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	**Injured Body Part:** **Date of Injury:**
Is this appointment due to a slip and fall/Liability? YES/ NO	**Injured Body Part:** **Date of Injury:**
Is this a worker's compensation appointment? YES\ NO	**Injured Body Part:** **Date of Injury:**
Is Case closed? YES/ NO or N/A	**Is an attorney involved? YES/ NO** **Attorney Name:**
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: «PatientEmail»**
Emergency Contact: **Ph#:**	**Pharmacy:**

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, American Express, Discover, and Care Credit.. 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).

I, «PatientFullName», consent to receiving emails, texts, (SMS), auto-dialed and/or artificial or pre-recorded message to my cellular phone or to any telephone number or email provided by me to Florida Joint & Spine Institute or its affiliates and their agents including, without limitation, any account management companies and independent contractors including debt collectors. I understand that consenting to the above is not required before I receive service from Florida Joint & Spine Institute.

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 hereby acknowledge that I have received or have been given the opportunity to receive a copy of Florida Joint & Spine Institute, PA Notice of Privacy Practices. 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. By signing below, I am "only giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

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 _____.

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

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. 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

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 #:_____

Date of Visit: _____

H: _____
W: _____
BP: _____
P: _____
BMI: _____

Chief Complaint

Reason for visit:

_____

Location of your pain:

_____Head _____Shoulder _____Mid Back _____Leg _____Ankle/Foot _____Wrist/Hand

_____Neck _____Headaches _____Low Back _____Knee _____Hips/Buttocks _____ Arm

History of Present Illness

Date of injury or symptom onset: _____

Please describe how you injured yourself:

_____

_____

_____

_____

Please describe your current symptoms:

_____

_____

_____

_____

PATIENT MEDICAL REGISTRATION

Date of Visit: _____

Patient Name: _____ DOB:_____ Patient #:_____

Circle the number that corresponds to the severity of your pain on a scale of 0-10.
"0" means no pain and "10" is the worst pain you can imagine.

At its worst: 0 1 2 3 4 5 6 7 8 9 10

At its best: 0 1 2 3 4 5 6 7 8 9 10

Which of the following best describes the character of your pain:

Timing:

__ Continuous, steady, constant
__ Rythmic, periodic, intermittent
__ Brief, momentary, Transient

Quality:

__ Throbbing
__ Aching
__ Sharp
__ Burning
__ Tingling/ numbness
__ Dull
__Superficial
__ Deep
_____

What makes your pain worse? _____

What makes your pain better? _____

How long/far can you sit? Sit_____ Stand_____ Walk _____

Since your injury how is your pain? ____ Better _____ Same _____ Worse

If your pain has changed, what percentage? 10 20 30 40 50 60 70 80 90 100%

Have you had any loss of bowel or bladder control? ____ Yes ____ No

Previous Treatment

Have you had treatment since your injury? _____Yes _____ No Have you been to the ER for this? _____Yes _____ No

Have you had any of the following tests or procedures performed?

X-rays _____ MRI _____ Epidurals_____ CT Scan_____ EMG_____

Other (please explain) _____

Medical:

Dr._____ Date of 1st visit _____ Last visit _____
Diagnosis given _____
Medication given _____
Treatment provided _____

Chiropractic: _____Yes _____ No

Dr._____ Date of 1st visit _____ Last visit _____
Diagnosis given _____
Frequency: _____Every Day _____Three times a week _____Two times a week ____ Weekly
Has it helped? _____ Yes _____ No

Physical Therapy: _____Yes _____ No

Therapist:_____ Date of 1st visit _____ Last visit_____
Has it helped? _____ Yes _____ No Home exercise program given? _____ Yes _____ No

