AVORS MEDICAL GROUP

Antelope Valley Orthopedic & Rehabilitation Specialists

Alon Antebi, DO Thomas S. Nasser, DO Justin Heller, MD Justin Sherfey, DO
Orlando Pena, DO Tony Smith, DC

AVORS Medical Group
New Patient Forms Packet

- ☑ Patient Information
- ☑ Insurance Information
- ☑ Assignment & Release
- ☑ Physician-Patient Arbitration Agreement
- ☑ Payment Policy
- ☑ Authorization to Release Medical Information
- ☑ Notice of Privacy Practices Acknowledgment
- ☑ Pain Management/Chiropractic Agreement
- ☑ Health History Questionnaire

AVORS Medical Group

42135 10th Street W., Suite 101
Lancaster, CA 93534

23838 Valencia Blvd, Suite 260
Valencia, CA 91355

301 North Drummond Blvd
Ridgecrest, CA 93555

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Patient Information

Date _____ Home Phone _____ Cell Phone _____

Name _____ Sex ☐ M ☐ F Age ___ Date of Birth _____

Address _____ City_____ State ____ Zip _____

Employer _____ Occupation_____ Drivers License #_____

Email _____ Social Security Number _____ - _____ - _____

Primary Treating Physician/Family Physician? _____

In case of emergency, who should be notified? _____ Phone _____

Race _____ Ethnicity _____ Preferred Language _____

Preferred method of contact ☐ Mail ☐ Web Message

Insurance Information

Is this a Workers Compensation Claim? ☐ No ☐☐Yes

Primary Insurance _____ ID # _____ Group #_____

Subscriber Name_____ Relationship to patient _____

Cardholder Date of Birth _____ Drivers License #_____

Secondary Insurance _____ ID # _____ Group #_____

Subscriber Name _____ Relationship to patient _____

Cardholder Date of Birth _____ Drivers License #_____

Assignment & Release

I certify that I and/or my dependent(s) have insurance coverage with the above insurance listed and assign directly to **AVORS Medical Group** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I will be responsible for all collection/attorney fees if may account becomes delinquent. I authorize the use of my signature on all insurance submissions. The above-named physician may use my healthcare information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This release is valid until I notify the practice in writing with any changes.

_____ _____

Signature of patient, guardian or legal representative Date

_____ _____

Printed name of patient, guardian or legal representative Relationship to patient

Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intension of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services. _____
Patient's or Patient Representative's initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledgement that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: **AVORS Medical Group** _____ By: _____ _____
Date Patient's or Patient Representative's Signature Date

By: _____
Print Patient's Name

_____ _____
Print or Stamp Name of Physician, Medical Group, or Association Name (If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.
6/07

Payment Policy

The providers and staff at AVORS Medical group appreciate that you have chosen us for your medical care. In order to facilitate a positive relationship, we want to make you aware of our Financial Policy.

We are always eager to hear your feedback on how we can do a better job for you. Please feel free to speak with your physician or any staff member directly if you have suggestions or concerns.

1. You will be responsible for all co-pays, coinsurances, and deductibles at the time of visit.

2. All self-pay patients will be expected to pay in full at the time of service.

3. All self-pay patients and any patient with an outstanding balance over $500 will be required to apply for CareCredit prior to any payment arrangements being set up. You may elect not to apply for CareCredit, however, you will be responsible for all payments due at the time of service.

4. All self-pay patients will be required to pay for elective surgery prior to surgery.

5. We will submit to all patients (2) statements of current patient balances by mail. If we receive no response to these statements, we will begin the collection process immediately. If your account is sent to an outside collection agency, you will be responsible for all collection and legal fees.

6. We encourage you to stay in contact with our office regarding financial issues, as we will attempt to work with you.

7. We accept MasterCard, Visa, American Express, Cash, Check and CareCredit.

8. Returned Check fee is $25 fee.

9. If you cancel your appointment in less than 24 hours or 'No Show' for an appointment, you may incur a $25-$50 fee.

I have read and understand the above payment policy.

_____ _____

Patient's Name Account #

_____ _____

Signature of Patient/Guardian Date

HIPAA Protected Health Information

In general, the Health Information Patient Accountability Act (HIPAA*)* privacy rule *gives* individuals the right to request a restriction on use or disclosure of their protected health information (PHI). The Individual is also provided the right to request confidential communications or that a communication of PHI *be* made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

This office will generally contact patients by written communication or phone calls. We will send letters or call the number the patient has provided on the Patient Information sheet.

