Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. you are seeing today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **YOUR INFORMATION** | |
| **Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Member ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Group#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Policy Holder DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Member ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Group#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Policy Holder DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Primary**  **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_** | **Secondary**  **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_** |
| **Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Is this appointment due to a motor vehicle accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Is this a worker’s compensation appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Preferred Language:** | **Occupation:** |
| **Employment Status:** Employed \_\_\_\_\_\_ Self Employed \_\_\_\_\_ Unemployed \_\_\_\_\_\_ Disabled \_\_\_\_\_ Retired \_\_\_\_ Student \_\_\_\_\_ Military \_\_\_\_\_\_ | |
| **Marital Status:** Single \_\_\_\_\_\_ Married \_\_\_\_\_\_ Divorced \_\_\_\_\_\_ Widowed \_\_\_\_\_\_ Legally Separated \_\_\_\_\_\_ Life Partner\_\_\_\_\_\_\_\_ | |
| **Race:** Asian \_\_\_\_\_\_ African American \_\_\_\_\_ Caucasian \_\_\_\_\_\_ American Native/ Alaskan \_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Ethnicity:** Hispanic \_\_\_\_\_\_ Non-Hispanic \_\_\_\_\_\_ | |
| **Primary Care Physician(if applicable): Cardiologist (if applicable):** | |
| **Who referred you to us?** Physician: Friend: Other: | |
| **Email Address:** | |
| **Pharmacy Name:** | **City:** |

**IF PATIENT IS A MINOR:**

**PARENT/LEGAL GUARDIAN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance and Authorization**

**(Please read and sign below)**

I hereby authorize Florida Joint & Spine Institute, P.A. to furnish information to insurance carriers concerning my illness and treatments and understand that I am responsible for any amount not covered by insurance. I authorize any holder of medical or other information about me to release to the social security administration and health care financing administration or its intermediaries or carriers, or to the billing agent of this Physician or supplier. I permit a copy of this authorization to be used in place of the original, and this as a direct assignment of my rights and benefits under the applicable insurance policy to Florida Joint & Spine Institute, P.A. Payment is expected at the time professional services are rendered. We will wait up to sixty (60) days for payment from your insurance company. If the insurance company has not paid within sixty (60) days, we will expect the balance in full from you at that time. We accept cash, check, visa, mastercard, and discover. In the event that any litigation is required to collect the sums due from you under this agreement, Florida Joint & Spine Institute, P.A. shall be entitled to recover from you, all its legal costs and expenses, including reasonable attorney fees, before trial, at trial and in any appellate proceedings. In the event that the account is delinquent, all collection agency fees will be the responsibility of the guarantor. I authorize Medicare crossover secondary insurance payments to the provider who accepts assignment (medigap). I hereby authorize payment directly to the named doctor of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of treatment, and authorize release of any information relating to this claim. I have read and stated financial policy of Florida Joint & Spine Institute, P.A. and agree to abide by the terms as stated above.

Your signature acknowledges that you have read and understand the Terms and Conditions set by Florida Joint & Spine Institute, P.A.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

**AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT,OR HEALTH CARE OPERATIONS**

I hereby authorize the release or use of my individually identifiable health information and medical record information by **Florida Joint & Spine Institute, P.A.** in order to carry out treatment, payment or health care operations. You are encouraged to review The Practice’s Notice of Privacy Practices for a more complete and detailed description of the potential release and use of such information, and have the right to review such Notice prior to signing this form.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. However, **Florida Joint & Spine Institute, P.A.** is not required to agree to such restrictions.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **Florida Joint & Spine Institute, P.A.** reserves the right to change their Notice and Practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **Florida Joint & Spine Institute, P.A.** change their Notice, they will send a copy of any revised notice to the address I’ve provided (whether U.S. mail or, if I agree, email).

**RESTRICTIONS:** I wish to have the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION:** I hereby authorize Florida Joint & Spine Institute, P.A. to release information regarding my treatment to the following individual(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ I do **NOT** give my permission to Florida Joint & Spine Institute, P.A. to leave **ANY** medical information related to my treatment to anyone other than myself.

