UNIVERSITY ORTHOPEDIC CARE

Expertise in Orthopedics, Sports Medicine and Spine

NEW PATIENT PACKAGE

Patient Name :

LAST FIRST MIDDLE

Address:_____City_____State:_____Zip_____

Home Phone: (____)_____**Work Phone**: (____)_____**Cell Phone**: (____) _____

Date of birth:_____/_____/_____**Age:** _____ **Gender Identity:** Male_____Female_____Other_____

MM DD YYYY

Social Security #: _____-_____-_____ **Email Address**: _____

Employment status: Unemployed Full-Time Part-Time Retired Self-Employed Student Other

Employer:_____**Employer Address**: _____

Primary Care Physician_____**Date of Accident:** _____

Attorney/Case Manager Name & Number: _____

SPOUSE / PARENT / GUARDIAN INFORMATION

Name: _____ **Relationship to Patient**: _____

Address:_____**City:**_____**State:**_____**Zip:** _____

Home Phone: (____)_____**Work Phone**: (____)_____**Cell Phone**: (____) _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship to Patient**: _____

Address:_____**City:**_____**State:**_____**Zip:** _____

Home Phone: (____)_____**Work Phone**: (____)_____**Cell Phone**: (____) _____

POLICYHOLDER INFORMATION (If policyholder is different from patient, please provide the following)

Policyholder's Name: _ **Relationship to Patient**: _____

Policyholder's Date of Birth:_____/_____/_____**Policyholder's Employer**: _____

Policyholder's SS # _____ **Policy #** _____

Patient Signature _____

Guardian Signature: _____

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Office Policies

Please review the policies below and sign.

Appointments

Please arrive 15 minutes **prior** to your appointment time and bring the following with you to your visit:

- Vehicle Insurance Card
- Photo ID
- List Prescription medicine and over the counter medications you take
- MRI, CT, X-ray reports and CDs

We ask that you allow plenty of time to get to our office for your appointments. **If you arrive more than 15 minutes late for your appointment, then we may have to reschedule**. We will strive to stay on time. From time to time, a patient emergency arises, and we may be running late for your visit. You may wait or have the option to re-schedule your visit. We will keep you informed of how long of a delay you may experience.

Transportation

We provide transportation to those who are in need. If you require transportation to your appointments in our offices, please let our staff know 24-48hrs **prior** to your appointment.

Missed Appointments

We understand that appointments sometimes need to be changed, so we ask that you call 24 hours in advance to cancel/re-schedule your appointment. If a 24-hour notice is not given this will count as a no-show.

Prescription Refills

For your convenience, we have an in-house dispensing program, if you opt out and prefer your personal pharmacy, **you must contact your pharmacy first for all refill request.** Your pharmacy will then contact us for the refill. Please allow us 72 hours to refill your prescriptions. We will not refill any medications after office hours or on weekends.

By signing this form, you are acknowledging that you have read and understand our office policies

Patient Name: _____ ***Date of Birth:*** _____

Signature: _____ ***Date:*** _____

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Medical Intake Form

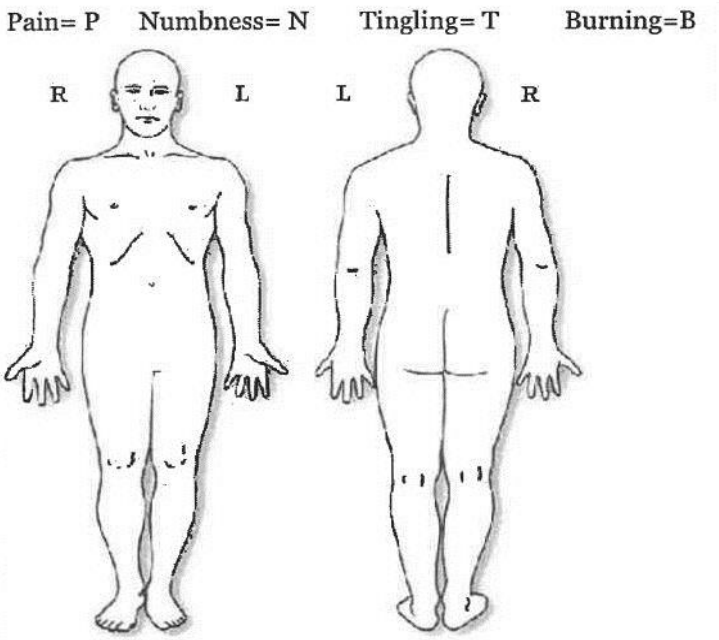
DEMOGRAPHICS

Patient Name: _____	DOB: _____	Sex: Male / Female
Occupation: _____	Ht/Wt: _____	Marital Status: _____
Referred by: _____	PCP: _____	Hand Dominance: Right / Left

REASON FOR VISIT:

What is the main reason for your visit today?_____

PAIN DIAGRAM: Please indicate areas of pain, numbness, tingling, and or burning on the following diagram (2 body part limit):



SEVERITY: How severe is your pain? (Circle #)

0	123	4567	8910
No Pain	Mild	Moderate	Severe

NATURE: Pain is

☐ Occasional ☐ Continuous ☐ Intermittent
☐ Sharp ☐ Shooting ☐ Aching ☐ Dull
☐ Improving ☐ Worsening ☐ Unchanged

EFFECT ON DAILY LIFE: Does the condition

Wake you up at night? ☐Yes ☐No
Interfere with work activities? ☐Yes ☐No
Interfere with recreational activities? ☐Yes ☐No

INCREASING/DECREASING FACTORS:

What makes pain worse?

