San Jose Sports Medicine & Orthopedics

A Medical Corporation

DATE: _____ REFERRED BY: _____

HMO PATIENTS: AUTHORIZATION# _____ PRIMARY CARE PHYSICIAN _____

PATIENT NAME _____ MALE / FEMALE AGE _____ BIRTHDATE _____

RACE _____ ETHNICITY _____ LANGUAGE _____

PATIENT BEING SEEN TODAY FOR - LEFT RIGHT BODY PART _____ ON GOING – YES NO

IF THIS IS AN INJURY – DATE OF INJURY _____ WHERE DID INJURY OCCUR? _____

RESIDENCE _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____

EMP ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENT NAME _____ RELATIONSHIP _____ BIRTHDATE _____ SS# _____

RESIDENCE _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____

EMP ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENT NAME _____ RELATIONSHIP _____ BIRTHDATE _____ SS# _____

RESIDENCE _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____

EMP ADDRESS _____ CITY _____ STATE _____ ZIP _____

ACCOUNT GUARANTOR / RESPONSIBLE PARTY _____ / _____
RELATIONSHIP TO PATIENT

PRIMARY INSURANCE CO _____ SUBSCRIBER _____

ID# _____ GROUP# _____ CO-PAY $ _____ PHONE _____

CLAIMS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE CO _____ SUBSCRIBER _____

ID# _____ GROUP# _____ CO-PAY $ _____ PHONE _____

CLAIMS ADDRESS _____ CITY _____ STATE _____ ZIP _____

I HEREBY AUTHORIZE LEO B. SEMKIW, M.D. AND/OR HIS STAFF TO FURNISH MY INSURANCE COMPANY ALL INFORMATION WHICH THE INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT ILLNESS OR INJURY. I HEREBY ASSIGN TO LEO B. SEMKIW, M.D. ALL MONEY TO WHICH I AM ENTITLED FOR MEDICAL AND/OR SURGICAL EXPENSE RELATIVE TO MY PRESENT ILLNESS OR INJURY. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO LEO B. SEMKIW, M.D. FOR EXPENSES NOT COVERED BY THIS ASSIGNMENT.

_____ _____

SIGNATURE PARENT / GUARDIAN (Patient if 18 years or older) DATE

Medical History Form

Patients Name_____

Please indicate if you have or have had any of the following medical problems:
(circle any that apply)

AIDS/HIV	Alcoholism	Allergies/hay fever	Anemia
Arthritis	Asthma	Bleeding disorders	Blood clots
Bronchitis	Cancer	Cataracts	Chemical dependency
Coronary Artery Disease	Diabetes	Depression	Dermatitis/skin problems
Eating Disorders	Emphysema	Gastritis	Gout
Headaches/migraines	Heart murmurs	Hepatitis	Hernias
High Cholesterol	High Blood Pressure	Kidney Disease	Liver Disease
Neurological problems	Pneumonia	Strokes	Thyroid problems
Tuberculosis	Ulcers	Venereal Disease	Vascular problems

Please indicate if you have had any: (circle all that apply)

Fevers/chills	Excessive fatigue	Night sweats	Significant weight gain/loss
Easy bruising/bleeding	Sores that will not heal	Tattoos/Body piercing	

Please list any previous surgical procedures: _____
_____
_____
_____
_____

Please list all current medications taken on a regular basis (including vitamins, dietary supplements such as Metabolite, birth control pills):
_____
_____
_____

Please list allergies to any medications and type of adverse reactions: _____
_____
_____

Please list any family history of major medical problems (indicate relationship): _____
_____
_____

Do you smoke? Yes No If yes, how many packs per day _____ for how many years ____
Do you drink any alcohol? Yes No If yes, how much do you drink _____

Your Height _____

Your Weight _____

Thank you for filling out this important medical history form.

LEO B. SEMKIW, M.D.
SAN JOSE SPORTS MEDICINE & ORTHOPEDICS
2430 SAMARITAN DRIVE, SAN JOSE, CA 95124
PHONE (408) 371-5300 FAX (408) 371-1747

I have read and understand the patient brochure provided to me by Leo B. Semkiw, M.D. This includes but is not limited to the financial policies, the HIPAA Notice of Privacy Practices, my responsibilities with respect to my medical insurance plan(s), the missed appointment / appointment cancellation policy and surgical cancellation fee policy.

Appointment reminders, laboratory results, X-ray results, MRI results, may be left at the following: (Check all that apply)

- ☐ **Home # With A Family Member**
- ☐ **Home# Voice Mail**
- ☐ **Work# Voice Mail**
- ☐ **Cell # Voice Mail**

PATIENT SIGNATURE (Parent/Guardian if patient is a minor) _____ DATE _____

PRINT NAME _____ RELATIONSHIP TO PATIENT _____

HIPAA Notice of Privacy Practices

Leo B. Semkiw, M.D.
Diplomate American Board of Orthopedic Surgery
2430 Samaritan Drive, San Jose, CA 95124
(408) 371-5300 Fax (408) 371-6387
Fellowship Trained

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT 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" 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 related health care services.

1. Uses and Disclosures of Protected Health information

Uses and Disclosures of Protected Health Information
Your protected health information 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 protected health information 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

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

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in 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 protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situation include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: 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 the 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 the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny 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 and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

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 to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing complaint.**

This notice was published and becomes effected on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practice with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____ Date_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Leo B. Semkiw, M.D.
2430 Samaritan Drive
San Jose, CA 95124

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-08)