Warren G. Kramer III, MD, Sten E. Kramer MD, Ryan S. Labovitch MD,
Jennifer A. Coy MS, PA-C, Robin L. Ray MS, PA-C

Name: _____ **Date of Birth:** _____/___/_____ **Age:** _____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Sex: ❑F ❑M **Height**: _____ **Weight**:_____ **Race**:_____ **Ethnicity**:_____ **Primary Language:** _____

Patient's Marital Status_____ **Emergency Contact:** _____ **Phone:** _____

Patient's Address_____ **City**_____ **Zip**_____

Name of Responsible Party if Patient is a Minor_____

Insurance_____ **Main subscriber on the insurance**_____ **DOB**_____

Patient SS#_____ **Home Phone** ( )_____ **Cell**( )_____

Email_____ **Patient's Employer** (If minor, Responsible Party) _____

Occupation_____ **Work Address**_____ **Work Tel** ( ) _____

Spouse's Employer_____ **Spouse's Name**_____ **Work Tel** ( ) _____

Referred here by (check one) ❑Self ❑Family ❑Friend ❑Doctor ❑Other Health Professional

Name of person making referral: _____

Primary Care Physician/Internist: _____ Cardiologist: _____

(Would you like records sent to any of these Doctors? (Yes/No) **Please Circle One**

Have you had a recent medical evaluation by one of these doctors? _____ Name of Doctor: _____

What is your primary problem for being seen today?

Where is your Pain? **Body Part:** _____ **Right or Left (circle one)**

Length of Symptoms:_____ **Date of Injury**:_____

Describe your injury and symptoms: _____

_____

Does your pain **Radiate** up or down? YES NO (If yes: up down both)

Do you have any weakness? YES NO

Do you have **Numbness and/or tingling** YES NO

Have you had **Surgery** on this body part? YES NO

If yes, describe the procedure: _____

Date(s) / Surgeon(s): _____

Have you had **Physical Therapy**? YES NO If yes, how many visits ____

Have you had any **Images** taken on this body part? MRI CT EMG Bone Scan X-ray (circle all that apply)

Findings:_____

Have you had an **Injection**(s)? YES NO If yes, how many _____

What **Pain Medicine** are you taking for this problem? _____

Past Medical History:

In the past 4 weeks, have you had a cough, cold, sore throat or bronchitis that required treatment? _____

List any medical conditions you have: (ex High blood pressure, mitral valve prolapsed)

_____

Any Known Drug Allergies: _____

Type of Reaction: _____

Name: _____

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Current Medications (List any medications you are taking. Include such items as aspirin, vitamins, calcium, **DIET PILLS** ETC)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Have you used blood thinners, such as **Coumadin, Heparin, Aspirin, Ibuprofen, Xarelto, Pradaxa or Plavix**, with in the past 2 weeks? **Yes/No** If yes, please list: _____

Have you ever taken steroids, such as Prednisone or Medrol, by mouth? ___ If yes, when and for how long? _____

Do you take medication for Osteoporosis such as Fosamax, Actonel, or Boniva?_____

List All Surgeries	Date	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Social and Family History

Have you ever smoked? □ Yes □ No Quantity/Amount: _____ If quit, how long ago?_____

Do you drink alcohol? □ Yes □ No number per week ___Has anyone ever told you to cut down on drinking? □ Yes □ No

Do you use recreational drugs, such as marijuana, cocaine, or methamphetamine? □Yes □No If yes, please list_____

Name: _____

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ASSIGNMENT AND AUTHORIZATION TO PAY PHYSICIAN

For value received, I hereby assign to Warren G. Kramer, III, M.D., Inc., *and/or* Sten Erik Kramer, M.D., Inc, *and/or* Ryan S. Labovitch, M.D *and/or* Jennifer Coy MS, PA-C *and/or* Robin L. Ray MS, PA-C *all sums payable to me under any policy of insurance for any portion of the charge for the diagnosis and treatment described below. I further hereby assign payment directly to* Warren G. Kramer, III, M.D., Inc., *and/or* Sten Erik Kramer, M.D., Inc., and/or Ryan S. Labovitch, M.D., Inc. *and/or* Jennifer Coy MS, PA-C *and/or* Robin L. Ray MS, PA-C *of such sums which would otherwise be payable to me, but not to exceed said charge. I understand that I am financially responsible to the physician for charges not covered by this assignment and authorization.*

Date:_____ Signed:_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Warren G. Kramer, III, M.D., Inc., and/or Sten Erik Kramer, M.D., Inc. and/or Ryan S. Labovitch, M.D., Inc., and/or Jennifer Coy MS, PA-C and/or Robin L. Ray MS, PA-C to release said insurance company any information regarding my illness and/or injury including laboratory reports, x-rays and diagnosis which is needed by said insurance company to process the claim.

Date:_____ Signed:_____

APPOINTMENT AND CANCELLATION POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/ cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

CANCELLATION OF AN APPOINTMENT

If it is necessary to cancel your scheduled appointment we require that you call 24 hours in advance or there will be a **$50.00** fee. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. To cancel appointments please call (949) 720-1944. If you do not reach the receptionist you may leave a detailed message with the exchange. We will keep a record of the cancelled appointment in your records.

