



MISSION PEAK ORTHOPAEDIC MEDICAL GROUP, INC.

ORTHOPAEDIC SURGERY ♦ SPORTS MEDICINE ♦ SHOULDER & ELBOW SURGERY ♦ KNEE SURGERY & ARTHROSCOPY
JOINT REPLACEMENT ♦ PODIATRY ♦ FOOT & ANKLE SURGERY ♦ ORTHOTICS

In order to bill your Insurance. Please fill out the following information completely

1) PATIENT REGISTRATION		CHART #	DR:	DATE:
WHO MAY WE THANK FOR YOUR REFFERAL ?		DOCTOR	CITY	OTHER
YELLOW PAGES	FRIEND	WEBSITE		
FIRST NAME	MIDDLE	LAST	BIRTHDATE	AGE
CIRCLE ONE MR. MS. MRS. MISS	SOCIAL SECURITY NO	DRIVER'S LICENSE		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
STREET ADDRESS	CITY	STATE	ZIP	HOME PHONE
WORK PHONE	CELL PHONE	EMAIL	DATE OF INJURY	
MAY LEAVE MESSAGE WITH:	<input type="checkbox"/> HOME ANSWERING MACHINE	<input type="checkbox"/> ANYONE ANSWERING HOME PHONE		
	<input type="checkbox"/> WORK ANSWERING MACHINE	<input type="checkbox"/> ANYONE ANSWERING WORK PHONE <input type="checkbox"/> NO ONE		
EMPLOYER NAME OR NAME OF SCHOOL		NAME OF SKILLED NURSING FACILITY		

2) EMERGENCY CONTACT				
NAME OF PERSON	RELATIONSHIP	HOME/CELL PHONE	WORK PHONE	
3) INDIVIDUAL RESPONSIBLE FOR PAYMENT				
NAME OF PERSON	SOCIAL SECURITY #	BIRTHDATE		
HOME PHONE	CELL PHONE	WORK PHONE	RELATIONSHIP TO PATIENT	
		<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER		
STREET ADDRESS	APT#	CITY	STATE	ZIP
EMPLOYER	PHONE NUMBER			

4) PRIMARY INSURANCE COMPANY			<i>Please present insurance card to the receptionist</i>
INSURANCE COMPANY NAME	SOCIAL SECURITY #	BIRTHDATE	
NAME OF INSURED	INSURANCE ID#	GROUP #	

5) SECONDARY INSURANCE COMPANY			<i>Please present insurance card to the receptionist</i>
INSURANCE COMPANY NAME	SOCIAL SECURITY #	BIRTHDATE	
NAME OF INSURED	INSURANCE ID	GROUP #	

6) WORK RELATED INJURIES		YES	NO
NAME OF COMPENSATION INSURANCE CARRIER	ADJUSTER AND PHONE NUMBER		
CARRIER'S ADDRESS			
NAME OF EMPLOYER(AT THE TIME OF INJURY)	ADJUSTER FAX NUMBER		
ADDRESS			DATE OF INJURY
AUTHORIZATION GIVEN BY	NURSE CASE MANAGER	PHONE NUMBER	
INDUSTRIAL CLAIM/CASE NUMBER			
<input type="checkbox"/> CONSULT ONLY	<input type="checkbox"/> CONSULT AND TREAT	<input type="checkbox"/> TRANSFER CARE	

PLEASE READ AND SIGN BACK PAGE

SIGNATURE _____ DATE _____



Patient Name _____ Date _____

TO OUR PATIENT OR LEGAL REPRESENTATIVE PLEASE READ AND SIGN:

IF PATIENT IS A MINOR: Please fill out the following CONSENT FOR MEDICAL TREATMENT

I, _____ (Print name), am the parent/legal guardian of _____ (print name of minor), currently a minor, whose date of birth is ____/____/____. I authorize Mission Peak Orthopaedics to provide medical care to my son/daughter, including, but not limited to, diagnostic examinations (including radiological and laboratory testing).

SIGNATURE OF CUSTODIAL PARENT/LEGAL GUARDIAN

PLEASE BE ADVISED THAT WE BILL YOUR INSURANCE ON YOUR BEHALF. HOWEVER, IT IS THE PATIENT'S RESPONSIBILITY TO KNOW AND UNDERSTAND POLICIES AND BENEFITS OF THEIR OWN INSURANCE PLAN.

ASSIGNMENT OF BENEFITS-FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Mission Peak Orthopaedic Medical Group for services rendered. I understand that **I am financially responsible for all charges whether or not they are covered by insurance.** In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all necessary information to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

HIPAA COMPLIANCE

As mandated by the Federal Government and office of Civil Rights, Mission Peak Orthopaedic Medical Group is required to follow the **HIPAA Compliance Act to ensure patient confidentiality.** I understand that as part of my healthcare, Mission Peak Orthopaedic Medical Group maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care treatment.

I understand that this information serves as a 1) basis for planning my care and treatment; 2) means of communication amongst the many healthcare professionals who contribute to my care; 3) source of information for applying my diagnosis and surgical information to my bill; 4) means by which a third-part can verify that services billed were actually provided; 5) a tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right: 1) to object to the use of my health information for directory purposes; 2) to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operation—and that the organization is not required to agree to the restrictions requested; 3) to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I REQUEST THE FOLLOWING RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION:

Detailed message regarding test results can be left on my answering machine: Yes No

MEDICAL INFORMATION CAN BE DISCUSSED WITH PATIENT ONLY FAMILY MEMBER OR FRIEND _____

PHYSICIAN OTHER _____ OTHER RESTRICTIONS _____

Signature of Patient or Legal Representative

If you are a Medicare patient, please read and sign.

MEDICARE AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made or on my behalf to Mission Peak Orthopaedic Medical Group for any services rendered by physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is complete, my signature authorizes releasing information to the insurer of the agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of Medicare. The patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon the charge determination made by the Medicare carrier.

Signature of Patient or Legal Representative



MISSION PEAK ORTHOPAEDIC MEDICAL GROUP, INC.

ASHAY A. KALE, MD SOHEIL MOTAMED, MD JOSHUA VAN GOMPEL, DPM CO BANH, MD

686 MOWRY AVENUE, FREMONT, CA 94536 (510) 797-3933 FAX (510) 797-5184
27206 CALAROGA AVE. SUITE 120, HAYWARD, CA 94544 (510) 797-3933 FAX (510) 797-5184
5924 STONERIDGE DRIVE, SUITE 110, PLEASANTON CA, 94588 (925) 846-6200 FAX (510) 797-5184

Mission Peak Orthopedics

Mission Peak Orthopedics Commitment to Quality Medical Care

Mission Peak Orthopedics is committed to providing you with high quality medical care. We participate in continuing medical education to keep our knowledge and skills current and strive to ensure that our patients receive high quality medical care from this practice.

We also understand that as a patient, you may at times have concerns about our services. We encourage you to communicate your concerns to our staff. **Please tell us if you have a concern-We value your feedback.** Please tell us if you have any questions about your care, suggestions to improve the delivery of health care in this office, or complaints about any aspect of your treatment. We appreciate being part of your health care team and **Greatly** value your feedback. If you have any questions regarding our practice which we are not able to mutually resolve **Contact the Alameda-Contra Costa Medical Associates at (510) 654-5383.**

We offer this NOTCIE TO CONSUMERS: Medical doctors are licensed and regulated by Medical Board of California (800/663-2322 or www.mbc.ca.gov).

I have read and understand the options available to me in regards to my medical care. I understand that medical doctors are licensed and regulated by the Medical Board of California.

Patient/Patient Representative Signature

Patient/Patient Representative Name- Please Print

Date