California Sports and Cartilage Institute
Gregory T. Heinen, M.D.

Patient Name: _____ Account #: _____

MEDICAL CONSENT

The undersigned consents to any x-ray examination, laboratory procedure and medical treatment rendered the patient under the general or special supervision of, or upon the advice of a physician.

_____
Initials

RELEASE OF INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement to the California Sports and Cartilage Institute, portions of the patient's record, including the patient's medical records, may be disclosed to any person or corporation(or any agent of such person of corporation) which is or may be liable for all or any portion of charges by California Sports and Cartilage Institute(included by not limited to insurance companies, health care services plans, worker's compensation carriers and employers.

_____
Initials

ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my insurance benefits (otherwise payable to me) to California Sports and Cartilage Institute. Payment shall not exceed the group's regular charges for treatment. I understand that I am financially responsible to the medical group for charges not covered by this authorization. This authorization is valid for all family members who receive medical treatment.

_____
Initials

FINANCIAL AGREEMENT

In consideration of the services to be rendered to the patient, the undersigned agrees, whether they sign as patient, as agent, or as financially responsible party, to pay all the charges for patient's care to California Sports and Cartilage Institute. In accordance with the medical group's current rates and terms **(ALL CHARGES ARE DUE AND PAYABLE AT THE TIME OF SERVICE)**.

The undersigned in (agreeing to pay charges for patient's care) is responsible for payment in full, whether or not charges are covered by patient's insurance, and regardless of the time settlement with the patient's insurance carriers. I understand that charges shown by statement are correct and reasonable unless protested in writing within thirty (30) days.

If it is necessary to employ an attorney to enforce this agreement, or collect any judgment based upon this agreement the undersigned patient and/or other financially responsible party is liable for all court costs and attorney fees, including bankruptcy court and appellate court.

_____
Initials

AUTHORIZATION TO TRANSFER FUNDS

Should a credit balance appear on my account with California Sports and Cartilage Institute during the course of my care, I authorize use of the credit balance to be applied to any unpaid balance due to California Sports and Cartilage Institute, for which I have accepted responsibility.

_____
Initials

The undersigned certifies that they have read the foregoing, received a copy of the same and accepts all of its terms and conditions.

Patient, or Patient Representative_____Date_____

Witness_____

a) If the patient is a minor, the parent, having legal custody, a legal guardian, or a person authorized by them in writing must sign.
b) If the patient is incompetent, a legal guardian or conservator must sign.

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PATIENTS RIGHTS AND RESPOONSIBILITIES

To comply with new federal regulations (HIPPA), this office has established procedures to make your identity and medical records more secure. Our only use of your personal information is for billing purposes and for proper medical treatment. We must have on record a signed acknowledgement that you have read your rights and responsibilities as patients and that you understand them. Please ask the office staff if you have any questions.

PATIENT'S RIGHTS

To receive service within a reasonable period of time.
To receive medically necessary services.
To be treated with respect and courtesy..
To receive all available information about your care and treatment, including risks and options.
To have your medical coverage explained to you.
To have all medical and personal records treated as confidential.
To participate in treatment decisions.
To refuse treatment.
to receive impartial access to treatment.
To receive second opinions regarding any treatment plan.
To review or to receive a copy of your medical record subject to legal restrictions and reasonable copying charges.
To request review of your medical record by the physician and to request corrections if necessary.
To be given information on how to file a complaint/grievance.
To formulate an advanced directive if you have a life threatening illness or injury.
To provide, or have provided for you, an interpreter in your primary language.

PATIENTS RESPONSIBILITIES

Having appropriate identification, insurance membership cards, coverage stickers, etc. at the time of the appointment.
Keeping appointments or contacting this office in advance to cancel an appointment.
Fulfilling financial obligations at the time of service such as deductible or co-pay fees.
Providing complete and accurate information.
Following the health plan you and the physician agree on.
Being considerate of others.
Providing legal documentation of guardianship of a minor being treated.
Providing a list of persons who may receive medical information about you, on your behalf, in an emergency.

Please Sign and return this form to the front desk.
*If you prefer a longer version, you may request one.

Patients Name:_____Date:_____

Print Name:_____

ID Number (to be completed by staff):_____

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PATIENT INFORMATION SHEET

Please PRINT all of the Information

Date of Injury or Illness:_____/_____/_____ Who referred you to our office?_____
Is this a work related injury? Yes OR No

PATIENT INFORMATION

Legal Name:_____ Home Number:_____

Home Address: _____ City/State:_____ Zip:_____

DL Number: _____

Date Of Birth: _____/_____/_____ Age: _____ Sex: FEMALE OR MALE

SS# _____-_____-_____ Primary Care Doctor _____City_____

* To request ANY medical treatment, the insurance companies require the patient's Social Security Number.

Marital Status: Single OR Married OR Divorced OR Separated OR Widowed Date of Injury: _____/_____/_____

Injured Area:_____

Email (To send your upcoming
appointments):_____

INSURANCE INFORMATION – TO BE COMPLETED IF THE PATIENT IS A MINOR

Insured Person Name: _____ Employer:_____

SS# _____-_____-_____ Date Of Birth: _____/_____/_____

Address if different from the minor's: _____ City/State:_____ Zip:_____

SPORTS INJURY

Sport You Play: _____ School's Name:_____

Athletic Trainer's Name: _____ Phone Number: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name:_____ Phone Number:_____

*To be signed by parent if the patient is a minor.

Patient Signature:_____ Date:_____