Welcome

Dear Patient and Family

Thank you for choosing me to provide your orthopedic care. My office staff, team and I will make every effort to treat you with courtesy, respect and kindness, while providing the highest level of care possible. I truly understand the frustration of having to complete new forms each time you see another physician; however, in order to help me treat you accurately and efficiently, I would greatly appreciate it if you would take a few minutes to complete the appropriate forms as thoroughly as possible and would like to thank you in advance for doing so. Please be sure to fill out a separate musculoskeletal questionnaire sheet for each area of the body, for which you have been scheduled for your appointment, if multiple body sites are affected.

I typically spend an ample amount of time during the first visit educating my patients and their family about their diagnosis and together determining a customized treatment plan that will best suit their needs. As a result of this philosophy, and the occasional need to fit in patients with emergency conditions, we will at times find it hard to stay on schedule. Please know that we do respect your time, and we will make every effort to see you as close to your scheduled time as possible. For up to date office wait times please visit www.youthsportsortho.com prior to coming to your visit.

We understand that schedules change and that there may be a need to cancel or re-schedule your appointment. Please give us at least 24 hours notice so that we can offer your appointment time to another patient. I look forward to getting to know you and helping with your orthopedic problem.

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Sincerely,
John A. Schlechter, DO

Preparing for Your Visit

1. Please read the patient welcome letter on our website which explains my philosophy of care.

2. Please complete my forms on the website:
   APOS Patient Registration Forms and the
   Dr. John Schlechter Pediatric and Adolescent Musculoskeletal Questionnaire

3. Insurance information
   Please bring your insurance card and a photo ID

4. Imaging studies
   Please bring any recent x-rays, MRI or CT scans related to your injury. Please bring a CD of the studies or the actual films, not just the Reports

5. Clothing
   - Female shoulder patients - please bring or wear a tank top, halter or sports bra

   - Hip, knee and ankle patients – please bring or wear a pair of shorts

Dr. John Schlechter
Pediatric and Adolescent
Musculoskeletal Questionnaire

Please answer each question as completely as possible; this information will help with the diagnosis & treatment of your condition. Check boxes to indicate a positive response.

Name _____ Age _____ yrs _____ mo Sex _____

Height _____ Weight _____ Date of Birth _____ School Grade _____

Referred by _____

Primary Care Physician/Pediatrician _____ Fax # _____

Dominant Hand ☐ Right ☐ Left

Body part to be examined: ☐ Right ☐ Left

☐ Shoulder ☐ Elbow ☐ Wrist/Hand

☐ Knee ☐ Ankle ☐ Hip

☐ Other _____

How and **When** did the injury occur or the symptoms begin? Date of Injury = _____

Type of Sport= _____

Did you notice any of the following at the time of injury?

☐ A "pop" ☐ tearing sensation ☐ immediate swelling

What treatment have you received for this problem?

☐ X-ray result:
☐ MRI/CT Scan result:
☐ Bone Scan result:
☐ EMG result:
☐ Medication result:
☐ Cortisone result:
☐ Physical Therapy result: location:
☐ Surgery what procedure and when:
result:

What physician is currently treating you for this condition? _____

Dr. John Schlechter
Pediatric and Adolescent
Musculoskeletal Questionnaire

Name _____

Which of the following describes your pain?

☐ Sharp	☐ Aching	☐ Burning
☐ Constant	☐ Intermittent	☐ Awakens me from sleep
☐ During activities	☐ After activities	

Where is your pain located?

☐ Front ☐ Back ☐ Inner side ☐ Outer side ☐ Top

What aggravates your symptoms?

Which of the following symptoms do you currently have?

☐ Catching or popping	caused by:
☐ Grinding	caused by:
☐ Swelling	caused by:
☐ Shooting / radiating pain	from where to where:
☐ Numbness / tingling	where:
☐ Loss of motion	describe:
☐ Weakness	with the following uses:

Does it feel at times like the involved joint dislocated or "slips out"?

Does anything improve your symptoms?

Have you had prior injuries or complaints related to this area of your body?
(If yes please describe the injury and its prior treatment.)

Dr. John Schlechter
Pediatric and Adolescent
Musculoskeletal Questionnaire

Name _____

HEALTH HISTORY

This information will remain confidential and will not be released without patient authorization. Please be as complete as possible and print clearly.

Drug Allergies / Sensitivities (Please describe the adverse reaction) _____

_____

_____

Medical Illnesses:	Yes	No	Explain all YES answers
Heart Disease / Condition	☐	☐	_____
High Blood Pressure	☐	☐	_____
Asthma	☐	☐	_____
Diabetes	☐	☐	_____
Seizures	☐	☐	_____
Bleeding Disorder / Tendency	☐	☐	_____
Sickle Cell Anemia	☐	☐	_____
Cancer	☐	☐	_____
Kidney Disease	☐	☐	_____
Mental Illness	☐	☐	_____
Hepatitis / Liver Disease	☐	☐	_____
HIV	☐	☐	_____

Previous Surgeries: _____

_____

Current Medications (include herbs, supplements and diet pills) _____

_____

Family History (Any medical problems in your family) _____

_____

Social History:

Do you currently smoke cigarettes? ☐ Yes ☐ No _____ packs daily
Do you drink alcohol? ☐ Yes ☐ No
Do you use any other drugs? ☐ Yes ☐ No

Sports and leisure activities: _____

Signature _____ Physician _____

Thank You For Filling Out This Form

ADULT AND PEDIATRIC ORTHOPAEDIC SPECIALISTS

Dr's Mc Master, Weinert, Rosenfeld, Dobyns, Aminian, Lalonde, Schlechter
1310 W. Stewart Dr. Suite 508, Orange, CA 92868 (714)633-2111 FAX (714) 633-5615
25982 Pala Dr. Suite 230, Mission Viejo, CA 92691 (949)600-8800 FAX (949) 600-8813

