



Orthopedic Surgery
ASSOCIATES OF NORTH COUNTY

About Your Visit:

Our office is located at 15525 Pomerado Road, Suite A1, Poway, CA 92064. If you are unable to keep your scheduled appointment, please let us know by calling (858) 485-0050, option 1, this will get you to a staff member who can assist you.

In preparation of your first visit; please bring a picture ID, your insurance card and complete the new patient paperwork before your visit. There are various steps in our registration process that must be completed prior to seeing the doctor, so we ask that you arrive 15-20 minutes before your scheduled appointment. This will help you move through the visit with ease.

Bring the following items with you to your appointment:

- New Patient Forms – please complete all sections and be thorough when completing the health questionnaire. Forms are found online at www.archhealth.org.
- Picture ID
- Insurance card
- Co-payment
- All relevant X-rays, MRIs and test results with written reports

The following is important information that will allow us to better serve your needs.

- We will bill your insurance. If you do not have insurance coverage; payment will be expected at time of service.
- We are unable to bill out of the country insurances; this will require payment in full at the time of visit; a copy of the super bill will be provided to you at the end of your visit.
- All co-pays are due at the time of your visit. We are legally obligated to collect your co-pay.
- Our office only keeps outside x-ray or MRI films for 3 months. If you would like to retain these records, either 1) request them prior to 3 months after your treatment or 2) let us know you would like to take them with you after your visit.
- All prescription requests require 24-hour notice. As a courtesy to all patients, we are unable to accommodate walk-in patient requests to obtain samples or have prescriptions filled while you wait, this will allow our physicians and staff to attend to patients who are present in the office seeking treatment.
- We will call and obtain insurance eligibility and coverage benefits prior to your appointment. You will be asked to review and sign the information obtained from your insurance. Your signature will indicate you understand your financial responsibility.

We look forward to seeing you soon. Please do not hesitate to contact our office if you have any questions.

Sincerely,

The Physicians and Staff
Arch Health Partners - Orthopedic Surgery Associates



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PATIENT REGISTRATION INFORMATION

1. Patient Information

Patient Name: _____ Sex: Male _____ Female _____
(Last) (First) (MI)
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____
Month Day Year
Marital Status (Check One): Married _____ Single _____ Divorced _____ Widow(er) _____ Child _____
Employment Status (Check One): Employed _____ Retired _____ Student (Full Time) _____ (Part Time) _____ Not Employed: _____
Employer Name: _____ Address: _____ City/State _____ Zip _____

2. Responsible Party

Patient Name: _____ Sex: Male _____ Female _____
(Last) (First) (MI)
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____
Month Day Year
Marital Status (Check One): Married _____ Single _____ Divorced _____ Widow(er) _____ Child _____
Employment Status (Check One): Employed _____ Retired _____ Student (Full Time) _____ (Part Time) _____ Not Employed: _____
(Check One)
Employer Name: _____ Address: _____ City/State _____ Zip _____

3. Insurance Information (Please present your insurance card to be photo copied for billing)

Primary Insurance: _____ ID# _____ Group# _____
Name of person insured: _____ Date of Birth _____/_____/_____ Relationship to pt: _____
Primary Insurance: _____ ID# _____ Group# _____
Name of person insured: _____ Date of Birth _____/_____/_____ Relationship to pt: _____

4. Referral Information

Name of Referring Physician _____ Primary Care Physician: _____
Name of other physicians that care for you: _____
Has the patient been seen by any of the providers listed? (Please Check) Dr. Owsley _____ Dr. Bried _____ Dr. Cohen _____

5. Emergency Contact

Name of person not living with you: _____ Relationship _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Patient Authorization to Treat:

Signature _____ Date: _____

Reason for Visit

Orthopedic treatment is often a result of an accident or injury, your insurance company may require the details of your visit before processing your claim(s) for payment; this information is often used to determine financial liability. Most insurance companies will not pay claims without this information.

