Tri-Valley Orthopedic Specialists, Inc.
Solving Musculoskeletal Problems Since 1985

**In order to bill your Insurance, Please fill out the following information completely.**

## 1) PATIENT REGISTRATION

ACCT #: DR.: APPT. DATE:

| FIRST NAME | MIDDLE | LAST | BIRTH DATE | AGE |
|---|---|---|---|---|

| CIRCLE ONE MR. MS. MRS. MISS | SOCIAL SECURITY NO. | DRIVER'S LICENSE | ☐ MALE ☐ FEMALE |
|---|---|---|---|

| STREET ADDRESS | CITY | STATE | ZIP | HOME PHONE |
|---|---|---|---|---|

| WORK PHONE | CELL PHONE | EMAIL | DATE OF ILLNESS OR INJURY |
|---|---|---|---|

MAY LEAVE MESSAGE WITH: ❑ HOME ANSWERING MACHINE ❑ ANYONE ANSWERING HOME PHONE
WORK ANSWERING MACHINE ANYONE ANSWERING WORK PHONE NO ONE

| EMPLOYER NAME OR NAME OF SCHOOL | NAME OF SKILLED NURSING FACILITY |
|---|---|

## 2) EMERGENCY CONTACT

| NAME OF PERSON | RELATIONSHIP | HOME / CELL PHONE | WORK PHONE |
|---|---|---|---|

## 3) INDIVIDUAL RESPONSIBLE FOR PAYMENT

| NAME OF PERSON | SOCIAL SECURITY # | BIRTH DATE |
|---|---|---|

| HOME PHONE | CELL PHONE | WORK PHONE | RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT OTHER_________ |
|---|---|---|---|

| STREE ADDRESS | APT# | CITY | STATE | ZIP |
|---|---|---|---|---|

| EMPLOYER | PHONE NUMBER |
|---|---|

## 4) PRIMARY INSURANCE COMPANY

*Please present insurance card to the receptionist*

| INSURANCE COMPANY NAME | SOCIAL SECURITY # | BIRTH DATE |
|---|---|---|

| NAME OF INSURED | INSURANCE ID # | GROUP # |
|---|---|---|

## 5) SECONDARY INSURANCE COMPANY

*Please present insurance card to the receptionist*

| INSURANCE COMPANY NAME | SOCIAL SECURITY # | BIRTH DATE |
|---|---|---|

| NAME OF INSURED | INSURANCE ID # | GROUP # |
|---|---|---|

## 6) WORK RELATED INJURIES ❑ YES ❑ NO

| NAME OF COMPENSATION INSURANCE CARRIER | ADJUSTER AND PHONE NUMBER |
|---|---|

| CARRIER'S ADDRESS |
|---|

| NAME OF EMPLOYER (AT THE TIME OF INJURY) | ADJUSTER FAX NUMBER |
|---|---|

| ADDRESS | DATE OF INJURY |
|---|---|

| AUTHORIZATION GIVEN BY | NURSE CASE MANAGER | PHONE NUMBER |
|---|---|---|
| INDUSTRIAL CLAIM / CASE NUMBER | KAISER PHYSICIAN AND OFFICE | KAISER ID # |

| ☐ CONSULT ONLY | ☐ CONSULT AND TREAT | ☐ TRANSFER CARE |
|---|---|---|

SIGNATURE_________________________________DATE_____________________

Tri-Valley Orthopedic Specialists, Inc.
Solving Musculoskeletal Problems Since 1985

**Name: _______________________________________________ Date: __________________**

## ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Tri-Valley Orthopedic Specialist, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. Refunds will be issued upon request. I hereby authorize this healthcare provider to release all necessary information to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

**Patient Signature:________________________________________**

## MEDICARE AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made either to me or on my behalf to Tri-Valley Orthopedic Specialists for any services furnished me by physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is complete, my signature authorizes releasing of the information to the insurer of the agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

**Patient Signature: ________________________________________**

## HIPAA Compliance

As mandated by the Federal Government and Office of Civil Rights, Tri-Valley Orthopedic Specialists is required to follow the **HIPAA Compliance Act to ensure patient confidentiality.** I understand that as part of my healthcare, Tri-Valley Orthopedic Specialists, Inc., maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care treatment.

