Alan M. Hirahara, MD, FRCSC

Orthopaedic Surgeon / Specialist in Sports Medicine

2801 K Street, #330, Sacramento, CA 95816, USA
Phone: (916) 732-3000 Fax: (916) 732-3022
www.HiraharaMD.com

DATE	PRIMARY CARE PHYSICIAN (PCP)	REFERRING PHYSICIAN

Patient Information

FIRST NAME	LAST NAME	SOCIAL SECURITY NO.

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

EMAIL ADDRESS	MAY WE SEND YOU FOLLOW-UP QUESTIONNAIRES VIA EMAIL? ☐ Yes ☐ No

ARE YOU EMPLOYED? ☐ Yes ☐ No	NAME OF EMPLOYER	OCCUPATION

DATE OF BIRTH	AGE	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Other

EMERGENCY CONTACT	RELATIONSHIP TO PATIENT

HOME PHONE	WORK PHONE	CELL PHONE

Primary Insurance (Copay expected at time of service)

INSURANCE PROVIDER	ID NUMBER	GROUP NUMBER

SUBSCRIBER NAME (FIRST, LAST)	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Other

TYPE OF INSURANCE ☐ HMO/EPO (Name): ☐ PPO/POS/PI ☐ Med/Legal ☐ Private Pay

Secondary Insurance

INSURANCE PROVIDER	ID NUMBER	GROUP NUMBER

SUBSCRIBER NAME (FIRST, LAST)	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Other

Person Responsible for Your Account (If self, skip this section)

FIRST NAME	LAST NAME	SOCIAL SECURITY NO.

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

RELATIONSHIP TO PATIENT ☐ Spouse ☐ Parent ☐ Other	DATE OF BIRTH	SEX ☐ Male ☐ Female

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PATIENT'S LAST NAME	PATIENT'S FIRST NAME	DATE

Card Images

PRIMARY INSURANCE CARD

SECONDARY INSURANCE CARD

PHOTO ID

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Welcome. Please take a moment to provide us with some information about yourself.

LAST NAME	FIRST NAME	DATE	HEIGHT	WEIGHT

Medical & Surgical History

Check all items that pertain to your medical history, whether past or present. Please provide us with an explanation below for any checked item, as well as a doctor's name and number if you are currently being treated.

- ☐ Arthritis
- ☐ Bleeding Problems
- ☐ Blood Clot
- ☐ Cancer/Leukemia
- ☐ Diabetes
- ☐ Heart Problems/Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Problems/Asthma
- ☐ Neck or Back Problems
- ☐ Neurologic Problems
- ☐ Previous Surgery
- ☐ Stomach & Intestinal Problems
- ☐ Stroke/Seizures
- ☐ Thyroid Problems
- ☐ Anesthesia Problems
- ☐ Psychiatric Problems
- ☐ I may be pregnant
- ☐ I am or was a smoker
- ☐ I used to or currently drink alcohol
- ☐ I use or have used recreational drugs
- ☐ Other

EXPLANATION	DOCTOR NAME / NUMBER (IF APPLICABLE)

Allergies

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No	ARE YOU ALLERGIC TO LATEX GLOVES? ☐ Yes ☐ No	ARE YOU ALLERGIC TO SURGICAL TAPE? ☐ Yes ☐ No

If yes to any of the above, please provide details below:

ALLERGY	REACTION

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Patient Information

LAST NAME	FIRST NAME	DATE

Medications

Please list any medications you are currently taking (including over-the-counter medications such as Advil, Tylenol, Aleve, Asprin, etc.). Please also list all natural vitamins, supplements, steroids, diet pills and herbs that you take.

MEDICATION	DOSE	FREQUENCY (HOW OFTEN YOU TAKE)

Are You Physically Active?

If yes, please describe the type and frequency of activities. (This may include work-related activities.)

TYPE OF ACTIVITY	FREQUENCY

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LAST NAME	FIRST NAME	DATE

Financial Agreement

Dr. Hirahara's practice specializes in orthopaedic surgery, which involves treating bone, joint, muscle, and ligament disorders. Before we are able to assist you, it is important that you understand you are responsible for the payment of any charges incurred during your visits to this office. For your benefit, we have explained the two scenarios that govern the financial agreement between our office and you, the patient.

