

The Ryu Hurvitz Orthopedic Clinic

PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____

Date of Birth: _____ SS#: _____ Marital Status: _____ Gender: M / F

Address: _____

City/State/Zip Code: _____

Phone Home: _____ Mobile: _____

Email: _____

Emergency Contact: _____ Phone Number: _____

Employer: _____ Preferred Pharmacy: _____

Referring Physician: _____

I hereby authorize discussion of my general medical condition, diagnosis, treatment, payment and health care options with: (Check all that apply)

Spouse/Name _____ Children/Name _____

Other/Name _____

INJURY

Body Part Injured: _____ () Right () Left Date of injury? _____

Was it work-related? _____ Brief description of the injury: _____

PRIVACY NOTICE ACKNOWLEDGEMENT:

I acknowledge that a copy of the Notice of Privacy Practices from The Ryu Hurvitz Orthopedic Clinic has been made available to me. I am aware that a paper copy of this Notice will be provided at my request.

Initials: _____

FINANCIAL POLICY

Please understand that payment of your bill is part of this treatment and care. Please remember that insurance is not a substitute for payment.

For your convenience, you will find the answers to a variety of commonly-asked questions below.

*We accept payment by cash, check, VISA, MasterCard or American Express.

The Ryu Hurvitz Orthopedic Clinic

*Your financial responsibility depends on a variety of factors: Deductible, Co-Insurance and Co-pays. You must also be eligible at the time of service. If you do not understand your benefits, please contact your insurance company member services for detailed explanation.

*It is the patient's responsibility to inform us promptly of any changes regarding insurance coverage, address or phone number.

*If you cannot make it to your appointment, we ask that you notify us or re-schedule your appointment *at least* 24 hours in advance.

*The Ryu Hurvitz Orthopedic Clinic has the right to send you to collections for any patient balance that is still outstanding after 3 monthly statements have been sent to you, or if patient balance is still outstanding 6 months after insurance has processed claims, unless arrangements have been made.

*If you are having surgery, the Surgery Coordinator will contact your insurance company for benefits and pre-certification/authorization. You may be required to pay a pre-surgical deposit, depending on your coverage and deductible.

*A parent or legal guardian must accompany patients who are minors on the patient's visits. This accompanying adult is responsible for signing all the paperwork on behalf of the patient.

*The doctors are PPO providers and they take Medicare. Below is a list of plans that they are NOT contracted with:

- Dr Ryu is NOT contracted with: Anthem Blue Cross Pathway or Pathway X, Blue Shield SHOP, State Medi-Cal or HMOs (except for Physicians Choice of Santa Maria and Blue Shield HMO in Santa Maria with a referral from PCP).
- Dr Hurvitz is NOT contracted with: Anthem Blue Cross Pathway or Pathway X, Blue Shield Exclusive/IFP, Blue Shield SHOP, United Health Care Core/W500, State Medi-Cal or HMOs (except for Physicians Choice of Santa Maria and Blue Shield HMO in Santa Maria with a referral from PCP).
- Dr Yau is NOT contracted with: Anthem Blue Cross Pathway or Pathway X, Health Net, State Medi-Cal or HMOs.

*If your doctor is not contracted with your plan, he will still be glad to see you. We will still bill your insurance and they will process the claims as out-of-network. We do collect at the time of service.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayment, coinsurance, and deductible, are my responsibility.

I authorize my insurance benefits be paid directly to Dr. Richard Ryu, Dr. Graham Hurvitz or Dr. Jervis Yau.

I authorized Dr. Richard Ryu, Dr. Graham Hurvitz or Dr. Jervis Yau to release pertinent medical information to my insurance company when requested, or to facilitate payment of claim.

