BERNARD ONG, M.D.

ORTHOPAEDIC SURGERY

8551 W. LAKE MEAD BLVD • SUITE 251 • LAS VEGAS, NV 89128
Phone: (702) 796-7979 Fax: (702) 456-7979

PATIENT INFORMATION

Last Name: _____ (Jr., Sr., etc.) Sex: M or F Right Handed ☐ Left Handed ☐

First name: _____ Middle Initial: _____

Address: _____ Apt./Space: _____

City: _____ State: _____ Zip Code: _____

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

Date of Birth: _____ Age:_____ Social Security #: _____

Employer: _____ Occupation: _____

Email: _____

RESPONSIBLE PARTY FOR PAYMENT

SAME AS ABOVE CHECK HERE ☐

Name: _____ Phone: _____

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

REFERRED BY: _____ Date of Injury: _____

Primary Care Physician: _____ Phone: _____

On The Job Injury? ☐ Yes ☐ No If Yes, Worker's Comp. Insurance Co. _____ Claim # _____

Was this an Auto Accident? ☐ Yes ☐ No ☐ Other If Other Please specify: _____

Do you have an Attorney pertaining to this injury? ☐ Yes ☐ No

If Yes, Attorney's Name: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

PRIMARY INSURANCE INFORMATION		**SECONDARY INSURANCE INFORMATION**	
Name of Insurance Co.	Phone	Name of Insurance Co.	Phone
Insurance Co. Claims Address		Insurance Co. Claims Address	
Name of Insured	Relationship to Patient	Name of Insured	Relationship to Patient
Policy #	Group #	Policy #	Group #
Insured's Social Security No.	Date of Birth of Insured	Insured's Social Security No.	Date of Birth of Insured

I hereby authorize payment of medical benefits to BERNARD ONG, M.D. for services furnished me. I also authorize the physician to release any information in the course of my examination or treatment. This assignment will remain in effect until revolted by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I hereby consent to and authorize medical treatment, tests, and procedures that my physician deems advisable and necessary based on his judgement.

_____ _____

Patient's Signature or Responsible Party Signature Date

IF YOU ARE COVERED BY MEDICARE, PLEASE COMPLETE THE MEDICARE ASSIGNMENT ON THE FINANCIAL POLICY FORM.

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HISTORY FORM

Name: _____

Height: _____ Weight: _____ Today's Date: _____

CHIEF COMPLAINT

Injured Body Part: _____ Date of Injury: _____

How were you injured? _____

Have you been to a physician previously for this problem: ☐ Yes ☐ No If yes, when? _____

X-Rays Taken ☐ Yes ☐ No MRI ☐ Yes ☐ No If Yes, Where? _____

Allergies:	Reaction:

Medication	Dose	How Long Taken

REVIEW OF SYSTEMS

Are you currently or have you had problems with:			Describe all Yes responses
Eyes	No	Yes	
Ears, Nose Throat	No	Yes	
Lungs, Breathing	No	Yes	
Digestion	No	Yes	
Bladder Problem	No	Yes	
Diabetes	No	Yes	
Heart Disease	No	Yes	
High Blood Pressure	No	Yes	
Bleeding Problems	No	Yes	
Balance Problems	No	Yes	
Numbness / Tingling	No	Yes	
Blackouts / Fainting	No	Yes	
Psychological Problems	No	Yes	
Cancer	No	Yes	
Arthritis	No	Yes	
Polio	No	Yes	
Epilepsy	No	Yes	
HIV	No	Yes	
Hepatitis	No	Yes	
Tuberculosis	No	Yes	
Other	No	Yes	

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HISTORY FORM

PAST MEDICAL HISTORY

Surgeries / Hospitalization	Year	Complaint

Have you ever had general anesthesia? □ No □ Yes

Any problems with anesthesia? □ No □ Yes If yes, please explain _____

SOCIAL HISTORY

□ Single □ Married □ Divorced □ Separated □ Widowed

Children □ No □ Yes If yes, How many? _____

Do you live alone? □ No □ Yes

Exercise: □ Daily □ Weekly □ Monthly □ Rarely □ Never

What type of exercise? _____

Are you on a special diet? □ No □ Yes Describe: _____

History of substance abuse? □ No □ Yes Describe: _____

Do you smoke? □ No □ Yes _____ pack(s) per day for _____ year(s)

