VALLEY ORTHOPAEDIC SURGERY ASSOCIATES

IF YOU ARE BEING SEEN TODAY FOR AN INJURY OR A PROBLEM THAT OCCURRED **ANYWHERE BUT THE WORKPLACE**, PLEASE FILL IN THE QUESTIONS BELOW. THIS IS NEEDED FOR YOUR INSURANCE COMPANY TO PROCESS OUR CLAIMS IN A TIMELY MANNER. INSURANCE COMPANIES DELAY CLAIMS PROCESSING UNTIL THEIR MEMBERS ANSWER THESE QUESTIONS.

1. WHEN DID YOUR INJURY OR PROBLEM OCCUR? (IF NO SPECIFIC DATE, APPROX WHEN SYMPTOMS STARTED).
   CUANDO OCCURIO SU ACCIDENTE O PROBLEMA? (SI NO OCURIO EN UN DIA EXACTO CUANDO COMENZARON LOS SINTOMAS?)

2. WHERE DID IT HAPPEN? (EXP: AT HOME, MALL FREEWAY, ETC…)
   DONDE OCURIO? (EJEMPLO: CASA, MALL, AUTOPISTA?)

3. HOW DID IT HAPPEN? (EXP: CUT MYSELF, SLOWLY DEVELOPED, AUTO ACCIDENT, ETC.)
   COMO OCURIO? (EJEMPLO: ME CORTE, ACIDENTE DE AUTO, ETC.)

4. NAME AND ADDRESS OF THE INSURANCE COMPANY THAT WILL BE RESPONSIBLE FOR THIS ACCIDENT. (NAME OF INSURED & POLICY #)
   NOMBRE Y DIRECCION DE LA COMPANIA QUE SERA RESPONSABLE

_____
SIGNATURE / FIRMA

_____
DATE / FECHA

LESIN, BALFOUR & ZIV
A PROFESSIONAL MEDICAL CORPORATION
14624 SHERMAN WAY, SUITE 303 - VAN NUYS, CA 91405
(818) 902-2800 FAX: (818) 782-8979

BY SIGNING THIS FORM, YOU ARE VOLUNTARILY GIVING YOUR GENERAL CONSENT FOR THE PHYSICIAN TO EXAMINE, EVALUATE AND TREAT YOUR ORTHOPAEDIC CONDITION. IF IT IS DETERMINED THAT YOU WILL REQUIRE AN INVASIVE PROCEDURE, YOU WILL BE ASKED TO SIGN A MORE SPECIFIC INFORMED CONSENT.

_____ _____

PATIENT'S SIGNATURE **DATE**

OR

_____ _____

LEGAL GUARDIAN'S SIGNATURE **DATE**

AUTHORIZATION & ASSIGNMENT FORM

I HEREBY AUTHORIZE LESIN, BALFOUR & ZIV, A PROFESSIONAL MEDICAL CORPORATION (DR. BENJAMIN E. LESIN, DR. GEORGE W. BALFOUR AND DR. ELI T. ZIV), TO PROVIDE MY INSURANCE COMPANY AND/OR MY EMPLOYER THE INFORMATION THEY REQUIRE TO COMPLETE MY CLAIM.

I ALSO AUTHORIZE MY INSURANCE COMPANY TO PAY LESIN, BALFOUR & ZIV DIRECTLY FOR MY SURGICAL/MEDICAL BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION (PRIVATE PATIENTS ONLY).

A PHOTOCOPY OF THIS AUTHORIZATION AND ASSIGNMENT SHALL BE CONSIDERED TO BE VALID AS THE ORIGINAL.

_____ _____

SUBSCRIBER'S SIGNATURE **PATIENT'S SIGNATURE**

_____

DATE

VALLEY ORTHOPAEDIC SURGERY ASSOCIATES
A MEDICAL GROUP

PRIVATE PATIENTS PLEASE COMPLETE

Today's Date: _____ Marital Status: S M D W Ethnicity: _____ Language _____

Patient's Name: _____ Age: _____ Birthdate: _____

Home Address: _____
Number Street City State Zip Code

Home Phone: (_____) _____ Cell: _____ Email: _____

Social Security Number: _____ Driver License Number: _____

Name of Employer: _____ Occupation: _____
(If Industrial PLEASE put name of employer at time of injury)

