

2625 West Alameda Avenue • Suite 116 • Burbank, CA 91505-4870 • Phone (818) 841-3936 • Fax (818) 841-5974

Stephan V. Yacoubian, M.D.
Sports Medicine
Shoulder, Hip & Knee Specialist
Arthroscopic & Reconstructive Surgery

Raymond B. Raven III, M.D.
Surgery of the Hand & Upper Extremity
Hand, Wrist & Elbow Specialist
Microsurgery & Reconstruction

Shahan V. Yacoubian, M.D.
Adult Reconstructive Surgery
Joint Replacement & Revision Specialist
Pelvic, Hip & Knee Reconstruction

Yuri Falkinstein, M.D.
Spine Surgery
Cervical, Thoracic & Lumbar Specialist
Minimally Invasive Spine Surgery

Vaz Galstjan, PA-C
Physician Assistant Certified

Carlos Villarreal, PA-C
Physician Assistant Certified

Susan Swindell
Practice Manager

Welcome to Orthopaedic Surgery Specialists. We look forward to helping you. Below is a checklist to ensure that you are prepared for your appointment. We will do our best to maintain your scheduled time.

1. Bring the following:

- Completed Patient Personal Form, Medical Questionnaire, and Office Policies form.
- Any tests (x-rays, CT Scans, MRIs) relevant to your problem. It is important to bring the actual films and/or the CD of the studies, in addition to the reports.
- A complete and accurate list of your current medications.
- Your valid health insurance card, photo ID, and payment.
- Referring doctor contact information so our doctors may send medical notes and letters to him/her after your visit.

2. Clothing to facilitate your medical visit:

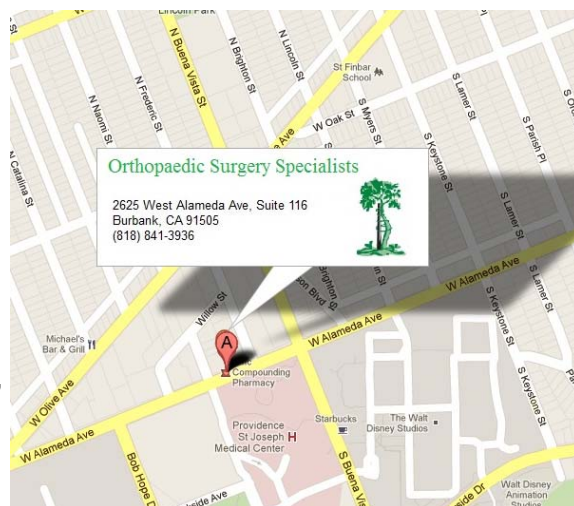
- If you are a female and are being seen for your shoulder, then please bring or wear a tank top or sports bra.
- If you are being seen for your hip, knee and/or ankle, please bring or wear a pair of shorts.
- If you are being seen for your neck and/or back, then we will provide an examination gown.

3. If you need to cancel or reschedule your appointment, please give us at least 24 hours notice so that we can offer your appointment time to another patient.

4. Our contact information:

2625 West Alameda Avenue
Suite 116 (First Floor)
Burbank, California 91505
Tel. (818) 841-3936

Parking is available in the parking structure adjacent to the office building. Parking fees do apply. However, we do not validate. Alternatively, you can find street parking.



Orthopaedic Surgery Specialists prides itself on one-on-one, personalized patient care. To keep our commitment to excellent service, we ask that you review our policies. ***Kindly sign and date to confirm you understand and will follow our practice's policies.***

FINANCIAL POLICY

We appreciate your business and we want to thank you for being responsible in managing the financial element of your care. If you have any questions based on the information below, please discuss them with our staff before you see our doctors.

Our doctors are contracted with many Preferred Provider Organization (PPO) health insurance plans. We accept patients who are "In Network" and "Out of Network." Note: Even if your health plan indicates that you have "out of network" benefits, please consult our staff so we can verify your authorized benefits. We welcome Medicare, Worker's Compensation plans, and patients who pay by cash (self-pay).

- We accept cash, check, Visa and MasterCard
- The adult accompanying a minor is responsible for payment of all services rendered to minor patients.
- Please update our staff with a change of address and/or telephone number anytime a change occurs.

