



# PATIENT MEDICAL REGISTRATION

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

DOB: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

Physician: \_\_\_\_\_

Patient Number: \_\_\_\_\_

## YOUR INFORMATION

Primary Insurance: _____ Member ID: _____ Group #: _____ Policy Holder: _____ Policy Holder DOB: _____ Policy Holder SSN: _____	Secondary Insurance: _____ Member ID: _____ Group#: _____ Policy Holder: _____ Policy Holder DOB: _____ Policy Holder SSN: _____
Primary Residence Address: _____ _____ City/State/Zip: _____	Secondary Residence Address: _____ _____ City/State/Zip: _____
Primary Phone: _____	Cell Phone: _____
Work Phone: _____	Preferred Phone Method: (Circle One) Home      Cell      Email      Text Message
Is this appointment due to motor vehicle accident? YES/NO	Is this a worker's compensation appointment? YES/NO
Injured Body Part: _____ Date of Injury: _____	Injured Body Part: _____ Date of Injury: _____
Is case closed? Yes or No	Is case closed? Yes or No
Preferred Language: _____	Occupation: _____
Marital Status: _____	Employment Status: _____ Employer: _____
Ethnicity: Hispanic _____ Non-Hispanic _____ Race: Asian _____ African American _____ Caucasian _____ American Native/ Alaskan _____ Other: _____	
Primary Care Physician: _____	Cardiologist (if applicable): _____
Referring Physician: _____	
Do you have Internet Access? Yes or No	Email Address: _____
Preferred method of contact: Phone / Email / Text	Pharmacy: _____

Do you have an advanced care plan in place?

Yes

No

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



# PATIENT MEDICAL REGISTRATION

## 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

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
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 \_\_\_\_\_.



# PATIENT MEDICAL REGISTRATION

## 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.

**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 MEDICAL REGISTRATION

## 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.

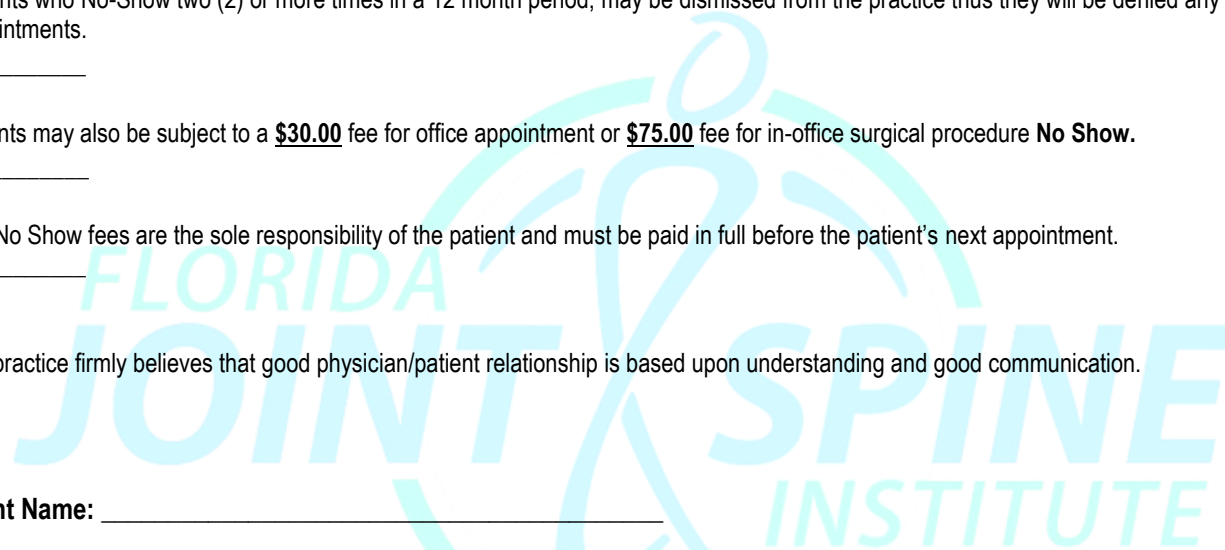
X \_\_\_\_\_

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

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

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

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





# PATIENT MEDICAL REGISTRATION

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

DOB: \_\_\_\_\_

Patient Number: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

## YOUR MEDICATIONS

**No Medications** \_\_\_\_\_ List all the medications you take, both prescription and nonprescription below:

Medication or Brand Name	Dose	Medication or Brand Name	Dose

**Preferred Pharmacy:** «PatPharmacyName»

**Pharmacy Phone:** «PatPharmacyPhone»

## YOUR ALLERGIES

**No Allergies** \_\_\_\_\_ Indicate all the allergies you have to medications and/or food & describe reaction below:

Common reaction include - Anaphylaxis (Life Threatening), Hives, Itching, Nausea/Vomiting, Trouble breathing