Business Address: _____
Number Street City State Zip Code

Business Phone: (_____) _____ Department or Extension: _____

Spouse or Parent's Name: _____

Social Security Number: _____ Driver License Number: _____

Name of Employer: _____ Occupation:_____

Business Address:_____
Number Street City State Zip Code

Business Phone: (_____) _____ Department or Extension: _____

By Whom Were You Referred to This Office? _____

Address: _____ Phone: _____
Number Street City State Zip Code

Nature of Injury: _____ Date of Injury: _____

Name & Address of Insurance Company: _____

Subscriber: _____ Certificate: _____ Group: _____

Date of Birth: _____

Secondary Insurance: _____

Subscriber: _____ Certificate: _____ Group: _____

Date of Birth: _____

Name of Nearest Relative or Friend (Not Living in the Same Household), or Person to Contact in Case of an Emergency: _____

Phone Number: _____

Your Signature: _____

MUST BE COMPLETE FOR YOUR EXAM

Name _____ Date of Birth _____ R/L Handed _____

Height _____ Weight _____ Married _____ Single _____ Widowed _____ Divorced _____

The following information is required to assist your physician in determining your state of health:

1. In the past, have you had problems with, or injuries to, your hands, elbows, forearms, or shoulders? If so, what and when?
   _____
2. In the past, have you had problems with, or injuries to, your neck, back, knees, or legs? If so, what and when?
   _____
3. Have you ever had a broken bone? If so, which bone and when? _____
4. Have you ever had any surgery (including cosmetic i.e. breast implant) or chemotherapy treatment? If so, what, when and by whom? _____
5. Have you ever had a major accident? If so, what and when? _____
6. Have you ever been hospitalized? If so, why? _____
7. Are you allergic to any medications? If so, what? _____
8. What medications/anticoagulants, are you presently taking? _____
9. Are you under any other doctor's care? If so, why? _____
10. Do you smoke? _____ How much? _____ Do you drink alcohol? ____ How often and how much? _____
11. Do you have any history of:

	YES	NO
Cancer	_____	_____
Hepatitis (A B C)	_____	_____
Diabetes	_____	_____
Heart Trouble	_____	_____
High Blood Pressure	_____	_____
Blood/Bleeding Problems	_____	_____
Ulcers/Stomach Problems	_____	_____
Asthma/Lung Problems	_____	_____

12. Family History:
    Are both your parents alive? _____
    Mother's Age _____ Father's Age _____
    If deceased:
    Mother's age at death _____
    Father's age at death _____
    Cause of death _____
    FEMALE PATIENTS ONLY:
    Are you pregnant at this time? _____
13. Has any one in your family had the following:

	YES	NO	WHO		YES	NO	WHO
High Blood Pressure	_____	_____	_____	Diabetes	_____	_____	_____
Tuberculosis	_____	_____	_____	Epilepsy	_____	_____	_____
Mental Illness	_____	_____	_____	Arthritis	_____	_____	_____
Bleeding Disorders	_____	_____	_____	Sickle Cell Disease	_____	_____	_____
Heart Trouble	_____	_____	_____	Gout	_____	_____	_____
Kidney Disease	_____	_____	_____	Cancer	_____	_____	_____

14. Please circle whichever of the following you have had or presently have:

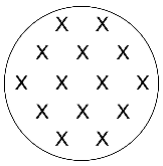
Frequent or severe headaches	Heartburn	Frequent coughs
Frequent dizziness	Food intolerance	Coughing up blood
Pins and needles	Painful urination	Pneumonia
Frequent fainting	Bloody urine	Tuberculosis
Emotional disorders	Difficulty urinating	Joint pains
Vision or hearing problems	Leaking of urine	Muscle pains or weakness
Recent or frequent vomiting	Frequent urinating at night	Numbness
Recent or frequent constipation	Heart disease	Bruisability
Recent or frequent diarrhea	Chest pain	Heat or cold sensitivity
Weight loss	Heart murmur	Hair or skin changes
Black stool	Palpitations	Thyroid problems
Change in appetite	Leg swelling	Goiter
Abdominal pains	Shortness of breath	Sleep problem

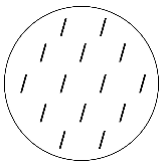
VALLEY ORTHOPAEDIC SURGERY ASSOCIATES

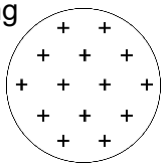
Name: _____ Date: _____

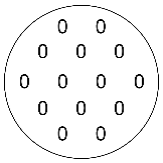
Sex: M F (circle) Dominance: R L (circle) Occupation: _____

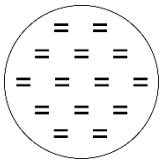
Please use these symbols to indicate affected areas

