BELL SPORTS MEDICINE INSTITUTE

DAVID M. BELL, M.D. ORTHOPAEDIC SURGERY & SPORTS MEDICINE
5924 STONERIDGE DRIVE, SUITE 202 PLEASANTON, CA 94588 925-600-7020 BELLSPORTMED.COM

My Medical History

Name	Age	Height	Weight	Today's Date

Medications I am currently taking:

☐ I am currently taking no medications regularly

Medication	Medication

Medical conditions that I have:

☐ No medical problems I know of

☐ High blood pressure	☐ Stomach ulcers/gastritis	☐ Thyroid problems	☐ Osteoarthritis
☐ High cholesterol	☐ Stomach reflux/GERD	☐ Kidney problems	☐ Rheumatoid arthritis
☐ Heart problems	☐ Irritable bowel/IBS	☐ Prostate problems/BPH	☐ Osteoporosis
☐ Heart attack	☐ Asthma	☐ Liver problems/hepatitis	☐ Stroke/CVA
☐ Diabetes	☐ Emphysema/COPD	☐ HIV/AIDS	☐ Neuropathy
☐ Blood clot formation/DVT	☐ Pulmonary embolus	☐ Sleep Apnea	☐ Depression
☐ Blood flow problems	☐ Pneumonia	☐ Cancer of:	☐ Alzheimer's

Other medical conditions:

Allergies I have to medications:

☐ I have no known allergies to any medications

Medication	Type of reaction I had (rash, nausea, stopped breathing, etc.)

Operations I have undergone in the past:

☐ I have had no major operations in the past

☐ Previous Orthopaedic bone or joint surgery: ☐ ☐ ☐ ☐	☐ Appendectomy ☐ Tonsillectomy ☐ Vasectomy ☐ Colonoscopy/endoscopy ☐ Cardiac/Heart procedure	☐ Other surgeries:

Family Medical History:

☐ No medical problems in my family I know of

Medical problem:	In my (mother, father, etc.):	Medical problem:	In my: (mother, father, etc.):
☐ High blood pressure		☐ Osteoarthritis	
☐ High cholesterol		☐ Rheumatoid arthritis	
☐ Heart problems		☐ Other joint problems	
☐ Diabetes		☐ Osteoporosis/brittle bones	
☐ Asthma		☐ Neuropathy	
☐ Blood clot formation/DVT		☐ Stroke/TIA/CVA	
☐ Bleeding problems		☐ Problems with Anesthesia	
☐ Cancer of:		☐ Other:	

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My Medical History

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Name: _____

I am active in:

☐ No specific sports or exercise	☐ Cycling	☐ Basketball	☐ Gymnastics
☐ Walking for fitness	☐ Mountain biking	☐ Golf	☐ Skiing
☐ Exercising at the gym	☐ Hiking	☐ Tennis	☐ Snowboarding
☐ Weight training	☐ Baseball/Softball	☐ Volleyball	☐ Dance/cheer
☐ Running	☐ Soccer	☐ Lacrosse	☐ Other:
☐ Swimming	☐ Football	☐ Hockey	

Alcohol Use:	Tobacco use:	Recreational drug use:
☐ None/ rarely	☐ I don't smoke	☐ None
☐ 1-2 drinks/week	☐ I quit in _____ after smoking	☐ Occasionally
☐ 1-2 drinks/day	_____packs/day for _____years	☐ Regularly
☐ Three or more drinks/day	☐ ½ to 1 pack/day	☐ Drugs I commonly use:
☐ Difficulty with heavy alcohol use in the past	☐ 2 or more packs/day	

Here's why I want to get this treated:

☐ Relief from the pain	☐ Get back to exercising, like:
☐ Get back to normal day to day living	☐ Get back to sports, like:
☐ Heavy work on the job	

Review of systems:

Symptoms I commonly experience (check only if yes): None of the below: ☐

☐ Seasonal allergies/hay fever	☐ Decreased hearing	☐ Headaches
☐ Dermatitis	☐ Ringing in the ears	☐ Speech difficulty
☐ Frequent itching	☐ Dizziness	☐ Stroke/TIA
☐ Skin reactions	☐ Hoarseness	☐ Numbness, tingling
☐ Reactions to Latex/rubber gloves	☐ Sinusitis	☐ Seizures/epilepsy
☐ Runny nose	Describe:	☐ Balance problems, falls
Describe:		Describe:
	☐ Bleeding tendency	
☐ Fever	☐ Easy bruising	☐ Double vision
☐ Fatigue	☐ Lymph node enlargement	☐ Blurry vision
☐ Unexplained weight loss	☐ Anemia	☐ Eye trauma
☐ Weakness all over	Describe:	☐ I wear glasses/contacts
Describe:		Describe:
☐ Chest pain	☐ Abdominal pain	☐ Mood swings
☐ Heart palpitations	☐ Nausea	☐ Sleep problems
☐ Rapid heart beats	☐ Stomach ulcers/reflux	☐ Depression
☐ Irregular heart beats	☐ Heartburn/indigestion	☐ Anxiety
☐ High blood pressure	☐ Appetite change	☐ Substance abuse
Describe:	☐ Change in bowel habits	☐ Heavy alcohol use/drinking
	☐ Diarrhea	Describe:
☐ Changes in skin color	☐ Constipation	
☐ Skin rashes	☐ Loss of appetite	☐ Shortness of breath
☐ Skin masses	Describe:	☐ Asthma
☐ Skin sores/ulcers		☐ Bronchitis
☐ Skin cancers	☐ Bone fractures	☐ Chronic lung problems
Describe:	☐ Joint sprains	☐ Chronic cough
☐ Frequent thirst	☐ Joint swelling	Describe:
☐ Frequent hunger	☐ Low back pain	☐ Difficulty passing urine
☐ Hyperactivity	☐ Joint stiffness	☐ Incontinence
☐ Hypoactivity	☐ Osteoarthritis	☐ Frequent urination
☐ Growth changes	☐ Rheumatoid arthritis	☐ Urinary tract infections
☐ Hair changes	☐ Fibromyalgia	☐ Painful menstruation/PMS
Describe:	Describe:	Describe:

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Consent to Treat

I hereby acknowledge that I or the child entrusted to me need medical care and treatment, and I authorize and consent to the Bell Sports Medicine Division of Bay Area Surgical Specialists, Inc. and its physicians and providers to perform medical services. I consent to the use of diagnostic and therapeutics means to treat the medical condition, including but not limited to examination, radiographs, local anesthetics, injections, bracing, casting, laboratory tests, physical therapy and diagnostic imaging.

Assignment of Benefits

I hereby assign and transfer to the Bell Sports Medicine Division of Bay Area Surgical Specialists, Inc., the benefits, monies and sums or other credits payable to myself or child for treatment of their medical condition, or other insurance policy, or any other state, federal or private insurance policy which might be applied toward payment of or reimbursement for any and all services rendered or goods supplied as a result of treatment contemplated by this agreement. If for any reason I am unable to assign or transfer such rights, I hereby authorize and appoint Bay Area Surgical Specialists, Inc. as my agent with respect to the pursuance, receipt and application of such funds as it sees fit.

I understand that I am financially responsible to pay in full in the event that my health insurance does not reimburse in full for services rendered.

Medicare Authorization: I certify this information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf to Bell Sports Medicine, Inc., and its physicians and providers rendering service during my treatment(s).

I understand that Bay Area Surgical Specialists, Inc., does not participate in the Medi-Cal program, and that patients will be financially responsible for services rendered.

I understand that I may be referred for professional services to other facilities and physicians and providers that are not employees or agents of Bay Area Surgical Specialists, Inc. Examples would include outpatient surgery centers, hospitals, anesthesiologists, physical therapists, medical supply companies, cryotherapy unit companies, MRI facilities and laboratories. Bay Area Surgical Specialists, Inc. is not responsible for the acts or omissions of these facilities or practitioners. The financial relationship will be between the patient and the facility or provider and not the Bell Sports Medicine Division of Bay Area Surgical Specialists, Inc.

Authorization to use or disclose my health information

Note: This is a legal requirement for patient privacy. Your medical information will not be used for marketing purposes.

I have read and reviewed the Notice of Privacy Practices.

Bay Area Surgical Specialists, Inc. may use or disclose the following health care information:

☐ None OR ☐ All my health information maintained by Bell Sports Medicine Institute, Inc.

Bay Area Surgical Specialists, Inc. may disclose this information only to:

☐ No one OR ☐ Person(s) specified to receive information: _____Relationship:_____

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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 this 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" (PHI) 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 health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your PHI 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 PHI 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, your PHI may be provided to a physician to whom you have been referred to ensure that physician has the necessary information to diagnose or treat you.

Payment: Your PHI 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 PHI be disclosed to the health plan to obtain approval for hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. The activities include, but are not limited to, quality assessment activities, employee review activities, training programs licensing, and conducting or arranging for other business activities. For example, we may use a sign-up 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 PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization as required by law: Public Health issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements. Legal proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donations, 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 Department of Health and Human Services to investigate or determine our compliance with 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 physician's practice has taken action in the reliance on the use or disclosure indicated in the authorization.

Patient Rights: The following is a statement of your rights with respect to PHI:

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of sue in a civil, criminal, or administrative action of proceeding, and PHI that is subject to law that prohibits access to PHI. We may request a reasonable fee for copying your records.

You have the right to request restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members of friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must list 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 disclosures of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communication from us by alternative means or at an alternative location. Upon your request, you have the right to obtain a paper copy of this Notice from us even if you have agreed to accept this Notice alternatively, such as electronically.

You may have the right to have your physician amend your PHI. If your physician denies 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 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 or certain disclosures we have made, if any, of your PHI. 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 the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. To file a complaint with DHHS, call 877-696-6775. You may file a complaint with us by notifying our privacy officer, our office manager of your complaint. We will not retaliate against your complaint.

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 PHI. If you have any objections to this Notice, please ask to speak with our HIPAA Compliance Officer, our office manager, in person or by phone 925-600-7020.
Effective Date April 14, 2003.

Forms Policy

In order to cover the costs of processing forms you bring to our office for us to complete, we ask for a **$20 fee per form** to be paid at the time you drop them off with us. Please be advised that it will take our office three business days to complete the forms. We ask that you do not contact our office to determine if they have been completed, as this takes away from our valuable time with patients. We will contact you when your papers are ready to be picked up.

The section below is mandated by the State of California and the federal government:

Notice to Consumers and Patients:

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov, email licensecheck@mbc.ca.gov or call (800) 633-2322.
I acknowledge that I understand that physicians are licensed and regulated by the Medical Board of California.

Open Payments Database Notice:

"For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here: https://openpaymentsdata.cms.gov. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public."
My signature below confirms that I have read and understand that notice above.

Signature: I agree to all the above and the attached notices

Signature	Print Name	Date	Relationship (if signing for minor)