DATE___________________________

NAME____________________________________ DOB_______________________

HAVE YOU BEEN VACCINATED FOR COVID -19 YES - NO

HAVE YOU TRAVELED OUT OF STATE OR COUNTRY IN THE LAST 14 DAYS? YES - NO

HAVE YOU HAD ANY CONTACT WITH ANYONE WHO HAS TRAVELED OUT SIDE OF STATE OR THE COUNTRY IN THE 14 DAYS? YES NO

ANY ABNORMAL LOSS OF TASTE OR SMELL? YES NO

ANY FEVER, FATIGUE OR FLU LIKE SYMPTOMS? YES NO

ANY SHORTNESS OF BREATH OR COUGH? YES NO

ANY SYMPTOMS OF SORE THROAT , RUNNY NOSE OR CONGESTION? YES NO

ANY ABNORMAL BOWEL MOVEMENT OR DIARRHEA? YES NO

HAVE YOU EVER BEEN TESTED FOR COVID-19? YES NO

HAVE YOU EVER BEEN TESTED POSSITIVE FOR COVID-19? YES NO

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 $30.00 charge to your account for the missed appointment.

Surgery Patients please note: Our office works hard to help you coordinate your surgery date. Please be advised deductible will be collected on the day surgery is scheduled. This does not include professional, anesthesia or facility fee. DEDUCTIBLE:In a health insurance plan, your deductible is the amount of money you need to spend out of pocket before your insurance starts paying some of your health care expenses. The out-of-pocket maximum, on the other hand, is the most you'll ever spend out of pocket in a given calendar year. Once you spend enough to reach your plan's maximum, the insurer will cover 100% of your medical bills.

As a courtesy to Dr. Chi and your surgical facility, we require 5 business day notice for any surgery cancellation or rescheduling request. Failure to allow 5 business days on surgery cancellation will result in a $300.00 fee, any SURGERY NO SHOW result in a $500.00 fee

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 ______________

New Patient Form

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

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**

____ ______________________

New Patient Form

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

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.
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 $30.00 charge to your account for the missed appointment.
5. There is a $25.00 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 3 business day notice for any surgery cancellation or rescheduling request. Failure to allow **5 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. 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 and Signature **DOB**

Today’s Date

______________________________ ______________________________

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

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 ____________________

New Patient Form

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: HR: BP: Height: Weight: O2 Sat %

Extremities: □NO CLUBBING, CYANOSIS

Xrays:

Other studies:

Medical Decision Making:

Physician Signature___________________________________ **Date / Time:**_________________________________

New Patient Form

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

Date: ________________________ **MARITAL STATUS:** ☐S ☐M ☐OTHER **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 to**: __________________**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.	

Pharmacy: _____________________ **Phone**: __________________ **Medication Allergies** : ________________________

PAST MEDICAL HISTORY:

☐ **High BP**
☐ **Arthritis**
☐ **Cancer**
☐ **Stroke**
☐ **Hepatitis**
☐ **Heart Disease / Angina**
☐ **Tuberculosis**
☐ **Blood Clots**
☐ **Liver Disease**
☐ **High Cholesterol**
☐ **Diabetes**
☐**Thyroid**
☐ **Ulcer**
☐ **Asthma**
☐ **Other** _____

PAST SURGICAL HISTORY: **Date** ☐ **None** **Date** ☐ **None**

Joint Replacement ____________
Spine Surgery ____________
Hand Surgery ____________
Gall Bladder ____________
Tonsil/Adenoid ____________
Coronary Bypass/Stent ____________
Other: ____

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? ____

New Patient Form

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

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? Xray, 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?__________________________

□All system viewed and negative **□ All others negative**

Constitutional	**Skin**	**Neurologic**	**Cardiovascular**	**Respiratory**
□Fatigue	□Easy Bruising	□ Headache	□Chest Pain	□Cough
□Weakness	□Rashes	□Dizziness	□S.O.B	□Wheezing
□Fever	□ Hair Loss	□Numbness	□S.O.B./Exertion	□Lung Pain
□Weight loss __lbs	□Psoriasis	□Memory Loss	□Swelling Feet	□Asthma
□Weight gain __lbs	□Photosensitivity	□Seizures	□Blood Clot	□Short breath
□Reviewed normal	□Reviewed normal	□Reviewed normal	□Heart Murmur	□Reviewed Nl
			□Palpitation	
			□Reviewed normal	

GU	**Endocrine**	**GI**	**ENT**
□Urine Frequency	□Cold Sensitivity	□Nausea	□Dry Eyes
□Urethral Discharge	□Polyuria	□Difficulty Swallowing	□Redness of Eyes
□Kidney Stone	□Heat Sensitivity	□Peptic Ulcer	□Ringing of Ears
□Enlarged Prostate	□Thyroid problem	□Abdominal Pain	□Nose Bleed
□ Frequent UTI	□Polydypsia	□Blood in Stool	□Blurry Vision
□Incontinence	□Reviewed normal	□Diarrhea	□Dry Mouth
□Reviewed normal		□Reviewed normal	□Reviewed normal

Musculoskeletal	**Allergies**	**Hematologic/Lymphatic**	**Psychiatric**
□Cramps	□Rhinitis	□Enlarged Nodes	□Depression
□Muscle Pain	□Hay Fever	□Bleeding Tendency	□Anxiety
□Swelling	□Sinusitis	□Lymphedema of arm or leg	□Mood disorder
□Neck Pain	□Reviewed normal	□Reviewed normal	□Reviewed normal
□Back Pain			
□Reviewed normal			

Physician Signature__________________________________**Date/Time**________________________