SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

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PATIENT INFORMATION

PATIENT'S NAME____**DATE** ______________________________

HAVE YOU EVER BEEN TREATED BY THESE DOCTORS? ☐ **Yes** ☐**No** **If so, what doctor?** ____________________

CELL PHONE __________________________________**HOME PHONE** ______________________________________

ADDRESS____

CITY_________________________________**STATE**___________________________**ZIP**_______________________

AGE__________**DATE OF BIRTH**______________________**SOCIAL SECURITY #**____________________________

☐ **MALE** ☐ **FEMALE** **MARITAL STATUS:** ☐**Married** ☐**Single** ☐**Divorced** ☐**Widow**

ETHNICITY: ☐**Hispanic or Latino** ☐ **Not Hispanic or Latino**

SPOKEN LANGUAGE ☐ **English** ☐ **Spanish** ☐ **Other, specify** ___________

RACE ☐**Black or African American** ☐ **White** ☐ **Asian** ☐ **American Indian or Alaska Native** ☐ **Other** ________

PRIMARY DOCTOR: Dr.________________________________ **Address**_______________________________________

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EMPLOYER'S NAME & ADDRESS ____

EMPLOYER'S PHONE #_________________**OCCUPATION**____

NAME OF SPOUSE/ PARENT____

SPOUSE/PARENT ADDRESS____

SPOUSE/PARENT SOCIAL SECURITY #/ ____

SPOUSE/PARENT EMPLOYER'S NAME ____

SPOUSE/PARENT EMPLOYER'S PHONE ____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT ____

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PRIMARY INSURANCE COMPANY NAME ____

PRIMARY INSURANCE COMPANY ADDRESS ____

GROUP # ____________________**POLICY #**_____________________**SUBSCRIBER NAME** ________________________

SUBSCRIBER DATE OF BIRTH ___________________**SUBSCRIBER SOCIAL SECURITY #**_______________________

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SECONDARY INSURANCE COMPANY NAME ____

SECONDARY INSURANCE COMPANY ADDRESS ____

GROUP # ___________________**POLICY #**_____________________**SUBSCRIBER NAME** _________________________

SUBSCRIBER DATE OF BIRTH___________________**SUBSCRIBER SOCIAL SECURITY #**_________________________

PHARMACY NAME________________________ **LOCATION**______________________ **PHONE**____________________

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

MEDICAL HISTORY & INTAKE FORM

Patient's Name:______________________________ **Date**: ______________

PATIENT HISTORY:

Reason for visit:______________________________ **Patient Age:**______

For how long has this been bothering you? ______________________________

If Upper Extremity Involved, What is Your Dominant Hand **Right** ☐ **Left** ☐

Pain at Rest or Pain That Awakens From Sleep? ______________________________

Severity (Mild/Moderate/Severe)______________________________

What Makes Symptoms Better? ______________________________

What Makes Symptoms Worse? ______________________________

Describe Any Prior Treatment (Surgery/Therapy/Injections/Medications)

____

____

____

____

PAST MEDICAL HISTORY, PRIOR SURGERIES AND HOSPITALIZATIONS:

____

____

SOCIAL HISTORY:

Patient Education (in years)________ Employment Description______________________________

Living Situation ______________________ Alcohol Use (amount & type)______________________

Drug Use (amount & type) ______________________ Tobacco Use (# of packs/cigarettes daily)______________

ALLERGIES:

____

____

REVIEW OF SYSTEMS - Are you currently having or have you had problems with:

CIRCLE ALL THAT APPLY

NO	YES	
☐	☐	Arthritis Swelling of Joints Osteoporosis Fibromyalgia Fractures Muscle Atrophy
☐	☐	Rashes Masses or Lumps Problems with Scars Itching
☐	☐	Headaches Stroke Seizures Weakness
☐	☐	Depression Sleep Disorders Hallucinations Anxiety Disorder
☐	☐	Diabetes Thyroid
☐	☐	Easy Bruising or Bleeding Anemia Swollen Glands or Lymph Nodes
☐	☐	Dermatitis Latex Allergy Food Allergy Environmental Allergy
☐	☐	Asthma Wheezing Cough COPD Coughing up Blood
☐	☐	Nausea Vomiting Stomach Pain Bloody Stools Diarrhea Constipation Loss of Appetite
☐	☐	Difficulty with Urination Pain or Burning on Urination Blood in Urine Incontinence Menstrual Problems Prostate Problems Erectile Dysfunction
☐	☐	Fever Night Sweats Chills Weight Loss Tiredness Malaise
☐	☐	Visual Problems Glasses
☐	☐	Hearing Problems Sinus Problems Vertigo Dizziness Hoarseness
☐	☐	Ankle Swelling High Blood Pressure
☐	☐	Chest Pain Shortness of Breath Abnormal Heart Beat

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

PATIENT'S REQUEST TO RELEASE HEALTH INFORMATION

I request and authorize South Florida International Orthopaedics, P.A. to provide a copy of the specific health and medical information as described below.

Patient Name__________________________________Date______________________

The request applies to the following information to be provided one time, as soon as possible. Select only ***ONE*** of the following:

☐ All health information pertaining to any medical history, mental or physical condition and treatment received. [***OPTIONAL***]

Except____

☐ Only the following records or types of health information (including any dates)

____

The designated information should be sent to:

Name____

Address____

____

Telephone___________________________Fax___________________________________

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.

Patient Signature_________________________ Witness Signature____________________
OR CIRCLE ONE: Representative Spouse Financially Responsible Party

A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a non-profit hospital plan, a health care service plan or an employee benefit plan.

Designation of Personal Representative

As required by the Health Information Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Patient Name: ___________________________________ Date: ________________
(LAST) (FIRST) (M.I.)

