ROBERT AFRA, M.D.
SAN DIEGO ORTHOPEDIC SURGEON

317 N. EI Camino Real, Suite 405
Encinitas, CA 92024
(760) 994-2663

Dear Patient:

We are very happy to welcome you to Orthopedic Surgery San Diego. We appreciate the opportunity to take care of you and your family. Our office is focused on providing you with high quality treatment and compassion.

Our staff members will assist you with all your needs to ensure your visit is as pleasant as possible. We take value in all of our patients and we appreciate you choosing Orthopedic Surgery San Diego.

Enclosed you will find a health history form and information on locating our office. Please complete the Patient Demographics and History and bring it with you to your first visit. Also, please bring your driver's license, insurance card and a form of payment should one apply at the time of your appointment. We are happy to help you obtain your insurance benefits and will assist you with filing your claim with any of our contracted insurances.

Thank you for choosing our office. We look forward to meeting you.

Sincerely,

Robert Afra MD
Jason Kart DC
Amanda Martin DPT
Jaime Ross DPT
Mo Javaherian DOAM LAC
Jennifer Martin, Yoga Instructor
Bill McDonald, Strength and Conditioning Coach
And Staff

Orthopedic Surgery San Diego
Financial Policy

Welcome to Our Office

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. If you have questions about your account, charges, insurance or payments, please speak with one of our billing representatives at (760) 573-4411. Otherwise, you are welcome to call our office for any general questions or needs at (760) 994-2663 (BONE). Please have available at the time of your visit the following insurance and identification information:

1. Your insurance identification card
2. Your driver's license.
3. Credit Card
4. Your referral or authorization for services when applicable.

Billing Process and Credit Card on File:

I understand that Orthopedic Surgery San Diego agrees to bill my insurance as a courtesy. The anticipated patient portion of all fees for services provided (copay, deductible, cost share, coinsurance) are collected at the time services are rendered with the credit card on file. This policy entails patients to provide a credit card to our office that is maintained securely. This credit card is used to pay account balances after insurance adjudication; this is the balance that your insurance carrier has deemed the patient's responsibility (copay, deductible, cost share, coinsurance).

Payment Policy

Insurance companies will deny payment if any information is not current. They will also deny payment if information is not submitted correctly within a certain amount of time. Please notify us of any changes in insurance, address or phone numbers. We will ask you about such changes at each clinic visit.

Many of our services are one-on-one (ie, no double-booking); which means missed appointments are lost revenue for the office and missed opportunities for other patients to be treated when needed. **A charge of $40 will be applied for appointments that are not cancelled or rescheduled with at least 24 hours notice.** You may incur an additional expense for the following services: copying of medical records, copy of x-rays, form completion.

Insurance Plans

We cannot accept HMO insurance plans. We are contracted providers (in network) with many PPO health plans, **not all**. **Please contact your insurance directly to be certain that Orthopedic Surgery San Diego (EIN 27-5562601) and the particular provider you are seeing is in your provider network; this is important.** In so doing, please verify coverage and discuss your benefits, co-insurance, and deductible specifically with regard to coverage when seeing a provider at Orthopedic Surgery San Diego. Unfortunately, we are unable to answer questions regarding such coverage and will direct you back to your insurance carrier. As contracted providers with insurance plans, we have agreed to accept certain payment amounts for most services that we provide. The provider cannot waive copayments, deductibles, coinsurance or other amounts you are responsible to pay under your health plan.

Out-of-Network Insurance

For patients with a PPO policy, you have the right to use a participating or nonparticipating provider

for your care. You have the right to use a participating provider and your in-network benefits for the entire in-office treatment.
If we are not contracted with your PPO insurance, we can still provide medical care to you and your family as out-of-network providers. This means that we don't have predetermined negotiated rates for services with your carrier. If that is the case, your fees **will be on-par with what many insurance carriers pay for in-network services.** We encourage you to contact your insurance carrier to determine your plan's out-of-network benefits, to see what they will cover. We are happy to bill your insurance, **but you are ultimately responsible for all charges incurred regardless of insurance payment.** As with all out-of-network providers, there will be a difference between our charges and the amount that your insurance pays. Any balance remaining after insurance payment is due from you within 30 days. Keep in mind that this balance payment and all treatment we recommend will be eligible for reimbursement from health savings or flexible spending accounts.

