WORKMAN COMPENSATION INFORMATION FORM

DATE: _______________

PATIENT NAME: ____________________________________ AGE: ______ BIRTHDATE: ____________

MALE FEMALE ADDRESS: ____

CITY: __________________ STATE: ____________ ZIP: __________ PHONE ( ) __________________

SS#: ________________ OCCUPATION: _________________ CELL PHONE: ( ) ___________________

EMERGENCY CONTACT PERSON: ___________________________ PHONE: ( ) _________________

YOUR EMPLOYER: __________________________________WORK PHONE: ( ) _______________

EMPLOYER ADDRESS: ____

CITY: _____________________ STATE: ______________ ZIP CODE: __________________________

WORKMAN COMPENSATION INFORMATION

DATE OF INJURY: _____________________ WHERE: _______________________________________

AREA(S) TO BE EXAMINED: ____

____

HAS ANOTHER PHYSICAIN TREATED YOU? YES NO IF YES, WHOM? _________________________
ANY PRIOR XRAYS OR MRI? YES NO if YES: WHAT FACILITY: _______________ DATE: __________

WHO REFERRED YOU TO THE SPORTS CLINIC: ____
PRIOR EMPLOYMENT (PLEASE LIST ALL EMPOLYERS FOR LAST TEN YEARS

____
____
____

INDUSTRIAL INSURANCE CARRIER

NAME: ____

ADDRESS: ____

CITY: _____________________ STATE: ________________ ZIP: ______________

ADJUSTER: ____________________________ ADJUSTER PHONE: __________________

CLAIM NUMBER: _______________________________ ADJUSTER FAX : ________________________

NOTES:

____
____

CONSENT TO RELEASE INFORMATION TO YOUR WORKMAN

COMPENSATION CARRIER

I, ____, HEREBY AUTHORIZE THE SPORTS CLINIC
(NAME OF PATIENT)

ORTHOPEDIC MEDICAL ASSOICATES, INC. TO DISCLOSE ALL NECESSARY INFORMATION FROM MY HEALTH/HOSPITAL RECORES WHICH WERE OBTAINED DURING MY TREATMENT AT THIS FACILITY, DIRECTLY TO MY WORKMAN COMPENSATION CARRIER, IN ORDER TO RECEIVE REIMBURSEMENT FOR SERVICES RENDERED.

THIS CONSENT WILL BECOME EFFECTIVE IMMEDIATELY, AND REMAIN IN EFFECT UNTIL WRITTEN CANCELLATION IS RECEIVED.

DATE: _______________ SIGNATURE OF PATIENT: ____

MEDICAL HEALTH QUESTIONNAIRE

NAME________________________________AGE_______DATE OF BIRTH__________________

MALE____FEMALE_____WEIGHT_____HEIGHT______RIGHT OR LEFT HANDED (**please circle**)

NAME OF INTERNIST/PRIMARY PHYSICIAN____

PRIOR SIGNIFICANT MEDICAL ILLNESSES:

Diabetes……………..	No	Yes	Heart Disease………..	No	Yes
Stroke……………….	No	Yes	Tuberculosis…………	No	Yes
Cancer……………….	No	Yes	Hepatitis…………….	No	Yes
Rheumatic Fever…….	No	Yes	Other serious diseases______________________		

OPERATIONS:

Have you had any surgery…………	No	Yes	Cataract………………..	No	Yes
Tonsils…………………………….	No	Yes	Hysterectomy………….	No	Yes
Hernia……………………………..	No	Yes	Other…………………..	No	Yes(please list)

Other surgeries:____

MEDICATIONS CURRENTLY TAKING:

Prescription drugs:

Name:__________________________________Dose__________________________________

Name:__________________________________Dose__________________________________

Name__________________________________Dose__________________________________

Over the counter drugs:

Name:__________________________________Dose__________________________________

Name;__________________________________Dose__________________________________

Name:__________________________________Dose__________________________________

Other drugs taken within past 6 months (circle one)			**Dosage**
Heart Medication………………………………………	Yes	No	___________
Anticoagulant ………….………………………………...	Yes	No	___________
Blood pressure medication…….………………………	Yes	No	___________
Tranquilizers …………………………………………..	Yes	No	___________
Diuretics………………………………………………..	Yes	No	___________
Sleeping medications………………………………….	Yes	No	___________
Cortisone………………………………………………	Yes	No	___________
Anti-inflammatory drugs………………………………	Yes	No	___________

ALLERGIES AND SENSITIVITIES

Penicillin or other antibiotics…………………….….	Yes	No
Codeine………………………………………..……….	Yes	No
Sulfa…………………………………………………..	Yes	No
Aspirin………………………………………………..	Yes	No
Iodine………………………………………………….	Yes	No
Any foods such as milk, eggs, chocolate………………	Yes	No

Any other drugs (please list)____

SOCIAL HISTORY:

SINGLE ______ MARRIED ________ SEPARATED ______ DIVORCED ______ WIDOWED _________

ALCOHOLIC BEVERAGES: NEVER ___________ RARELY ________________ NONE _____________

TOBACCO: CIGARETTES _______ PACKS PER DAY CIGARS __________ PIPE __________

OCCUPATION: ____

RETIRED: YES ______ NO _________

FAMILY HISTORY:

FATHER: IF LIVING AGE____ IF DECEASED AGE _______ HEALTH ISSUES ________________________

MOTHER: IF LIVING AGE ____ IF DECEASED AGE _______ HEALTH ISSUES ________________________

BROTHER/SISTER: AGES __________________ HEALTH ISSUES ___________________________

HAS ANY BLOOD RELATIVE BEEN DIAGNOSED:

(PLEASE CIRCLE BELOW)

CANCER

TUBERCULOSIS

DIABETES

HEART DISEASE

HIGH BLOOD PRESSURE

STROKE

SEIZURES

BLEEDING TENDENCY

GOUT

OTHER SERIOUS ILLNESS: ____

MEDICAL HISTORY 3

REVIEW OF SYSTEMS

(PLEASE CIRCLE YOUR POSITIVE RESPONSES)

GENERAL: RECENT WEIGHT CHANGE

CANCER TYPE ____

SKIN: SKIN DISEASE ____

EAR-NOSE-THROAT; EYE DISEASE SINUS DISEASE EASY NOSEBLEEDS

IMPAIRED HEARING DIZZINESS

NECK: STIFFNESS THYROID DISEASE ENLARGED GLANDS

LUNGS: ASTHMA SHORTNESS OF BREATH PNUEMNOIA

CARDIAC: CHEST PAINS HEART ATTACK HIGH BLOOD PRESSURE

GASTROINTESTINAL ULCERS GALLBLADDER DISEASE LIVER DISEASE

HEPATITIS HEMORRHOIDS ABNORMAL RECTAL BLEEDING

GENITOURINARY LOSS OF URINE CONTROL FREQUENCY OF URINATION BURNING

BLOOD IN URINE KIDNEY DISEASE

GYNECOLOGICAL SPECIFIC PROBLEMS _______________________________

MUSCULOSKELETAL PRIOR FRACTURES ____

PRIOR SKELETAL INJURIES __________________________________

UROLOGIC PROSTATE HYPERTROPHY URINARY RETENTION

HEMATOLOGIC BLOOD DISEASES EXCESSIVE BLEEDING WITH SURGERY

OTHER CONDITIONS ____

Dear Shoulder Patient:

We would appreciate if you could complete the enclosed questionnaire and provide it at your initial appointment. We appreciate your time in completing this form. Please circle the appropriate response **number** in each section.