Address: ____

Telephone: __________________________ Date of Birth: ________________________

I request the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my protected health information:

Name: ____

Address: ____

____

Telephone: ____

What relationship is this person to you? ____

This person is to be afforded all of the privileges that would be afforded to me with respect to my protected health information.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to South Florida International Orthopaedics, P.A. I further understand that any such revocation does not apply if that person or persons authorized to use or disclose my protected health information have already taken action on my behalf.

Patient's Signature______________________________Date:______________________

I hereby revoke this designation of a personal representative.

Patient's Signature: ____________________ Date: ______________________________

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

ASSIGNMENT OF BENEFITS/POLICY RIGHTS

The undersigned patient hereby assigns the rights and benefits of the applicable Personal Injury Protection (PIP), medical payments, and/or other insurance to **South Florida International Orthopaedics, P.A.**, for services and/or supplies rendered by it for diagnosis and/or treatment of personal injuries sustained in the incident of (date of occurrence)__________________ to the undersigned patient, which services are covered by Personal Injury Protection (PIP) or other insurance coverage inuring to the benefit of the undersigned patient, in accordance with Florida Statute 627.736(5). The undersigned patient agrees to pay any applicable deductible or co-payment not covered by the PIP or other insurance coverage.

This assignment includes, but not limited to, all rights to collect benefits directly from the Insurance Company obligated to provide benefits, in any action including legal suit, if for any reason the Insurance Company fails to make payment of benefits to which the undersigned is entitled. Specifically, this assignment includes the right to collect payment for reasonable costs connected with photocopying and mailing records to the insurer at the insured's request, in accordance with F.S. ' 627.736(5). This assignment also includes the right to recover attorney's fees and costs for any action brought by the provider as patient's assignee. I agree that **South Florida International Orthopaedics, P.A.**, may select any attorney it wishes to enforce the rights assigned herein, and I understand and agree that the attorney selected by **South Florida International Orthopaedics, P.A.**, may be different from the attorney handling my personal injury/bodily injury claim or case.

As part of this assignment of rights and benefits, I hereby instruct the insurance carrier, in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by **South Florida International Orthopaedics, P.A.,** is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payments so that it may exercise its legal rights. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true and correct to the best of my knowledge and belief. If it is necessary for **South Florida International Orthopaedics, P.A.,** to use a collection agency and /or attorney to collect its bill, I will also be responsible for all their fees and costs incurred in the collection of my bill. I will be responsible for any other costs involved in the collection of my bill including court costs. I will be responsible for a late charge of 1.5% monthly on any unpaid portion of my bill beginning 60 days after the date of service.

INFORMATION RELEASE: I hereby authorize **South Florida International Orthopaedics, P.A.,** to release any or all portions of my medical records and/or X-rays, including records of diagnosis, examination, and any treatment rendered to me to insurers as needed for processing of medical claims for care, and to other treating physicians and hospital personnel as my physician deems necessary.

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______I am NOT a Medicare patient.

______ I am a Medicare Patients (HMO Disclaimer): I hereby declare that I am not a member of any **HMO** or **PPO**. If Medicare benefits are denied because I am a member of an **HMO** or **PPO**, I agree that I will be personally responsible for my bill to **South Florida International Orthopaedics, P.A.** If it is necessary for **South Florida International Orthopaedics P.A., t**o use a collection agency and/or attorney to collect its bill, I will also be responsible for all their fees and costs incurred in the collection of my bill. I will be responsible for any other costs involved in the collection of my bill including court costs. I will be responsible for a late charge of 1.5% monthly on any unpaid portion of my bill beginning 60 days after the date of service.

PATIENT'S SIGNATURE__________________________________**Date**______________________________

Witness____

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.
(ASSIGNMENT OF BENEFITS/POLICY RIGHTS page two)

PATIENT'S NAME___________________________________**DATE**_______________________

CHECK OFF ONE OF THE FOLLOWING:

_______I am pregnant.

_______I am not pregnant at this time. If I am given any medication by Dr. Evans, Pell, Gombosh and/or Torregrosa, and become pregnant while taking it, I will immediately notify my obstetrician that I am taking this medication.

_______The above questions do not apply to me.

PROVIDER

South Florida International Orthopaedics, P.A. hereby accepts assignment of the insurance rights and benefits for services to the patient listed above to be paid directly to **South Florida International Orthopaedics, P.A.** This includes Personal Injury Protection (PIP) or other insurance coverage as listed above, in accordance with F.S.627.736 (5).

South Florida International Orthopaedics, P.A. E.I.N. # 27-3378728

By___________________________________ _____________
Authorized Agent/Representative Date

By___________________________________ _____________
Patient's Signature Date

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT******

I have received a copy of this Office's Notice of Privacy Practices:

Patient Name____

Patient's Signature____

Date____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgment.

_____ An emergency situation prevented us from obtaining acknowledgment.

_____ Other____

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

Financial Arrangements and Medical Insurance

We are committed to providing you the best possible care. If you have medical insurance, we are anxious to help you receive your maximum amount of benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We ask that you provide us with the necessary information to verify your insurance benefits. Once this has been done, the insurance secretary will explain to you what you are responsible for at the time services are rendered. We do accept MasterCard, Visa, American Express, Discover Card, Care Credit and personal checks.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. U.C.R is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse on an arbitrary “schedule” of fees, which bears no relationship to the current standard and cost of care in this area.

3. DEDUCTIBLES AND COPAYMENTS WILL BE DUE AT TIME OF SERVICE.

4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You will be responsible for these fees.

We must emphasize that as the health care providers, our relationship is with you, not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding coverage, PLEASE do not hesitate to ask us. We are here to help.