plan will be noted on your account until payment and/or an explanation of benefits (EOB) is received from the insurance company. We will bill your plan directly as a service to you, but not in substitute of your primary responsibility for payment. Charges which have not been paid by the insurance are the patient's responsibility. All patient due balances are expected to be paid upon receipt of an EOB. We may require a guarantee of payment in the form of a credit card which will be used to satisfy future patient responsibility balances. Alternatively, patients may place a deposit on account toward future balances.

We may provide account balance and payment notification via SMS message (text), email and/or phone in addition to our normal customary process and you herby grant authorization for us to do so. Request for alternate methods of payment will be reviewed on an individual basis. Every effort will be made to come to an agreed upon method of payment.

There will be a $20 service charge on all returned checks.

Some of the physicians at Sierra Pacific Orthopedics have a financial interest in the following facilities:

Fresno Surgical Hospital
Summit Surgical

A list of these physicians is available at the administrative offices of Sierra Pacific Orthopedics on the 3rd floor.

I have read the above policy and agree to comply with its provisions. I understand that I am responsible for payment for all medical services rendered. I understand that if I am covered by a third party payment service such as an insurance plan, your office may bill them directly as a convenience to me, but I am personally responsible for such charges until they are paid in full.

***Assignment and Release**: I hereby authorize my insurance benefits to be paid directly to SIERRA PACIFIC ORTHOPEDICS and that I am financially responsible for services that the insurance considers to be non-covered. I authorize SIERRA PACIFIC ORTHOPEDICS to release any information required to process my claim.*

Patient Name: _____ Date of Birth: _____

Responsible Party Signature: _____ Date: _____