No Insurance
We also welcome families with HMO or those choosing not to use medical insurance. Payment is due at time of service. We accept cash, Mastercard, Visa, American Express, and personal check. For any billing questions, please call (760) 573-4411 or email billing@orthopedicsurgerysandiego.com.

Specialized Treatments
Any service from an outside specialist, laboratory, advanced imaging (ie MRI), emergency department, hospital, or any facility other than Orthopedic Surgery San Diego is a transaction between you and them. It is your responsibility to know your insurance coverage prior to these appointments. You are financially responsible for any services they provide to you.

Your provider may have a financial interest in, or may benefit from, the various diagnostic and/or treatment measures/modalities offered at Orthopedic Surgery San Diego. Some aspects of the treatments/services may not be covered by your particular insurance plan. If the provider and/or recommended services are not contracted with or covered by your particular insurance plan, the following may apply. Services provided by the provider will be treated as out-of-network. If you have out-of-network benefits, you will be responsible to pay your share of the out-of-network costs, based on your benefits. If you do not have out-of-network benefits, you will be responsible for the full cost of the services provided. If you do not have out-of-network coverage, your carrier may deny the claim for the services provided. This means that you will be responsible for any charges not covered by the plan. If that is the case, your fees **will be on-par with what many insurance carriers pay for in-network services.** We recommend you take this opportunity to contact your carrier before obtaining these services to confirm your benefits and to obtain/confirm names of participating providers. Keep in mind that this balance payment will be eligible for reimbursement from health savings or flexible spending accounts.

Medicare
Your physician with Orthopedic Surgery San Diego is a participating Medicare provider. We will bill Medicare and a supplemental insurance if you have one. At times, treatment recommendations may include durable medical goods and other services that are not be covered by Medicare from our office. You have the option of receiving a prescription for the device and procuring it elsewhere as a covered service or immediately being fitted and paying out of pocket for the device.

Third Party Liability Injuries

For patients who have been involved in a liability/third party accident, payment in full is expected at the time of service.

Workers' Compensation

If you are involved in an "on-the-job" work injury, prior to seeing the physician the following information must be obtained and verified prior to your visit:

- Date of injury
- WCAB# if applicable
- Adjuster's name
- Employer
- Case or claim number
- Workers' Compensation insurance carrier information
- Adjuster's telephone number

Sport Physicals

Orthopedic Surgery San Diego also provides sports physicals on a walk-in basis at a self payment of $40.00 at the time of the physical (you must bring your sports physical form), between the hours of 9:00 AM - 11:00 AM and 1:00 PM to 4:00 PM. Please call before coming in to ensure that there is a physician available.

Name:_____**Today's Date** _____

Sex □ M □ F Birth Date: _____ Age: _____ SSN: _____

Address: _____ City/State _____ Zip: _____

Home # _____ Cell # _____ Work # _____

Email: _____ Occupation: _____

Ethnicity: _____ Race: _____ Preferred Language: _____

Primary Care Doctor: _____ Address: _____ Phone: _____

Name of your insurance plan: _____

Responsible Party Information: (Please fill out the information completely)

Name: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____ Email: _____

Relationship to patient: □ Spouse □ Parent □ Self Date of Birth: _____ SSN: _____ -_____- _____

Primary Insured: (Please fill out the information completely)

Name: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____ Email: _____

Relationship to patient: □ Spouse □ Parent □ Self SSN: _____ - _____ - _____

I acknowledge by signing this form that I am ultimately responsible for all incurred charges, regardless of insurance payment. I have been informed that my provider may or may not participate with my particular medical insurance carrier and that recommended treatments may or may not be covered by my particular plan. I have chosen to receive services by the previously noted physician and the other associated health care professionals, and **I accept responsibility for the potential additional costs that may be incurred. I understand that Orthopedic Surgery San Diego agrees to bill my insurance as a courtesy. The anticipated patient portion of all fees for services provided (copay, deductible, coinsurance, cost share) are collected at the time services are rendered with the credit card on file. I understand that some services and/or products provided may not be covered by my insurance (ie out of network). A $40.00 fee will be assessed for appointment cancellations with less than 24 hours notice.**

Credit Card on File:

Card Holder Name:_____ Last four:_____ CVV:_____ EXP:_____

MEDICARE RECIPIENTS WRITTEN ACKNOWLEDGMENT: At times, treatment recommendations may include durable medical goods and other services that are not be covered by Medicare when procured from our office. You have the option of receiving a prescription for the device and procuring it elsewhere as a covered service or immediately being fitted and paying out of pocket for the device.