PAIN

Present all the time, unbearable, strong medications frequently	1
Present all of the time, bearable, strong medication occasionally	2
None or little at rest, present during light activity, aspirin like meds frequently	4
Present during heavy or particular activity only, aspirin like meds occasionally	6
Occasional and slight	8
None	10

FUNCTION

Unable to use the limb	1
Only light activities possible	2
Able to do light housework, and most activities of daily living	4
Most housework, shopping, driving possible, able to fix hair, dress, do brassiere	6
Slight restriction only, able to work about shoulder level	8
Normal activities	10

QUESTIONNAIRE CONTINUED (page 2)

Patient Self-Evaluation: Instability Questionnaire

Does your shoulder feel unstable (as if it is going to dislocate)?	YES NO **Circle one**
How unstable is your shoulder (mark line)? ______________________________ 0 10 Very stable Very Unstable	

Patient Self-Evaluation: Activities of Daily Living Questionnaire

Circle the number in the box that indicates your ability to do the following activities:
0=unable to do, 1=very difficult to do; 2=somewhat difficult, 3= not difficult

ACTIVITY	RIGHT ARM	LEFT ARM
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your painful or affected side	0 1 2 3	0 1 2 3
3. Wash back or do up bra in back	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10 lb. above the shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhead	0 1 2 3	0 1 2 3
9. Do usual work-list:	0 1 2 3	0 1 2 3

We appreciate your time in completing this questionnaire. At the end of the year, we will be mailing you the same questionnaire to complete. Thank you again for your time.

- Inspections and Copies: the right to inspect and obtain copies of the medical information that may be used to make decisions about you, including medical records, billing records, but not including psychotherapy notes. In order to inspect or obtain records, you must submit the request in writing to the address on the back of the brochure.

- Amendment: the right to ask us to amend your medical information if you believe it is incorrect or incomplete, and you may request and amendment for as long as the information is kept by or for our organization. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request and the reason for your request in writing to the address in the back of this brochure. Also, we may deny the request if you ask us to amend information that is accurate and complete; not part of the information kept by or for our organization; not part of the information which you are permitted to inspect and copy; not created by our organization, unless the individual or entity that created the information is not available to amend the information.

- Accounting of Disclosures: the right to request an accounting of disclosures made of your medical information to entities whom you do not have an established relationship with. In order to obtain an accounting, you must submit your request in writing to the address on the back of this brochure. All requests may not be longer than 6 years and may not include dates prior to October 16, 2002. The first request in a 12 month period is free of charge. You will be charged for any additional lists requested in a 12 month period.

- Right to File a Complaint: If you believe your rights have been violate, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing the complaint. All complaints must be submitted in writing at the address listed below.

- Right to Provide an Authorization of Other uses and Disclosures: our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or are not permitted by applicable law. Any authorization you provide to us regarding the use and disclosure if your medical information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your medical information for the reasons described in the authorization. Of course, we will not be able to take back any disclosures that we have already made with your permission.

- Right to a Paper Copy of This Notice: you are entitled to receive a paper copy of this notice of privacy practices. You will be asked to sign an acknowledgment proving receipt of this Notice of Privacy Practices.

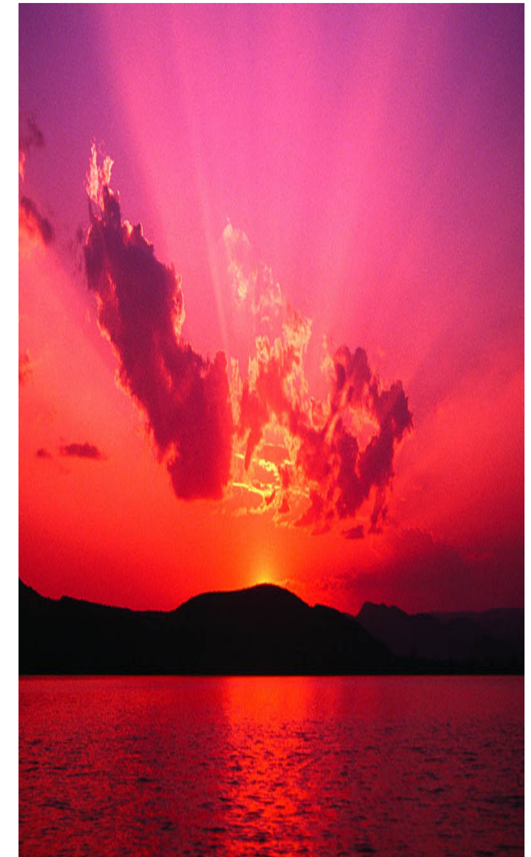
The Sports Clinic Orthopaedic Medical Associates, Inc.