## 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

**Alcohol Use:** Yes No Former

**Caffeine Use:** Yes No

**Type:** \_\_\_\_\_

**Type (Circle):** Beer Wine Liquor

**Type:** \_\_\_\_\_

**Packs/Day:** \_\_\_\_\_

**Frequency:** \_\_\_\_\_

**Daily Amount:** \_\_\_\_\_

**Years Used:** \_\_\_\_\_

**Amount per Sitting:** \_\_\_\_\_

**Have you Ever tried to quit?** Yes No

**Last Drink:** \_\_\_\_\_

## 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): \_\_\_\_\_



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DOB: \_\_\_\_\_

Patient Number: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

YOUR PAST MEDICAL HISTORY			
Disease Type:		Disease Type:	
Hypertension	Blood Thinners	Hernia	Anemia
Kidney Disease	Angina Pectoris	Peripheral Vascular Disease	Osteoarthritis
Heart Disease - I or II	COPD	Anxiety	Bipolar Disorder
Diabetes	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:		___/___/___	

## PAST ORTHOPEDIC SURGICAL HISTORY

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:					

## OTHER ORTHOPEDIC PROCEDURES

DATE	PROCEDURE	SIDE	PHYSICIAN	FACILITY WHERE PERFORMED	STILL HAVING PAIN?



# PATIENT MEDICAL REGISTRATION

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

DOB: \_\_\_\_\_

Patient Number: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

### 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: ( ) - \_\_\_\_\_  
 Phone: ( ) - \_\_\_\_\_

### MODIFYING FACTORS: CIRCLE THE NUMBER BELOW THAT BEST DESCRIBES THE AMOUNT OF PAIN RELIEF 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



# PATIENT MEDICAL REGISTRATION

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

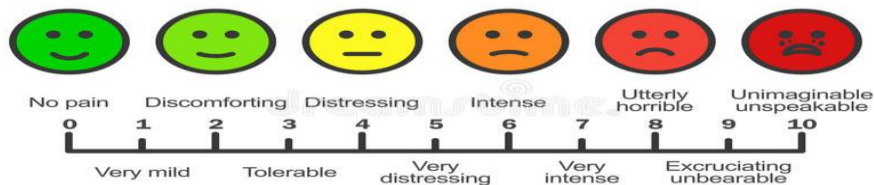
DOB: \_\_\_\_\_

Patient Number: \_\_\_\_\_

Have you been in the Emergency Room for treatment of your pain? Yes No		
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: _____
<b>COMPLETE THIS BOX ONLY IF YOU WERE INVOLVED WITH AN AUTO ACCIDENT</b>		
Were you wearing a seatbelt? 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? _____		
Did you experience pain in the same location previous to this accident? Yes No		
If Yes, Please explain: _____		

REVIEW OF SYSTEMS			
All Negative Below _____		Circle if you have the following:	
General	Cardiovascular	Metabolic	Skin
Fever	Palpitations/Murmur	Cold Intolerance	Rash Itchy Skin
Weakness	Leg Swelling/Edema	Heat Intolerance	Skin Infections
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 (Blood in Urine)	Insomnia	

“0” means no pain and “10” is the worst pain you can imagine.



**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





## PATIENT MEDICAL REGISTRATION

Dear Patient,

Florida Joint and Spine Institute has selected MyHealthRecord.com for your patient portal access. You will be able to access your medical records anytime, anywhere, manage your office appointments, talk privately with your care team and receive the best care possible.

At your convenience you can view your health record, exchange secure messages with your healthcare provider, request and manage appointments, request your medical records, request a prescription refill, and pay your bill online.

Once you are signed up for your patient portal, **send your healthcare providers a confirmation email letting them know that you have successfully registered for the portal.**

If you have any questions please call us at 863-385-2222 and we will assist you.

Once you receive your email invite to our new patient portal:

- Click on the link to open the portal
- Type in your name, date of birth and zip code
- Choose a user name, password and security questions
- Accept registration disclaimer
- Click on My Message, click new
- Choose your provider. Select question type...asks a medical question. Let us know you have signed up and/or ask us any questions you may have.
- Click send
- You will receive a Welcome email once completed successfully.

Thank you,  
Florida Joint & Spine Team

Please use the following internet address to educate yourself and look up information pertaining to diagnosis in your chart problem list or assessment. <http://orthoinfo.aaos.org/>

6325 US Hwy 27 North · Suite 201 · Sebring, FL 33870 · Ph 863-385-2222 · Fax 863-382-8765  
1204 Carlton Avenue · Lake Wales, FL 33853 · Ph 863-676-9523 · Fax 863-676-1654  
400 Avenue K. SE Building 4 · Winter Haven, FL 33880 · Ph 863-299-3210 · Fax 863-299-2968  
[www.floridajointspine.com](http://www.floridajointspine.com)