NewportCare®
Orthopaedic & Spine Center

Newport Care Medical Group
3300 West Coast Hwy
Newport Beach, CA 92663
949-491-9991 (o)
949-258-5858 (f)

Today's Date_____

Patient Name_____ Social Security No. _____

Address_____ Telephone (_____)_____

Occupation_____ Birth Date_____ Age_____ Sex_____

Employer-Name_____ Driver's License No._____

Employer Address_____ Telephone No. _____

☐ Married ☐ Single ☐ Divorced ☐ Widow

Spouse/or Responsible Parent _____ Social Security No._____

Address_____ Telephone (_____)_____

Occupation_____ Birth Date_____ Age_____ Sex_____

Employer-Name_____ Driver's License No._____

Employer Address_____ Telephone No. _____

Emergency Contact (Other than husband or wife) person not living with you

Name_____ Relationship_____

Address_____ Telephone (_____)_____

- Please Complete if patient is under 21 years of age or a student

Father's Name_____ Mother's Name_____

Father's Occupation_____ Mother's Occupation_____

Father's Employer_____ Mother's Employer _____

Address_____ Address_____

Medical Insurance Information

Primary Insurance Subscriber_____ Secondary Insurance Subscriber_____

Insurance Co._____ Insurance Co._____

Billing Address_____ Billing Address_____

Identification Number_____ Identification Number _____

Group Number_____ Group Number_____

Referred by: _____Address:_____Phone:_____Fax:_____

Family Dr:_____Address:_____Phone:_____Fax:_____

Chief Complaint:_____

Is your condition related to an accident or injury? Yes No

Is this accident/injury related to: Auto Job Other _____

Date of accident/injury:_____ Are you right or left hand dominate? Right Left

Injection: Yes No Occupation: _____ Hobby: _____

Have you had: Physical Therapy? Yes No Use of assisted devices:_____

Have you had a: CT Scan MRI Xrays Other:_____

Past/Current Medical History:

None	Asthma	Cancer	Heart Disease	Heart Failure
Lung Disease	Stroke	GERD/Heartburn	Hypertension	Seizure
Diabetes	Other_____			

Past Surgical History None Other:_____

Family History: Non contributory Other:_____

Social History:

None	Smoker: ____ x packs/days x yrs		Recreational drug use:_____
Alcohol	Daily	Weekly	Monthly	Rare

Review of Systems: All systems negative except as noted below

General:	Fatigue	Unexpected Weight Loss
Eye:	Blurred vision	Other:_____
ENT	Sore Throat	Nasal Drainage/Congestion Other:_____
Pulmonary	Cough	Sputum Other:_____
Cardiovascular	Chest Pain	Shortness of breath Other:_____
GI	Abdominal Pain	Nausea/Vomiting Incontinence Other:_____
Skin	Skin Rash	Other: _____
Genito-Urinary:	Problems Urinating	Abnormal discharge Incontinence Other:_____
Psych:	Depression	Anxiety Other:_____
Hemotology:	Bruising	Other:_____
Endocrine:	Temperature Intolerance	Other:_____
Immune System:	Choking Status Post Environmental Exposure	Other:_____

Please list all current medications:

Please list all allergies:

Pharmacy Contact Info:

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Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

Only upon request, your organization will provide a copy of Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at this address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are required to agree to my requests, and by agreeing to such requests; you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

Patient Name _____

Signature _____

Relationship to Patient _____

Date _____

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Release of Records

I _____, hereby give Newport Care Medical Group authorization to discuss my medical condition and test results with:

Please list all the names and phone numbers as appropriate.

Spouse_____

Mother _____

Father_____

Sister(s) _____

Brother(s)_____

Son(s) _____

Daughter(s)_____

Caregiver_____

Answering machine at phone number _____

Other _____

No one but patient_____

Patient Name _____

Signature _____

Relationship to Patient _____

Date _____

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Acknowledgement of Receipt of Notice of Privacy Practices

The Practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices.

Patient Name _____

Signature _____

Relationship to Patient _____

Date _____

Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of Notice of Privacy Practices on _____.

The Acknowledgement was not obtained because.

* The patient was undergoing emergency treatment

* The patient declined to sign the Acknowledgement

* Other _____

Patient Name_____

Name of Staff Member_____

Signature_____

Date_____

Physician Order Rx/Request for Authorization: Prescription Form/ Certificate of Medical Nevessity

Paitent Name _____ Physician Name _____

Surgery Center _____ Primary ICD-9 Code(s) _____ DOI: _____ ☐ Right ☐ Left

Product Description	Product Description	Product Description
Place Sticker Here	Place Sticker Here	Place Sticker Here

Narrative Report:
My signature below acknowledges that, in my judgment, the prescribed item is medically indicated & necessary and consistent with current accepted standards of medical practice and treatment of this patients physical condition. My signature also serves to confirm the veracity of all information included in this document.