NO SHOW POLICY

A "no show" is someone who misses an appointment without cancelling in 24 hours in advance. No shows inconvenience those individuals who need access to medical care in a timely manner. Late cancellations will be considered as a "no show". A failure to be present at the time of a scheduled appointment will be recorded in the medical record as a "no show". For any "no show" the patient will be sent a letter alerting them to the fact that they have failed to show up for a routine or follow up appointment and did not cancel the appointment. A fee of **$50.00** will be billed to their account and sent to the patient's home. For consults, in-office procedures and new patients there will be a fee of **$50.00**.
A copy of the letter will be placed in the patient's file.

Date:_____ Signed:_____

NOTICE OF PRIVACY PRACTICES

Notice to Consumers

Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2322 www.mbc.ca.gov

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. Insurance Portability and accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

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5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of you health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the
information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billings records, but not including psychotherapy notes. You must submit your request in writing to our Practice Privacy Officer at 1401 Avocado Ave., Suite 307, Newport Beach, California 92660.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Practice Privacy Officer at 1401 Avocado Ave., Suite 307, Newport Beach, California 92660
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Practice Privacy Officer at (949) 720-1944. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
If you have any questions regarding this notice or our health information privacy policies, please contact our Practice Privacy Officer at (949) 720-1944.

I hereby acknowledge that I have been presented with a copy of *Warren G. Kramer, III, M.D., Inc.,* and/or *Sten Erik Kramer, M.D., Inc., and/or Ryan S. Labovitch, M.D., Inc.* and/or *Jennifer Coy MS, PA-C* and/or *Robin L. Ray MS, PA-C* Notice of Privacy Practices.

Date:_____ Signed:_____

Kramer Orthopedics Financial Policy

Kramer Orthopedics is committed to providing you the best medical care. In order to achieve this goal, you must have a clear understanding of our financial policy which is important in order to sustain a professional relationship.
As a patient entering our practice, we will require identifying information, including a current Driver's License or State ID Card, and insurance ID cards.

Payment methods: Kramer Orthopedics accepts Cash, Checks, Visa, MasterCard, and Discover.

Uninsured or Self-Pay Patients: Payment is due in full at the time of service.

Insurance Billing: It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. Kramer Orthopedics will follow the insurance contract guidelines for billing and collections. Please verify if Kramer Orthopedics is a preferred provider with your insurance plan prior to receiving services. If you do not have your insurance card available and we do not have one on file, you will be required to pay cash for the services rendered that day.

Covered California: Kramer Orthopedic Providers ARE NOT participating Providers in Blue Cross PPO coverage purchased through Covered California exchange.

Co-pays & Deductibles: All co-pays, unmet deductible, or patient share of cost is due at the time of service. For co-pays not paid at the time of service, $15 Administrative Fee will be added to cover the cost of billing and collections.

Surgery Deposits: Deposits are due in full at the time of the pre op visit. Deposit amounts vary based on your level of benefits and include any unpaid deductible or co-insurance. Kramer Orthopedics charges only for professional services provided by your physician. You will receive separate billing, which may include a bill after the surgery for the Physician, Facility, and/or the Anesthesiologists.

Durable Medical Equipment (DME): DME is provided as ordered by your physician. Your insurance will be billed in accordance to your insurance coverage guidelines; however, you will be responsible for any unmet deductible and co-insurance rates. Some DME products are not covered by insurance, in which case, you will be notified of the item and its cost. DME is intended for single patient use only and is not subject to returns.

Referrals for Physician & Ancillary Services: When being referred to an outside organization as part of your care (i.e. Physical therapy, MRI, DME Providers, Physicians, etc.), Kramer Orthopedics does not verify if these organizations are preferred providers with your insurance plan. Please verify this directly with your insurance company prior to obtaining services.

If you choose to seek care at a non-preferred/ non-participating provider for ancillary services, you may be responsible for higher copayments and costs in excess of your insurance company's allowable amounts, up to the non-preferred provider's total billed charges. Patients accept the financial responsibility for any additional cost for service when obtaining services from a non-preferred/non-participating provider regardless of being referred by Kramer Orthopedics. For assistance locating a preferred provider for ancillary services, you may contact your insurance company directly.

Charges for Disability Forms: We are happy to complete disability and FMLA forms. Due to the time and medical expertise involved, we charge a fee of $50 for the initial paperwork, and $25 for extensions. This fee will be collected prior to releasing the form. It will be your responsibility to complete your portion of the form and return it to the appropriate institution.

CD of X-rays: If you would like a copy of your x-rays put on a CD for your personal use, there will be charge of $10.

Returned Checks: There will be a $25.00 fee charged for any returned checks. We will be unable to accept your check for any services thereafter.

Collections: If unable to make payment in full, contact our in house billing department immediately at (949) 720-1944 to make payments arrangements. If the account is referred for collections, you will be responsible for the balance of your account plus a collection agency charge of 25% of the balance and reasonable attorney's fees. If your account becomes delinquent or is referred for collections, your provider and/or any collection agency of your provider has authorization to obtain your credit report to assist them in the collection of your bill.

By signing below you are acknowledging that you have received, read, and agree to Kramer Orthopedics Financial Policy.

Financial Policy (attached)

I have read the Financial Policy. I understand and agree to the Financial Policy.

Print name: _____

Sign: _____

Date: _____

Thank you

Kramer Orthopedics