COAST ORTHOPEDICS

APPOINTMENT DATE : _____

JEFFREY M. COLBERT, M.D.
4644 LINCOLN BOULEVARD, SUITE 530
MARINA DEL REY, CA., 90292
TEL: (310) 421 - 2111
FAX: (310) 822 - 4104

PATIENT REGISTRATION

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Patient's Name : _____ Date of Birth : _____
Home Address : _____ City/State/Zip: _____
Mailing Address : _____ City/State/Zip: _____
Social Security # : _____ Driver's License # : _____
Home Tel: (_____) _____ Mobile Tel: (_____) _____

NOTE : Our office utilizes an Automated Reminder System that notifies you 1 to 2 days BEFORE your scheduled appointment date and time, so please indicate the Preferred Telephone # you would like to be called :
(Circle One) :: HOME # / MOBILE # / WORK #

E-mail Addresses : _____ _____
Marital Status (Circle One) : Single / Married / Divorced / Separated / Other: _____

PATIENT'S EMPLOYER INFORMATION

Company : _____ Work Tel:(_____) _____ ext: _____
Address : _____ City/State/Zip: _____

PATIENT'S INSURANCE INFORMATION

(A) Name of **Primary** Insurance : _____
Name of Primary Insured : _____
The patient's relationship to primary insured,(Circle one):: SELF /SPOUSE /CHILD /OTHER: _____
Primary Insured Social Sec. #: _____ Primary Insured's Date of Birth: _____
Subscriber ID #: _____ Group #: _____
Is there another Insurance Coverage ? **NO / YES**

(B) Name of **Second** Insurance, if Applicable : _____
Name of Primary Insured : _____
The patient's relationship to primary insured,(Circle one):: SELF /SPOUSE /CHILD/OTHER: _____
Primary Insured Social Sec. #: _____ Primary Insured's Date of Birth: _____
Subscriber ID #: _____ Group #: _____

Name of Referring Physician : _____
Referring MD's Address : _____
Referring MD's Tel.# : (_____) _____ Fax.# (_____) _____
Name of Primary Care Physician, if different from Referring MD : _____
Primary Care MD's Address : _____
Primary Care MD's Tel.#: (_____) _____ Fax.# (_____) _____
Emergency Contact Information:
Name : _____ **Tel.#**(_____) _____ **(Home/Work/Mobile)**
Your Relationship to this person: _____

Office Disclaimer : By signing here, I agree that all the above information is correct and that it is my responsibility to update any future changes in any or all the information provided herein, from the date of this document .
I hereby authorize Dr. Colbert to furnish this information to the insurance carriers, if requested, for the purpose of the release of payments for the services rendered.

_____ _____
SIGNATURE OF THE PATIENT/INSURED SIGNATURE OF THE PRIMARY INSURED

_____ _____
PRINTED NAME OF THE PATIENT or PRIMARY INSURED DATE SIGNED

JEFFREY M. COLBERT, M.D.

Patient Questionnaire = Please Print Clearly

Name of Patient: _____ Current Age: _____ Today's Date: _____

Current Height: _____ft. _____in. Current Weight: _____lbs. Select One: RIGHT-handed / LEFT-handed

List Any Food and/or Drug Allergies: _____ _____

_____ _____ _____

_____ _____ _____

Your Current Occupation: _____ For how long? _____

List of Your Current Medications and Dosages:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List of Your PAST Surgeries and estimated dates:

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

(6) _____

List of Your Past Medical Problems:

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

(6) _____

Social History:

Do you consume any alcoholic beverages: (_)NEVER (_)RARELY (_)MODERATELY (_)DAILY

Do you smoke or use any tobacco products: (_)NEVER (_)YES, # of cigarettes per day: _____

Do you use any recreational drugs: (_)NEVER (_)YES, what type: _____

For Your Visit this date, List your Current Medical Problems, When and How did each condition start:

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

(6) _____

Is Your Current Medical Condition Work-Related? (_)NO (_)YES, Please complete the following informations:

Name of Work-Comp Carrier: _____

Date of Injury: _____ Claim #: _____

Name of Claims Adjustor: _____

Claims Adjustor's Tel. #: (____)_____ Fax. #: (____)_____

Was authorization Obtained? (_)NO (_)YES – Please provide authorization letter at the Front Desk

JEFFREY M. COLBERT, M.D.

