CHRISTOPHER C. LAI, M.D. ORTHOPEDIC SURGERY, APC.

SS#_______________ REFERRED BY _______________

NAME____
NOMBRE LAST (APELLIDO) FIRST (NOMBRE) MIDDLE

ADDRESS_______________ TELEPHONE _______________
DOMICILIO TELEFONO

CITY, STATE, ZIP CODE_______________ EMAIL_______________
CIUDAD, ESTADO, CODIGO POSTAL CORREO ELECTRONICO

BIRTHDATE________ AGE___ MALE___ FEMALE___ MARTIAL STATUS (CIRCLE) M S W D SEP
FECHA DE NACIMIENTO EDAD HOMBRE MUJER ESTADO CIVIL(CIRCULE) C S V D SEP

EMPLOYER (PATIENT)_______________ OCCUPATION_______________
EMPLEADOR DEL PACIENTE OCCUPACION

BUSINESS ADDRESS_______________ TELEPHONE_______________
DIRECCION TELEFONO

SPOUSE OR PARENT'S NAME_______________ INSURED'S DOB#_______________
NOMBRE DE ESPOSO/A O PADRES DEL PACIENTE INSURED'S SS#_______________

EMPLOYER (SPOUSE) OR (PARENTS)_______________ OCCUPATION_______________
EMPLEADOR DE ESPOSO/A O DE LOS PADRES DEL PACIENTE OCCUPACION

WORKMAN'S COMPENSATION: YES___ NO___ DATE OF ACCIDENT_______________
COMPENSACION DE TRABAJADORES SI NO FECHA DE ACCIDENTE

COMP. CARRIER_______________ TELEPHONE_______________
NOMBRE DE LA ASEGURANZA NUMERO DE TELEFONO

ADDRESS_______________ CLAIM NUMBER_______________
DIRECCION NUMERO DE CASO
_______________ ADJUSTER_______________
NOMBRE DE AJUSTADOR

PERSONAL INSURANCE: YES___ NO___ INSURANCE COMPANY_______________
ASEGURANZA PERSONAL SI NO NOMBRE DE LA ASEGURANZA

POLICY NUMBER_______________ GROUP NUMBER_______________
NUMBERO DE POLIZA NUMERO DE GRUPO

MEDICARE NUMBER_______________ MEDI-CAL NUMBER_______________
NUMERO DE MEDICARE NUMERO DE MEDI-CAL

***EMERGENCY NAME AND NUMBER (NOT RESIDING IN THE SAME HOUSEHOLD)**
NOMBRE Y NUMERO DE TELEFONO EN CASO DE EMERGENCIA (ALGUIEN QUE NO RESIDA EN SU CASA)

NAME_______________ TELEPHONE_______________ RELATIONSHIP_______________
NOMBRE NUMERO DE TELEFONO RELACION

THE ABOVE PATIENT INFORMATION IS HEREBY GIVE TO THE CLINIC FOR PURPOSE OF RECEIVING MEDICAL CARE. AS GUARANTOR OF THE ACCOUNT, I UNDERSTAND THE CLINIC CREDIT POLICIES AND AGREE TO PAY UNDER THE TERMS OF THE CLINIC AS OUTLINED.
LA INFORMACION AQUE PROVEIDAPOR EL PACIENTE SE HA PROPORCIONADO A LA OFICINA CON EL PROPOSITO DE RECIBIR CUIDADO MEDICO. COMO RESPONSIBLE DE ESTA CUENA, YO ENTIENTDO LA POLIZA DE CREDITO DE ESTA OFICINA Y ME COMPROMETO A PAGAR BAJO LOS TERMINOS DE ESTA OFICINA COMO SE INDIQUE.

GUARANTOR'S SIGNATURE_______________ DATE_______________
FIRMA DE LA PERSON RESPONSIBLE FECHA

****INCOMPLETE FORMS WILL NOT BE ACCEPTED. ****

PATIENT HISTORY (PLEASE PRINT) DATE

Last Name First Name Middle Initial

CHIEF COMPLAINT

What troubles you most?

Please check appropriate options

PAIN____ **WEAKNESS**____ **SWELLING**____
LIMP____ **BLEEDING**____ **STIFFNESS**____

What part(s) of your body?
Have you had any previous similar illness or injury?
If yes, when?

HISTORY OF CHIEF COMPLAINT

Date you first noticed this
If an accident, date of accident
Place of accident
How did it start

If injury, describe in detail how it happened

If auto accident, describe in detail how it happened

Where were you sitting?
Were you thrown from the car?
Were you unconscious?
Were you thrown around in the car?
Were you taken to a hospital?
If yes, which hospital?
Name of the doctor who saw you?
Treatment?

Did you have x-rays taken?
If yes, where are the x-ray films?