If you have a health plan that we accept, please:

- Present your health plan card and proof of identity (e.g. driver's license) at each visit. Note: Some health plans issue a pharmacy card too. We only accept your medical health plan card.
- Update our staff with a change of insurance **anytime** a change occurs.
- Expect that we will bill your health plan IF YOU ARE covered by one of these plans that we accept. Be prepared to pay the co-payment or co-insurance at the time of service. When we contract with insurance companies, these agreements state we can't charge you (the patient) other than co-pays, deductibles and items deemed by the carrier as billable charges to the patient. If we later receive a check from the insurer, we will refund any overpayment to you.
- A prepayment of your deductible and co-insurance will be required for your portion of our fees, based on our contracted allowable rate, for scheduled surgical procedures. Any balance remaining, after your health insurer pays, is your responsibility. Payment is due upon receipt of a statement from our office.
- Respond promptly to your insurance company to provide any information that it may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming overdue and payable, in full, immediately.
- Be aware that all health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. We recommend you **READ YOUR INSURANCE BOOKLET** or a copy of the contract your policy falls under to determine your benefits.
- When you are charged a "global" fee for surgery or office care of a fracture, laceration repair, excision of an ingrown toenail, etc., the fee not only includes the service on the day it is performed, but includes routine follow-up care as well. The global period ranges from 10-90 days depending on the procedure and your health plan. X-rays and supplies (such as casting or dressing materials, splints, braces, etc) are not included in the global fee and a charge will be made for these items. Services related to complications are not included in the global fee.
- **Out of Network:** We will bill your insurance company. Insurance companies typically pay out-of network fees directly to the insured. If your insurance company pays our office directly and the total amount paid (out-of-pocket + insurance payment) is more than the amount billed, you will receive a refund within 30 days of payment.



FINANCIAL POLICY (continued)

Fracture Care (Broken Bones):

- Health plans have created a series of numeric codes to be used by doctors when treating patients. Insurance companies mandate that your doctor use these codes. There are special codes for patients with fractures.
- If you are being treated for a fracture you may encounter these “codes” on your Explanation of Benefits statement (EOB). They may often times be referred to as “office surgery” or “office procedure.” Many patients are alarmed when they see “surgery” on their bill, when they know that they have not had surgery. This is simply how your insurance company has elected to process and label insurance claims.
- Fracture care codes have a 90-day global period. A 90-day global period is a period of 90-days after a procedure (surgery or initial visit for fracture care) which entitles you to 90-days of follow up care. This means that your physician is paid only the first time they see you for your fracture (broken bone). This fee covers your care for the next 90-days. Moreover, this fee does NOT cover any repeat X-rays, supplies (braces, casts), or new complaints. These are billed separately.
- Often times your physician will examine you, interpret your X-rays, consider different treatment plans, and determine which is best for you. This may involve a manipulation of the fracture (bone setting) with possible splinting or casting, and careful continued observation. Whatever the treatment rendered, the fracture care code will cover the costs of all your follow up visits for 90-days (excluding repeat X-rays casts/splints).

I have read and I understand the above Financial Policy and I agree to abide by its terms.

Signature of Patient or Responsible Party: _____ Date: _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my insurance carrier, including Medicare, to pay directly to my physician, Orthopaedic Surgery Specialists & Affiliated Associate, for services rendered for me. I hereby authorize my physician to release information from my medical records necessary to bill my insurance carrier for these services. A photocopy of my signature on this form is to be considered as valid as the original.

Patient or Insured Name (print): _____

Signature: _____ Date: _____

NARCOTIC (PAIN) PRESCRIPTION POLICY

Our doctors prescribe Narcotic Medications only in cases of acute injury and after surgery for a period of no more than 6 weeks. If you require long term pain control, you will be referred to your primary care physician or to a pain management specialist.

Our office requires 48 hours to process narcotic prescription refills. Please contact us or your pharmacy so you will not run out of medication while waiting for your prescription to be processed. ***Prescriptions will only be refilled between 8:30 AM - 4:30 PM, Monday through Friday.***

I have read and I understand the above Narcotic (Pain) Prescription Policy and I agree to abide by its terms.