**MESSAGES:** I hereby authorize Florida Joint & Spine Institute, P.A. to leave messages regarding office visits and appointment confirmations, as well as any other medical information related to my treatment at the following phone number(s):

|  |  |
| --- | --- |
| Method: | Phone Number w/Area Code: |
| Home Phone |  |
| Cell Phone |  |
| Work Phone |  |
| Other (specify): |  |

**I understand it is my responsibility to notify the practice in writing of any changes to the above information.**

**I have read and understand the terms of this consent.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Authorized Representative Signature Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**FOR OFFICE USE ONLY**

[ ] Consent received by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient’s medical record on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Florida Joint & Spine Institute, P.A.**

**Financial Policy**

Thank you for choosing Florida Joint & Spine Institute, P.A. as your health care provider. We are committed to the success of your treatment. The medical services provided by our office are services you have elected to receive which imply a financial responsibility on your part.

**Medicare:** We are a participating Medicare Part B provider. Patients are responsible for 20% co-insurance and their annual deductible. As a courtesy to our patients, we will file your secondary insurance. However, any balance owed after Medicare pays will become the patient’s responsibility and will be due within 30 days. After 30 days, it is the patient’s responsibility to obtain collection from their supplemental insurer.

**Co-Payments & Deductibles:** **All co-payments and deductibles must be paid in full at time of service.** This arrangement is part of your contract with your insurance company. Patients who are unable to make their co-payment or deductible will not be seen and will need to reschedule their appointment.

**Self-Pay:** All new patients without proof of insurance will be required to pay a deposit at time of service in the amount of $400. All new fracture patients will be required to pay $650 at time of service. For all follow-up appointments the patient will be required to pay $250 at time of service. Patients scheduled for injections and other office procedures may be required to pay additional amounts at time of service. PATIENTS SHOULD BE AWARE THIS IS ONLY A DEPOSIT! THE TOTAL CHARGES MAY BE MORE OR LESS THAN THE INITIAL DEPOSIT COLLECTED.

**Non-Participating Insurance Plans:** As a service to our patients, we will file your claim with your insurance company. If however, we are not a participating provider with your insurance plan you will be responsible for any balance owed after the claim has been processed.

**Referrals:** If your insurance plan requires a referral from your primary care physician, it is your responsibility to obtain the written referral prior to scheduling an appointment. If a referral is not obtained prior to your appointment, the appointment will be cancelled until a referral is provided.

**Worker’s Compensation:** Any injury on the job must be reported to the patient’s employer prior to scheduling an appointment. The initial appointment must be scheduled by the worker’s compensation adjustor. Cancelled or rescheduled appointments must be handled through the patient’s adjustor. Florida Joint & Spine will not be responsible for cancelling or rescheduling appointments without a phone call from the adjustor.

**Motor Vehicle Accidents (MVA):** Because Florida is a **“no fault”** state, the patient will be responsible for providing our office with the following information prior to scheduling an appointment: **patient’s** auto insurance information, claim adjustor’s name and contact number, claim number, date of accident, and health insurance information. Prior to scheduling your appointment, our office will contact your insurance company to verify benefits. As of January 1, 2013, Florida law states that if you are injured in an accident you are required to obtain medical treatment within 14 days or there is NO PIP COVERAGE FOR ANY MEDICAL BENEFITS! If not treated within 14 days of accident, the patient will be required to pay a $750 deposit. Additionally, patients who do not have proof of health insurance will be required to pay $400 for the first visit and $250 for each follow up visit.

**Collections**: Patients sent to collections will be assessed a 25% fee which shall be added to their account balance. Balances sent to collections must be paid directly to our collection agency, not to Florida Joint & Spine.

**Minors:** Minors will not be treated without a parent/guardian present. In matters of child custody, Florida Joint & Spine will bill the insurance carrier for the parent signing the consent forms. The parent signing the consent for services will be responsible for any outstanding balance, unless a court order is provided stating otherwise.