23961 Calle de Magdalena, Suite 229

Laguna Hills, CA 92653

HIPAA

PATIENT PRIVACY RIGHTS NOTIFICATION



HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following describe the different ways in which we may use and disclose your medical information.

1. Treatment: in order to treat you and may disclose information to others who assist with your care or treatment.

2. Payment:: in order to bill and collect payment for services you receive from us. We may use and disclose information to obtain payment from third parties that may be responsible for such costs such as family members. We may use your medical information in order to bill you directly for services and items.

3. Health Care Operations: to operate our business to ensure you receive quality care and to assure our organization is well run.

4. Appointment Reminders: to remind you that you have an appointment at the daytime number you provide us with.

5. Treatment Alternatives: to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

6. Fundraising: in order to contact you as part of fund raising activity. We may disclose your information to a business associate or to a foundation related to our organization to raise money for our organization. Name and address only will be used.

7. Marketing: to make a marketing communication to you that occurs in a fact-to-face encounter with you; concerns products or services of nominal value; or concerns our health-related products or services, or those of another party, provided that we tell you that we are the party communicating with you, and tell you if we have received, or will receive, directly or indirectly, any money or other remuneration for making the communication to you.

8. Required By Law: when required by applicable law regarding crime or criminal conduct; warrant, summons, subpoena or legal process. If served with a legal subpoena for records (contains a release of records signed by you or verbal authorization obtained from you or your attorney of record or proof of service from the requesting party) we must honor the request.

9. Public Health Activities: to control disease, injury, or disability; maintain vital records such as birth or death; report child abuse or neglect; exposure to communicable disease; drug reactions or FDA warnings; recalled devices or medications. To notify appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient including domestic abuse if the patient agrees or we are required or authorized by law to do so. Under limited circumstances, to your employer for related workplace injury or illness or medical surveillance.

10. Coroners, Medical Examiners, and Funeral Directors: as needed to carry out their duties required by law.

11. Organ and Tissue Donation: to organizations that handle organ and tissue procurement, banking or transplantation.

12. Research: subject to special approval process, information may be used on research projects or studies. The information will not leave our premises.

13. Serious Threats to Health Or Safety: to reduce or prevent a serious threat to your health and safety or that of another individual or the public. We will only disclose to persons or organizations able to help prevent the threat.

14. Specialized Government Functions: if you are a member of U.S. or foreign military forces (including veterans) and if required by appropriate military command authorities; or to federal officials for intelligence and national security.

15. Workers Compensation: our organization will release your medical information for workers' compensation and similar programs to all parties as required by state and federal law.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding the medical information that we maintain about you. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when necessary to treat you. In order to request a restriction in our use or disclosure of your medical information , you must make your request in writing to the address on the back of this brochure.

- Requesting Restrictions: the right to request a restriction in our use or disclosure of your medical information for treatment, payment or health care operations. You have the right to limit our disclosure to individuals involved in your care or the payment for your care such as family members and friends.
- Confidential Communications: the right to request our organization communicate with you about your health and related issues in a particular manner or certain locations without stating a reason for your request.

THE SPORTS CLINIC
ORTHOPEDIC MEDICAL ASSOCIATES, INC.
23961 Calle de la Magdalena #229 Laguna Hills, CA 92653
949-581-7001

PRIVACY RIGHTS NOTIFICATION AND ACKNOWLEDGEMENT

I hereby acknowledge that I have received the notice of Privacy Practices ((Patient Privacy Rights Notification)

Signature: ____

Print Name: ____

Date: ________________________

Secure Phone Option:

Is there a telephone number on which personal health information can be left on your message recording in the event that you are not available when we call? YES NO

IF yes, what is the number: ___________________________ __________________
Initials

**This acknowledgement reflects the proposed modifications to s164.520 of the Privacy Standards as set forth by the Department of Health and Human Services at 67 Fed. Reg.14814 (March 27, 2002). It applies to health care providers with direct treatment relationships. This acknowledgement or some other form of acknowledgment (i.e. initials) must be on a cover sheet accompanied by the disclosure log, kept in a separate, visible place in the patient record, apart from the Medical PHI.

