

Patient Information

COPAY \$ _____

Today's Date: _____

Last name _____ **First name** _____ **MI** _____

Date of Birth _____ **Sex:** M F **SSN#** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Cell#:** _____

Work Phone _____ **Fax #** _____

Employer _____ **Email:** _____

Business address _____

City _____ **State** _____ **Zip** _____

Emergency Contact Name and Relationship to you: _____

Emergency Contact Ph#: _____ **Marital Status:** _____

Chief Complaint _____

Date of injury or onset _____ **Is this a work-related injury?** YES NO

How did you hear about this office? (please circle) Ins Co Website Yellow Pgs Friend Other _____

Who referred you to this office? _____

Primary Care Physician _____

Phone # _____ **Fax #** _____

Address _____ **City/ST** _____ **Zip** _____

Primary Insurance Company _____

Subscriber Name: _____ **SS#:** _____ **DOB:** _____

Employer Name & address: _____

Phone # _____ **Fax #** _____

Ins. Address _____ **City/ST** _____

Policy # _____ **Group #** _____

Industrial Carrier/Workers Comp OR secondary ins name _____

Sub Name _____ **SS#** _____ **DOI:** _____

Phone # _____ **Fax #** _____

Bill to Address: _____ **City/ST/ZIP** _____

Claim #: _____ **ID#** _____

Adj/Nurse Address: _____ **City/ST/Zip** _____

Adjuster Name: _____ **Nurse Case Mgr:** _____

Adj Ph#: _____ **Nse Ph#:** _____

Adj Fax #: _____ **Nse Fax:** _____

Patient: _____, ID _____ Date _____

12.)Do you have any Medical Problems?

- No
- Yes, please mark below/describe:**
- Anemia
- Bad Teeth
- Bleeding Problems
- Blood Clots
- Cancer
- Depression
- Diabetes
- Lung Problems:
 - Asthma
 - Emphysema
 - Other
- Heart Problems:
 - Angina
 - Arrythmia
 - Heart attack
- High Blood Pressure
- Kidney Disease
- Liver disease/hepatitis
- Stomach Ulcers
- Stroke
- Thyroid
- Tuberculosis
- Other

13)Do you have any other Muscle or Skeletal problems?

- No
- Yes, please list and describe**
- Neck, Back- upper, Back lower
 - Left Right
- Shoulder
- Arm
- Elbow
- Forearm
- Wrist
- Hand
- Hip
- Thigh
- Knee
- Leg
- Ankle
- Foot

14.)Do you have any other Problems?

- No
- Yes, please mark and describe**
- Cardiovascular
- Ears, Nose, Mouth, Throat
- Eyes
- Genitourinary system
- blood, lymph, or immune system
- Neurological or nerves
- Psychiatric
- Lungs or Respiratory
- Skin

15.)Has any one related to you by blood had any medical problems?

- No
- Yes, please list and describe**
- Heart problems
- Diabetes
- Cancer
- Other

16.)Have you ever Smoked Tobacco?

- No
- Yes, when and how much**

17.)Do you Drink more than 1 drink per day (7 drinks a week)?

- No
- Yes

18.)Are you married or do you live with a partner?

- No
- Yes, How long** _____

19.)Do you have Children?

- No
- Yes, how many? _____,ages? _____**

20.)What is your height and weight? _____

Paul B. Roache, MD

Orthopaedic Surgeon

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Office Hours: Monday through Friday 9am to 5pm

Prescription Refills: Refills can only be handled during regular office hours. Plan accordingly to allow 1 business day for processing. Have your pharmacy fax the refill request to speed up your order. The Emergency Operators cannot put through after-hour prescription refills. Requests arriving after the above office hours will not be processed until the following day.

After Hours: The Emergency Operators will only contact Dr. Roache (or the on-call physician) for the following:

- a. Post-Surgical patients with urgent concerns regarding a change in their condition.
- b. Current patients with an acute Orthopaedic Emergency.

Billing Questions: All questions should be directed to our business office- and to your insurance company.

PATIENT FINANCIAL RESPONSIBILITIES

By law and courtesy, we must inform our patients of our financial policies.

Payment in full: Full payment is customary and required at the time of your visit. You, as the patient, are financially responsible for the services provided.

Insurance coverage: You can meet your financial responsibility by being an eligible member of an insurance company with whom we are contracted. You must provide us with a valid insurance card prior to being seen by the doctor.

HMO Patients: In addition to your insurance card, you must have a valid referral from your primary care MD.

Deductibles: If your health plan has a deductible, you are responsible for payment at time of service if the deductible has not been met.

Co-payment: If your insurance company requires a co-payment, it is due at the time of service. This is a contractual and

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legal requirement for many health plan contracts.

Worker's Compensation:

In addition to your insurance card, you will need the following:

- a. your claim number
- b. your employer information and group number
- c. comp carrier name and address
- d. the name and contact information of your claims representative

If you do not currently have insurance or are a member of a health plan with which we are not contracted, payment in full is required at the time of your visit.

Assignment of Benefits:

Your signature on the signature page constitutes full assignment of benefits to our office if we bill your insurance plan, including Medicare. However, if your insurance company does not pay the claim, the bill will become your responsibility.

Payment Arrangements:

Payments may be made in cash, by check or credit card (Visa and Mastercard).

Cancellation Charges:

Appointments cancelled without a minimum of 24-hours notification may be charged the full appointment fee.

Service Charges/ Late Fees:

Any balance carried to the next billing cycle will be subject to a service charge at the following rates.

Account Balance	Fee per month
<\$10.00	\$1.00
\$11.00-\$100.00	\$10.00
\$100.00 and over	\$25.00

Collections:

If it becomes necessary to assign your account to a collection agency and/or an attorney, you will be responsible for all of our collection agency and attorney fees and costs.

We are happy to discuss with you any questions relating to the preceding information and thank you for choosing our office for your Orthopaedic needs.

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Assignment of Benefits:

I hereby assign all medical and/or surgical benefits to which I am entitled, including major medical benefits, Medicare, private Insurance, and other health plans, to Paul B. Roache, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by paid insurance. I hereby authorize said assignee to release all information necessary to secure payments.

Patient

Signature: _____ Date: _____

Print

Name: _____

HIPAA:

The **H**ealth **I**nformation **P**ortability **A**ccountability **A**ct is a Federal Law that gives individuals the right to request a restriction on the uses and disclosures of their protected health information. We are required by law to provide patients with a copy of the HIPAA regulations. We are also required by law to discuss how we intend to contact you. If any of the below are not satisfactory, cross them out and write an alternative. Your signature verifies that you have been offered a copy of the HIPAA regulations and that we have permission to:

- Call your home phone and leave a message with detailed information.
- Call your work and leave a message
- Mail information to your home address
- E-mail to your personal email non-medical information
- Fax to your designated fax number non- medical information.

Patient

Signature: _____ Date: _____

Print

Name: _____

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