Patient Questionnaire = Please Print Clearly

YOUR MEDICAL HISTORY: Please CHECK if you ever had, or currently have, the following:

Diabetes	(_)NO	(_)YES	High Blood Pressure	(_)NO	(_)YES
Heart Problem	(_)NO	(_)YES	Stroke / CVA	(_)NO	(_)YES
Arthritis / Gout	(_)NO	(_)YES	Convulsions / Seizures	(_)NO	(_)YES
Bleeding Tendencies	(_)NO	(_)YES, What Type: _____			
Hereditary Defects	(_)NO	(_)YES, What Type: _____			
Acute Infections	(_)NO	(_)YES, What Type: _____			
Cancer	(_)NO	(_)YES, What Type: _____			
		In Remission? (_)NO (_)YES			

PHYSICAL CONDITIONS:

Good General Health	(_)NO	(_)YES
Recent Weight Change	(_)NO	(_)YES
Fever	(_)NO	(_)YES
Fatigue	(_)NO	(_)YES
Headaches	(_)NO	(_)YES

CARDIOVASCULAR SYSTEM:

Heart Trouble	(_)NO	(_)YES
Chest Pain / Angina	(_)NO	(_)YES
Palpations	(_)NO	(_)YES
Shortness of Breath	(_)NO	(_)YES
Swelling of Ankles / Feet	(_)NO	(_)YES

RESPIRATORY SYSTEM:

Chronic / Frequent Cough	(_)NO	(_)YES
Spitting Up Blood	(_)NO	(_)YES
Shortness of Breath	(_)NO	(_)YES
Asthma / Wheezing	(_)NO	(_)YES

GASTROINTESTINAL SYSTEM:

Loss of Appetite	(_)NO	(_)YES
Nausea or Vomiting	(_)NO	(_)YES
Frequent Diarrhea	(_)NO	(_)YES
Constipation	(_)NO	(_)YES
Rectal Bleeding	(_)NO	(_)YES
Black Stools	(_)NO	(_)YES
Abdominal Bloating	(_)NO	(_)YES
Abdominal Pain	(_)NO	(_)YES
Heartburn	(_)NO	(_)YES
Gastro-Esophageal Reflux	(_)NO	(_)YES
Ulcers	(_)NO	(_)Yes

MUSCULOSKELETAL SYSTEM:

Joint Pain	(_)NO	(_)YES
Joint Stiffness	(_)NO	(_)YES
Locking of Joints	(_)NO	(_)YES
Joint Popping / Cracking	(_)NO	(_)YES
Joint Grinding / Grating	(_)NO	(_)YES
Muscle Weakness	(_)NO	(_)YES
Pain or Stiffness on Arising	(_)NO	(_)YES
Limping	(_)NO	(_)YES
Leg Cramps on Walking	(_)NO	(_)YES

NERVOUS SYSTEM:

Numbness / Tingling	(_)NO	(_)YES
Shooting Pain to Arms	(_)NO	(_)YES
Shooting Pain to Legs	(_)NO	(_)YES
Tremors	(_)NO	(_)YES
Light-Headedness	(_)NO	(_)YES
Dizziness	(_)NO	(_)YES
Paralysis	(_)NO	(_)YES
Which Side?	LEFT / RIGHT	

GENITOURINARY SYSTEM:

Bladder Problems	(_)NO	(_)YES
Burning on Urination	(_)NO	(_)YES
Pain on Urination	(_)NO	(_)YES
Urgency on Urination	(_)NO	(_)YES
Kidney Stones	(_)NO	(_)YES
For Males Only=		
Prostate Disease / Problem	(_)NO	(_)YES

CIRCULATORY and INTEGUMENTARY SYSTEMS:

Cellulitis	(_)NO	(_)YES	Bruising Tendencies	(_)NO	(_)YES
Phlebitis	(_)NO	(_)YES	Cold Hands	(_)NO	(_)YES
Bleeding Tendencies	(_)NO	(_)YES	Cold Feet	(_)NO	(_)YES
Anemia	(_)NO	(_)YES, What Type: _____			

Name of Subscriber (Please Print)

Name of Patient (Please Print)

NOTICE TO OUR PATIENTS AND/OR CONSUMERS
Jeffrey M. Colbert, M.D. is licensed and regulated by the Medical Board of California
(800) 633-2322 I www.mbc.ca.gov

ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS): I authorize and assign the direct payment to Jeffrey M. Colbert, M.D. any insurance benefits (including but not limited to hospital insurance and unemployment compensation disability benefits) otherwise payable to or on my behalf for these outpatient services, including emergency services if rendered. I understand that Jeffrey M. Colbert, M.D., as a courtesy will bill my insurance company, if applicable, and that I will be responsible for any charges not paid under this assignment. I also certify that any information that I provide relating to applying for payment under the participating provider contracts that Dr. Colbert is a preferred provider.

