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**_____

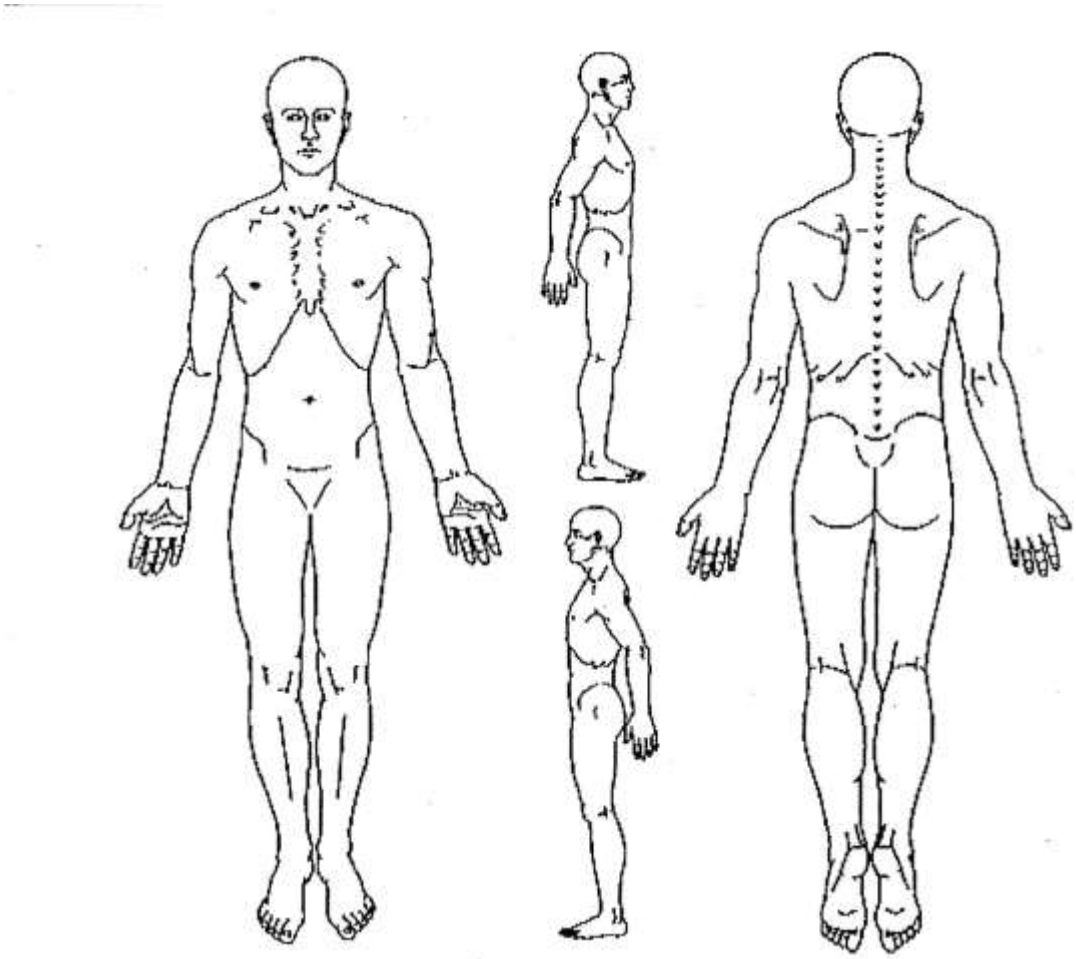
SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

COMPLAINT DIAGRAM

PATIENT'S NAME: _____ _____ **DATE:** _____

How long have you had pain _____Weeks _____Months _____Years

On the diagram below, please indicate where you are currently experiencing pain or other symptoms.



A = ACHE	**B = BURNING**	**N = NUMBNESS**
P = PINS & NEEDLES	**S = STABBING**	**E = ELECTRICAL**

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, OTHER MEDICAL PROBLEMS:

_____

_____

_____

PRIOR SURGERIES AND HOSPITALIZATIONS:

_____

_____

_____

FAMILY HISTORY: MARK IF FAMILY MEMBER HAS ANY OF THE FOLLOWING:

☐ **Arthritis** ☐ **Hypertension** ☐ **Heart Disease** ☐ **Diabetes** ☐ **Endocrine or Glandular Problems** ☐ **Muscular Disease**

MEMBER	ALIVE	DECEASED	AGE	HEALTH STATUS OR CAUSE OF DEATH
Father	☐	☐	_____	_____
Mother	☐	☐	_____	_____
Sister/Brother	☐	☐	_____	_____
Sister/Brother	☐	☐	_____	_____
Sister/Brother	☐	☐	_____	_____

SOCIAL HISTORY:

Patient Education (in years)_____Employment Description_____

Marital Status ☐ Single ☐ Married Number of Children_____Children(s) Ages_____

Living Situation_____Alcohol Use (amount & type)_____

Drug Use (amount & type)_____Tobacco Use (# of packs/cigarettes daily)_____

ALLERGIES:

_____

_____

MEDICATIONS (INCLUDING VITAMINS AND SUPPLEMENTS):

_____

_____

_____

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

For all questions answered YES, explain: _____

_____

_____

_____

***IF VISIT TODAY IS FOR PAIN OR INJURIES SUSTAINED IN AN ACCIDENT (AUTOMOBILE, WORK PLACE, O OTHER), ANSWER THE FOLLOWING QUESTIONS. OTHERWISE SKIP TO LAST PAGE AND SIGN)**