Pain Management: _____Yes _____ No

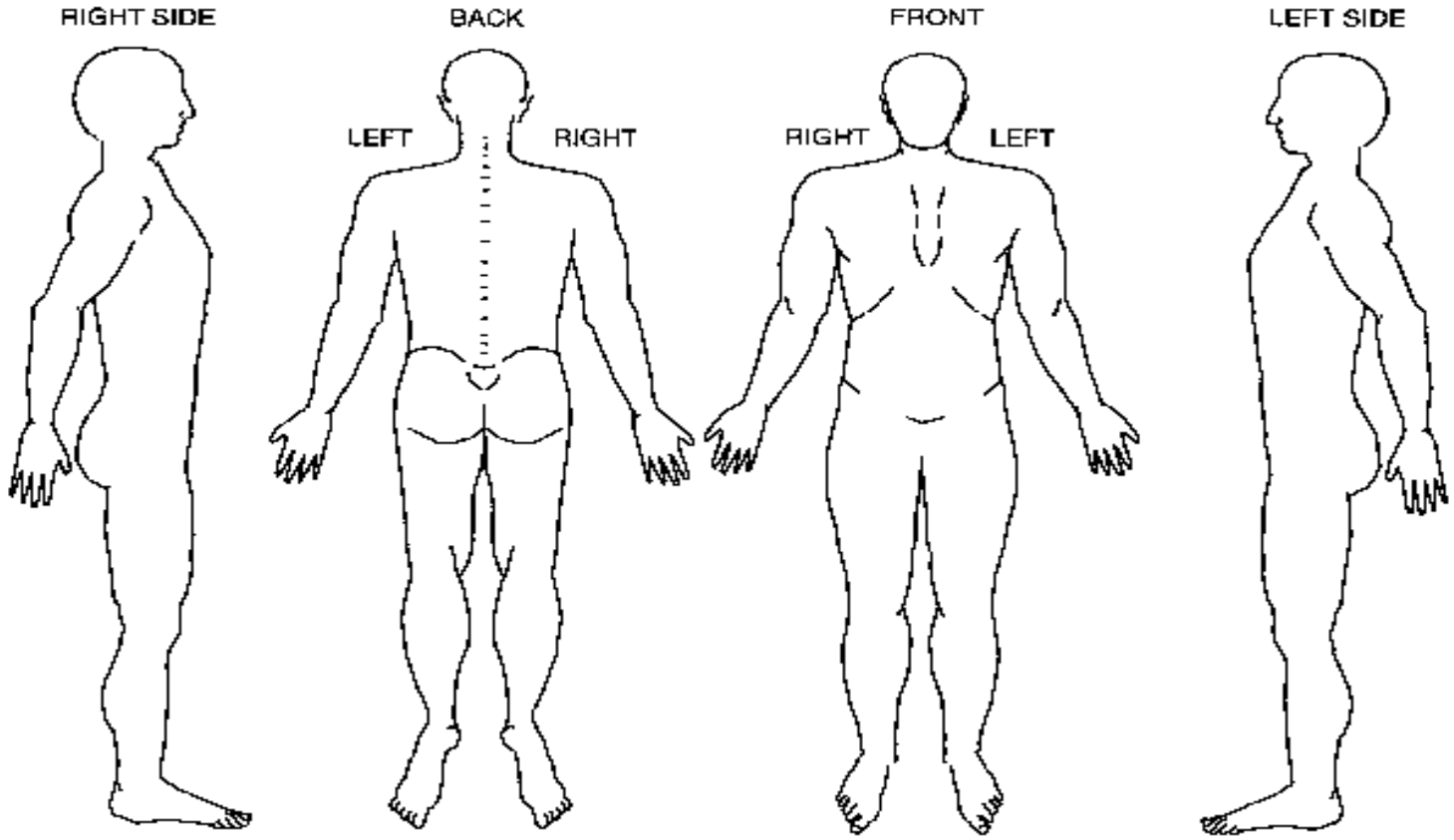
Radio Frequency Ablation: ____Yes ____ No Epidurals ____Yes ____ No Other:_____

