



Dr. Ying Chi
11190 Warner Ave. Suite 307
Fountain Valley, CA 92708
T: 714-434-3518
F: 714-434-3759

Patient Name: _____

To be completed by Physicians:

CC:

HPI:

Location:

Duration:

Severity:

Modifying factors:

Physical Exam:

Temp: RR: HR: BP/P: Height: Weight: O2 Sat %

Extremities: NO CLUBBING, CYANOSIS

X-rays:

Other studies:

Medical Decision Making:

Physician Signature _____ Date / Time: _____



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Date: _____ MALE FEMALE **Age:** _____

Patient Name: _____ **D.O.B** _____

Address: _____ **SSN:** _____

City: _____ **State/ Zip** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Employer: _____ **Occupation:** _____

Email Address: _____ **Insurance:** _____

Spouse Name: _____ **DOB:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Family Doctor: _____ **Tel:** _____ **Fax:** _____

How did you hear about Dr. Chi?

Edinger MG Memorial Care / Prompt Care **Other** _____

HISTORY AND PHYSICAL:

Height: _____ **Weight:** _____

Current Medications:

Family History:

1.	6.	Cancer	Y/N
2.	7.	Diabetes	Y/N
3.	8.	Heart Disease	Y/N
4.	9.		
5.	10. Any blood thinners:	Cardiologist:	

**** **Pharmacy:** _____ **Phone:** _____ **Medication Allergies:** _____

PAST MEDICAL HISTORY:

- | | | |
|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> High BP | <input type="checkbox"/> Heart Disease / Angina | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other _____ |

PAST SURGICAL HISTORY:

Date	<input type="checkbox"/> None	Date	<input type="checkbox"/> None
Joint Replacement	_____	Gall Bladder	_____
Spine Surgery	_____	Tonsil/Adenoid	_____
Hand Surgery	_____	Coronary	_____
Other:	_____	Bypass/Stent	_____

SOCIAL HISTORY:

Have you ever smoked cigarette? Yes No Do you currently smoke? Yes No

If you smoke, how many? _____ Pack(s)

Do you drink alcohol? Yes No How often? _____



Date: _____

Gender: Male/Female

Name: _____ DOB: _____ Age: _____

Right / Left Hand dominant?

Reason you are seeing Dr. Chi today? _____

Is it due to an injury? Yes / No

Date of Injury or Onset: _____

Previous injection? Yes/No

Date of Injection: _____

Previous therapy? Yes/No

Today's pain level on scale of 0-10: _____/10

Previous treatments? _____

Any Studies so far? X-ray, CT, MRI, Nerve Test? _____

Do you have popping or clicking in the hand, or trigger finger? _____

Do you have numbness or tingling in the hand, or carpal tunnel? _____

FOR PHYSICIAN USE ONLY:

All system viewed and negative

All others negative

Constitutional

- Fatigue
- Weakness
- Fever
- Weight loss ___ lbs
- Weight gain ___ lbs
- Reviewed normal

Skin

- Easy Bruising
- Rashes
- Hair Loss
- Psoriasis
- Photosensitivity
- Reviewed normal

Neurologic

- Headache
- Dizziness
- Numbness
- Memory Loss
- Seizures
- Reviewed normal

Cardiovascular

- Chest Pain
- S.O.B
- S.O.B./Exertion
- Swelling Feet
- Blood Clot
- Heart Murmur
- Palpitation
- Reviewed normal

Respiratory

- Cough
- Wheezing
- Lung Pain
- Asthma
- Short breath
- Reviewed NI

GU

- Urine Frequency
- Urethral Discharge
- Kidney Stone
- Enlarged Prostate
- Frequent UTI
- Incontinence
- Reviewed normal

Endocrine

- Cold Sensitivity
- Polyuria
- Heat Sensitivity
- Thyroid problem
- Polydypsia
- Reviewed normal

GI

- Nausea
- Difficulty Swallowing
- Peptic Ulcer
- Abdominal Pain
- Blood in Stool
- Diarrhea
- Reviewed normal