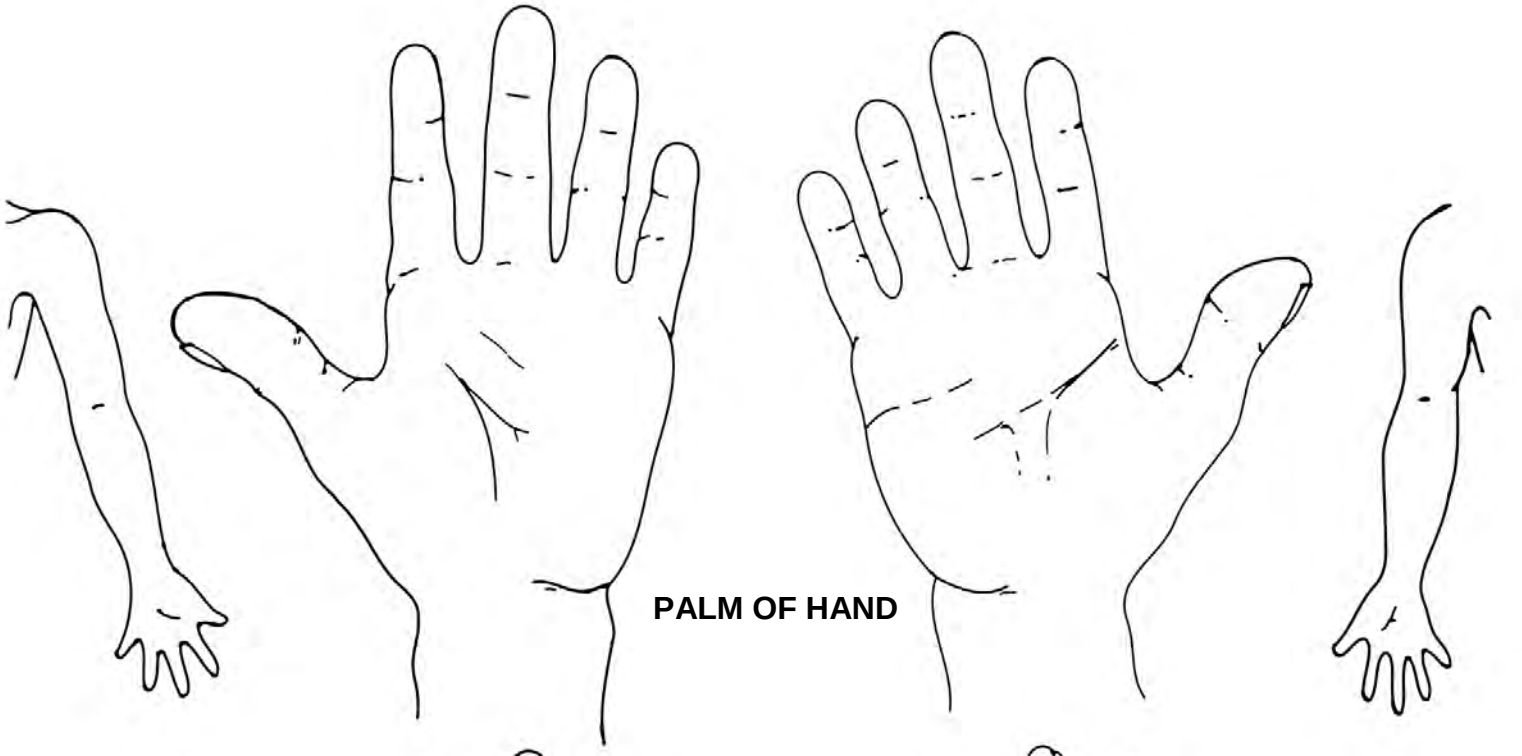
Pain 

Numbness 

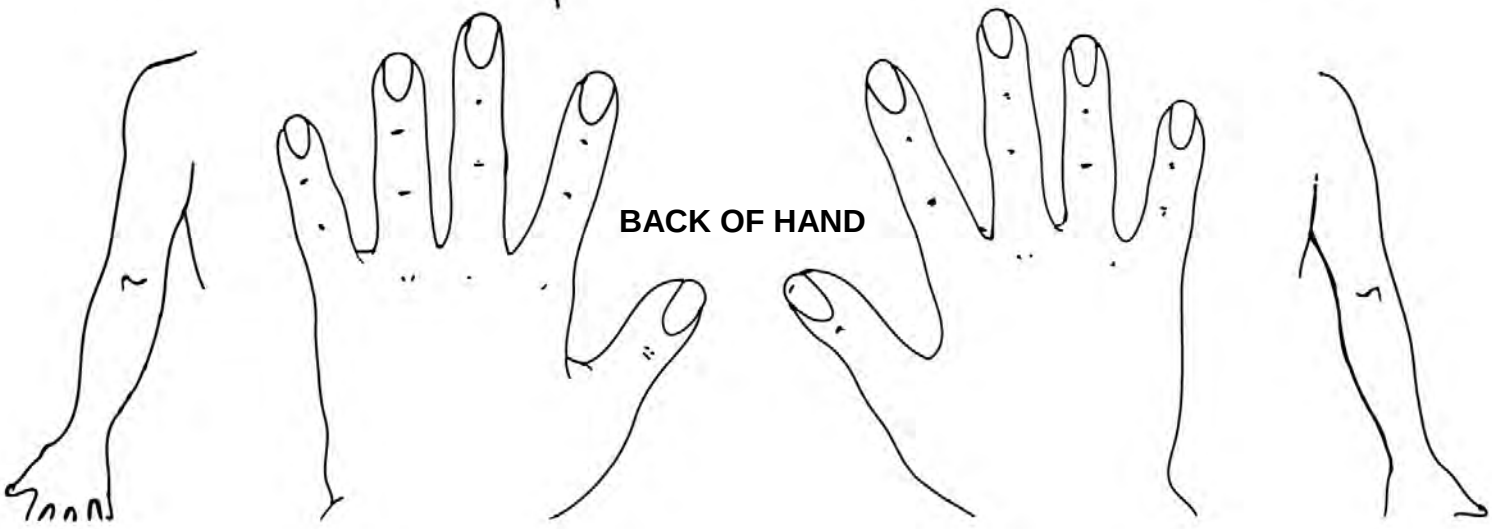
Burning 

Tingling 

Decreased Sensation 



PALM OF HAND



BACK OF HAND

GEORGE W. BALFOUR, M.D.

Surgery of the Hand ♦ Orthopaedic Surgery

DIPLOMATE AMERICAN BOARD OF ORTHOPAEDIC SURGERY
CERTIFIED WITH ADDED QUALIFICATIONS * SURGERY OF THE HAND

FELLOW AMERICAN OF ORTHOPAEDIC SURGEONS
MEMBER AMERICAN SOCIETY FOR SURGERY OF THE HAND

OUR POLICY REGARDING THE RELEASE OF X-RAYS AND MRI STUDIES

Federal and state laws require this office to keep all X-rays and MRIs as part of our patient's medical records. We, therefore, DO NOT release original X-rays or MRIs. In the event you would like a copy of your original X-rays or MRIs, we will be happy to provide them at a cost of $15 per X-ray film or $15 per CD.

Please note that our office will requires a minimum of two weeks to process your films.

Thank you for your understanding.

George W. Balfour, M.D.

I have read the above and understand the office policy regarding the release of X-rays and MRIs.

