Stephen M. Howell, M.D.
8120 Timberlake Way Suite 112 Sacramento, CA 95823
Phone (916) 689-7370 Fax (916) 688-5610
www.drstevehowell.com

1 PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ M.I:________

Sex: ☐ Male ☐ Female Date Of Birth: _______ /________ / 20_______ Age: ___________ Social Security: ___________-__________-____________

Home Phone: (_________) ___________-_____________ Cell Phone: (________) _________-____________ Opt In For Text Messages: ☐ Yes ☐ No

Email: ____________________ ____________________@__________________________________ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Language Preference: ☐ English ☐ Spanish ☐ Other ____________________________ ☐ Domestic Partner ☐ Separated

Address: ____City:_______________________State______________ Zip________________

Employer: ____________________________________Work Phone: (__________) __________-____________ Occupation: ______________________________

Employment Status: ___________________________ Are You Here For A Work Related Injury? ☐ Yes ☐ No Date Injured: ________/_________/__________

*** Primary Care Physician**:____ *** Primary Care Phone** (_______) ____________-_____________

*** Primary Care Physician Address**: ____

Emergency Contact: Name: ______________________________ Relationship: ___________________________ Phone: (________) ___________-__________

2 INSURANCE INFORMATION

PRIMARY INSURANCE: ______________________________________ Name of Insured Person: ____

Relationship to Patient: _______________________________________ Social Security # of Insured Person: _____________________________________

Date of Birth of Insured Person: _______________________________ Subscriber ID #: ____

Group #: ____ Medical Group: ____

SECONDARY INSURANCE: ___________________________________ Name of Insured Person: ____

Relationship to Patient: _______________________________________ Social Security # of Insured Person: ___________________________________

Date of Birth of Insured Person: ________________________________ Subscriber ID#:____

Group #: ____ Medical Group: ____

3 RESPONSIBLE PARTY FOR PAYMENT

First and Last Name: ____ M.I: __________ DOB: _______/_______/ 19______

Home Phone #: (___________) __________-_______________ Social Security #: _____________-_____________-______________

Address: ____ City: _________________________ State: ________ Zip Code: ___________

4 ASSIGNMENT AND RELEASE

I have been provided a copy of Steven J. Barad, M.D., and or Stephen M. Howell, M.D., Privacy Notice and have been provided with a Patient Consent Form for treatment. The financial/credit policy has also been provided to me and I agree to the terms as stated in that policy. I hereby assign to Steven J. Barad, M.D., and or Stephen M. Howell, M.D., all benefits payable under the terms of my insurance policy as listed above. I realize that I am responsible for any balance not payable by my insurance company. I also understand that I will be responsible for any expenses incurred in the collection of outstanding balances that I may have, whether it be from a collection agency or an attorney.

______________________________	______________________________	______________________________
Responsible Party Signature	Relationship	Date

Steven J. Barad, M.D. ◊ *Stephen M. Howell, M.D.* **Medical History**

Name: ______________________________________ Date of Birth: _______/________/19_________
☐ Male ☐ Female Weight: ________lbs Height: _____' _____" Pregnant: ☐ Yes ☐ No
Dominate Hand: ☐ Right ☐ Left Legal Matter: ☐ Yes ☐ No

SOCIAL HISTORY:

Occupation: ______________________________________

Hobbies: ______________________________________

____

Recreation: ______________________________________

____

Sports: ______________________________________

____

Position Played: ______________________________________

Do you dip or chew tobacco? ☐ Yes ☐ No
How much per day? _________________
Smoker? : ☐ Yes ☐ No _________________ Packs Per Day
Do you drink alcoholic beverages? ☐ Yes ☐ No
If yes, how many drinks per week? ________________

CURRENT MEDICATIONS:

☐ **Not currently taking medication**

Name: *Dose:* *Frequency:*

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________

Have you ever taken any of the following?
Prednisone: ☐ Yes ☐ No
Anabolic: ☐ Yes ☐ No

Have you ever been addicted to the following?
Alcohol: ☐ Yes ☐ No
Drugs: ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No
If so what is the allergy? ______________________________
Allergies to Medications: ______________________________

____

____

____

☐ No known medication allergies.

SURGICAL HISTORY: ☐ **No Previous surgery**

Past Surgical History:
Operation: D/M/Y

____

____

____

____

____

Do you have a Cardiologist? ☐ Yes ☐ No

Cardiologist Name: ______________________________
Cardiologist Phone: (______)-__________-_________________

Anesthetic Complications: ☐ Yes ☐ No
Describe: ______________________________________

____

Bleeding Complications: ☐ Yes ☐ No
Transfusions? ☐ Yes ☐ No

Have you ever used illegal drugs? ☐ Yes ☐ No
When: __________________ Type: ____________________
Frequency: ______________________________________

PAST MEDICAL HISTORY:

Illnesses: ______________________________________

____

____

____

Injuries: ______________________________________

____

____

Please check if you ever had any of the following:

☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Chemical Dependency
☐ Diabetes
☐ Emphysema
☐ Gastrointestinal Disease
☐ Genitourinary Disease
☐ Heart Disease
☐ Hepatitis A B C
☐ HIV Positive
☐ Kidney Disease
☐ Liver Disease
☐ Lung Disease
☐ Pacemaker
☐ Blood Clots
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Phlebitis
☐ Recurrent Infections
☐ Syphilis

Date: ______/______/**20**______

Steven J. Barad, M.D.
Stephen M. Howell, M.D.
8120 Timberlake Way Suite 112
Sacramento CA, 95823
Office Phone: 916-689-7370 Fax: 916-688-5610

I acknowledge that I have received or been offered a copy of Dr. Barad and or Dr. Howell HIPPA PRIVACY NOTICES & PRACTICES POLICY.

