☐ Registered Date:

_______ / _______ / _______

Account Number

South Coast Orthopaedic Associates, P.C.

2699 NORTH 17TH STREET • COOS BAY, OREGON 97420

INITIAL HISTORY SURVEY

If you need help with this form, please ask for assistance.

Physician being seen today:

SMH GTV AC
JSB RDP WJ

Date: _______ / _______ / _______

Primary Care Physician: ____________________

Date: ______________ Legal Name (First, Middle, Last): ______________________________

How would you prefer to be addressed (nickname/short name): ______________________ ☐ Male ☐ Female

SS#: ______________ DOB: ______________ Oregon Driver's Lic. #: ______________

Physical Address: ______________________ E-Mail: ______________________

Billing Address: ____

City/St/Zip: ______________ Home Phone: ______________ Cell Phone: ______________

Ethnicity Questions: Do you consider yourself? ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined

Race Questions: Which category best describes your race? ☐ White ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaska Native

Preferred language: ☐ English ☐ Spanish ☐ Other ______________

Employer: ______________________________ Occupation: ______________

Address: ____

City/St/Zip: ______________________________ Work Phone: ______________

Spouse's Name: ______________________________ Spouse's DOB: ______________

Spouse's Employer: ______________________________ Occupation: ______________

Emergency Contact: Name ______________________________ Phone: ______________

Today's visit will be billed to: ☐ Regular Medical Insurance ☐ Worker's Comp. ☐ Motor Vehicle Accidental Liability ☐ Self-Pay

RESPONSIBLE PARTY

☐ Self ☐ Parent OR ☐ Other ______________________

Name of Responsible Party: ______________________ DOB: __________ SS#: ______________

Address: ____

City/St/Zip: ______________________ Home Phone: ______________ Work Phone: ______________

Employed By: ______________________ Occupation: ______________ Length of Employment: ________

MEDICAL INSURANCE INFORMATION

Insurance Co. #1: ______________________ Mailing Address: ______________________

Ins. Co. Phone: ______________ Group #: ______________ SS or ID #: ______________

Subscriber Name: ______________ Address: ______________________ DOB: __________ Sex: ☐M ☐F

Insurance Co. #2: ______________________ Mailing Address: ______________________

Ins. Co. Phone: ______________ Group #: ______________ SS or ID #: ______________

Subscriber Name: ______________ Address: ______________________ DOB: __________ Sex: ☐M ☐F

WORKER'S COMPENSATION

For Worker's Compensation, claim is: ☐ Open ☐ Closed ☐ New ☐ Disputed

Insurance Co. Name ______________ Address: ______________ City/St/Zip: ______________

Claim #: ______________ Injury Date: ______________ SS or ID #: ______________

Employer Name at Time of Injury: ______________________ Last Day Worked: ______________

MOTOR VEHICLE ACCIDENT/LIABILITY

Motor Vehicle Accident/Liability

Name of Insured: ______________________ Policy/Claim #: ______________

Insurance Name & Address: ______________________ Phone #: ______________

Agent Name: ______________ City/State: ______________ Date of Accident: ______________

YOUR SIGNATURE IS NEEDED ON THE BACK

Form No. 105, Rev. 12/19

I. ASSIGNMENT OF INSURANCE PAYMENT

I hereby authorize Doctors of South Coast Orthopaedic Associates to furnish the insured's insurance company all information which said insurance company may request. This authorization extends to all treating physicians. I understand that all information is confidential and my records, with respect to HIV status, alcohol and drug abuse, are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for In the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

I hereby assign to the Doctors of South Coast Orthopaedic Associates all insurance proceeds to which I am entitled for medical and/or surgical expense relative to the services performed from time to time, but not exceed by Indebtedness to said physicians and surgeons. It is understood that any money received from the above named insurance company, over and above my indebtedness, will be refunded to me when my bill is paid in full.

I understand that this assignment does not relieve me from responsibility for charges not paid by my insurance company. I understand my health insurance may not pay for the services I am requesting. I am agreeing to pay for these services personally if not covered by my health plan.

Even though an insurance claim is pending you will receive a statement each month if your account has an outstanding balance. The Doctor cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account from the date of service.

II. ACKNOWLEDGMENT AND CONSENT

I understand that South Coast Orthopaedic Associates (referred to below as "SCOA") will use and disclose ***"Protected Health Information"*** or ***"PHI'"*** about me. I understand that my ***PHI*** may include information both created and received by SCOA, may be in the form of written or electronic records. I understand that my ***PHI*** may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information. I understand and agree that SCOA may **use and disclose** my ***PHI*** in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how SCOA will handle ***PHI*** about me. This written description known as a **Notice of Privacy Practices** and describes the uses and disclosures of ***PHI*** made and the information practices followed by the employees, staff and other office personnel of SCOA, and my rights regarding my ***PHI***. I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of the current **Notice of Privacy Practices**. I also understand that a copy or a summary of the current **Notice of Privacy Practices** in effect will be posted in waiting and reception area and is available on our website at **www.scoastortho.com.** I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the **Notice of Privacy Practices** and I understand that SCOA is not required by law to agree to such requests.

II. FINANCIAL POLICY

I acknowledge, understand and accept the Financial Policy provided separately. I understand that any questions about any of the following on the Financial Policy copy can be answered by either calling 541-266-3600 or asking at the time of patient's appointment.

By signing below, I agree that I have reviewed and understand the information above and that I may request a copy of the Notice of Privacy Practices.

PATIENT NAME: ____

PATIENT/RESPONSIBLE PARTY SIGNATURE:

____ DATE ______________________