

Orthopedic & Sports Medicine Center
A Medical Clinic
Shaik M. Saheb, M.D., Inc
Diplomate, American Board of Orthopedic Surgery
Fellow, American Academy of Orthopedic Surgeons

Dear Patient,

Please note the date and time you have scheduled your appointment:

Date ____/____/____ Time _____ AM PM

Please complete and sign the patient information sheet and health questionnaire included in this packet and bring them with you for your visit.

As a new patient we do ask that the first visit be paid at the time of service. We are happy to bill your medical insurance and any payment and/or adjustments will be refunded to you once processed by your insurance. If you would like us to verify your insurance and coverage prior to your visit, please call or fax your insurance information to our office at the numbers above. If we are able to verify your coverage and benefits prior to your visit, then you will be asked to cover your co-insurance/co-payment and/or deductible amounts only at the time of service.

If you have medical records at another medical office that you feel Dr. Saheb should have, then please sign and complete the medical release form enclosed, and send it directly to your previous Doctor's office.

Please feel free to give us a call with any questions or concerns you may have. We welcome you to our practice, and look forward to meeting you soon.

Sincerely,
Eileen
Office Administrator

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Patient Registration Form

Patient Information: (To be completed for all patients)

Last Name _____ M.I. _____ First Name _____
D.O.B. _____ SSN ____-____-____ Age _____ Sex _____ Marital Status _____
Address: _____ City _____ State _____ Zip _____
Tel: Home (____) _____ Work (____) _____ Cell (____) _____
Referring Physician _____ Primary physician _____

Private Insurance Information:

Insurance Company _____ Tel: (____) _____
Address: _____ City _____ State _____ Zip _____
Policy # _____ Group # _____
Policyholder's Name (if different) _____ Guarantor Spouse Parent
SSN _____ DOB _____ ID# _____
Secondary Insurance _____ ID# _____
Address _____ City _____ State _____ Zip _____

For Workers Compensation & P.I. (Med-Pay & Lien) Only:

Referring Physician/Attorney/Insurance _____
Insurance Company _____
Address: _____ City _____ State _____ Zip _____
W/C Claim # (Required) _____ P.I. Policy # _____
Adjuster _____ Fax # (____) _____ Tel # (____) _____
Date of Accident/Injury _____ First Consultation Date _____
Body Part Injured _____
Attorney _____ Fax# (____) _____ Tel # (____) _____
Address _____ City _____ State _____ Zip _____

Assignment of Benefits of Insurance Payment to Provider & Third Party Lien

I, _____, instruct and direct my insurance company to pay for all medical services performed by Dr. Saheb. Please mail checks to:

Shaik M. Saheb M.D., Inc

23502 Lyons Avenue Suite

202A

Newhall CA 91321

This is a direct assignment of my rights and benefits under this policy. I also authorize the release of any and all information pertaining to my case to any insurance company, adjuster, or attorney involved in this case. My signature below attests that I have read and fully understand this agreement.

_____/____/____

Signature of policyholder or claimant

Date

****Please attach a legible copy of ID and Insurance Cards****

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Patient History and Information

Date: _____

Name: _____ Employer: _____

Age: _____ Occupation: _____

Date of Injury: _____ Were you injured at work? Yes ___ No ___

Briefly Describe job Duties at the time of the accident:

Did you report the accident/injury to your supervisor? Yes ___ No ___

Did you receive Medical Care? Yes ___ No ___ Therapy? Yes ___ No ___

If yes, please list doctors or Hospital:

Were any tests done? (Please circle) X-rays Cat Scan MRI Other

Where: _____ Results: _____

Are you taking any medications now? Yes ___ No ___ Please List: _____

Are you working now? Yes ___ No ___ Any Restrictions? _____

In No, Last day worked: _____

Do you use any crutches, braces, or support? Yes ___ No ___

Please describe _____

Please check areas where you have pain: (Indicate Right or Left)

Head _____ Shoulder _____ Hip _____

Neck _____ Arms _____ Thighs _____

Mid Back _____ Wrist _____ Knees _____

Low Back _____ Hands _____ Feet _____

Patient History and Information

HIPAA Notice of Privacy Practices

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 health care 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.