I understand that this information serves as a 1) basis for planning my care and treatment; 2) means of communication with the many healthcare professionals who contribute to my care; 3) source of information for applying my diagnosis and surgical information to my bill; 4) means by which a third-party can verify that services billed were actually provided; 5) a tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right: 1) to object to the use of my health information for directory purposes: 2) to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operation – and that the organization is not required to agree to the restrictions requested: 3) to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Comments and Restrictions: ____________________________________________________________________

Detailed message regarding test results can be left on my answering machine: ❑ Yes ❑ No

______________________________________________________

**Signature of Patient or Legal Representative**

Tri-Valley Orthopedic Specialists, Inc.
Solving Musculoskeletal Problems Since 1985

# Medical History

Date_______________

Name:_____________________________________________ Age:________________

Have you or any member of your family been treated at Tri-Valley Orthopedics? ☐ Yes ☐ No _______________

Occupation:____________________ How Long:___________ Employer: __________________How Long: ________

Name of physician who requested that you contact TVO for this appointment (telephone # and location): __________

_____________________________________________________________________________

If you would like a letter sent to your family/primary care physician, please provide *name and location:* __________

_____________________________________________________________________________

Describe the problem and the DATE your symptoms began: Side affected ☐ Left ☐ Right ☐ Both

_____________________________________________________________________________

______________________________________________________ DATE SYMPTOMS BEGAN: _______________

Cause of problem? ☐ Car accident ☐ Work injury ☐ Sports injury ☐ Home ☐ Other__________________

Who has given you treatment for this condition and what treatment did you receive? _________________________

_____________________________________________________________________________

Have any tests been done? ☐ X-rays ☐ CT scan ☐ MRI ☐ EMG ☐ NCT ☐ Other: ______________

Have you had, or do you presently suffer from:

1. Seizures ☐ Yes ☐ No
2. Stroke ☐ Yes ☐ No
3. Cardiac/Heart problems ☐ Yes ☐ No
4. High Blood Pressure ☐ Yes ☐ No
5. Respiratory problems ☐ Yes ☐ No
6. Cancer ☐ Yes ☐ No
   If yes, Site____________________
7. Diabetes ☐ Yes ☐ No
8. HIV ☐ Yes ☐ No
9. Hepatitis / Jaundice ☐ Yes ☐ No
10. GERD ☐ Yes ☐ No
11. Ulcer / GI problems ☐ Yes ☐ No
12. Thyroid Disorder ☐ Yes ☐ No
13. Depression ☐ Yes ☐ No
14. Anxiety ☐ Yes ☐ No
15. Blood Clots / Phlebitis ☐ Yes ☐ No
16. Bleeding Disorder ☐ Yes ☐ No
17. Difficulty Urinating ☐ Yes ☐ No
18. Kidney / Bladder Infection ☐ Yes ☐ No
19. Psoriasis / Skin rash ☐ Yes ☐ No
20. Have you had Cortisone? ☐ Yes ☐ No
    If yes, Site:____________________
21. Chemical Dependency ☐ Yes ☐ No
22. Alcoholism ☐ Yes ☐ No
23. Reaction to Anesthesia ☐ Yes ☐ No
    If yes, Reaction? ______________
24. Smoke Cigarettes ☐ Yes ☐ No
    If yes? Amount ________________
25. Drink Alcohol? ☐ Yes ☐ No
    If yes? Amount ________________
26. Recreational Drugs? ☐ Yes ☐ No
    If yes, Name: ________________
    If yes, frequency:______________

List any other medical problems not mentioned above: __________________________________________

Please list ALL MEDICATIONS (prescription and non-prescription) that you are presently taking: _______________

_____________________________________________________________________________

List ALL ALLERGIES: ________________________________________________________________

List all past surgery (include dates of possible): ____________________________________________

_____________________________________________________________________________

Any illnesses / medical conditions that "run" in your family? ______________________________________

Patient Signature: ______________________________Physician Signature: ____________________________

Physician use only (B/P_______ HR_______ Resp ______)

PATIENT-Please complete information in square to the right and below!