A: I have health insurance

If you carry health insurance, the total fee for medical services rendered is still charged to you and not the insurance company (unless otherwise stated); which means that your name, not the insurance company's, will be on the bill as the one responsible for charges. Once we generate a bill, we will submit it on your behalf to your insurance carrier. Depending on your coverage, the insurance carrier will cover all, a portion of, or none of the fees. Any balance due will be your responsibility, and as such, you will receive an invoice from our office.

If a procedure is not covered by your insurance carrier, and you still request to have that procedure performed, we will bill your insurance carrier first as a courtesy. If the claim is denied, you will be responsible for the full amount of the procedure.

Unfortunately, this office cannot accept responsibility for collecting unpaid insurance claims or for negotiating a settlement on a disputed claim. While we facilitate the process, you are ultimately responsible to ensure payment in a timely manner.

B: I wish to pay for services on my own

In some cases, our patients ask to pay directly for services. We are happy to accommodate such arrangements.

Please indicate your payment instructions:

☐ **I would like my final invoice to be submitted to my insurance carrier.**

I hereby authorize my insurance benefits be paid directly to Dr. Hirahara by my insurance carrier and authorize the release of any information necessary to process all claims. A copy of this authorization shall be as valid as the original.

☐ **I would like to pay my invoice directly.**

I hereby direct that Dr. Hirahara shall not bill my insurance company for services provided to me, and instead, I agree to pay all fees associated with my visits to his office.

Or

I do not have insurance, or insurance Dr. Hirahara accepts, and would like to pay out-of-pocket for my visit.

PATIENT/GUARDIAN SIGNATURE DATE

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Please initial each of the items below

Records Release

I hereby authorize Dr. Alan Hirahara and his office staff to release to my referring physician, insurance company, attorney, or legal guardian, any information, including diagnosis and records or treatment, concerning my medical history and orthopaedic care. Any data collected may be used in any publication, providing my real name is not used.

_____
INITIAL HERE

Media Release and Consent

I give Dr. Alan Hirahara all rights, title and interest in the photographs, audio recordings, video recordings, and/or interview/ questionnaire answers (collectively or individually "Information") obtained of or from me to be used in any manner, and in any media, in connection with the services rendered by Dr. Hirahara. Your name and any other identifying information will be removed and never used or shown.

_____
INITIAL HERE

Medicare Patient Signature Authorization (for Medicare patients only)

I authorize any holder of medical or other information about me to release my complete records to the Social Security Administration and Health Care Financing Administration — or its intermediaries or carriers, billing agent of Dr. Hirahara, or supplier — needed for this or related Medicare plan.

I permit a copy of this authorization to be used in place of the original, and I request that payment under Medicare be made to Dr. Hirahara on any bills for services provided to me by him during the period from _____ to December 31, 20____.

_____
INITIAL HERE

Privacy Policy Acknowledgement

I acknowledge I have access to, have reviewed or have received a copy of Dr. Hirahara's Notice of Privacy Practices.

_____
INITIAL HERE

"No Show" Policy

We require a 24-hour notice on cancellations or rescheduled appointments. Failure to do so will result in a $35 charge.
You may be discharged as a patient and sent to your primary care physician for referral to another orthopaedic surgeon if you:

- Cancel or reschedule more than 3 times
- No show or failure to cancel or reschedule appointment prior to 24 hours more than 2 times

_____
INITIAL HERE

☐ **I have read and agree to all of the initialed items above.**

PATIENT/GUARDIAN SIGNATURE DATE

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LAST NAME	FIRST NAME	DATE	DOMINANT ARM ☐ Right ☐ Left

Injury Description

WHICH SHOULDER IS AFFECTED? ☐ Right ☐ Left	DATE OF INJURY OR ONSET (IF NOT SURE, ESTIMATE):	DID YOU HAVE ANY PREVIOUS PROBLEMS WITH THIS SHOULDER? ☐ Yes ☐ No

DESCRIBE PROBLEM

WAS INJURY RELATED TO WORK? ☐ Yes ☐ No	WAS INJURY RELATED TO AN AUTO ACCIDENT? ☐ Yes ☐ No	IS THIS INJURY POTENTIALLY GOING TO BE IN LITIGATION? ☐ Yes ☐ No

Previous Treatment

Have you taken NSAID's for your shoulder pain? (i.e. motrin, ibuprofen, advil, naprosyn, aleve, celebrex, etc.) ☐ Yes ☐ No

WHICH ONES?	DID THEY HELP THE PAIN? ☐ Yes ☐ No

Have you done physical therapy for this shoulder? ☐ Yes ☐ No

WHERE?	DID THEY HELP THE PAIN? ☐ Yes ☐ No

Have you had any shots to this shoulder? ☐ Yes ☐ No

WHAT KIND OF SHOT? (I.E. CORTISONE, HYALURONIC ACID, PRP, ETC.)	HOW MANY?	WHEN WAS THE LAST ONE?	DID THEY HELP THE PAIN? ☐ Yes ☐ No

Have you had previous surgery on this shoulder? ☐ Yes ☐ No

BY WHO?	WHEN?	WHAT WAS DONE?