When did you quit smoking? □ This year □ > 1 Year □ > 5 Years □ > 10 Years

Drink alcohol? □ No □ Yes If yes, how often? □ Daily □ 1-2 times per week □ 1-2 times per month □ 1-2 times per year

FAMILY HISTORY

Member	Alive?		Age	Health Status or Cause of Death
Father	Yes	No		
Mother	Yes	No		
Sister / Brother	Yes	No		
Sister / Brother	Yes	No		
Sister / Brother	Yes	No		
Sister / Brother	Yes	No		

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CONSENT FORM FOR CARE and /or INJECTION / ASPIRATION

I, _____ understand and voluntarily agree that (initial each statement after reviewing)

___ I agree to be evaluated and treated by Dr. Bernard Ong as deemed medically appropriate. I acknowledge that no procedure will be performed without having been provided appropriate information regarding treatment and possible side effects or consequences. Signing this document implies informed consent on the part of the patient. In this arena, Bernard Ong, MD is released from harm. Although the physician and staff will make efforts to obtain my appropriate medical history and information, the Practice shall not be held responsible for issues of omission or negligence on the part of the patient.

___ I further acknowledge that the Practice is not functioning as my primary care/family physician, and if there are issues dealing with my primary care or internal medicine, they may be referred to my primary care physician by the Practice. There may also be instances where Dr. Ong will refer me to additional specialty care and evaluation as needed.

___ As for my responsibility to the Practice, I agree to attend appointments, obtain MRI's and therapies as scheduled. Multiple missed appointments, or inappropriate behavior may result in termination of services and referral to their physicians. Multiple failures to cancel or no show for appointments will be subject to a charge for that visit.

___ As part of my care, I may receive injections of one kind or another. This joint injection may be a steroid, a hyaluronic acid series or PRP. This consent for treatment acknowledges that there can be RISKS from any injection. The risks, although rare, can include but are not limited to the following: pain, joint stiffness, discoloration, bruising, swelling, allergic reaction, infection, injury to blood vessels or nerves (temporary or permanent), dizziness or fainting, or bleeding. You may not encounter any discomfort or ill effects as a result of the injection.

___ I am aware that there are alternatives to an injection that exist for the treatment of my condition and may include the following: no treatment, surgical intervention, physical therapy, medications, alternative therapies.

If a procedure is going to be done, a further discussion will ensue, but you are encouraged to ask questions. We wish to empower you to seek a higher level of health by getting involved. Help us to understand you.
I hereby certify that I have read and understand this document.

Printed Name: _____ Signature: _____

Date: _____

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FINANCIAL POLICY, ASSIGNMENT OF BENEFITS & INSURANCE WAIVER OF LIABILTY

All fees for medical care are based on the usual, reasonable, and customary fee charged in this area by physicians of equal training and experience.

PAYMENT FOR MEDICAL SERVICES RENDERED ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. **This means that you will be expected to pay your insurance co-payment at each visit.** You are responsible for any collection fees if applicable. There will be a $35.00 charge for any checks returned to our office. There will be a $25 cancellation fee applied to appointments canceled less than 24 hours prior to your appointment, up to $125 for appointments requiring additional time.

We will do all we can to assist you with your insurance claims; however, insurance is a contract between you and your insurance carrier. Final responsibility of payment of your account rests with you. The exception is for those patients with injuries that are work-related and are covered by Worker's Compensation. These patients are not responsible for their bills unless their claim is denied. You are responsible for providing correct insurance information. Balances and /or payment penalties, as a result of incorrect insurance coverage information provided to us, is patient responsibility. You are also responsible for collection/late fees, if applicable.

Prior authorizations obtained for procedures by this office on your behalf do not guarantee payment but rather are based on medical necessity. Claims are subject to policy provisions and your insurance carrier determines final payment. If you are scheduled for surgery and an assistant is required, the assistant's fee is in addition to the surgeon's fee. Your insurance will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) of the Social Security Act. This usually applies to DME's (Durable Medical Equipment) which includes slings, splints and braces. If the physician prescribes a DME that your insurance does not cover, you would be responsible for the cost if you accept the DME.

Having read the above, I hereby authorize payment by my insurance carrier or other designated payor of medical benefits to BERNARD ONG, MD., for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of the assignment is considered as valid as the original.

I also authorize, BERNARD ONG, MD., to release to my insurance carrier or their agents any medical information about me needed to determine these benefits or the benefits payable for service.