AT PRESENT

How many blocks can you walk?
How long can you stand for?
How long can you sit for?
How many pounds can you lift?
Are you right or left handed?
Body weight height

LIST OF ALL CURRENT MEDICATIONS

LIST ALL PRIOR SURGERIES WITH DATE (MO/YEAR)

DESCRIPTION OF PAIN

Sharp Dull
Pins and needles

Does pain travel? If so where?
Head Shoulder
Hand Elbow
Groin Hip
Knee Ankle
Coughing increase pain?
Does coughing make pain travel?
If yes, where?
Straining increase pain?
Straining make pain travel?
If yes, where?
What else increases pain?

What decreases pain?

Does the pain awaken you at night?
Is pain worse in the morning or the evening?

WORK HISTORY

What kind of work do you do?
Have you missed any work?
If yes, how many days?
Last day worked full time?
Last day worked part time?

Do you have any of the following (yes/no)

Diabetes Hypertension
Cancer Heart disease
Asthma Allergies
Allergies to medication(s)?
If yes, which medication(s)?

Additional medical history not listed?

Pharmacy

Are you a smoker? ☐ Yes ☐ No

***Please attach additional pages if any space exceeds.**

HIPAA Notice of Privacy

Christopher C. Lai, M.D.
196 W. Legion Rd.
Brawley, CA 92227
Telephone Number: (760) 344-9093

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 describes how we 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 our health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, if necessary, to a home health agency that provides care to you. Or, 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.

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 activities, employee review activities, training of medical students, licensing, 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 appointments.

We may use or disclose your protected health information in the following situations with your authorizations. These situations include, as required by Law: Public Health issues, Communicable disease, health oversight, abuse or neglect, Food and Drug Administration requirement, legal proceedings, law enforcement, coroners, funeral directors and organ donation research, criminal activity, military activity and national security, Worker's Compensation Inmate Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164 500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by Law.

You may revoke this authorization at any time, in writing, except to the exam 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

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protect 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 a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request, to receive confidential communications 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 may have the right to have your physician amend 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 we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by posting any changes in the patient waiting area. You then have the right to object or withdraw as provided in this notice.

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 privacy contact (Krystal Perdomo, Office Coordinator) of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before April 4, 2003.

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: ______________________ Signature: ______________________ Date: ______________

CHRISTOPHER C. LAI, M.D.

BOARD CERTIFIED ORTHOPEDIC SURGEON
ORTHOPEDIC SURGERY, SPORTS MEDICINE, ARTHRITIS CENTER
JOINT REPLACEMENT

OFFICE SERVICE FEES

$20.00	-All forms are a minimum of $20.00 depending on how many signatures required. (Disability, FMLA, jury duty excuse, DMV parking placards, private insurance, etcetera)
$25.00	-If you need to cancel your appointment with us, you must do so at least 24-hours in advance. Failure to do so will result in this $25.00 fine.
$25.00	-Minimum for medical Records. (Price may increase depending on file.)
$350.00	-Self-pay initial consultation, not including x-ray fees.
$200.00	-Self-pay follow up, not including x-ray fees.

OFFICE POLICIES

- If you are 15 minutes late to your appointment, you will need to be rescheduled due to other patients' scheduling.
- Any and all co-pays will be collected at time of service.
- All billing information is required at time of service.
- Our office requires that you provide us with your social security number and/or the policy holder's social security. If this information is not provided to us, we have the right to refuse service.
- If your insurance has changed since the last time you were seen, please notify the front desk immediately to better serve you.

I acknowledge that I have read and understood the office service fees/policies listed above and I am willing to comply accordingly.

Print Name:________________________ Signature:___________________________ Date:__________

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of this Notice of Privacy Practices of Dr. Christopher C. Lai Orthopedic Surgery, APC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Office Coordinator, Krystal Perdomo at (760) 344-9093.

If you have any questions about our Notice of Privacy Practices, please contact:

Dr. Christopher C. Lai Orthopedic Surgery, APC
Krystal Perdomo, Office Coordinator
196 West Legion Road
Brawley, CA 92227

Phone (760) 344-9093
Fax (760) 344-4309

I acknowledge receipt of the Notice of Privacy Practices of Dr. Christopher C. Lai Orthopedic Surgeon, APC.

Signature ______________________________ Date ______________________
(Patient/Parent/Conservator/Guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only in no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgment was not obtained.

Signature of provider representative ______________________ Date ______________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby assign to Dr. Lai, any and all benefits for service otherwise payable to me for the services as described on attached claim. I understand that I am responsible for payment of all charges not covered by insurance.

Guarantor's Signature ______________________________ Date ______________________

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorized Dr. Lai to release or obtain any information required in the course of my treatment, payment, and/or health care operations.

Guarantor's Signature ______________________________ Date ______________________