Date

Signature

Printed Name

THE RYU HURVITZ ORTHOPEDIC CLINIC
Problem Questionnaire

Last Name: _____ First Name: _____ Age: _____

1. Where is your main problem? _____

Right () Left () Bilateral ()

2. Are you experiencing the following problems (circle all that apply):

- | | |
|---------------|----------------------------------|
| 1. Pain | 5. Unstable or Dislocating Joint |
| 2. Night Pain | 6. Swelling |
| 3. Weakness | 7. Numbness |
| 4. Stiffness | 8. Other (Explain) |

3. How did your problem start? Please Explain.

4. How long have you had this problem, approximately? _____

(Give # of days, weeks, months, or years)

5. Is your problem (please circle): Improving Worsening Staying the Same

6. Is your pain or problem (please circle): Intermittent or Constant

7. What makes your problem worse?

- | | | |
|-------------|----------------------------------|---------------------|
| 1. Exercise | 5. Repetitive motions | 9. Nothing |
| 2. Sitting | 6. Overhead activities | 10. Other (Explain) |
| 3. Standing | 7. Coughing, Sneezing, Straining | _____ |
| 4. Walking | 8. Rest | _____ |

8. Are you right or left handed? _____ Right _____ Left

9. What helps your problem? _____

10. Have you had this problem before? Yes or No If yes, when and for how long? _____

11. Have you had previous medical treatment for this? Yes or No (If yes, please explain)

12. Are you taking any medications specifically for this problem? If so, please specify:

13. Have you tried the following conservative options: (check the ones you have tried)

- | | |
|----------------------------------|------------------------|
| Physical therapy () | Tylenol () |
| Aleve/ Ibuprofen/ Advil/ Etc () | Home Exercise () |
| Rest () | Aspiration () |
| Icing/ Hot Pads () | Steroid Injections () |

14. Who is your primary care physician or internist? _____

15. What tests have you had for this problem? At what facility? _____

- | | |
|-------------|-----------------------|
| Xrays () | Nerve Test ((EMG) () |
| CT Scan () | Ultrasound () |
| MRI () | Other _____ |

16. If you are working, does your job require the following?

- | | |
|------------------------------------|-------------------------|
| Heavy Lifting () | Extending Walking () |
| Frequent Bending or Lifting () | Continuous Standing () |
| Frequent Squatting or Kneeling () | Sitting () |
| Climbing () | Repetitive Motions () |

17. On a scale of 1 to 10, how bad is your pain or problem now? _____

18. Please list all of your current medications and supplements?

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

19. Do you have any medication allergies? Yes or No If yes, please list allergy & reaction:

20. Do you have any food or metal allergies? Yes or No If yes, please list allergy & reaction:

21. Do you have a history of any of the following illnesses, please circle all that apply to you:

- | | | |
|------------------------|----------------|--------------------------------|
| 1. Heart Disease | 4. Blood Clots | 7. Tuberculosis |
| 2. High Blood Pressure | 5. Stroke | 8. Cancer: if yes, which type: |
| 3. Diabetes | 6. Hepatitis | _____ |

22. Do you have any other medical conditions? (please list) _____

23. Please list any prior surgeries with approximate date(s): _____

24. Does anyone in your immediate family have any major medical problems such as those listed

above? Yes or No If yes, please explain: _____

25. Marital Status? Single Married Divorced Widowed Domestic Partner

26. Do you have any children? Yes or No If so, how many? _____

27. What is your occupation: _____

28. Do you plan to apply to any of the following programs because of this problem?

Disability: Yes or No

Worker's Compensation: Yes or No

29. What is your present work status?

Not Working

Part Time

Full Time

Retired

30. Do you drink any alcohol? Yes or No How many drinks per week? _____

31. Do you smoke tobacco? Yes or No How many packs per week? _____

32. Do you use illicit drugs? Yes or No If so, what? _____

33. Please check if you are currently having problems in the following areas.

Eyes ()

Integumentary/ Skin ()

Ear/ Nose/ Throat ()

Neurological ()

Cardiovascular/ Heart ()

Psychiatric ()

Respiratory ()

Endocrine/ Hormones ()

Gastrointestinal ()

Genitourinary ()

Blood/ Thinning/ Clotting ()

Allergy/ Immunology ()

Musculoskeletal- Other than the condition you are being seeing for today ()

Please give details:

Weight: _____ lbs and Height: _____ ft _____ in

Signature of Patient, Parent, or Guardian: _____ Date: _____