**Form Completion:** Patients should allow 7-10 business days for the completion of all forms. The following fees apply to all forms: FMLA (Family Medical Leave) = $30, All other forms 1 page or less = $15, All other forms 2 pages or more = $35. Forms will **not** be completed without pre-payment. Patient is responsible for all fees!

**Surgery Pre-Payment:** Patients are required to pay their portion of surgical fees two (2) days prior to surgery. Patients unable to pay will have their surgery rescheduled. If the patient does not notify the office more than 48 hours in advance, regarding their payment, a **$200 cancellation fee** will apply and must be paid prior to rescheduling the surgery.

**CareCredit:** CareCredit is a dedicated resource available to our patients for use when paying for procedures not covered by insurance. CareCredit offers a 6 month no interest plan for amounts above $200. For more information, please contact one of our office staff or call 1-800-365-8295. You may also apply online at [www.carecredit.com](http://www.carecredit.com). Patients having procedures who do not qualify for Care Credit have the option of making monthly payments until the amount is paid in full. Please keep in mind, the procedure will not be scheduled or performed until the balance is paid in full!

**Refunds**: Patients will be refunded any overpayment once all claims have been processed and the patient has been released from care.

**I understand that it is my responsibility to inform Florida Joint & Spine, P.A. of any changes in my health insurance information and/or contact information. I understand and accept the terms of this Financial Policy.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Representative Signature Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **YOUR FAMILY HISTORY** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Family History Unknown** | | | | | |
| **Mother** | **Father** | | **Sister** | | **Brother** |
| Alive & Well | Alive & Well | | Alive & Well | | Alive & Well |
| Cancer– Type: | Cancer– Type: | | Cancer– Type: | | Cancer– Type: |
| CVA/Stroke | CVA/Stroke | | CVA/Stroke | | CVA/Stroke |
| Diabetes | Diabetes | | Diabetes | | Diabetes |
| Hypertension | Hypertension | | Hypertension | | Hypertension |
| Other: | Other: | | Other: | | Other: |
| **YOUR SOCIAL HISTORY** | | | | | |
| **Tobacco Use:** Current Former Never  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Packs/Day: Years Used: Have you ever tried to quit? Yes No | | **Alcohol Use:** Yes No Former  Type (Circle): Beer Wine Liquor Frequency: Amount per Sitting:  Last Drink:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Caffeine Use:** Yes No  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Daily Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **YOUR MEDICATIONS** | | | |
| **No Medications \_\_\_\_\_\_\_ List all the medications you take, both prescription & nonprescription below:** | | | |
| **Medication or Brand Name** | **Dose** | **Medication or Brand Name** | **Dose** |
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| **YOUR ALLERGIES** | | | |
| **No Allergies \_\_\_\_\_\_\_\_ Indicate all the allergies you have to medications and/ or food & describe reaction below:**  Com mon reactions include – Anaphylaxis (Life Threatening), Hives, Itching, Nausea / Vomiting, Trouble Breathing | | | |

|  |  |  |
| --- | --- | --- |
| **PREVIOUS VACCINES** | | |
| **Influenza Vaccine**: YES \_\_\_ NO\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ | **Pneumovax Vaccine**: YES\_\_\_NO\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_ | **Tetnus:**  YES\_\_\_\_ NO \_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ |
| **SUBSTANCE ABUSE:** | | |
| **Are you PRESENTLY using any of the following drugs or substances? (Please check all that apply)**  **Alcohol \_\_\_\_ Cocaine \_\_\_\_ Heroin \_\_\_\_ IV Drugs \_\_\_\_ Marijuana \_\_\_\_\_ Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Hip Replacement - RT / LT N/A | \_\_\_/\_\_\_/\_\_\_ | Fracture Care–Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A | \_\_\_/\_\_\_/\_\_\_ |
| Knee Replacement – RT / LT N/A | \_\_\_/\_\_\_/\_\_\_ | Reverse Shoulder Replacement– RT / LT N/A | \_\_\_/\_\_\_/\_\_\_ |
| Rotator Cuff Repair – RT / LT N/A | \_\_\_/\_\_\_/\_\_\_ | Total Shoulder Replacement – RT / LT N/A | \_\_\_/\_\_\_/\_\_\_ |
| MAKOplasty – RT / LT N/A | \_\_\_/\_\_\_/\_\_\_ | Hip Pinning – RT/ LT N/A | \_\_\_/\_\_\_/\_\_\_ |
| ORIF – Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A | \_\_\_/\_\_\_/\_\_\_ | Carpal Tunnel – RT / LT N/A | \_\_\_/\_\_\_/\_\_\_ |
| Kyphoplasty - Site\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A | \_\_\_/\_\_\_/\_\_\_ | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_ |
| Any additional surgical Information: | | | |