Pain Evaluation

HOW SEVERE IS THE PAIN RIGHT NOW? 0 = NONE / 10 = SEVERE PAIN
(CIRCLE ONLY ONE NUMBER) ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

WHEN DO YOU FEEL THE PAIN AND HOW LONG DOES IT LAST?
(AM, PM, INCREASES OVER DAY, CONSTANT, ETC.)

WHAT MOVEMENTS MAKE THE PAIN WORSE?
(THROWING, REACHING OUT OR BACK, OVERHEAD ACTIVITIES, LIFTING, ETC)

DO YOU HAVE PAIN THAT WAKES YOU UP FROM SLEEP? ☐ Yes ☐ No	DO YOU HAVE PAIN RIGHT NOW WHILE NOT MOVING? ☐ Yes ☐ No

DOES YOUR SHOULDER PROBLEM LIMIT YOU ?
(I.E. WORK, SPORTS, ACTIVITIES OF DAILY LIVING)

INFORMED CONSENT AND HIPAA AUTHORIZATION

Orthopaedic sports medicine, arthroscopy, and related surgery registry using the web-based Surgical Outcomes System (SOS).

'You' refers to you or your child.

INTRODUCTION AND PURPOSE

You are being asked to participate in a global registry for orthopedics and sports medicine using the web based Surgical Outcomes System (SOS). The purpose of this research study is to create a large clinical database to collect information on patients undergoing orthopaedic and sports medicine related surgery and treatment, and to look at the outcomes and cost-effectiveness associated with treatment procedures. Approximately 3000 doctors will participate in this worldwide research study. Each doctor will be able to include 800 patients ages 12 and older, each a year.

Your participation in this study will involve that you complete outcome surveys that ask questions such as your level of pain, how you feel, and your ability to perform certain activities in your daily life. Through your completion of these surveys, your doctor has the opportunity to monitor your progress after treatment, even when you may not be scheduled to see him/her. Your doctor is also able to compare your outcomes to the average de-identified global data.

Your participation in the SOS study is voluntary and will not change your treatment in any way. Please read the information below and ask questions about anything you do not understand before deciding whether or not to participate.

PROCEDURES

Your participation will involve completing surveys on your level of pain, function and well- being before and after treatment for at least five years on a web based secure site. Data collection time points are before treatment, multiple times after treatment during the first 6 months, 6 months, and 1,2,3,4 and 5 years after treatment. Depending upon your type of surgery or treatment, you may be requested to complete these same surveys up to 15 years. Completion of these surveys will take approximately 15 minutes or less to complete.

You will be asked to complete these surveys by providing your email address and/or phone number. An email or text reminder that has a secure link to the survey will be sent to you. If you do not complete the surveys online, you will be sent another reminder. Your information will be kept secure and confidential. You will be provided the opportunity to unsubscribe. If you do not have access to a computer or internet, or do not have an email address or cell phone, your doctor or designated study staff has the option to collect the survey information over the phone or at the office and enter it into SOS on your behalf.

Before and after your treatment or surgery, your doctor will enter your medical information (for example, your name, medical record number, age, date of birth, medical history, diagnosis and procedures, financial charges) ,email address and phone number into the registry. Your name, email address, phone number and medical record number will be the only information that directly identifies you and these will be stored encrypted.

POTENTIAL RISKS AND DISCOMFORTS AND ANTICIPATED BENEFITS

There are no known physical risks associated with being in this study; however the privacy of your health information cannot be guaranteed. You will be told about anything new that might change your decision to be in this study, such as how the data will be collected and used. You may not receive a direct benefit if you agree to participate; however participation gives your doctor the opportunity to remotely monitor your health progress and outcomes. Future patients may benefit from the information obtained from this study.