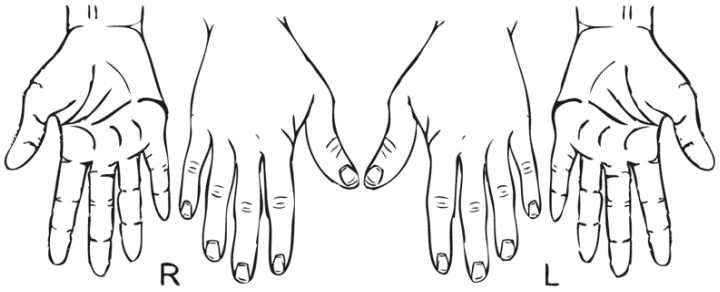
PATIENT MEDICAL REGISTRATION

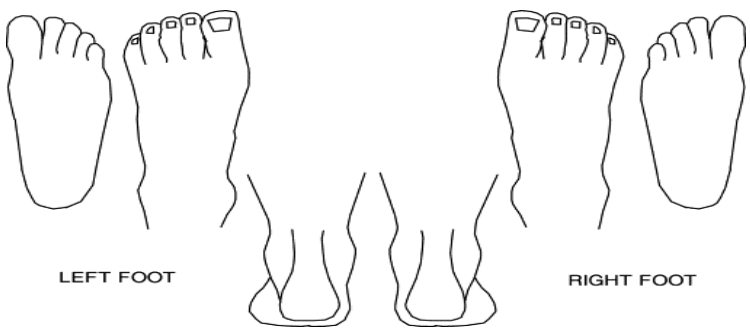
Patient Name: _____ DOB : _____ Patient #: _____

Date of Visit: _____

Mark on the areas on your body where you feel the described sensations. Use the Symbols listed. Mark the areas of the radiating pain or numbness as well. Include all affected areas.







Numbness 000

Tingling ::::

Burning XXX

Stabbing/sharp ////

Aching ^^^

Cramping *

PATIENT MEDICAL REGISTRATION

Patient Name: _____ DOB:_____ Patient #: _____

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

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: _____

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):_____

PATIENT MEDICAL REGISTRATION

Patient Name: _____ DOB:_____ Patient #: _____

Date of Visit: _____

YOUR PAST MEDICAL HISTORY			
Disease Type:		**Disease Type:**	
Hypertension	Blood Thinners	Hernia	Anemia
Kidney Disease	Angina Pectoris	Peripheral Vascular Disease	Bipolar Disorder
Heart Disease - I or II	COPD	Anxiety	Herniated Disc
Diabetes	GERD	Depression	Thyroid Disorders
Osteoarthritis	GOUT	Stroke	High Cholesterol
Osteoporosis	Sleep Apnea	DVT/Blood Clots	Seizure Disorders
Rheumatoid Arthritis	Prostates Disorders	Ulcers	Pulmonary Embolism
Cancer– Type:_____	Pneumonia	AIDS/HIV	Other:_____
Hepatitis – Type:_____	Hearing Loss	Scoliosis	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	___/___/___		___/___/___
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:

Back Surgery		
Date	Surgery Type/ Side	Physician

PATIENT MEDICAL REGISTRATION

Patient Name:_____ DOB:_____ Patient #: _____

Date of Visit: _____

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:**
COMPLETE THIS BOX ONLY IF YOU WERE INVOLVED WITH AN AUTO ACCIDENT		
Were you wearing a seatbelt? Yes No	Were you the driver? Yes No	Were you the passenger? Yes
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:		

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

Patient Name: _____ DOB: _____ Patient #: _____

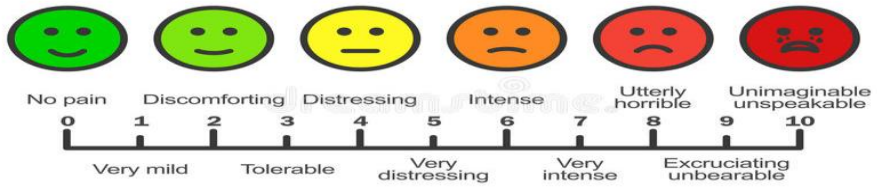
Date of Visit: _____

REVIEW OF SYSTEMS

Please check here if no symptoms today: _____
Circle if you have any of the following today:

General	Cardiovascular	Metabolic	Skin
Fever	Palpitations / Murmur	Cold Intolerance	Rash
Weakness	Leg Swelling / Edema	Heat Intolerance	Skin Infections
Weight Gain or Weight Loss	Syncope / Fainting		Skin Lesions
			Itchy Skin
Ears, Nose &	**Gastrointestinal**	**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**
Difficulty Breathing	Difficulty Urinating	Anxiety	Excessive Thirst
Recent Infections	Frequent Urination	Depression	Excessive Sweating
Wheezing	Blood in Urine	Insomnia	

Circle the number that corresponds to the severity of your pain on a scale of 0-10.
"0" means no pain and "10" is the worst pain you can imagine.



Would you like a copy of your Office visit summary for today? _____ Yes _____No

Patient 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/**