1. Uses and Disclosures of Protected Health Information

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 care 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 to remind you of 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, Communicable Diseases: Health Oversight Abuse or Neglect, Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: 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

The 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 not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state 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 the 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. We will not retaliate against you for filing a 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.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print name _____ Signature _____

SHAIK M. SAHEB, M.D
Orthopedic Surgeon
PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient. This agreement is also intended to bind any children, of the patient whether born or unborn at the time of the occurrence giving rise to any claim. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator: (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter.

Either party shall have the absolute right to bifurcate the arbitration of liability and damage issues upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that the provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this Arbitration Agreement including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code §3333.1), the limitation on recovery for non-economic losses (Civil Code §3333.2) and the right to have a judgment for future damages conformed to periodic payments (CCP §667.7).

Article 4: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

 Patient's Initials

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

<i>Physician</i>	<i>Date</i>
<i>Authorized Representative</i>	<i>Date</i>
<i>Patient's Agent</i>	<i>Date</i>

 Relationship

A signed copy of this document is to be given to the Patient. The original is to be filed in the Patient's medical records.

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FINANCIAL POLICY

We're in this together. We will bill your insurance promptly and accurately but you have to uphold your part as well to help us.

WE CANNOT BILL YOUR INSURANCE WITHOUT A VALID CARD. If you have a plan in which we do not participate or you do not have a current card, you will be responsible for paying at the time of service.

COPAYMENTS AND DEDUCTIBLES must be collected at the time of service. To not do so is fraud on both our parts.

INSURANCE CHANGES must be reported to us before or at the time of your next visit. If your claim is rejected because we billed your lapsed insurance, you will be responsible for full payment.

MISSED APPOINTMENTS will be billed at \$35 for each incident and appointments must be canceled 24 hours in advance.

IF YOUR CHECK IS RETURNED, we will charge you \$35 plus the original amount.

IF A CLAIM IS DENIED, it is your responsibility to contact the insurance company. If a claim is not paid, the balance will be billed to you.

IF YOU RECEIVE A BILL IN THE MAIL, it is your responsibility to pay it within 30 days.

COPYING RECORDS OR DICTATED REPORTS require considerable doctor and staff time and are charged according to the complexity of the service.

I have read and understand this financial policy and agree to abide by its terms.

Signature _____

Printed Name _____

Date ___/___/___

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Dear Patients:

This notice is to inform you for our office policy regarding credit card authorization forms. We are requiring all patients to fill out a credit card form which authorizes Orthopedic and Sports medicine center to run any Delinquent balances on your credit card.

We are putting this policy to decrease our costs in collecting delinquent balances. It is very costly to send out numerous statements. The time spent tracking and making phone calls regarding these past due accounts continues to increase.

We realize some patients will be resistant to this policy. Please be aware that your credit card number is CONFIDENTIAL. After your insurance has paid your claim we will send you a statement with a due date of 30 days.

AS LONG AS YOUR BILL IS PAID WITHIN THE 30 DAY TIME FRAME, WE WILL NOT HAVE TO USE YOUR CREDIT CARD. Please note that no more than \$100.00 will ever be applied to your credit card per month.

Thank you in advance for your understanding. We are working hard to find ways to keep our health care costs as low as possible.

Sincerely,
Dr. Shaik M. Saheb

Credit Card Authorization

I authorize Orthopedic and Sports Medicine Center to charge my credit card in the amount that my account becomes delinquent or if my check is returned by the bank.

NAME OF CREDIT CARD _____

CREDIT CARD NUMBER _____

EXPIRATION DATE _____

NAME AS IT APPEARS ON THE CARD _____

SIGNATURE _____

DATE _____

Release