PEDIATRICIAN/PHYSICIAN/PCP:_____ Referred?_____

Physician's Address: _____ City_____ State____ Zip_____

Physician's Phone #: (_____)_____ Fax #: (_____)_____

NAME OF PATIENT: Last_____ First_____ Middle_____

Home Address:_____ City_____ State____ Zip_____

Home Phone #: (____)_____ Date of Birth: ___ /___ /___ Age: _____ Sex ☐ M ☐ F

FATHER'S NAME: Last_____ First_____ M.I.___ SS#: ____-___-_____

Date of Birth: ___ / ___ / ___ E-Mail Address:_____

Home Address: _____ City_____ State____ Zip_____

Home Phone #: (___)_____ Work #: (___)_____ Cell #: (___)_____ Text: Yes☐No☐

Employer: _____

Employer Address: _____ City_____ State____ Zip_____

MOTHER'S NAME: Last_____ First_____ M.I.___ SS#: ____-___-_____

Date of Birth: ___ / ___ / ___ E-Mail Address:_____

Home Address: _____ City_____ State____ Zip_____

Home Phone #: (___)_____ Work #: (___)_____ Cell #: (___)_____ Text: Yes☐ No☐

Employer: _____

Employer Address: _____ City_____ State____ Zip_____

INSURANCE INFORMATION

Insurance Name:_____ I.D. #:_____ Group #: _____

Name of Subscriber: _____ Date of Birth: _____ SS#: _____-____-_____

Relationship to Patient: _____

I hereby attest that I am eligible member of a contracted health plan as noted above, I agree, that should it be determined that I am ineligible or services are denied to me under the health plan noted above, that I will be responsible for payment to: **ADULT AND PEDIATRIC ORTHOPAEDICS SPECIALISTS**.
I authorize release of my medical history and documentation directly to my insurance company for the purpose of payment for medical services and that the payment(s) be made directly to: **ADULT AND PEDIATRIC ORTHOPAEDIC SPECIALISTS**.

Signature of parent, legal guardian or responsible party requesting care.

Signature_____ Date_____

APOS

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment for services.
- Conduct normal health care operations

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at 714-633-2111 at any time to obtain a current copy of the "Notice of Privacy Practices"
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

Patient Name _____

Patient Representative _____

Signature _____

Date _____

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Consent for Electronic Mail ("Email") Use

APOS ("Office") offers patient the opportunity to communicate by Email for non-urgent matters. This form provides the guidelines regarding Email communications, and documents your consent.

IN CASE OF A MEDICAL EMERGENCY, DO NOT USE E-MAIL. CALL 911

Email Use

Email communications should be between the office and an adult patient 18 years of age or older, or the parent or guardian of a minor.

Do Not Use Email For

Do not use Email for communicating sensitive medical information such as sexually transmitted diseases, HIV, hepatitis, substance abuse, mental health or presence of malignancy. Do not use Email to request records. Please call your office.

Privacy, Security & Confidentiality

Although the office has implemented reasonable technical safeguards, the office cannot and does not guarantee the privacy, security or confidentiality of any Email messages sent or received over the Internet. There is a potential that Email sent or received over the Internet can be intercepted, altered, forwarded, and / or read by others. The office is not responsible for Email messages that are lost due to technical failure during composition, transmission, or storage.
The office will not forward Emails to independent third parties without your prior written consent, except as authorized or required by law. If any of this is a concern to you, you should not communicate with the office through Email.

Creating a Message

In the "Subject" line of the email, please include general topic of your message (i.e., prescription, appointment, medical advice, billing question).
In the body of the message, please include the patient's name and date of birth. This information is necessary to verify your identity and make sure we pull the correct medical file.

Content of the Message

Email should only be used for non-sensitive and non-urgent issues. Email communications are appropriate for the following type of transactions:

- Appointment scheduling
- Prescriptions / refills
- General medical advice after an initial face-to-face visit
- Lab/Test Results
- Referrals
- Attachments such as: physical education excuse note, etc.

Response Time

Although APOS will endeavor to read and respond within 24 hours to any Email, we cannot guarantee that any particular Email will be responded to within any particular period of time. If you have not received a response within 3 days, please call our office.

Documentation In Medical Record

Email communications regarding treatment will be documented in your medical record by placing a copy of the message in your file.

Ending Email Relationship

You may discontinue using Email as a means of communication by sending an email or letter to the office.

I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of Email as one form of communication with the office.

Email Address:_____

_____ _____
Signature of Patient, Parent or Personal Representative Date

_____
Relationship (if other than patient)

APOS

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PATIENT CONSENT AND WAIVER FORM

I, _____, understand that I am, or will be, responsible for all of the charges associated with my appointment today, as well as any subsequent appointments relating to the testing, x-rays, diagnosis, and all treatment, including, but not limited to the following items:

1. **ALL DURABLE MEDICAL EQUIPMENT, IF NOT COVERED BY INSURANCE PLAN.**

2. **NO REFERRAL AT TIME OF VISIT:** If you wish to be seen today, but did not bring a referral with you, nor do you have a valid referral already here in the office, you will be responsible for all charges.

3. **NO INSURANCE:** You will be responsible for all charges associated with all visits.

4. **MISSED APPOINTMENTS:** Appointments are confirmed prior to your appointment date. If an appointment is cancelled up to 24 hours prior, you will not be charged. If you fail to show up for your confirmed appointment, you will be charged $25.00.

5. **CHANGES IN INSURANCE:** All co-pays and fees are due in full at the time of service.

6. **DELINQUENT ACCOUNTS:** In the event that your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing costs and processing fees.

Patient or Responsible Party:

Signature_____ Date_____