AO SPORTSMED
ADVANCED ORTHOPAEDICS & SPORTS MEDICINE
Patrick McGahan, MD

Patient Name: (Last, First)_____ Date of Birth: _____

Primary Physician: _____

Referring Physician: _____

Address:_____ City: _____ State: _____ Zip Code: _____

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

E-Mail:_____ Social Security #: _____ - _____ - _____

EMERGENCY CONTACT

Name: _____

Relation to Patient: _____

Cell Phone: _____

Home Phone: _____

PRIMARY HEALTH INSURANCE

Insurance Carrier:_____

Subscriber's Name: _____

ID #: _____ Group/Plan _____

Patient Relationship to Insured: Self ☐ Spouse ☐ Dependent ☐

Secondary Insurance Carrier:_____

This office requires cash/check payment on the day you are treated if you are not covered by a current health insurance policy. If you are a member of a Health Maintenance Organization (HMO) or a Preferred Physician Organization (PPO), please give us your insurance card to copy for our files.

I understand that this office has agreed to bill my insurance as a courtesy for services rendered and I am financially responsible for all charges, regardless of my insurance coverage. I hereby authorize the doctor to release all information necessary to my insurance company to process all claims incurred. I hereby authorize my insurance company to make payment of benefits directly to the physicians of Advanced Orthopaedics & Sports Medicine.

**CO-PAYMENT IS REQUIRED AT THE TIME OF SERVICE, UNLESS OTHER FINANCIAL ARRANGEMENTS ARE MADE IN ADVANCE**

Signature of Patient or Guardian:_____ Date:_____

**CONSENT TO EMAIL**

As a convenience to both patients and our practice, we often rely on email to communicate with you about your healthcare. In order to comply with the Federal Government's privacy guidelines (HIPAA), we are required to inform you that although our email and computers require a login and password, our emails are secure but not encrypted. Encrypted servers require a separate login and password, in addition to your regular email login and password. Often, these extra security steps undo the convenience that makes email attractive. If you would like to communicate with the doctors and /or staff in our practice via email, we ask that you provide us with informed consent. Please read the consent below and provide your signature.

*I understand that my email communications with physicians of Advanced Orthopaedics & Sports Medicine Inc. are secure but not encrypted. However, I would like to communicate via email and understand the risks.*

Signature of Patient or Guardian:_____ Date:_____

Patrick J McGahan, MD
*Orthopaedic Surgeon Specializing in*
*Sports Medicine/Shoulder Reconstruction*

**450 Sutter St, Ste 400; San Francisco, CA 94108**
**(p) 415-900-3000 (f) 415-900-3001**
**www.patrickmcgahanmd.com**

# HEALTH HISTORY QUESTIONNAIRE

Patient Name: Today's Date: Date of Birth:

Who referred you to our office?

Name of your Primary Care Physician:

Please list an emergency contact:

Relationship: Phone: ( )

## *I. Medical History (Problems), Surgery History, and Hospitalizations*

Please list all medical history (problems), surgery history, and hospitalizations

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Are you allergic to any medications? ☐ Yes ☐ No If yes, which one(s):

Do you have any other known allergies? ☐ Yes ☐ No If yes, list here:

Your preferred pharmacy:

Pharmacy Name:

Pharmacy Location & Phone number:

## II. *CURRENT COMPLAINTS*

What is the reason for your visit today (state body part)?

Please rate your pain on a scale of 1 to 10 (10 being the most painful): At rest:
At its worst:

Is the pain: ☐Worsening ☐Stable ☐ Improving ☐Constant ☐Occasional ☐Sharp
☐Dull ☐Aching ☐Stabbing ☐Throbbing

What symptoms are you experiencing? ☐Locking ☐Catching ☐Giving Way ☐Popping ☐Grinding
☐Bruising ☐Numbness ☐Tingling ☐Other (describe): _____

What, if anything, makes your symptoms **better**? ☐Rest ☐Activity ☐ Cold Therapy ☐Heat Therapy
☐Medication ☐Other (describe):

What, if anything makes your symptoms **worse**? ☐Inactivity ☐Exercise (describe) _____
☐Other (describe):

What treatments have you tried? ☐Nothing ☐Physical Therapy ☐Exercise ☐Acupuncture
☐Chiropractic ☐Bracing ☐Injections (i.e.: Synvisc, Hyalgan) ☐Ice ☐Decreased activity
☐ Medications ☐Other

## III. *MEDICAL HISTORY*

Are you presently under a doctor's care for any other condition? ☐Yes ☐No If **yes**, please mark table below:

**Please review and check if any of the following apply:**

| Disease | Personal History | Family History | Disease | Personal History | Family History |
|---|---|---|---|---|---|
| Asthma/Bronchitis | ☐ | ☐ | High Cholesterol | ☐ | ☐ |
| Bone/Joint Disease | ☐ | ☐ | High Blood Pressure | ☐ | ☐ |
| Psychiatric Illness (specify): _____ | ☐ | ☐ | Deep Vein Thrombosis (DVT) | ☐ | ☐ |
| Chest Pain/Angina | ☐ | ☐ | Pulmonary Embolism (PE) | ☐ | ☐ |
| Cancer | ☐ | ☐ | Irregular Heart Beat | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | Osteoarthritis | ☐ | ☐ |
| Digestive Problems | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| Stomach Ulcer | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Drug dependency | ☐ | ☐ | Gout | ☐ | ☐ |
| Epilepsy/Seizures | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | Nerves | ☐ | ☐ |
| Hay Fever | ☐ | ☐ | Numbness | ☐ | ☐ |
| Headaches/Migraine | ☐ | ☐ | Genetic Disease/Syndrome | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | Poor Circulation | ☐ | ☐ |
| Anemia | ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ |
| Bleeding Tendency | ☐ | ☐ | Stroke | ☐ | ☐ |
| Hemophilia | ☐ | ☐ | TB/Tuberculosis | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | AIDS/HIV | ☐ | ☐ |
| Alcohol dependency | ☐ | ☐ | **OTHER**: | ☐ | ☐ |

**Please mark any other problems which you may also be experiencing at the present time:**

| **Musculoskeletal** | **Neurological** | **General** | **Respiratory** |
|---|---|---|---|
| ☐ Joint pain | ☐ Paralysis | ☐ Weight loss | ☐ Wheezing |
| ☐ Stiffness | ☐ Tremors/Shakiness | ☐ Weight gain | ☐ Coughing |
| ☐ Fractures | ☐ Gait disturbances | ☐ Fevers | ☐ Pain in breathing |
| ☐ Joint Swelling | ☐ Other | ☐ Chills | ☐ Blood clots |
| ☐ Muscle weakness | | ☐ Other | ☐ Other |
| ☐ Other | | | |
| | | | |
| **Skin** | **Head** | **Eyes** | **Ear, Nose, Throat** |
| ☐ Rashes, itching | ☐ Headaches | ☐ Changes in vision | ☐ Hearing loss |
| ☐ Ulcers/sores | ☐ Seizures | ☐ Photophobia | ☐ Vertigo |
| ☐ Bruising | ☐ Loss of consciousness | ☐ Pain/redness | ☐ Nosebleed |
| ☐ Bleeding tendencies | ☐ Other | ☐ Excessive tearing | ☐ Snoring |
| ☐ Other | | ☐ Other | ☐ Tinnitus |
| | | | ☐ Other |
| | | | |
| **Genitourinary** | **Cardiovascular** | **Gastrointestinal** | **Other (please list below)** |
| ☐ Loss of bladder control | ☐ Chest pains | ☐ Difficulty with swallowing | |
| ☐ Urinary frequency | ☐ Shortness of breath | ☐ Heartburn | |
| ☐ Other | ☐ Palpitations | ☐ Nausea/Vomiting | |
| | ☐ Other | ☐ Blood in bowel | |
| | | ☐ Other | |

| ***Medical History*** ***(continued)*** |
|---|
| Surgeries: Include type of surgery and when surgery was performed: |
| |
| |
| |
| Hospitalizations. Please list any dates of hospitalizations and reasons: |
| |
| |
| |
| Are you pregnant or could become pregnant? ☐Yes ☐No |
| Do you have a history of fracture(s)? ☐Yes ☐No If yes, list here: |
| |
| |
| **IV. *SOCIAL HISTORY*** |
| Exercise: ☐Sedentary (No exercise) ☐Mild (i.e. climbing stairs, walk 3 blocks, golf) ☐Occasional, vigorous (less than 4 times a week for 30 minutes) ☐Regular Vigorous (4+ times a week, 30+ minutes) |
| Caffeine: Please indicate amount of cups consumed daily for each. ☐None ____ Coffee ____Tea ____Soda |
| Do you smoke? ☐Yes ☐No If yes, amount per day: |
| Do you drink alcohol? ☐Yes ☐No If yes, how much: How often: |
| Illicit drugs: Do you currently use any type of recreational/street drugs? ☐Yes ☐No If yes, please indicate type of product used and how much used on a daily basis:<br><br>Have you ever been admitted into a drug rehabilitation program? ☐Yes ☐No If yes, please indicate when you attended: |
| Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed |
| Do you have any children? ☐Yes ☐No If yes, how many? |
| Do you have any hobbies or any recreational activities that you enjoy participating in on a regular basis? ☐Yes ☐No If yes, please list. |
| What is your primary language? |
| Do you speak any other languages? ☐Yes ☐No If yes, please list. |
| What state or country were you born in? |
| Right or left hand dominant? |
| What is your current occupation? |
| Height: Weight: |
| Patient Signature: Date: |
| Printed Name: |