Commitment to Education

The Sports Clinic physicians teach at national medical meetings and also hold their own continuing medical education courses in surgical techniques to orthopaedists and allied professionals.

Dr. Nottage maintains an academic teaching staff position at UCI Medical Center as a Clinical Professor in the Department of Orthopaedic Surgery.

The Sports Clinic is the only institution in South Orange County providing fellowship training for Orthopaedic Surgeons in sports medicine.

We provide community lectures about injury prevention and treatment. Our physicians provide medical coverage to local high school teams with educational programs for athletes, coaches and parents.

Contact with Referring Physicians

When patients are referred to *The Sports Clinic*, we maintain close contact with the referring physician to ensure that they are kept abreast of the evaluation and treatment provided by *The Sports Clinic* physicians.

Appointments

For more information about the Sports Clinic, or to schedule an appointment, please call: **949-581-7001** between 9:00 a.m. and 5:00 p.m. We are never too busy for you, please call **anytime**. In case of emergencies, a physician is **always** available.

HOSPITAL MEMBERSHIPS INCLUDE:

Saddleback Memorial Medical Center
Mission Regional Medical Center
Saddleback Valley Surgery Outpatient Center

The Sports Clinic is located next to Saddleback Memorial Medical Center, on the 2nd floor, Suite 229 in the office building at 23961 Calle de la Magdalena. Parking is available in the parking structure in front of the building.

Wesley M. Nottage, M.D.

23961 Calle de la Magdalena, Suite 229
Laguna Hills, CA 92653

Phone: 949-581-7001
Fax: 949-581-8410

www.thesportsclinic.net

It's More than Just a Game

Accurate Diagnosis

Injuries are best treated when an accurate diagnosis and appropriate treatment is instituted early. Hence, our goal for each patient is to facilitate a rapid and safe return to sports, work and an active lifestyle.

Personalized Attention

The Sports Clinic is staffed by health care professionals who believe that our patient's best interests come first. We do our very best to accommodate your needs, with flexible and rapid accessibility to an orthopaedist. Our physicians and staff provide you with personalized attention, education and treatment.

Advanced Research

The Sports Clinic is involved in ongoing research projects focused on developing improved techniques, instrumentation and treatment in arthroscopic surgery.

Wesley M. Nottage, M.D.

Established Excellence

The Sports Clinic's founding physician, Dr. Wesley Nottage, has established a reputation for excellence in orthopaedic care, having practiced in the South County area for more than two decades.

EDUCATION

Dr. Nottage graduated from the University of California Irvine School of Medicine and completed his residency in Orthopaedic Surgery at UCI Medical Center. He received specialized training as a Clinical Fellow with Richard O'Connor, M.D. in Arthroscopy.

CERTIFICATION

Diplomate, American Board of Orthopaedic Surgery

MEMBERSHIP

Fellow, American College of Surgeons
Fellow, American Academy of Orthopaedic Surgeons
Arthroscopy Association of North America
International Arthroscopy Association
American College of Sports Medicine
Western Orthopaedic Association
American Shoulder and Elbow Surgeons
American Orthopaedic Society for Sports Medicine

Treatment Services

- Injury assessment
- Progressive rehabilitation programs
- Innovative outpatient surgical procedures
- Administrative assistance with insurance carriers and payment plans

We are fully equipped to deal with your insurance plan, whether it is private, worker's compensation or a managed care policy. Our computerized billing department will assist you in filing your claims to insure that you receive the highest value for your health care dollar.

Expertise, Experience

Our physicians are Sports Medicine and/or Arthroscopy Fellowship-trained orthopaedic surgeons, with expertise in knee and shoulder arthroscopic reconstructive techniques.

State of the Art

The Sports Clinic is endowed with the latest, state-of-the-art equipment for accurate diagnosis and treatment. With the advanced skills and techniques, clinical experience and proficiency provided by our surgeons, patients benefit from rapid recovery and mobilization.