FINANCIAL AGREEMENT: Professional and Hospital Services: I agree to pay for all charges for healthcare services and professional services provided to me by Jeffrey M. Colbert, M.D. I also agree to pay for hospital services provided to me in accordance with the regular rates and terms. When my spouse or a financial guarantor signs the agreement, the spouse or financial guarantor shall be jointly and individually liable with me. Should the account(s) be referred to an attorney or a collection agency, the undersigned shall pay the actual attorney's fees (including costs) and collection expenses incurred in addition to other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

Signature of Patient

Signature of patient's representative
Or Parent if patient is a minor

Relationship to Patient

Jeffrey m. Colbert, M.D. Representative

Signature of witness/translator

Date of Signing

Time of Signing

Date: _____

When did injury occur or condition start? _____

Where did injury occur? _____

How did injury occur? _____

_____

_____

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

USE AND DISCLOSURE OF YOU PROTECTED HEALTH INFORMATION

Your protected health information will be used by Jeffrey M. Colbert, M.D., and/or his authorized medical staff/office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

NOTICE OF PRIVACY PRACTICE

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION

You may request a restriction on the use or disclosure of your protected health information.

Jeffrey M. Colbert, M.D., and/or his authorized medical staff/office may or may not agree to restrict the use of disclosure of your protected health information

If Jeffrey M. Colbert, M.D., and/or his authorized medical staff/office agrees to your request, the restrictions will be binding on the practice. Use or disclosure of restricted information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCATION OF CONSENT

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES

Jeffrey M. Colbert, M.D., and/or his authorized medical staff/office reserved the right to modify the privacy practice outlined in the notice.

SIGNATURE

I received a copy of the Privacy Practices and have reviewed this consent form and give my permission to Jeffrey M. Colbert, M.D., and/or his authorized medical staff/office to use and disclose my health information in accordance with it.

_____

Name of Patient (print or type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient

Notice of Privacy Practices

THIS NOTICE DESCRIBES FOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOUE CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

USES AND DISCLOSURES

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff.

PAYMENT: Your health information may be used to seek payment from your health plan, from other sources of coverage, such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day-to-day activities and management of Jeffrey M. Colbert, M.D., and/or his authorized medical staff/office. For example, information on the services you received may be used to support budgeting and financial reporting, and the activities to evaluate and promote quality.

LAW INFORCEMENT: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state public health departments.

OTHER USES AND DISCOLSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION

INFORMATION ABOUT TREATMENTS: Your health information may be used to send you information on the treatment and management of you medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit correction to your protected health information
- The right to receive an accounting of how and to whom your protected health information had been disclosed
- The right to receive a printed copy of this notice

THE OFFICE OF JEFFREY M. COLBERT, M.D. DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes to federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Receptionist or Privacy Official.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Jeffrey M. Colbert, M.D.
4644 Lincoln Blvd., Suite 530
Marina Del Rey, CA 90292

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT PERSON

The name and address of the person you can contact for further information concerning our privacy practices is:

Jeffrey M. Colbert, M.D.
4644 Lincoln Blvd., Suite 530
Marina Del Rey, CA 90292
Tel.#: (310) 421-2111
Fax.#: (310) 822-4104

EFFECTIVE DATE

This notice is effective on or after April 14, 2003.

THE OFFICE OF DR. JEFFREY COLBERT DOES NOT VALIDATE FOR PARKING.

Parking for the medical office building at 4644 Lincoln Blvd. is as follows:

If parking at the Marina Del Rey Hospital lot, pay stations for the parking are located at an office to the RIGHT of the hospital just before entering the hospital lobby, OR at the parking lot exit with Credit Card only. The maximum rate is $11.00.

There is also a public parking lot at the intersection of Bali Way and Admiralty Way for the Marina Del Rey Hotel & Salt Restaurant. There are 2 pay stations located in the lot. You must pay before leaving your vehicle and place the ticket on your dashboard with the time facing up. The rate is $0.25/15 min. with a $5.00 maximum for a 24-hour period.