_____ _____

PATIENT'S SIGNATURE **DATE**

14624 SHERMAN WAY, SUITE 303 • VAN NUYS CA, 91405 • PHONE: 818-902-2800 • FAX: 818-782-8979
10640 RIVERSIDE DRIVE • NORTH HOLLYWOOD, CA 91602 • PH: 818-955-9898
43807 10TH STREET WEST, SUITE C • LANCASTER, CA 93534 • PH: 661-948-0385
2486 NORTH PONDEROSA DR, SUITE D-114 • CAMARILLO, CA 93010 • PH: 805-383-0271

LESIN, BALFOUR & ZIV
A PROFESSIONAL MEDICAL CORPORATION
14624 SHERMAN WAY, SUITE 303 - VAN NUYS, CA 91405
(818) 902-2800 FAX: (818) 782-8979

APPOINTMENTS:

WE REQUEST THAT EVERY PATIENT CALL AND MAKE AN APPOINTMENT BEFORE COMING INTO THE OFFICE. IN CASE OF AN EMERGENCY, **CALL FIRST BEFORE COMING IN**, IF POSSIBLE, TO INSURE THAT THE DOCTORS ARE IN**.**

CANCELING APPOINTMENTS:

WE APRECIATE A **24HR NOTICE** FOR CANCELING CHECK UPS, AND AT LEAST A 1HR NOTICE FOR CANCELING AN APPOINTMENT DUE TO ILLNESS OR OTHER PROBLEMS. A **$25 FEE** WILL BE BILLED FOR MISSED APPOINTMENTS WITHOUT NOTIFICATION. MISSED APPOINTMENTS WITHOUT PROPER NOTICE WOULD MEAN THAT FUTURE APPOINTMENTS WILL NO LONGER BE AVAILABLE.