Signature of Patient or Responsible Party: _____ Date: _____



PATIENT PERSONAL FORM

2625 WEST ALAMEDA AVENUE · SUITE 116 · BURBANK · CA · 91505-4870 · PHONE (818) 841-3936 · FAX (818) 841-5974

GENERAL

Patient Name		Last Name	First Name	M.I.	Today's Date (MM/DD/YYYY)	
Social Security Number	Driver's License Number and State Issued		Gender		Date of Birth (MM/DD/YYYY)	
			<input type="checkbox"/> Male <input type="checkbox"/> Female			
Email Address			Name of Spouse / Partner			
Home Address	Number	Street	City	State	Zip	
Primary Telephone (Best # to reach you)			Secondary Telephone			
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
Emergency Contact	Relationship		Home Telephone	Secondary Telephone <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		

EMPLOYMENT

Employer			Job Title			
Employer Address	Number	Street	City	State	Zip	
Is this a work related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			Claim #	Claim Adjuster and Telephone	Case Manager and Telephone	
If yes, has your employer been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No						

LEGAL

Is there a legal case or lawsuit involved with this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			Attorney or Liability Representative Name and Telephone			
Is an attorney, liability carrier, or auto insurance involved in payment? <input type="checkbox"/> Yes <input type="checkbox"/> No						

MEDICAL REFERRALS

Who referred you to our practice?

Name: Doctor Relative Friend Insurance Company Hospital Internet

PRIMARY INSURANCE

Insurance Company Name		I.D./Policy Number	Group Number	
Insured Name		Insured Social Security #	Insured Date of Birth (MM/DD/YYYY)	
Subscriber of the Health Insurance	Relationship to Insured	Subscriber Social Security #	Subscriber Date of Birth (MM/DD/YYYY)	

SECONDARY INSURANCE

Insurance Company Name		I.D. / Policy Number	Group Number	
Insured Name		Insured Social Security #	Insured Date of Birth (MM/DD/YYYY)	
Subscriber of the Health Insurance	Relationship to Insured	Subscriber Social Security #	Subscriber Date of Birth (MM/DD/YYYY)	

AUTHORIZATION

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize examination and all services deemed medically necessary. I authorize the release of all medical information necessary to process my claim. I agree to assume financial responsibility for ALL services provided.

X

Signature of Patient or Responsible Party

Date



MEDICAL QUESTIONNAIRE

2625 WEST ALAMEDA AVENUE · SUITE 116 · BURBANK · CA · 91505-4870 · PHONE (818) 841-3936 · FAX (818) 841-5974

GENERAL

Name	Last Name	First Name	M.I.	Today's Date (MM/DD/YYYY)
				/ /
Gender	Height	Weight	Age	Which is your dominant hand?
<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Left <input type="checkbox"/> Right
Referring Doctor & Phone			Primary Care Doctor & Phone	

CURRENT PROBLEM

What part of your body are you being seen for today? _____ Which side? (if applicable)
 Left Right

What is the goal of your appointment today?
 Pain Management Better Function Better Appearance Return to Work Return to Play Other: _____

How did the problem develop?
When did the problem start: Over Time (Duration: _____) Injury (Date of Injury: _____)

Is this work related? Yes No

On a scale of 0-10 (0=no pain, 10=worst possible pain) what is your level of pain? 0 1 2 3 4 5 6 7 8 9 10

Do you have: Numbness? Tingling? If yes, where: _____

Have you noticed any weakness? Yes No If yes, explain: _____

What other symptoms do you have? _____

Do your symptoms limit your ability to work? Yes No If yes, explain: _____

Do your symptoms affect your activities of daily living? Yes No If yes, explain: _____

Do your symptoms keep you awake at night? Yes No

What treatments have you tried? Injection Physical Therapy Chiropractic Medication: _____ Other: _____

Have any treatments helped? Yes No Please explain: _____

How many street blocks can you walk? _____

Do you use a walking device? Cane Crutches Walker Wheel Chair Not Applicable; Don't use a walking device

Describe how you use stairs: Place one foot per step Place both feet on step before proceeding to next Not Applicable; Don't use stairs

MEDICAL HISTORY: LIST ALL

Medical problems: _____

Medications: _____

Supplements: _____

Surgeries: _____

Drug allergies (include reaction): _____

SOCIAL HISTORY

Marital Status: Single Married Domestic Partner Divorced Widowed Name: _____

Hobbies / Interests: _____ Occupation: _____

Do you drink alcohol? Never Rarely Socially Daily If daily, how many drinks per day? _____

Do you use tobacco products? No Yes If yes, how many packs per day? _____

Do you use recreational drugs? No Yes Describe: _____

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (print) _____ Signature _____ Date ____/____/____

HEALTH REVIEW (Do you have any of the following?)