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **YOUR PAST MEDICAL HISTORY** | | | |
| **Disease Type:** |  | **Disease Type:** |  |
| Hypertension | Blood Thinners | Hernia | Anemia |
| Kidney Disease | Angina Pectoris | Peripheral Vascular Disease | Osteoarthritis |
| Heart Disease:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | COPD | Anxiety | Bipolar Disorder |
| Diabetes – I or II | GERD | Depression | Herniated Disc |
| Osteoarthritis | GOUT | Stroke | Thyroid Disorders |
| Osteoporosis | Sleep Apnea | DVT/Blood Clots | High Cholesterol |
| Rheumatoid Arthritis | Prostates Disorders | Ulcers | Seizure Disorders |
| Cancer– Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Pneumonia | AIDS/HIV | Pulmonary Embolism |
| Hepatitis – Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hearing Loss | Scoliosis | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **YOUR PAST SURGICAL HISTORY** | | | |
| **No Surgical History** | | | |
| **Surgery Type:** | **Year of Surgery:** | **Surgery Type:** | **Year of Surgery:** |
| Appendectomy |  | Prostate |  |
| Hysterectomy |  | Pacemaker |  |
| Cholecystectomy |  | Open Heart/By-Pass |  |
| Tonsillectomy |  | Spine – Type /Level: |  |
| Cataracts |  | Other: |  |