Please verify your phone numbers and complete the following:

Home Telephone (_____) - _____ - _____

- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only.

Cellular Telephone (_____) - _____ - _____

- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only.

Work Telephone (_____) - _____ - _____

- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only.
- ☐ Okay to fax to (_____) - _____ - _____

Written Communication

☐ Okay to mail to my home address:

_____

_____

☐ Please mail to another address:

_____

_____

The privacy rule generally requires healthcare providers lo take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply for use or disclosures made pursuant to any authorization requests by the Individual.

Record or Disclosures of Protected Health Information

I _____, authorize the office of AVORS Medical Group to contact the following person(s) in regards to my medical information.

_____ _____

Name/Relationship Telephone Number

_____ _____

Name/Relationship Telephone Number

_____ _____

Patient Name/ Date of Birth Patient Signature

Todays Date: _____

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Notice of Privacy Practices Acknowledgment

☐ I wish to receive a copy of the Notice of Privacy Practices at the time of my signature below.

☐ I decline to receive a copy of the Notice of Privacy Practices at this time. I understand I can obtain a copy at any time per my request.

_____ _____
Name Date of Birth

_____ _____
Signature Date

Notice of DMEPOS Supplier Standards

☐ I wish to receive a copy of the Notice of DMEPOS Supplier Standards at the time of my signature below.

☐ I decline to receive a copy of the Notice of Notice of DMEPOS Supplier Standards at this time. I understand I can obtain a copy at any time per my request.

_____ _____
Name Date of Birth

_____ _____
Signature Date

Patient Name: _____ DOB: _____ Date: _____

Reason for Visit

Please describe the problem you are being seen for (if this is a visit following discharge from a hospital please include your date of discharge and diagnosis.)

_____
_____
_____
_____
_____
_____

Did this problem/pain come on: ☐ Suddenly ☐Gradually

Please mark how the following affects your pain or pain:

	Better	Worse	No Change
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Bending Forward	☐	☐	☐
Bending Backward	☐	☐	☐
Driving	☐	☐	☐
Sleeping	☐	☐	☐
Lying Flat	☐	☐	☐

If you have Back Pain, please answer the following questions:

1. Do you have pain rising form a seat/seated position?	☐ Yes	☐ No
2. Do you have pain with coughing or sneezing?	☐ Yes	☐ No
3. Do you lean on a shopping cart at the store to relieve your back pain?	☐ Yes	☐ No
4. Are you awakened from sleep due to pain?	☐ Yes	☐ No
5. Do you have morning stiffness?	☐ Yes	☐ No
6. Do you have fevers or sweats accompanying your pain?	☐ Yes	☐ No

What medications have you tried for this problem, if any? (please include any over the counter or herbal supplements)

_____
_____
_____
_____
_____

Were any of these effective? If so, please describe

_____
_____
_____
_____
_____

Patient Name: _____ DOB: _____ Date: _____

What is the character of your pain? For example: is it dull, aching, sharp, throbbing, or pins and needles?

☐ Dull

☐ Aching

☐ Sharp

☐ Throbbing

☐ Pins and Needles

If you are experiencing pain, please rate your pain on a scale of 0-10, with 0 being no pain and 10 being the most. Please circle

Pain at best:	0	1	2	3	4	5	6	7	8	9	10
Pain at Worst	0	1	2	3	4	5	6	7	8	9	10

How long has the pain been going on? _____

Have you previously been seen by another physician for this? If so, which physician? _____

_____

Have you had any previous testing done for this problem? Please describe type of test and where it was performed. (For example: MRI, CT Scan, Bone Scan, EMG etc.)

_____
_____
_____
_____

Is this work related? ☐ Yes ☐No

Is this related to an auto accident? ☐Yes **If yes, please complete Personal injury Questionnaire

☐ No

If yes, what is the Date of Accident _____

Do you have legal representation? ☐ Yes ☐No

If Yes, Please list name, address and phone number

_____

_____

_____

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Patient Name: _____ DOB: _____ Date: _____

Who is your primary care physician? _____

Which physician referred you to our office? _____

Personal Medical History:

Conditions- current or treated in the past. (Check all that apply)