HMO PATIENTS:

YOU MUST HAVE AUTHORIZATION FROM YOU PRIMARY CARE PHYSICIAN BEFORE WE CAN SEE YOU. YOU ARE RESPONSIBLE FOR OBTAINING THIS AUTHORIZATION AND FOR ANY CHARGES THAT ARE INCURRED DUE TO LACK OF THE AUTHORIZATION OR CHARGES THAT ARE EXCLUDED BY **YOUR** INSURANCE. IN ADDITION: **YOUR COP-PAY MUST BE PAID AT THE TIME OF YOUR VISIT OR A $5 PER MONTH CHARGE WILL BE ADDED TO COVER THE COST OF BILLING THE CO-PAY.**

I HAVE READ AND REVIEWED THE ABOVE OFFICE POLICIES AND I UNDERSTAND THAT THE EXISTANCE OF ANY INSURANCE POLICY DOES NOT RELIEVE ME OF THE RESPONSIBILITY FOR PAYMENT OF SERVICES OR SUPPLIES RECEIVED.

****** THE CO-PAY PORTION OF THE STATEMENT APPLIES TO ALL PRIVATE INURANCES AND PPOs ******

PATIENT OR PARENT'S SIGNATURE _____

PRINT PATIENT'S NAME _____

RELATIONSHIP TO PATIENT _____

DATE _____

LESIN, BALFOUR & ZIV - A PROFESSIONAL MEDICAL CORPORATION
NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information.

Please read carefully:

At Lesin, Balfour & Ziv, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file may be performed by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of our services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, a member of our staff will enter your information in the computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not at home, we may leave this information on your answering machine or with the person who answers the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use your health information without your prior written authorization. You may request in writing that we do not use your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

Because we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your file for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment of change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you requested, but we will be happy to include your statement in your file. If we agree to an amendment or change we will not remove nor alter earlier documents, but will add new information.

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS NOTICE.

You may file a complaint with the Department of Health and Human Services; you will not be retaliated against for filling a complaint.

However, before filling a complaint, or for more information regarding your health information privacy, please contact our Privacy Officers, Agy Reich at (818) 902-2842 or Liza Calderon at (818) 902-2831.

This notice goes into effect as of April 14, 2003.

ACKNOWLEDGMENT

I have received a copy of the Lesin, Balfour & Ziv Notice of Privacy Practices. Date _____

Signed _____ Print name _____

Signed by a parent or guardian, please print the patient's name.

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 employee, 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.

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 with this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 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 rating 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's 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.

By: _____

Physician's or Authorized Representative's Signature (Date)

By: _____

Patient's or Patient's Representative's Signature (Date)

_____

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

_____

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.

THE QuickDASH OUTCOME MEASURE

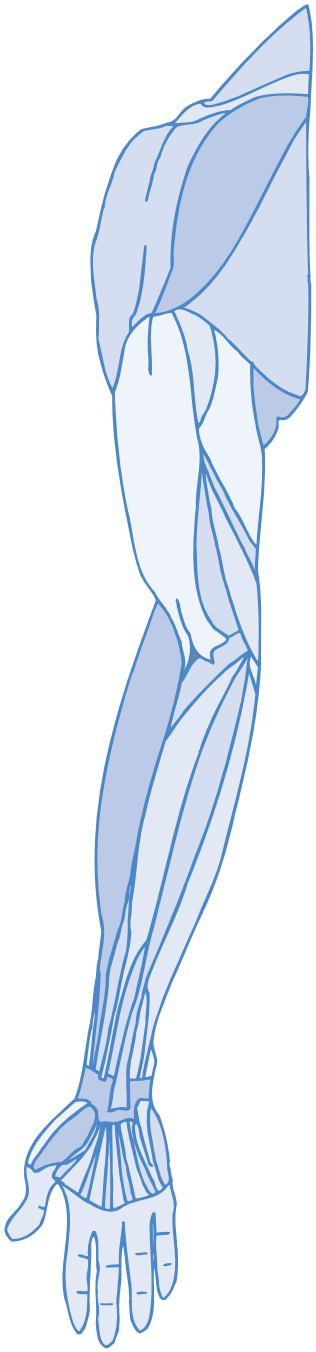
INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.



*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{sum of n responses}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:_____

☐ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. doing your usual work because of arm, shoulder or hand pain?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. doing your work as well as you would like?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. spending your usual amount of time doing your work?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

☐ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. playing your musical instrument or sport as well as you would like?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. spending your usual amount of time practising or playing your instrument or sport?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.