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| **PAST ORTHOPEDIC SURGERIES** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PREVIOUS ORTHOPEDIC PROCEDURES** | | | | | |
| **Date** | **Procedure** | **Side** | **Physician** | **Facility Where Performed** | **Still having pain?** |
|  |  |  |  |  |  |
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| **WHAT IS THE REASON FOR TODAY'S VISIT?** | | | | | | | |
| **Describe injury/pain:** | | | | | | | |
| **What date did pain occur?** | | | | | | | |
| **When did you first seek medical attention?** | | | | | | | |
| **Have you had any pain in the same location from a work injury? Yes No Is this a WORKCOMP injury? Yes No If yes, please explain:** | | | | | | | |
| **If it is NOT through your current employer, please list the name of the employer that it is through, along with a phone number: Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( ) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( ) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |
| **MODIFYING FACTORS: CIRCLE THE NUMBER BELOW THAT BEST DESCRIBES THE AMOUNT OF PAIN RELEIF THAT TREATMENT IS PROVIDING OR HAS PROVIDED IN THE PAST** | | | | | | | |
|  | | Never Tried | No Relief | |  | Complete Relief | Check If Receiving Now |
| Physical Therapy | |  | 0 1 2 3 | | 4 5 6 7 8 | 9 10 | [ ] |
| Surgery | |  | 0 1 2 3 | | 4 5 6 7 8 | 9 10 | [ ] |
| Injection/Nerve Block | |  | 0 1 2 3 | | 4 5 6 7 8 | 9 10 | [ ] |
| Drug/ Medication Therapy | | | 0 1 2 3 | | 4 5 6 7 8 | 9 10 | [ ] |
| Chiropractic Adjustment | | | 0 1 2 3 | | 4 5 6 7 8 | 9 10 | [ ] |
| TENS |  | | 0 1 2 3 | | 4 5 6 7 8 | 9 10 | [ ] |
| Acupuncture |  | | 0 1 2 3 | | 4 5 6 7 8 | 9 10 | [ ] |
| Biofeedback |  | | 0 1 2 3 | | 4 5 6 7 8 | 9 10 | [ ] |
| Other: |  | | 0 1 2 3 | | 4 5 6 7 8 | 9 10 | [ ] |
| **PLEASE INDICATE BELOW STUDIES DONE** | | | | | | | |
| **Study** | | | **Date** | **Location of Study** | | | |
| X\_Rays | | |  |  | | | |
| MRI | | |  |  | | | |
| EMG/Nerve Conduction Studies | | |  |  | | | |
| Myelogram | | |  |  | | | |
| BoneScan | | |  |  | | | |
| **DOCTORS/OTHER HEALTH PROFESSIONALS CONSULTED SINCE PAIN BEGAN** | | | | | | | |
| **Name** | | | **Phone Number** | | | **Dates Treated** | |
|  | | |  | | |  | |
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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Have you been in the Emergency Room for treatment of your pain? Yes NO**    **If yes, when and how often?** | | | | | | |
| **Worker’s Compensation Case?** Yes No | | | | | | |
| **Auto Accident?** Yes No | | | | | | |
| **Represented by Attorney?** Yes No **Attorney’s Name: Phone:** | | | | | | |
| **Lawsuit Pending?** Yes No **Case Manager’s Name: Phone:** | | | | | | |
| **COMPLETE THIS BOX ONLY IF YOU WERE INVOLVED WITH AN AUTO ACCIDENT** | | | | | | |
| **Were you wearing a seat belt?** Yes No | | **Were you the driver?** Yes No | | **Were you the passenger?** Yes No | |
| **Did you lose consciousness?** Yes No **If yes, for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **Briefly describe the accident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **How much damage was done to your vehicle? $** | | | | | |
| **How long after the accident did the pain begin?** | | | | | |
| **How long after the accident did you seek medical attention?** | | | | | |
| **Did you experience pain in the same location previous to this accident?** Yes No  **If yes, please explain:** | | | | | |
| **REVIEW OF SYSTEMS** | | | | | |
| **All Negative Below \_\_\_\_\_\_\_\_\_\_ Check if you have any of the following:** | | | | | |
| **General** | **Cardiovascular** | | **Metabolic** | | **Skin** | |
| Fever | Palpitations / Murmur | | Cold Intolerance | | Rash Itchy Skin | |
| Weakness | Leg Swelling / Edema | | Heat Intolerance | | Skin Infe ctions | |
| Weight Gain/Loss (Circle) | Syncope / Fainting | | Skin Lesions | |
| **Ears, Nose & Vision** | **Gastrointestinal (GI)** | | **Neurological** | | **Blood Disorders** | |
| Blurred Vision | Constipation | | Difficulty Walking | | Bleeding | |
| Nosebleeds | Diarrhea | | Dizziness | | Bruising | |
| Headaches | Nausea | | Poor Coordination | |
| Vertigo /Dizziness | Vomiting | | Muscle Weakness | |
| **Respiratory** | **Urinary** | | **Psychiatric** | | **Endocrine** | |
| Dyspnea (Difficulty Breathing) | Dysuria (Difficulty Urinating) | | Anxiety | | Excessive Thirst | |
| Recent Infections | Frequent Urination | | Depression | | Excessive Sweating | |
| Wheezing | Hematuria (Bloo d in Urine) | | Insomnia | |  | |

**YOUR ATTESTATION**

I attest that the above information is complete and accurate as it will be utilized as part of my care and treatment plan

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature / If minor, Guardian Signature Date

Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours’ notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours’ notice, we are unable to offer that slot to other people.

Please initial once you have read, understood and agreed to the following policy.

Patients who do not show up for their appointment without a call to cancel an office appointment or in-office surgical procedure appointment will be considered as **NO SHOW**.

**X\_\_\_\_\_\_\_\_\_\_**

Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments.

**X**\_\_\_\_\_\_\_\_\_\_

Patients may also be subject to a **$30.00** fee for office appointment or **$75.00** fee for in-office surgical procedure **No Show.**

**X\_\_\_\_\_\_\_\_\_\_**

The No Show fees are the sole responsibility of the patient and must be paid in full before the patient’s next appointment.

**X\_\_\_\_\_\_\_\_\_\_**

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