1. Nature of illness/injury/accident:
   Auto_____

   Work _____

   Other _____

2. Name and address of attorneys involved in this case, if applicable:

_____

_____

_____

3. Accident Date_____

4. Accident Location_____

5. Accident Time_____

Please describe the circumstances _____

_____

_____

***IF AUTO ACCIDENT, CONTINUE ANSWERING QUESTIONS, OTHERWISE SKIP TO QUESTION 20**

6. What kind of car were you in? _____

7. Where were you seated?

_____ Driver _____Front Passenger _____Rear Driver side_____ Rear Passenger side

8. Were you going?

_____North _____South _____East _____West

9. Were you moving or stopped? _____Moving _____ Stopped

10. What was the approximate speed of your vehicle? _____ mph

11. Where on your vehicle were you hit:

_____In the front (head on) _____In the front (left side) _____In the front (right side)

_____In the rear _____In the rear (left side) _____In the rear (right side) OR Other (list)_____

12. At the time of impact I was looking:

_____Straight ahead _____ To the left _____ To the right

13. Were you wearing your seatbelt? _____Yes _____ No

14. Were there airbags in your vehicle: _____Yes _____ No

If so, did they deploy? _____Yes _____ No

15. I was thrown after impact:

_____Forward _____Backward _____ Side-to-side

16. I struck:

_____Dashboard _____ Headrest _____Windshield _____Rear view mirror _____Door _____ Seat belt

_____Side window _____Steering wheel _____Other (list)_____

17. What part of your body did you strike?
_____Head _____Chest _____Face _____Knees _____Arms_____ Shoulder
_____Other (list)_____

18. I had:
_____Cuts _____Bruises _____ OR _____Both
on my: _____

19. _____I was_____I was NOT unconscious at the scene of the accident.

20. Was there:
_____Momentary Deafness _____Loss of Balance _____Nausea _____Ringing in Ears
_____Blurred visión _____Immediate Pain _____Dizziness

21. I was taken from the scene of the accident by:
_____Ambulance _____Friend _____Parents _____ Mother _____Other (list)_____
_____To Hospital _____Home _____ Other (list)_____

22. When did you first seek medical attention for this accident?_____
Who did you see? _____

23. At (hospital name)_____
I was examined by _____

24. Were you admitted? _____Yes _____ No

25. I was examined and given:
_____X-Rays _____Medication _____Neck Collar _____Brace _____ Stitches
_____Other (list)_____

26. After your release, what did you do?
_____Return Home to Bed _____ Return to Work
_____Other (list)_____

27. Work:
Have you lost any time from work since the accident?: _____Yes _____No
1. Are you still off work? _____Yes_____ No
2. If not, date returned to work _____

28. Give names of all other doctors that treated you for injuries from your accident:
A. Name_____ Date_____
What did he/she do?_____
What did he/she say was wrong? _____
_____

B. Name_____ Date_____

What did he/she do?_____

What did he/she say was wrong? _____

_____

29. Check symptoms you have noticed since the accident:

A_____Mid back (pain, stiffness)
B_____Low back (pain; stiffness)/
C_____Swelling?
Where?_____
D_____Restriction of neck motion
E_____Upper back pain and stiffness/
F_____Pins & needles in:
_____Arms _____Legs
G_____Numbness in:
_____Fingers _____Arms _____Legs
H_____HeadacheI
_____Neck pain
K_____Difficulty in excessive
_____Standing _____Walking
_____Riding _____Bending

L_____Neck pain, stiffness upon arising
M_____Low back pain, stiffness on arising
N_____Pain radiating into:
_____Arm _____Leg
O_____Difficulty in lifting:
_____Light _____Moderate
_____After lifting a few times
P_____Pain radiating into:
_____ Neck
_____ Base of skull
_____ Arms
_____ Hips
_____ Legs

30. I have pain in the following areas (most severe first, list all of them):

A. _____

B. _____

C. _____

D. _____

E. _____

31. My symptoms are aggravated by:

_____Walking _____ Standing ____Lifting _____Turning _____ Working
_____Sitting _____Playing sports _____ Lying down ___Exercise
_____Other (list) _____

32. My symptoms are helped by:

_____Resting _____Medication _____Bed rest _____Ice packs _____Hot shower_____Aspirin

_____Other (list) _____

33. Medication presently taking related to the injury (list all):

A. _____D._____

B._____ E._____

C. _____ F._____

34. Have you had prior injuries or received treatment to the areas that are currently injured? If yes:

Date_____ Name of doctor_____

Address of Doctor_____

35. _____ I have or _____ I have NOT been able to work since the accident. If you have not, list dates unable to work:

From _____ To _____ Other_____

36. What activities have changed since the accident?

A. Employment: _____ No change _____ Cannot do work _____ Hurts to work

B. Exercise: _____ Can still exercise _____ Cannot exercise _____ Hurts to exercise

C. Housework: _____ Can still do housework _____ Can do limited housework
_____ Hurts to do housework _____Cannot do housework

D. Sports: _____Can still do sports _____ Can do limited sports
_____Hurts to do sports_____ Cannot do sports

E. Lifting: _____ Can still lift _____Can do limited lifting_____Hurts to lift _____Cannot lift

F. Other:_____

37. _____ I have OR_____I have NOT been involved in other auto accidents.

If so, give date(s) and describe_____

38. _____ I have _____ OR_____ I have NOT been involved in ANY type of prior accident.

If so, give date(s) and describe _____

39. Do you have any type of disability or have you ever been given an impairment rating?

_____Yes _____No. If yes, explain_____

_____

_____

_____ _____

PATIENT'S SIGNATURE DATE

FOR OFFICE USE ONLY:

Liens and Cover letter sent out _____

Lien returned _____

Report fee paid _____

REV 8/26/2019

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.

REV 8/26/2019

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, Torregrosa and/or APRN Mauricio Aragon Caceres, 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

REV 8/26/2019

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

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: _____

REV 8/26/2019

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 would like 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.

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_____