☐ **None**		
☐ Allergies	☐ Eating Disorder (add comments below)	☐ Liver Disease
☐ Anemia	☐ Emphysema	☐ Miscarriage
☐ Arthritis	☐ Fibromyalgia	☐ Non Healing Wound
☐ Asthma	☐ Glaucoma	☐ Obesity
☐ Blood Clot/ Bleeding Disorders	☐ Gout	☐ Osteoporosis
☐ Breast Lump	☐ Headache	☐ Pacemaker
☐ Cancer (add comments below)	☐ Heart Attack	☐ Pneumonia
☐ Cataracts	☐ Heart Disease/ Gastric Reflux	☐ Prostate Problems
☐ Chemical Dependency	☐ Hepatitis	☐ Psychiatric Care (i.e. Depression, Anxiety, Bipolar etc)
☐ Chronic Fatigue	☐ Hernia	☐ Seizures
☐ Congestive Heart Failure	☐ High Cholesterol	☐ Thyroid Disease
☐ COPD / Breathing Problems	☐ HIV	☐ Tuberculosis
☐ Coronary Artery Disease	☐ Hypertension	☐ Urinary Tract Infections
☐ Dementia / Memory Loss	☐ Kidney Disease	☐ Vaginal Infections/STI (add comments below)
☐ Diabetes	☐ Kidney Stones	

Comments: _____
_____
_____

Surgical History (Check all that apply)

☐ Appendectomy	Date of Surgery: _____	☐ C-Section	Date of Surgery: _____
☐ Cardiac Bypass Surgery	Date of Surgery: _____	☐ Cholecystectomy	Date of Surgery: _____
☐ Hernia Repair	Date of Surgery: _____	☐ Skin Lesions Removed	Date of Surgery: _____
☐ Partial Hysterectomy	Date of Surgery: _____	☐ Total Hysterectomy	Date of Surgery: _____
☐ Tonsillectomy	Date of Surgery: _____	☐ None	

Additional Surgeries: _____
_____
_____
_____

Patient Name: _____ DOB: _____ Date: _____

Medication

Please list all medications you are currently taking:
****Please include all over-the-counter medications, vitamins and supplements.**
List Current Medications: (Please include Name, Strength, Directions, Which physician is prescribing)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List Any Known Allergies and Type of Reaction:

_____ _____
_____ _____
_____ _____
_____ _____

Preferred: Pharmacy Name and Address - _____

Family History

****Please note if the family member associated with a listed Medical Condition is not listed or if there is any other pertinent medical condition in your family history please write in information in comments box below.**

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Arthritis								
Asthma								
Dementia								
Depression								
Diabetes - Type I								
Diabetes - Type II								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Kidney Disease								
Obesity								
Osteoporosis								
Stroke								
Substance Abuse								
Cancer (add comments below)								

Family History Comments: _____
_____
_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widow

Do you live alone? (Please check all that apply) ☐ Alone ☐With Spouse ☐ With Children ☐ Roommate

Home Structure:☐ Single Story Residence ☐ Two Story Residence ☐ Apartment

Smoking Status: ☐ Never Smoker ☐ Former Smoker ☐ Unknown if Ever Smoked ☐ Currently Every Day Smoker ☐ Currently Some Day Smoker ☐ Heavy Tobacco Smoker ☐ Light Tobacco

Smoked Per Day: ☐ Less than 1 ☐ 1 to 9 ☐ 10 to 19 ☐ 20 to 30 ☐ 40 or more

Alcohol Use: ☐ Never Drank ☐ Denies Alcohol Use ☐ Social Drinker ☐ 1-2 Drinks Per Day ☐ 3 or more Drinks per Day ☐ 1 Drink Per Week ☐ 2-3 Drinks Per Week ☐ 1-3 Drinks Every 2-3 Months

Patient Name: _____ DOB: _____ Date: _____

Illicit Drug Use: ☐ Denies ☐Past Recreational Use ☐ Current Recreational Use ☐ Other: _____

Last Use: _____ Last Use: _____

Caffeine Use: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks

☐ 1-2 Drinks Per Day ☐ 3 or more Drinks per Day ☐ 1 Drink Per Week ☐ 2-3 Drinks Per Week ☐ 1-3 Drinks Every 2-3 Months

Size of Beverage: _____

Are You Employed? ☐Yes ☐ No ☐ Part Time ☐ Full Time Occupation: _____

Military Status: ☐ No Military Experience ☐ Active ☐ Retired

Preventive Screening Dates

☐ Bone Density Screening Date of Screening: _____

☐ Colonoscopy Date of Colonoscopy: _____

☐ Tetanus Booster: Date of Tetanus Booster: _____

_____ _____ _____

Print Name Signature Date