NAME (PLEASE PRINT): _____

If you are here for a reason OTHER THAN AN ACCIDENT, please complete this section

My visit is due to _____ Date first noticed: _____

Place occurred (home, work, school, etc) _____

Please describe how this may have occurred: _____

If you are here DUE TO AN ACCIDENT; please complete this section

My visit is due to an accident: No Yes If yes, date of accident: _____

Location of accident (home, work, school, care, etc) _____

Please describe how the accident occurred: _____

Name of Medical Insurance Company: _____

Is there any other insurance company or entity that may be financially responsible for payment of this claim, such as an automobile insurance, homeowners insurance, student insurance, etc.? If so, please explain and provide any additional information so we can determine who the appropriate entity is to be billed for your services.

Note: Although you may advise us that another entity is responsible for payment of the claims, *our office does not file third party billing*; and if it is determined that a third party is responsible, we will provide you with the necessary paperwork to submit your claims. In the meantime, you are financially responsible for any outstanding bills due Arch Health Partners Orthopedic Surgery Associates and payment will be expected upon receipt of the first itemized statement.

My signature below indicates that I have read the above and understand I am financially responsible for all medical care rendered, pending any liability disputes.

Signature: _____ **Date:** _____

[Patient Label Here]
Patient Name: _____
DOB: _____ MRN: _____

Patient Financial Agreement

The patient has a large role to play in ensuring that sufficient financial resources are available to maintain the availability of affordable health care services in the community. Our goal is to provide our patients with the highest quality of medical care and customer service.

Your Responsibilities and Acknowledgments

The patient or the patient’s Legal Representative* is responsible for the following:

- Determine if Arch Health Partners is a participant in your medical insurance plan.
- Know what services are covered by your medical and/or vision insurance. The cost of any service NOT covered by insurance is the responsibility of the patient and will be billed in full to the patient.
- Ensure we have your correct medical insurance and address information. Arch Health will bill your insurance for services rendered.
- Obtain approval for referrals to our specialists.
- Make co-payment at the time of the visit—before services are rendered. If co-payment is not paid at that time, Arch Health Partners may charge an additional fee of \$20.
- Arch Health will bill the patient for balance due from co-insurance, deductibles or for non-covered services.
- All outstanding charges shall be paid within the initial billing cycle—30 days.
- Arch Health Partners requires at least 24 hour notice if you must cancel an appointment. A charge of \$25 shall be made for missed appointments or cancellations made less than 24 hours in advance.
- “Self-Pay”—A Self-Pay patient is one who does not have medical insurance that covers Arch Health services. Self-Pay patients are expected to pay in-full at the time services are rendered unless other arrangements have been made. Please contact our business office at (858) 613-8936 to make prior arrangements for payment.
- Payments may be made via VISA, MasterCard, Discover, American Express, cash and personal checks. Returned checks will incur a \$30 service charge.
- Overdue accounts shall be sent to a collections agency or may be subject to legal action. Relevant personal and account information will be released in this course of action. The costs of such action shall be added to the patient’s outstanding balance.

*Legal Representative is defined as the parent of a minor child or person named in a legal document such as a Power of Attorney or Guardianship. Please provide us a copy of the pertinent legal document.

I agree to these terms and acknowledge that this is a binding agreement.

 Print Name of Patient or Patient’s Legal Representative

 Signature of Patient or Patient’s Legal Representative

 Date

(If legal representative, state relationship to patient)

**A MESSAGE TO OUR PATIENTS ABOUT
ARBITRATION**

At your first visit, you will be asked to review and sign an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

If there is a claim, by signing this agreement you are changing the place where your claim would be presented. You can still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then selects a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. This is because the time it takes to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

Sincerely,

James M. Bried, M.D.

Brad S. Cohen, M.D.

K.C. Owsley, M.D.

Patient Medical History Form

Patient: _____

Date: _____

Surgical History: Please list all previous procedures starting with the most recent

Past Operations	Year	Anesthesia (general, spinal)	Complications
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Your Medical History:

Weight: _____

Height: _____

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches
<input type="checkbox"/>	<input type="checkbox"/>	Angina, chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Drug/alcohol addiction
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Stroke
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart "attack"	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal hernia/ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis,Jaundice,Liver
Disease								
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Other illness(s)

	Yes	No	
Do you or have you smoked?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much? _____
Have you quit?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when? _____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how often? _____
Females – Could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	

Please list any medications you are taking or have taken in the last six months:

Please list any allergies to medications or tape:

Please list anything else important regarding your medical history:

Please provide the names of immediate family members:

Name	Relationship	Birth date
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