ALTERNATIVES TO PARTICIPATION

This is not a treatment study. Your alternative is to not participate.

PRIVACY AND SECURITY

The SOS registry is maintained by the study sponsor, Arthrex, Inc. or another qualified company working with Arthrex. Arthrex manufactures orthopedic medical products that may be used in your treatment; however, Arthrex does not participate in your doctor's selection of medical device or provision of treatment to you. Both your doctor and the study sponsor have taken precautions to protect the data collected for this research. These precautions include for example developing and using unique user ids and passwords to access the registry, not sharing that information with other people, special security clearance for your email address in the database, and using an electronic data storage system that is designed to ensure the security of patient health information according to HIPAA regulations. The information collected about you for this research may be shared with others such as the study staff, sponsor, other researchers, and federal and foreign government agencies as fully described below.

If you give permission and sign this consent, you are allowing your study site, Alan M. Hirahara, MD, FRCSC and your doctor and staff to use and release certain kinds of protected health information about you. This includes all health information in your medical and billing records that is related to the research study. For example, your name, medical record number, email address, phone number, date of birth, medical history, diagnosis and medical procedures, medical device(s), other medical data collected by the doctor and study staff and other healthcare providers as part of your normal clinical care, financial charges, and any survey data.

Your protected health information may be used by and released to the following: The research study staff and affiliated clinic/hospital/ambulatory surgery center employees, the research sponsor Arthrex, Inc., other companies that work for or with Arthrex, such as database administrators, and the Institutional Review Board that approved this study.

Your protected health information may be used and/or released for the following purposes: To conduct the research and establish a registry called the Surgical Outcomes System (SOS); (2) To host and provide technical support for the SOS database or other databases that contain the collected data; (3) To review the quality and security of the research; (4) To carry out statistical analyses, and prepare reports which may be provided to your doctor; (5) To remove from your health information any information that could be used to identify you, and (6) for other uses/disclosures required by laws or regulations.

Your de-identified data may additionally be used by your doctor and designated study staff, other doctors and study staff participating in the registry and Arthrex to (1) help other researchers and scientists carry out other studies or to draft reports for scientific publications relating to these outcomes; (2) to prepare analyses for governments and health insurers; (3) or for marketing purposes about surgical and non-operative benefits, cost-effectiveness and patient outcomes; (4) to make reports to government agencies that oversee Arthrex and the other people involved with the studies; and (5) to support future product development and improvements to products and surgical procedures. Publications or presentations that result from this study will not contain personal information that may identify you.

Protected health information, if released outside of your study site, may not be protected by federal privacy laws. Your decision to be in this study is voluntary. You will not be penalized or lose benefits if you decide not to participate or if you decide to stop participating. You may withdraw from this study at any time by contacting your doctor. When you withdraw your permission, no new health information will be entered into SOS after that date. Information that has already been gathered may still be used and given to others. If you leave the study before the planned final survey, you may be asked by your doctor to consider completion of a final survey. Your part in this study may be stopped at any time by your doctor or the sponsor without your permission.

FINANCIAL OBLIGATION

Responsibility for treatment payment is in no way different from responsibility for payment for patients who do not participate in the study. You will not be paid for your participation.

QUESTIONS AND CONCERNS

Contact your doctor at 916-732-3000 for questions about the study or if you think you have been harmed as a result of joining this study. Contact Salus IRB if you have questions about your rights as a research subject: 855-300-0815. Salus IRB is a group of people who perform independent review of research.

SIGNATURE

Your signature tells us read and understand this consent and all your questions have been answered. It also means that you want to participate and to authorize the use and disclosure of your personal health. You will be given a signed copy of this consent.

_____ _____

Signature of Research Participant Date

_____

Print Name of Research Participant

For Personal Representative of the Research Participant *(if applicable)*

_____ _____

Signature of Personal Representative Date

_____

Print Name of Personal Representative

_____

Personal Representative Relationship or Authority

****

The signature lines below are required when minor participants are involved.

_____

Printed Name of Minor Participant

_____

Printed Name of Parent or Legal Guardian Granting Permission for Minor Participant

_____ _____

Signature of Parent or Legal Guardian Granting Permission for Minor Participant Date

Study Site Name: _____

_____

Printed Name of Person Explaining Informed Consent Document

_____ _____

Signature of Person Explaining Informed Consent Document Date

FOR SALUS IRB USE ONLY
Initial draft mys: 18May18