THE CENTER FOR BONE & JOINT CARE
Orthopaedic Surgery / Sports Medicine / Joint Reconstruction

TRONG B. NGUYEN, M.D.
Board Certified Orthopaedic Surgeon Fellowship-Trained in Sports Medicine

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	HOME PHONE

ADDRESS	WORK PHONE

CITY, STATE	ZIP	MOBILE

EMAIL	SEX	MARITAL STATUS	AGE
	M-F	M S W D	

PATIENT'S EMPLOYMENT NAME	DATE OF BIRTH

ADDRESS	OCCUPATION	SOCIAL SECURITY

SPOUSE/GUARDIAN INFORMATION

SPOUSE/GUARDIAN FULL NAME	DATE OF BIRTH
	OCCUPATION

REFERRED BY (DOCTOR)	PHONE NUMBER
	FAX NUMBER

NAME OF NEAREST RELATIVE OR FRIEND - NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)	
NAME	CONTACT NUMBER
ADDRESS	**RELATIONSHIP**

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the above named doctor to furnish information to insurance carriers on my behalf concerning my illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits. On balances not paid within 90 days, I will be responsible for interest and penalties incurred at 10%

Patient/Guardian's Signature _____

Patient/Guardian's Print Name _____

DATE _____

HISTORY AND PHYSICAL:

CURRENT MEDICATIONS: ☐ **None**

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

PHARMACY: _____ **PHONE:** _____

DRUG ALLERGIES: _____

PAST MEDICAL HISTORY: ☐ None

Please select if condition applies to your medical history:

☐ High BP	☐ Heart Disease	☐ Diabetes
☐ Arthritis	☐ Angina	☐ Thyroid Disease
☐ Cancer	☐ Glaucoma	☐ Ulcer
☐ Stroke	☐ Jaundice	☐ Colitis
☐ Hepatitis	☐ TB	

Other: _____

PAST SURGICAL HISTORY: ☐ None

	DATE		DATE
Joint Replacement	_____	Gall bladder	_____
Arthroscopic Surgery	_____	Hysterectomy	_____
Neck Surgery	_____	Coronary Bypass	_____
Back Surgery	_____	Tonsil/Adenoid	_____
Hand Surgery	_____		

Other: _____

FAMILY HISTORY: ☐ None

	Father	Mother	Siblings	Children	Grandparent
Heart Disease	☐	☐	☐	☐	☐
High BP	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐

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Office Financial & Statement Policy

Thank you for choosing The Center for Bone & Joint Care. We are committed to the success of your treatment. We hope you understand the payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by doctor.

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 are 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 or **DO NOT have insurance** will be required to pay as a "Out of Pocket Patient" for the initial consultation in full. For any follow up visits, patients will need to pay accordingly. There may be 30% or more down payment prior to any surgery needed.

Dr. Nguyen has financial interest in certain facilities he operates with. There will be a fee of $250 for any surgery cancellation. These fees will offset the surgical preparations which are separate from the surgical facilites.

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 copay amount at time of each visit.

There is a fee of $40.00 or more for all disability, FMLA and any other forms/paperwork that you need to have filled out by the physicians. We may ask that you make an appointment to complete these forms.

There is a fee for any reports or medical records requested by attorneys, insurance companies, disability companies, etc… This charge will be determined by the information requested.

For prescriptions,

If you are in need of a refill, please have your pharmacy fax a request to **714-861-4777**. (Please allow 48 to 72 hrs.)
No pain medication will be given to post operative patients after 60 days of surgery.
Our physician **DOES NOT** prescribe pain medications to chronic pain patients. Patients with chronic pain syndrome are referred to pain management specialists for long term management.

Failure to make payment arrangements, or pay outstanding balances within 60 days of notification of amount due, may result in termination of care from The Center for Bone & Joint Care or possible collection agency.

Our accepted methods of payment are VISA, MasterCard, Discover Card and American Express, cash and checks. There will be a $45 fee for any bounced checks, thereafter, patients are required to pay with "cash". If requested a short payment schedule may be arranged for those patients who have special financial conditions.

It is the patient's responsibility to verify their benefits for their particular plan and to make sure all proper authorizations have been obtained. Some insurance plans will reduce benefits if the insured is treating the doctors outside of the designated network or if the proper authorizations have not been obtained.

Again, thank you for trusting us with your orthopaedic care. If you have any questions regarding financial responsible or payment options, please contact our office.

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

_____ _____

Signature (Patient/Guardian) Date

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and services that you expect and deserve. Achieving our best possible health requires a "partnership" between you and your doctor. As our "partner in health", we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (X-rays, Labs, EKG, MRIs etc.). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule visits with my doctor to complete recommended orders and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I DO NOT Hear the Results of Labs and Other Tests or Authorizations
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, it is my responsibility to call the office for my test results or any authorizations.

Inform My Doctor If I Decide NOT to Follow His Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he feels are best for my health. This might include prescribing medications, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not to follow his recommendations* so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature	Date	Physician Signature