COASTAL ORTHOPEDIC & SPINE INSTITUTE

Patient Information for Medical Records (Please Print)

First Name: _____ Last Name: _____ MI: ___

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Phone: _____

Birthday: ____ / ____ / _____ Age: _____ Sex: _____ Marital Status: _____

Occupation: _____

Family Physician: _____ Referred by: _____

In Case of Emergency Contact: _____

Relationship to you: _____ Phone: _____

Insurance Information

Is this a work related injury? Yes No Is there litigation related to this injury? Yes No

Primary Insurance Company: _____

If HMO, which IPA: Seaview Valley Care Ojai Valley BVMG

Subscriber #: _____ Group #: _____

Subscriber: _____ Subscriber Date of Birth: _____

Relationship to patient: _____

Secondary Insurance Company: _____

If HMO, which IPA: Seaview Valley Care Ojai Valley BVMG

Subscriber #: _____ Group #: _____

Subscriber: _____ Subscriber Date of Birth: _____

Relationship to patient: _____

CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE

Authorization for medical treatment, release of medical information and financial agreement.

I directly assign all medical/surgical benefits to the orthopedic surgeon and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the orthopedic surgeon to release all information necessary to secure the payment of benefits.

_____ _____ _____

Patient Signature or Legal Guardian Print Name Date

COASTAL ORTHOPEDIC & SPINE INSTITUTE

Patient Current Problem History (Please Print)

First Name: _____ Last Name: _____ MI: ___

Please describe your problem: _____

_____

Date of onset of symptoms: _____ Is your problem related to an injury? _____

If injury, how did it happen? _____

Is the problem constant? _____

Please circle the number that best describes your pain (1=hardly any pain, 10=worst pain of your life)

1 2 3 4 5 6 7 8 9 10

What activities make your pain worse? (Circle all that apply)

Exercise	Sitting	Standing	Lying Down
Bending Forward	Bending Backward	Reaching Down	Reaching Up
Walking	Lifting	Other: _____	

What activities make your pain better? (Circle all that apply)

Nothing	Lying down	Sitting	Standing
Walking	Medication	Other: _____	

What have you tried for it? Circle all that apply

Nothing	Medication	Rest	Bracing
Injections	Physical Therapy	Surgery	Other: _____

If you have tried medications, which medications? _____

If you have tried injections, where & who did them? _____

Are you claustrophobic (uncomfortable in small spaces)? Yes No

Do you have any retained metal (ie. Metal joints, pins, pacemaker)? Yes No

What pharmacy do you use? _____

Pharmacy phone number: _____

COASTAL ORTHOPEDIC & SPINE INSTITUTE

Patient Medical History
(Please Print)

First Name: _____ Last Name: _____ MI: ___

Have you ever had any of the following? (Please circle all that apply)

Cancer – Type: _____ Chronic Kidney Disease – Stage: _____

Deep Vein Thrombosis (DVT/Blood Clot) – Where? _____ When? _____

Diabetes – Last HbA1C: _____ Date: _____

Osteoporosis – Last Bone Density Exam: _____ Pulmonary Embolism (PE) – When? _____

AIDS/HIV
Alzheimer's Disease
Anemia
Arthritis
Artificial Heart Valve
Asthma
Congenital Heart Disorder
Congestive Heart Failure
Drug Addiction
Emphysema
Epilepsy or Seizures
Glaucoma
Gout
Heart Attack/Failure
Heart Murmur
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Leukemia
Liver Disease
Lung Disease
Lymphedema (chronic leg swelling)
Mitral Valve Prolapse
Peripheral Vascular Disease (PVD)
Renal Dialysis
Rheumatic Fever
Rheumatoid Arthritis
Scarlet Fever
Shingles
Sickle Cell Disease
Spina Bifida
Stomach Ulcers
Stroke/TIA
Thyroid Disease
Tuberculosis
Other: _____

Do you smoke/use nicotine products (ie. Chew, e-cigs, patches)? Yes No

If yes, how long have you used? _____ How much per day? _____

Do you use any alcohol? Yes No If yes, how much per day? _____

Do you use any recreational drugs? Yes No If yes, which ones? _____

Please list previous operations and dates

Surgery	Date

Please list all medications (including over the counter medications) that you take regularly.

Medication & Dosage	Frequency

Please list all known allergies and the reaction it gives you.

Allergy	Reaction

Do you have a family history of any of the following? (Please circle all that apply)

Arthritis

Bleeding Problems

Blood Clot (DVT or PE)

Cancer – Type: _____

Diabetes

Heart Disease

Hypertension

Stroke

Consent for E-mail & Text Message Communication
(Please Print)

First Name: _____ Last Name: _____ MI: ___

I, _____ am:

_____ A) an patient of Coastal Orthopedic & Spine Institute

_____ B) the legal representative of the established patient

I understand that Coastal Orthopedic & Spine Institute cannot guarantee the security and confidentiality of e-mail or text message communications. Coastal Orthopedic & Spine Institute will not be responsible for messages that are not received or delivered due to technical failures or for the disclosure of confidential information unless caused by intentional misconduct.

I understand that appointments should be made to discuss any new or any sensitive medical information.

I understand that I may stop using e-mail or text message as a means of communication upon my written request.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. Below are my consents for e-mail and text message communications to and from Coastal Orthopedic & Spine Institute.

____ I give consent for email communication at this email address: _____

____ I DO NOT give consent for email communication.

____ I give consent for text message communication at this phone number: _____

____ I DO NOT give consent for text message communication.

_____ _____ _____

Patient Signature or Legal Guardian Print Name Date

COASTAL ORTHOPEDIC & SPINE INSTITUTE

Privacy Official: Lissette
805-273-5478
Lissette@thecosi.com

400 Camarillo Ranch Rd, Suite 101
Camarillo, CA 93012

www.thecosi.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: 02/01/2020

This Notice of Privacy Practices applies to the following organizations.

Coastal Orthopedics & Spine Institute
Antulio B. Aroche, Jr. D.O. APC
Candice Brady DO, PC

By signing this form, I am consenting to allow Coastal Orthopedic & Spine Institute to use and disclose my protected health information to carry out treatment, payment and health care operations.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Coastal Orthopedic & Spine Institute may decline to provide treatment to me.

Print Name: _____

Signature: _____ Date: _____

Please complete the following information:

Primary Phone Number: _____ Cell Phone Number: _____

Please indicate any people that you give us permission to discuss your health information with:

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Privacy Official: Lissette 805-273-5478 Lissette@thecosi.com