I hereby consent to and authorize medical treatment, tests and procedures performed in the office that my physician deems advisable and necessary based on his judgment. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

_____

Printed Name

_____ _____

Patient's or Responsible Party's Signature Date

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TESTS AND TEST RESULTS

Formulating a diagnosis and treatment plan may require further information. The physician may recommend additional diagnostic testing, such as radiographic studies (i.e. x-ray, MRI, CT scan, Bone Scan etc) and/or lab work.

As a patient, it is important that you obtain the ordered/prescribed tests to optimize your care and prognosis. If the physician orders a test, it is your responsibility to proceed with the test prescribed.

Upon completion of your test, you, the patient, must return to the office within one week to review the test results with the physician. Test results are best reviewed with you in person. The physician/office will not contact you with your results. Test results are only reviewed and discussed in person upon your return visit.

This document confirms your understanding, as the patient, that it is your responsibility to obtain any prescribed/ordered test and follow-up within one week to review the results with the physician. It is not the responsibility of the physician/office to ensure that you proceed with the tests prescribed. Additionally, the physician/office will not be responsible for contacting you with the results. This responsibility rests upon you, the patient.

_____ _____

Signature Date

_____

Print Your Name

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Pain Treatment with Opioid Medications: Patient Agreement

I, _____understand and voluntarily agree that (initial each statement after reviewing)

___**I am responsible for my pain medication.** I will keep the medicine safe, secure and out of the reach of children and will not sell this medicine and/or share it with others. My treatment will be stopped otherwise.

___If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.

___I will take my medication as instructed and not change the way I take it without first talking to the doctor or his assistant. After 30 days of opioid use, I give consent to possible drug testing, when deemed necessary. Upon 90 days, if opioid medication is still required, I will be referred to a pain specialist.

___I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

___I understand opioids can be effective to treat pain but using them can increase my chances for addiction or overdose. Other methods of treatment include ibuprofen and acetaminophen, as well as physical therapy, massage or acupuncture.

___I will tell the doctor all other medicines that I take and let him know right away if I have a prescription for a new medicine.

___Prescriptions for medications with the potential for misuse, abuse, and addiction are carefully monitored through Nevada Prescription Monitoring Program. Requests for refills of these medications will be evaluated on
a case-by-case basis. If you lie or are otherwise dishonest about your use of these medications, you will be dismissed from the practice and the proper authorities will be notified.

___Opioids may cause sedation, interfere with breathing, urinary and bowel function (constipation), physical dependence, addiction, nausea, vomiting, itching, mood changes, muscle twitching, allergic reactions and injury to the fetus or unborn child in a pregnant woman.

___I understand an opioid antagonist is available without a prescription.

___Risks associated with minors and opioid use can be decreased with adult supervision and monitoring. Possible symptoms of abuse include withdrawal, agitation, paranoia or other aberrant behavior.

___I will use only one pharmacy to get all on my medicines: **Pharmacy name/phone#**_____

_____ _____

Patient Name: Patient Signature

Date_____

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I hereby authorize the release of my medical / health information to the following person(s) and / or entities:

1. **_____(relationship) _____**
2. **_____(relationship) _____**
3. **_____(relationship) _____**
4. **_____(relationship) _____**

_____ _____

Print patient's name **Signature / Date**

Pharmacy Name: **_____**

Pharmacy Address: **_____**

Pharmacy Phone: **_____**

I hereby confirm that I have read and received the HIPAA NOTICE OF PRIVACY PRACTICES for the office of Bernard Ong, MD. I also understand that a personal copy of the HIPAA Notice is available upon request.

_____ _____

Print patient's name **Signature / Date**

PLEASE INDICATE THE MONTH & YEAR OF YOUR MOST RECENT TEST/VACCINE FOR THE FOLLOWING:

Pneumonia Vaccine ______________________

Flu Vaccine ______________________

Colonoscopy ______________________

Mammogram (women only) ______________________

Covid Vaccine ______________________

Patient Name: ____

Race:

Please circle one:

Asian Native Hawaiian Other Pacific Islander Black/African American White

American Indian/Alaska Native More than 1 race Unreported/Refused to report

Ethnicity:

Please circle one:

Hispanic/Latino Not Hispanic / Latino Unreported / Refused to report

Preferred Language: ______________________________________

It is a federal requirement that we ask the above questions. If you are uncomfortable answering any of these, you have the option to decline by circling "Refused to report"