

John H. Serocki, M.D.

A Professional Corporation

Diplomate American Board of Orthopaedic Surgery

Sports Medicine - Orthopaedic Surgeon - Surgery of the Shoulder, Hand and Knee

9834 Genesee Avenue • Suite 228 • La Jolla, CA 92037
(858) 824-1703 • FAX (858) 455-6473
WWW.LJSO.ORG

955 Lane Avenue • Suite 200
Chula Vista, CA 91914

1763 West 24th Street • Suite 105 • Yuma, AZ 85364
(928) 344-4575 • FAX (928) 344-0577
E-MAIL: jserockimd@ljsso.org

Patient Name: _____

Last Name, First Name, MI

Birth date ____/____/____ Age: _____

Address: _____

Gender ____M ____F Marital Status: _____

City: _____ ST _____ Zip _____

Social Security Number: _____

Home Phone: (____) _____

EMAIL: _____

Cell Phone: (____) _____

Work Phone: (____) _____

Emergency Contact Name: _____

Phone Number: _____

Referred By: _____

Phone Number: _____

Current Employer: _____

Occupation: _____

Area(s) to be examined (body parts injured): _____

Insurance: Primary: _____ Secondary: _____

If your injury was work related, please complete the following information:

Employer at time of injury: _____

Date of Injury: _____

Attorney's Name: _____

Phone: _____

Authorization to pay Benefits to physician: I hereby authorization payment of medical and/or surgical benefits directly to John H. Serocki, MD, for services described on the insurance claim forms. I realize that the insurance payment may not represent full payment for services rendered and I will be responsible for the balance due including, but not limited to, deductibles, co-pays, co-insurances, and services not covered under my plan. It is my responsibility to know the coverage of benefits for my insurance policy. I agree to remit payment within 30 days of receipt of a statement and understand that John H. Serocki, MD charges \$5.00 for each past due statement generated for unpaid balances.

Authorization to release information: I hereby authorize the release of any medical or other information to my insurance company to process claims for services rendered.

HIPAA Policy: I hereby acknowledge that I have been offered the Notice of Privacy Practices of John H. Serocki, MD.

Notice to Consumers: Medical doctors are licensed and regulated by the Medical Board of California 800) 633-2322 www.mbc.ca.gov

Patient Signature

Date

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Health History Questionnaire

Patient: _____ **Date:** _____

Age: _____ Height: _____ Weight: _____ Dominant Hand: Left _____ Right _____

Occupation: _____

What symptoms are you having and when did they begin?

If you had a specific injury, please describe how the injury happened. If gradual onset, what activities caused your symptoms?

Have you had any prior treatment or symptoms for this condition or the injured region?

List any previous surgeries including the date(s) done

Surgery: _____ Date: _____ Work Related ? Y N

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Medications – List any current/regular medications you take and those specific to this injury:

Med Name: _____ Dose: _____ How Often?: _____

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Med Name: _____ Dose: _____ How Often?: _____

Allergies: - please list any drugs and/or substances and what your reaction to it is (include Anti Inflammatory medications such as Aleve or Motrin) -

Please Circle if No Known Allergies

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

List any serious accidents or injuries you have or have had

Type: _____ Date: _____
 Type: _____ Date: _____
 Type: _____ Date: _____

Any Injuries as a result of this/these accidents or injuries?

Circle or List any medical conditions that you have or have previously had

Heart Attack / MI	Rheumatoid Arthritis	Neurological Disease	Gastritis or Ulcers
Cardiac Disease	Gout	Recurrent Headaches	Thyroid Disease
Heart Disease	Osteoarthritis	Recent Weight Loss	Liver Disease
Mitral Valve Prolapse	Blood Clots	Constant Night Pain	Polio
Emphysema	High Blood Pressure	Fever or Chills	Tuberculosis
Stroke	Anemia	Depression	Fibromyalgia
Epilepsy	Diabetes		Hepatitis
Enlarged Prostate	Asthma	Hep B	Alcohol Abuse
			Drug Abuse
Other:			HIV/AIDS
			Hep C

Do you smoke? No Yes – How much and for how long? _____

Do you drink alcohol? No Yes – How much and for how often? _____

Please describe any leisure activities, including sports or athletic, that you participate in:

Comments:

Patient Name: _____

DOB: ____/____/____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS AND/OR FAMILY MEMBERS

In accordance with Federal Government Privacy rules implemented through the Health Information Portability and Accountability Act (HIPAA), in order for your physician or staff to discuss your medical information with members of your family or other individuals you designate, we must obtain your authorization prior to doing so. In the event of an emergency or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived. You have the option to decline the release of this information. Please indicate your preference below.

_____ Yes, I authorize the practice to verbally release any and/or all information concerning my medical care to any family member.

_____ Yes, I authorize the practice to verbally release any and/or all information concerning my medical care on any personal answering machine and/or voice mail system.

_____ No, I do not authorize the practice to verbally release any and/or all information concerning my medical care to any family member.

_____ No, I do not authorize the practice to verbally release any and/or all information concerning my medical care on any personal answering machine and/or voice mail system.

AUTHORIZATION TO OBTAIN MEDICAL RECORDS FROM MEDICAL PROVIDERS

By my signature below, I here by authorize John H. Serocki, M.D. and his staff to **OBTAIN** any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past. This would include receiving these records via facsimile and other secure electronic communication channels.

I understand that it may become necessary For John H. Serocki, M.D. and his staff to **DISCLOSE** treatment, billing or medical information to referring physicians, hospitals and any insurance companies, third party administrators or managed care companies. This would include disclosure via facsimile and other secure electronic communication channels.

Patient Signature

Date

Printed Name

Date of Birth

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FINANCIAL POLICY

The following is our financial policy. Our primary goal is that you receive the proper and optimal treatment needed to restore you to health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information and History forms prior to seeing Dr. Serocki.

Payment for services is due at the time services are rendered. We are a participating provider on most PPO health plans only. We do not participate in any HMO plans.

We will be happy to provide you with assistance in order for you to process your insurance claims for reimbursement. In special circumstances, we may accept assignment of insurance benefits or we may choose not to bill your secondary insurance. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are **NOT** a party to that contract. Our relationship is with you, not your insurance company.
2. **All charges are your responsibility whether your insurance company pays or not.** Not all services are a covered benefit of all plans. It is your responsibility to know what your insurance covers and what it does not cover. Some insurance companies arbitrarily select certain services they will not cover and you may be responsible for the cost of these services.
3. **Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.**
4. If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the insurance to help speed the process up. If the insurance does not pay within 45 days, we may require that you pay the balance in full and seek reimbursement from your insurance directly.
5. In the event insurance payments are received directly by you for services rendered that have not been paid for to our office, you promise to immediately sign over and forward those payments to our office.
6. In the instance that your claim is assigned to collections, a \$15.00 recovery fee will be assigned and payable.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you; however, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. You are ultimately responsible for the timely payment of your account.

By signing below, you attest that you have read the above Patient Financial Policy and have provided our office with true and correct insurance information and that you will notify the office if there is any change in the health insurance coverage.

A copy of this agreement may be used in place of the original.

Signature of Patient, Policy Holder or Legal Guardian

____/____/_____
Date

Printed Name

DOB