ENT

- Dry Eyes
- Redness of Eyes
- Ringing of Ears
- Nose Bleed
- Blurry Vision
- Dry Mouth
- Reviewed normal

Musculoskeletal

- Cramps
- Muscle Pain
- Swelling
- Neck Pain
- Back Pain
- Reviewed normal

Allergies

- Rhinitis
- Hay Fever
- Sinusitis
- Reviewed normal

Hematologic/Lymphatic

- Enlarged Nodes
- Bleeding Tendency
- Lymphedema of arm or leg
- Reviewed normal

Psychiatric

- Depression
- Anxiety
- Mood disorder
- Reviewed normal

Physician Signature _____ Date/Time _____



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Orange County Hand Surgery Specialists

Ying Chi, MD

Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations, such as quality assessments and physicians certifications

Only upon request, your organization will provide a copy of the Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information. I have been given the right to review such Notice Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are required to agree to my request, and by agreeing to such request, you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

Patient Name _____

Patient Signature _____

Relationship to Patient _____

(If patient is under 18 years of age)

Date _____



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Cancellation Policy

If you are unable to keep a scheduled clinic appointment, please call during normal business hours, 24 hours in advance to cancel the appointment. Failure to do so may incur a \$50.00 charge to your account for the missed appointment.

Surgery Patients please note: Please be advised that as noted in you New Packet, our cancellation policy will be enforced. This policy is in place to ensure that all patients have fair access to the care and treatment they need. If you need to cancel or reschedule your appointment, please provide adequate notice as outlined in your packet to avoid any applicable fees.

LATE CANCELLATION: \$300.00

SURGERY NO-SHOW: \$500.00

RESCHEDULING FEE: \$150.00 (NON-REFUNDABLE, NON-TRANSFERABLE)

As a courtesy to Dr. Chi and your surgical facility, we require 14 business day notices for any surgery cancellation or rescheduling request. Failure to allow 14 business days on surgery cancellation will result in a \$300.00 fee, any **SURGERY NO SHOW** result in a \$500.00 fee. Voicemail left are not valid forms of cancellation.

I acknowledge that I have carefully read and understand the Cancellation Policies, and agree to abide by them.

Printed Name _____

DOB _____

Signature _____

Today's Date _____



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Ying Chi, MD, Inc.
Statement of Policies

The following policies are established for mutual convenience and benefit. Please read them carefully and sign at the bottom to indicate your agreement of the statement of policies.

- 1. Ying Chi, MD, Inc., strictly provides orthopedic services only. Patients are expected to have or arrange for Primary Care Physician. Our practice does not treat chronic pain.
2. Deductibles and Co-Pays are payable at the time of service. Any previous balance is expected to be paid at time of service.
a. Copay is a set rate you pay for each prescription, doctor visits, and other types of care. A deductible is the set amount you pay for medical services and prescriptions before your coinsurance kicks in fully. Coinsurance is the percentage of costs you pay after you've met your deductible.
3. Patients are responsible for obtaining referrals and authorizations for services rendered at Ying Chi, MD, Inc., Orange County Hand Surgery Specialists.
4. If you are unable to keep a scheduled clinic appointment, please call during normal business hours, 24 hours in advance to cancel the appointment. Failure to do so may incur a \$50.00 charge to your account for the missed appointment.
5. There is a \$50.00 fee for all forms/ paperwork that you need to have completed by the physician. We may ask that you make an appointment to complete these forms.
6. There is a fee for any reports or records requested by attorneys, insurance companies, disability companies, etc. This charge will be determined by the information requested.
7. Surgery Patients please note: Our office works hard to help you coordinate your surgery date. As a courtesy to Dr. Chi and your surgical facility, we require a 14 business day notice for any surgery cancellation or rescheduling request. Failure to allow 14 business days on surgery cancellation will result in a \$300.00 fee, any SURGERY NO SHOW result in a \$500.00 fee. *** No fee will be charged for surgery reschedule due to Emergency.***
8. Prescription Policies:
a. If you are in need of a refill, please have your pharmacy fax a request to 714-434-3759.
i. Please allow 48 to 72 hours.
b. No refills will be given on Friday after 2:00 PM
c. No pain medication will be given to post-operative patients after 90 days of surgery.
d. Our physicians DO NOT prescribe pain medications to chronic pain patients. Patients with chronic pain syndrome are referred to pain management specialists for long term management.
9. To provide a calm and therapeutic environment for our patients, we have a "Zero Tolerance" policy for any verbal / physical abuse towards the physicians or staff or any inappropriate behaviors in clinic. Any such behavior will result in formal termination of physician-patient relationship per protocol.