GENERAL

Have you been in good general health most of your life No Yes
 Any allergies, including medication No Yes
 Any recent weight gain No Yes

SKIN

Skin Disease No Yes
 Jaundice No Yes
 Hives, eczema or rash No Yes
 Frequent infections or boils No Yes
 Abnormal pigmentation No Yes

HEAD, EYES, EARS, NOSE, THROAT

Eye diseases or injury No Yes
 Wear glasses No Yes
 Double vision No Yes
 Headaches No Yes
 Glaucoma No Yes
 Itching eyes or nose No Yes
 Sneezing or runny nose No Yes
 Nosebleeds No Yes
 Chronic sinus trouble No Yes
 Ear disease No Yes
 Impaired hearing No Yes
 Dizziness or transient episodes of unconsciousness No Yes

RESPIRATORY

URI (cold) now No Yes
 Spitting up blood No Yes
 Chronic or frequent cough No Yes
 Asthma or wheezing No Yes
 Difficulty breathing No Yes

CARDIOVASCULAR

Chest pain or angina pectoris No Yes
 Shortness of breath with walking or lying down No Yes
 Heart trouble or heart attacks No Yes
 High blood pressure No Yes
 Swelling of hands, feet or ankles No Yes
 Heart murmur No Yes

NECK

Stiffness No Yes
 Enlarged glands No Yes

FAMILY'S HEALTH REVIEW (Has any blood relative ever had any of the following?)

Cancer No Yes
 Tuberculosis No Yes
 Diabetes No Yes
 Heart trouble No Yes
 High blood pressure No Yes
 Stroke No Yes

GASTROINTESTINAL

Vomiting blood or food No Yes
 Gallbladder disease No Yes
 Liver trouble No Yes
 Hepatitis No Yes
 Painful bowel movements No Yes
 Black stools No Yes
 Hemorrhoids or piles No Yes
 Recent changes in bowel habits No Yes
 Frequent diarrhea No Yes
 Heartburn or indigestion No Yes

GENITOURINARY

Loss of urine No Yes
 Frequent urination No Yes
 Night time urinating No Yes
 Blood in urine No Yes
 Kidney trouble No Yes
 Kidney stones No Yes

LOCOMOTOR - MUSCULOSKELETAL

Varicose veins No Yes
 Weakness of muscles or joints No Yes
 Difficulty walking No Yes
 Pain in calves or buttocks on walking, relieved by rest No Yes

NEURO - PSYCHIATRIC

Ever had psychiatric care No Yes
 Ever been advised to see a psychiatrist No Yes
 Fainting spells No Yes
 Convulsions No Yes
 Paralysis No Yes

ENDOCRINE

Thyroid disease No Yes
 Hormone therapy No Yes
 Any change in hat or glove size No Yes
 Any change in hair growth No Yes
 Become colder than before or skin become dryer No Yes

HEMATOLOGICAL

Slow to heal after cuts No Yes
 Blood disease No Yes
 Anemia No Yes
 History of blood clots No Yes
 Bleeding problems No Yes

Convulsions No Yes
 Suicide No Yes
 Mental illness No Yes
 Bleeding tendency No Yes
 Gout or other arthritis No Yes
 Hereditary defects No Yes

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (print) _____ Signature _____ Date ____/____/____

NOTICE OF PRIVACY PRACTICES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT 1996 (HIPAA)

ORTHOPAEDIC SURGERY SPECIALISTS

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 takes effect on January 1, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies on a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$.25 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

A COPY OF THIS FORM IS AVAILABLE FOR YOU UPON REQUEST FROM RECEPTIONIST.

4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

STEPHAN V. YACOUBIAN, M.D. • RAYMOND B. RAVEN III, M.D. • SHAHAN V. YACOUBIAN, M.D. • YURI FALKINSTEIN, M.D.
2625 W. Alameda #116 • Burbank, CA 91505 • Phone (818) 841-3936 • Fax (818) 841-5974
Privacy Officer: Susan Swindell