☐ **CONSENT FOR TREATMENT:**

I acknowledge and understand that in presenting myself for medical care and treatment at the medical practice of Dr. Barad and or Dr. Howell that I authorize and consent to the administration and performance of any tests, examinations, and treatments which may be ordered by the physician and/or designated staff and carried out by Dr. Barad and or Dr. Howell I understand that this consent will remain in effect until I choose to revoke it in witting.
Minors must be accompanied by a parent or legal guardian in order to obtain medical services.

☐ **FINANCIAL POLICY/ASSIGNMENT OF BENEFITS:**

In consideration of any services rendered to me by Dr. Barad and or Dr. Howell, I hereby authorize and assign any and all reimbursement pertaining to said services to be made on my behalf and paid directly to Dr. Barad and or Dr. Howell. If my insurance benefits are provided to me through Medicare, I hereby authorize and assign any and all reimbursement made under my Medicare plan which pertains to any services provided to me by Dr. Barad and or Dr. Howell to be paid directly to Dr. Barad and or Dr. Howell.

☐ **AUTHORIZATION TO RELEASE INFORMATION:**

I authorize Dr. Barad and or Dr. Howell to release and disclose any medical information about me that pertains to any and all medical care, testes, treatment, or advice that was rendered to me by physicians and/or staff at the office of Dr. Barad and or Dr. Howell to my primary care physician, insurance companies, third party payers, authorized agents, claims review organizations, and/or Medicare in order to process a claim and/or payment on my behalf.

☐ **PAYMENT AGREEMENT:**

I understand that providing a valid and current insurance card prior to services being rendered, Dr. Barad and or Dr. Howell will file a claim to my insurance company but that does not guarantee payment which ultimately I am responsible for. I hereby accept and assume financial responsibility for any covered or non-covered services rendered to me and will be responsible for any services that are unpaid as a result of not providing Dr. Barad and or Dr. Howell with a valid referral. If there are any questions, problems, or delays regarding my coverage and or benefits, I understand that it is my responsibility to resolve these issues with my insurance carrier and the billing office administrator. ***Deductibles, copayments, and payment for non-covered services will be due at time of service.***

Please sign below and initial the provided boxes above if you have read and acknowledge all of the above:

SIGN: ____*Date*_________________________

Steven J. Barad, M.D.
Stephen M. Howell, M.D.

HIPPA SUMMARY PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you, in case of any changes to your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Public health issues as required by law, Communicable Diseases; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Criminal Activity: Military Activity and National Security: Workers' Compensation: inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes as described in this Notice of Privacy Practices. Your request must stat the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Steven J. Barad, M.D.
Stephen M. Howell, M.D.

Diplomate American Board of Orthopedic Surgery

Arthroscopic Surgery • Sports Medicine • Joint Replacement
Specializing in Disorders of the Knee and Shoulder

FINANCIAL POLICY

In order to avoid any misunderstanding between our patients and the office, we have adopted the following financial policy. If you have any questions please discuss them with our patient billing representatives. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, American Express, Discover, MasterCard and Visa.

- Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will file your insurance claims for you if you assign benefits to the physician. If your insurance company does not pay within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

- We have made prior arrangements with many health plans to accept an assignment of benefits. If you are covered by one of these plans, we will bill your plan and will only require you to pay the copayment or coinsurance due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We highly recommend that you READ YOUR INSURANCE BOOKLET or a copy of the contract your policy falls under to determine your benefits.

- You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full immediately.

- Be prepared to present your insurance card and proof of identity (e.g. driver's license) at each visit. You will be responsible for providing a change of address, telephone number, e-mail address and/or insurance information any time a change occurs.

- A prepayment of your deductible and coinsurance will be required for your portion of our fees, based on our contract allowable, for scheduled surgical procedures. Any balance remaining, after your health plan pays, is your responsibility, Payment is due upon receipt of a statement from our office.

- We look to the adult accompanying a minor for payment of all services rendered to minor patients.

When you are charged a "global" fee for surgery or office care of a fracture, that fee not only includes the service on the day it is performed, but includes routine followup care as well. The global period is 90 days depending on the procedure and your health plan. X-rays and supplies (such as casting or dressing materials) are not included in the "global" fee and a charge will be made for these items, Services related to complications are not included in the global fee.

PLEASE SIGN AND DATE AS AKNOWLEDGMENT OF POLICY: ____