I acknowledge that I have carefully read and understand the States of Policies, and agree to abide by them.

Name
Signature

DOB
Today's Date



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Name: _____ DOB: _____

Authorization and Agreement of Benefits:

It is the patient's responsibility to make sure that your physician and/or hospital are listed as being contracted providers with your insurance company and to understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit.

Ying Chi, M.D., Inc. is not responsible for any incorrect information that may be provided to us by your insurance company or their representative(s) as to your policy coverage, payments, exclusions, etc. Please note that Dr. Chi does NOT participate with plans provided through Covered California.

For the services rendered and those about to be rendered, I hereby assign to Ying Chi, MD, Inc., all medical benefits otherwise payable to me under the described policy not to exceed the charges made to such service. I further authorize the above mentioned insurance company to pay said benefits directly to Ying Chi, MD, Inc., and further direct that they make no payment to me. In the event that I receive payment from the insurance company, I agree to endorse such payment to Ying Chi, MD, Inc. I understand that I am directly and primarily responsible to Ying Chi, MD, Inc., for the usual and customary fee for the services rendered to me. I realize that if my insurance company fails to pay or there is a delay (more than 90 days) in their paying, it is my sole responsibility to promptly pay my bill directly. I also realize that any services not covered under my insurance company will be my responsibility to pay in full. I further understand and agree if I fail to make prompt and timely payments, I will be directly responsible for any and all cost of collection including the filing fees as well as reasonable attorney fees. I hereby authorize Ying Chi, MD, Inc., to release to my insurance company, any information acquired including the diagnosis and the records in the course of my treatment.

Signature

Date

Medicare Certification for Payment: (Lifetime Authorization)

I certify that the information given by me in applying for payment under the title XVII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that they payment of authorized benefits be payable to Ying Chi, MD, Inc., for by behalf. I also assign the benefits payable for physician service to the physician furnishing the services and authorize such physician to submit a claim to Medicare in my behalf.

Signature

Date



PHOTO AND VIDEO CONSENT FORM

Purpose of Photography/Video: I understand that photographs, video recordings, and/or other images may be taken of me (or my child/dependent) for the following purposes (check all that apply):

- Medical documentation and treatment
- Medical education and training
- Practice marketing (website, social media, brochures, advertisements)
- Other: _____

Consent: I authorize **OC Hand Surgery Specialist**, its employees, and authorized representatives to take and use photographs and/or video recordings of me for the purposes listed above.

I understand: My name and identifying information will not be used without additional written permission. Images may be edited for clarity or layout but will not be altered in a misleading way. Once images are shared publicly (for marketing or educational purposes), they may be seen by others and cannot be fully withdrawn.

Refusal of Consent for Public Use (Optional)

You may still consent to medical documentation but decline public/marketing use.

- I DO NOT consent to the use of my images for marketing, advertising, or social media.
- I only consent to use for medical documentation and internal clinical purposes.

Right to Withdraw: I understand that I may withdraw this consent at any time by providing written notice to the practice. Withdrawal will not affect images already used or published before the withdrawal date.

No Impact on Care: I understand that my decision to consent or refuse will not affect my medical care or treatment.

Release: I release and hold harmless **OC Hand Surgery Specialist** and its staff from any claims related to the use of these images as described above.

Patient / Legal Representative

Printed Name: _____ Date: _____

Signature: _____ DOB: _____