Products: ☐ Compression Stocking ☐ Walker Boot ☐ Post-Op Shoe ☐ Knee Immobilizer ☐ Post-Op Knee ☐ LSO ☐ Abdominal Binder ☐ Sling ☐ Shoulder Immobilizer ☐ Cervical Collar ☐ Wrist Brace ☐ Crutches ☐ Thumb Spica ☐ Front Wheel Walker ☐ Other _____

Pneumatic Intermittent Compression (PIC) Device with bilateral calf wraps

☐ **TAKE HOME PORTABLE DEVICE**

Place Label With Serial # Here

DEVICE: Pneumatic Intermittent Compression Device - Duration 1-30 Days
APPLIANCE(S): Segmental Gradient Pressure Pneumatic Appliance(s) X2 - Duration 1-30 Days
MEDICAL COMPLICATIONS: ☐ CVI ☐ Diabets ☐ DVT ☐ Lymphedema ☐ Other: _____

Narrative Report: In my evaluation of this patient. I have noted there is a higher risk of developing Deep Venous Thrombosis (DVT), due to the type of surgery performed combined with other risk factors. I am Prescribing DVT Prophylaxis involving the use of a pneumatic compression device and the necessary appliances. This patient will have decreased ability and duration of ambulation following surgery, which will significantly increase the risk factors associated with DVT, Pulmonary Embolism (PE), DVT and PE can be major complications associated with these surgeries, resulting in significant morbidity and mortality rates, as stated by the American College of Chest Physicians.

Significant published data is available on the incidents of DVT/PE, the effectiveness of various prophylactic techniques and the risks of hemorrhage when heparin is used, all of which provide positive and compelling evidence in support for the use of intermittent compression devices in DVT prevention. The plantar and lower leg wraps have added the advantage of reproducing the physiological mechanism of venous return. Impaired venous blood flow in post abdominal/orthopedic surgeries, trauma, and other conditions that impede or significantly decrease ambulation of patients most certainly will decrease circulation which can result in edema, pain, delayed healing and increased risk of DVT and PE. The clinical trials show clear evidence that these complications and risk factors can be significantly minimized with the use of the PIC devices.

For these reasons, PIC device and compression wraps are prescribed for this patient to maximize the most positive outcome of surgery and minimize the potential for serious complications. I have successfully used this device in my practice and my patients tolerate the treatment protocol with a very high degree of compliance. I feel this protocol is the most beneficial and cost effective treatment of my patients in greatly reducing the development of DVT, which when ignored can result in significant increase in morbidity and mortality and increased utilization of health care resources and dollars.

Rental to Purchase Option

NewportCare Medical Group makes every effort to provide you with equipment that is yours to keep. However, from time to time your doctor may prescribe a rental piece of equipment such as T.E.N.S. If you need a T.E.N.S. prescribed by your doctor, you may know your insurance may help pay for it. T.E.N.S. are normally rented on a monthly basis. If you wish to purchase the T.E.N.S. because you may need it for extended use, we will apply any daily rental rates to the purchase price. In making your decision to rent or purchase this equipment, you should know that you will be responsible for 20% of the service charge. If you choose the purchase option, you will be responsible for the purchase amount less than the rental.

Option
☐ Rental
☐ Purchase

Patient Acknowledgement & Authorization to Assignment of Benefits(PA/AOB)

I acknowledge receiving instruction, have demonstrated or verbalized my understanding in the proper use and care of the equipment or supplies received today described on this document & will follow them. I understand company business hours and a NewportCare Medical Group representative will be contacting me regarding my financial responsibilities related to this agreement. I acknowledge receipt & understand the Company Patient Information Privacy Notice and that all information on this document is correct. I understand and agree that I am responsible for payment or products and services provided by NewportCare Medical Group. I agree to make payment, in full, upon receipt of payment from insurance company to policy holder if not endorsed and forwarded to NewportCare Medical Group. I authorize release of any medical information necessary to process this claim and certify the above information is correct. I authorize any and all payments of medical benefits to NewportCare Medical Group for the products and services rendered.

Paitent Signature _____ Data _____

Product Delivery Acknowledgement (Required for Medicare Claims)

Paitent Signature _____ Data _____

Patisnt Sticker Here

License# _____ NPI# _____ Physician Signature _____

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NewportCare Medical Group
Office Financial Policy

Thank you for choosing NewportCare Medical Group. We are committed to the success of your treatment. We hope you understand that payment of your bills is considered part of your treatment. The following is a statement of our financial policy, which we require you read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by the doctors and physical therapists.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any copay amount due, at the time of services rendered. For patients with dual insurance coverage we will bill both the primary and secondary insurance if you have provided us with the necessary information.

Patients insured with plans which we are NOT contracted with will be required to pay for the first visit in full. For any follow-up visits you will need to pay 30% at the time services are rendered. There will be a 30% down payment prior to any surgery needed.

If you are insured with a plan which we ARE contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your copy amount, at the time of each visit. If for any reason the insurance company failed to pay, the patient will be responsible for the entire balance.

Patients with no insurance coverage are expected to pay for the services at the time services are rendered.

Failure to make payment arrangements, or pay outstanding balances within 60 days of notification of amount due, may result in termination of care from NewportCare Medical Group

Our accepted methods of payments are cash, check, Visa, MasterCard or Discover Card. If requested, a short payment schedule may be arranged for those patients who have special financial conditions.

Again, thank you for trusting us with your care. If you have any questions regarding financial responsibility of payment options, please contract our insurance department.

"I have read, understand and agree to the provisions of this policy"

Patient Name(Print)

Patient Signature / Guarantor

Date

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Financial Interest Consent

I, _____ (patient), acknowledge and accept that my physician(s) may have financial interest in hospitals, surgery centers, imaging centers, physical therapy and/or surgical devices that he/she chooses to utilize. I hereby recognize my rights to choose another physician or request the services of another facility or device be used.

Signature _____

Relationship to Patient _____

Date _____

Submit Reset