PHARMACY – NAME / ADDRESS______________________________

❑ Male ❑ Female

Height:_________Weight:__________

❑ Right-Handed ❑ Left-Handed

George B. Batten, M.D.

Kambiz Behzadi, M.D.

Alexandra M. Burgar, M.D.

Roger D. Dainer, D.O.

Gregory Horner, M.D.

David J. Jupina, M.D.

Robert H. Malstrom, M. D.

Ian A. Stine, M.D.

Kenneth G. Venos, M.D.

Pleasanton
4626 Willow Rd.
2nd Floor
Pleasanton, CA 94588

San Ramon
5601 Norris Canyon Rd.
Suite 130
San Ramon CA 94583

Tracy
2180 W. Grant Line Rd.
Suite 100
Tracy, CA 95377

Medical Office
tel 866-623-7600
fax 925-463-0473

Business Office
tel 925-469-0939
fax 925-469-0165

Rehab/Therapy
Pls - 925-463-1200
SR - 925-275-1296

# ACCIDENT QUESTIONNIARE

**Patient's Name:**__________________________________ **Date:**_________

**Insured Person:**_________________________________________________

**SS# of Insured Person:**____________________________________________

1. **Is today's visit the result of an accident?** ☐ Yes ☐ No
2. **If so, where and on what date did the injury occur?**

3. **How did the accident happen?**

4. **Is today's visit the result of an work injury?** ☐ Yes ☐ No
5. **Is today's visit the result of an auto accident?** ☐ Yes ☐ No

6. **Was another party involved in the accident who you believe to be liable?** ☐ Yes ☐ No

__________________________________ __________

**Signature of Insured Person** **Date**

Tri-Valley Orthopedic Specialists, Inc.

Solving Musculoskeletal Problems Since 1985

George B. Batten, M.D.

Kambiz Behzadi, M.D.

Alexandra M. Burgar, M.D.

Roger D. Dainer, D.O.

Gregory Horner, M.D.

David J. Jupina, M.D.

Robert H. Malstrom, M. D.

Ian A. Stine, M.D.

Kenneth G. Venos, M.D.

Pleasanton
4626 Willow Rd.
2nd Floor
Pleasanton, CA 94588

San Ramon
5601 Norris Canyon Rd.
Suite 130
San Ramon CA 94583

Tracy
2180 W. Grant Line Rd.
Suite 100
Tracy, CA 95377

Medical Office
tel 866-623-7600
fax 925-463-0473

Business Office
tel 925-469-0939
fax 925-469-0165

Rehab/Therapy
Pls - 925-463-1200
SR - 925-275-1296

# DISCLOSURE LETTER

**Effective October 1, 2005**

**Dear Patient:**

**During the course of your treatment, you may be referred to a Tri-Valley Orthopedic Specialist service and/or facility. It is our duty to inform you that one or more of our physicians may have a financial interest in a facility or service associated with your orthopedic care. You have the option to choose any organization you wish in obtaining the necessary services which we request and order for you.**

**Your physician would be more than happy to discuss your options and answer any questions you might have. Potential sources of Information concerning alternatives can either be obtained from the Yellow Pages or the county medical association which can be reached at 510-654-5383.**

**Sincerely,**

***The Physicians at Tri-Valley Orthopedic Specialists, Inc.***

______________________________ ____________

**Patient Signature** **Date**