

ORTHOPAEDIC SURGERY CENTER of LA JOLLA

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Mr. Mrs. Ms. Miss _____
Last Name First Middle

Address _____

City _____ St _____ Zip _____

Home Phone _____ Mobile Phone _____

E Mail Address _____ Date of Birth _____

Drivers License # _____ SS # _____

Parent/Legal Guardian Name & ss # (if patient is minor) _____

Name & Phone # of Friend/Relative not living with you _____

Employer _____ Employer Phone # _____

Primary Insurance Co Name _____ ID # _____

Name of Insured _____

Secondary Insurance Name _____ ID # _____

Name of Insured _____

Was your injury a result of an accident (check one) Yes No

Work Related Occupation _____ Auto Accident Personal Injury N/A

Date of your injury _____ How did injury occur _____

Name & Phone # of Attorney (if applicable) _____

I certify that the information contained above is accurate, truthful and completed to the best of my knowledge.

Signature _____

Date _____

ORTHOPAEDIC SURGERY CENTER of LA JOLLA

PATIENT AGREEMENTS ON ADMISSION

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by La Jolla Orthopaedic Surgery Center and are accessible to La Jolla Orthopaedic Surgery Center personnel and medical staff. La Jolla Orthopaedic Surgery Center personnel and physicians in attendance may use and disclose medical information for surgery center operations and functions and to any other physician or health care personnel involved in my continuum of care for this admission. Safeguards are in place to discourage improper access. La Jolla Orthopaedic Surgery Center and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or self-insured employer group liable for any part of La Jolla Orthopaedic Surgery Center's charges and to any health care provider who is or may become involved with my care.

RELEASE OF RESPONSIBILITY

La Jolla Orthopaedic Surgery Center is hereby released from any responsibility for any items of personal property I do not provide to it for safekeeping.

ASSIGNMENT OF GROUP HEALTH/MEDICARE INSURANCE BENEFITS

I agree that insurance benefits for La Jolla Orthopaedic Surgery Center charges payable to the insured are to be made payable to La Jolla Orthopaedic Surgery Center. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. I understand that I am responsible for any balance after insurance payment, including all costs incurred in collecting the balance if the account becomes delinquent, such as court costs, attorney's fees and/or collection agency commissions or charges.

WORKERS' COMPENSATION INSURANCE BENEFITS

I understand that if I am being treated for an approved work-related injury that La Jolla Orthopaedic Surgery Center will obtain reimbursement from my workers' compensation carrier directly. I understand that if my claim is found to be non-compensatory according to the Workers' Compensation Appeals Board retroactively, that I will then become fully responsible for all charges.

FINANCIAL RESPONSIBILITY

As consideration for the services provided me, payment is guaranteed for any amount due for such services provided by La Jolla Orthopaedic Surgery Center unless otherwise agreed to in writing by La Jolla Orthopaedic Surgery Center. I understand that I may receive additional bills relating to my surgical services, including, but not limited to physician/surgeon professional, assistant surgeon, anesthesia, lab and third party vendor services.

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient, or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by this facility is in our **PRIVACY NOTICE**, which you should read before signing this agreement. A copy is included in your admissions packet and is posted throughout La Jolla Orthopaedic Surgery Center.

I have received a copy of La Jolla Orthopaedic Surgery Center's Notice of Privacy Practices.

Patient or Responsible Party

Relationship

Date/Time Signed

Witness

Basis for refusal, if refused: _____

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As of January 1, 2005, the State of California, Office of Statewide Health Planning and Development (OSHPD) mandates that ambulatory surgery centers collect individual encounter data (California Health and Safety Code, Division 107, Part 5-Health Data, Section 128737). The data will be used for health planning projects, including management of state health care delivery and public health programs, efficient administration of health care services, continuous improvement in the quality of care provided by hospitals and ambulatory surgery centers, effective procurement of healthcare services and identification and correction of disparities in health care access and outcomes. Individually identifiable patient information is protected and encrypted within the state system.

In addition to information collected at the time when surgery is scheduled, we also need you to select your race and ethnicity along with your primary language spoken:

RACE: (choose one)

- R1 American Indian or Alaska Native
- R2 Asian
- R3 Black or African American
- R4 Native Hawaiian or Other Pacific Islander
- R5 White
- R9 Other Race

ETHNICITY: (choose one)

- E1 Hispanic or Latino
- E2 Non Hispanic or Non Latino

PRIMARY LANGUAGE SPOKEN: (choose one)

- English
- Spanish
- French
- Chinese
- Italian
- Vietnamese
- Tagalog
- Other: _____

If you have any questions, please contact the Patient Date Section of OSHPD at 619-323-7679. Additional information is available on the internet at www.oshpd.ca.gov/mirca