HIPAA: I have read and understand the HIPAA Protected Health Information Privacy Notice 3.S.1A. I understand that upon request a complete copy of the complete notice will be provided to me. I hereby consent to and authorize the administration of all treatment that may be considered advisable or necessary in the judgment of the physician, and I hereby authorize Orthopedic Surgery San Diego or contracted agents to release as determined appropriate for any lawful use without limitation, any medical information regarding the patient's history, condition or treatment. I understand that I am entitled, upon demand, to a copy of this authorization. I agree to pay the doctor's usual fees for any legal testimony or work requested by myself, my attorney or agent or any other entity which arises from any legal action to which I am a party.

Signature:_____ Date: _____ Relationship to Patient: _____ (v15.10.25)

History of Present Illness:

Patient name: _____ Age: _____

Sex □ M □ F Are you □ Right handed □ Left handed Job title and description:_____

Date of Injury: _____

Were you sent to our office by a physician? □ Yes □ No Physician's name: _____ Phone: _____

Have you seen any other physician for this problem? □ Yes □ No Their name: _____

Why are you here today? _____
Brief description

Location of problem? _____ Cause/context: _____
Site of problem. Where is it? What caused discomfort to begin?

Quality? _____ _____
Describe discomfort (sharp, dull, achy, weakness, giving away, catching, burning) Improving, same, getting worse

Severity of pain? □ 1 □ 2 □ 3 □ 4 □ 5 Does the pain travel? _____ Duration: _____
Body location (infrequent, intermittent, occasional, frequent , constant)

Modifying Factors: What makes discomfort better? _____ makes it worse? _____

Associated signs/symptoms: _____
Any other associated symptoms, numbness, tingling, swelling, weakness, instability

Review of systems:

□ Reading Glasses	□ Toothache	□ Frequent Headaches
□ Change of Vision	□ Gum Trouble	□ Blackouts
□ Loss of Hearing	□ Nausea or Vomiting	□ Seizure
□ Ear Pain	□ Stomach Pain	□ Frequent Rash
□ Hoarseness	□ Ulcers	□ Hot or Cold Spells
□ Nosebleeds	□ Frequent Belching	□ Recent Weight Change
□ Difficulty Swallowing	□ Frequent Diarrhea	□ Nervous Exhaustion
□ Morning Cough	□ Frequent Constipation	WOMEN ONLY
□ Shortness of Breath	□ Hemorrhoids	□ Irregular Periods
□ Fever or Chills	□ Frequent Urination	□ Vaginal Discharge
□ Heart or Chest Pain	□ Burning on Urination	□ Frequent Spotting
□ Abnormal Heartbeat	□ Difficulty starting Urination	□ Other
□ Swollen Ankles	□ Get up more than once for urination during the night	
□ Calf Cramps with Walking		
□ Poor Appetite		

Additional space for comments: _____

_____

_____

Past or Present Medical History: (check all that apply) **□ None apply**

□ AIDS or HIV	□ Epilepsy □ Seizures	□ Kidney Disease	□ Scoliosis
□ Arthritis	□ Gastric Reflux	□ Osteoporosis	□ Sleep Apnea
□ Asthma	□ Glaucoma	□ Pneumonia	□ Stroke
□ Atrial Fibrillation	□ Gout	□ Polio	□ Thyroid Disease
□ Bladder Infections	□ Heart Attack	□ Psoriasis	□ Tuberculosis
□ Blood Clot/DVT	□ Hemophilia	□ Pulmonary Embolus	□ Ulcer
□ Bronchitis	□ Hepatitis A B C	□ Renal Failure	
□ Cancer/type_____	□ High Blood Pressure	□ Rheumatic Fever	
□ Diabetes	□ Mitral Valve Prolapse	□ Rheumatoid Arthritis	

Surgical History (including spine):

1. _____ **2.** _____ **3.** _____

Date: _____ **Date:** _____ **Date:** _____

Medications that you are currently taking:

1. _____ **2.** _____ **3.** _____ **4.** _____

Medication Allergies: 1. _____ **2.** _____

Family History:

- **Health status or cause of death of parents, siblings, children:** _____

  _____

- **Family history of rheumatoid or other congenital medical problems:** _____

  _____

Social History:

- **Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other**
- **Use of tobacco (packs per week, number of years)** _____
- **Use of alcohol (daily use, social, special occasion)** _____
- **Describe your level of activity (low, moderate, extreme, elite)** _____