**Physician Signature**_____**Date**_____

AO SPORTSMED
ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

**Patrick J McGahan, MD**
450 Sutter St, Ste 400
San Francisco, CA 94108
415-900-3000

NAME: _____ DATE: _____

# CURRENT MEDICATION SHEET

Please list your medications, including any over the counter medications such as Asprin, Advil, Aleve, Tylenol, etc. Please list all natural vitamins, supplements and herbs that you take.

| MEDICATION | DOSE | FREQUENCY (How often you take) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

AO SPORTSMED
ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

**450 Sutter Street, Suite 400 San Francisco, CA 94108**
**Phone (415) 900-3000 · Fax (415) 900-3001**

# HIPAA Notice of Privacy Practices

**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 the consultation, 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 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 your and remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations 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 the 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 physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**
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 operations. 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 and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a 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 form 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 a complaint.**

This notice was published and becomes effective on/or before **April 14, 2015.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices 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:

Signature: _____ Date: _____

Print Name: _____

AO SPORTSMED
ADVANCED ORTHOPAEDICS & SPORTS MEDICINE
450 Sutter Street, Suite 400
San Francisco, CA 94108
Phone (415) 900-3000 Fax (415) 900-3001

**CONSENT TO EMAIL**

As a convenience to both patients and our practice, we often rely on email to communicate with you about your health care.

In order to comply with the Federal Government's privacy guidelines (HIPAA), we are required to inform you that although our email and computers require a login and password, our emails are secure but not encrypted. Encrypted servers require a separate login and password, in addition to your regular email login and password. Often, these extra security steps undo the convenience that makes email attractive.

If you would like to communicate with the doctors and /or staff in our practice via email, we ask that you provide us with informed consent. Please read the consent below and provide your signature.

I understand that my email communications with physicians of Advanced Orthopaedics & Sports Medicine are secure but not encrypted. However, I would like to communicate via email and understand the risks.

_____ _____

Signature Date

_____

Print Name

_____

Email Address

# Arbitration Agreement

**Article 1**

*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 incompletely 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 right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*

**Article 2**

a. **Parties To The Agreement.** The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "Provider" as used in the Agreement includes the undersigned doctor, nurse practitioner, nurse midwife, or other healthcare provider and his or her professional corporation or partnership, and any employees, agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities. The Provider signing this Agreement signs it on behalf of all the foregoing individuals and entities, and intends to bind each of them to arbitration to the full extent permitted by law.

b. **Treatment Covered.** Patient understands and agrees that any dispute of the sort described in Article 1 between Provider and Patient will be subject to compulsory, binding arbitration.

**c.** **Other Providers (If Applicable).** Patient understands that he or she may at times receive treatment from one or more healthcare providers who take call for or otherwise practice jointly with the undersigned Provider. It is understood and agreed that any such healthcare providers will be subject to compulsory, binding arbitration.

**d.** **Coverage of Prenatal Claims (If Applicable).** Patient understands and agrees that, if Provider treats her during pregnancy, any dispute of the sort described in Article 1 as to medical treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

**Article 3**

a. **Informal Resolution of Disputes**. In the event Patient feels that a problem has arisen in connection with the medical care rendered by Provider to Patient, Patient will promptly notify Provider so that Provider may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running of the statute of limitations for 90 days.

b. **Method of Initiating Arbitration**. If the dispute is not resolved by mutual agreement, Patient may initiate arbitration by notifying Provider to that effect and by designating an arbitrator to act on Patient's behalf. Within 20 days of receipt of such notice, Provider will designate an arbitrator to act on Provider's behalf. In the event that more than two parties participate, parties aligned with Patient shall select one arbitrator, and parties aligned with Provider shall select a second arbitrator. The two "party" arbitrators shall select a neutral arbitrator. The controversy shall then be submitted to the three arbitrators for a final and binding decision.

c. **Applicable Law**. The arbitration shall be conducted pursuant to the California Arbitration Act (C.C.P. 1280-1296). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California which shall apply to the same extents as if the dispute were pending before a superior court of this State.

d. **Interpretation of Agreement**. If any part of this Agreement is held unenforceable, it shall be served and shall not affect the enforceability of the remainder. This Agreement supersedes and replaces any previous arbitration agreement between Provider and Patient and applied to all care previously rendered by Provider to Patient.

**Article 4**

- **Rescission**. Once signed, this Agreement governs all subsequent medical services rendered by Provider to Patient until or unless rescinded by written notice within 30 days of signature. Written notice may be given by a guardian or conservator of Patient if Patient is incapacitated or a minor.

---

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.

Patient's Name (please print): _____

Date: _____ Signed: _____

Provider's Name (please print): _____

Date: _____ Signed: _____