☐ Activity ☐ Work ☐ Exercise ☐ _____

What makes pain better?

☐ Rest ☐ Heat ☐ Ice ☐ _____

Comments: _____

DETAILS OF THE CURRENT INJURY:

How did the injury / symptoms occur?

☐ Previous injury / recurrence ☐ Gradual onset ☐ Sudden / Traumatic ☐ Lifting ☐ Bending ☐ Fall
☐ Twisting ☐ Whiplash ☐ Running ☐ Throwing ☐ Other _____

Where did the injury occur?

☐ Home ☐ Work ☐ Sports/Recreation ☐ School ☐ Vehicle (MVA) ☐ Other _____

How long have you had these symptoms / injuries?

Date of Injury:_____/How long have you had these symptoms _____

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PREVIOUS SURGERY:	
PLEASE LIST SURGERIES AND DATES:	
1. _____	2. _____
3. _____	4. _____
5. _____	6. _____
7. _____	8. _____

DIAGNOSTIC TEST:	TREATMENT HISTORY:	ALLERGIES:
Please check and list date if you have had any of the following tests performed for current problem.	Please check box and list date if you have tried any of the following for your current problem.	Please list any drug or food allergies:
☐ X-Ray	☐ Cortisone Injection	1.
☐ MRI	☐ OTC Pain Medication	2.
☐ Ultrasound	☐ Surgery	3.
☐ EMG	☐ Physical Therapy	4.
☐ Bone Density Scan	☐ Crutches /Brace/Cane	5.
☐ CT	☐ Wheelchair	6.

CURRENT MEDICATIONS:	
Please list the name and dosage of any medications you are currently taking including prescription, over the counter and herbals:	
1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

ADDITIONAL INFORMATION:				
Are you currently having or have you had problems with: (Please Circle)				
AIDS	ARTHRITIS	BALANCE	BLACKOUT/FAINT	BLADDER
BOWEL MOVEMENT	CANCER	DIABETES	DIGESTION	EAR, NOSE, THROAT
EPILEPSY	EYES	HIGH BLOOD PRESSURE	LUNGS/BREATHING	NUMBNESS/TINGLING
POLIO	PHYSCHOLOGICAL	TUBERCULOSIS	HEPATITIS	BLEEDING PROBLEMS
ANESTHEISA COMPLICATIONS	MALIGNANT HYPERTHERMIA	SEIZURE DISORDER	PREVIOUS STROKE	CARDIAC/ MI / ARRYTHMIA

SOCIAL HISTORY:	WORK IN HOME	EMPLOYED	RETIRED	STUDENT
SMOKING HISTORY:	NEVER	SOMETIMES	PREVIOUS	CHEW / CIGAR / PIPE
ALCOHOL INTAKE:	DAILY	WEEKLY	SOCIAL/OCCASIONAL	NEVER
RECREATIONAL DRUGS:	DAILY	WEEKLY	SOCIAL/OCCASIONAL	NEVER

I certify that to the best of my knowledge, all information listed above is true. I further certify that I have not falsified or intentionally omitted any information related to my health or past medical history.

Signature of patient or guardian:_____Date: _____

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Assignment of Benefits

I _____ hereby authorize _____

(Name of Patient) (Name of Insurance carrier)

To make payments payable to and mailed directly to: Florida Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Florida Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care any benefits under any policy of insurance, and indemnity agreement, or any other collateral source as identified in Florida Statues for any services and or charges provided by Florid a Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care. In the event that my insurance company does not pay Florida Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care bills in full and pursuant to the terms of my policy of insurance, I hereby instruct the insurance carriers to set aside all funds in an amount that would be sufficient to pay such bills in full in accordance with the charges submitted. As part of this assignment of benefits, I further instruct insurance carrier to notify the provider immediately after any dispute as to the payment so that I may preserve and exercise its legal right. Also, in addition to notifying me and my legal representative, I instruct the insurance carrier to immediately notify the Provider of any scheduled examination under oath or independent medical examinations. 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 here in and it is true to the best of my knowledge and belief.

Initials_____

Medical Release: A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to the Florida Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care or any insurers providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm all actions taken by the said attorney in accordance with the special power and which the set attorney shall do or cause to be done by virtue of these presents. Release of Information: I hereby authorize this medical provider to: furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non-redacted PIP payouts sheet from the insurers; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, x-rays, and MRIs received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third-party vendors, without the patient's and the provider's prior expressed written permission. **Initials**_____

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICE RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY. Known by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Florida Orthopedics and Neurosurgery, LLC d/b/a University Orthopedic Care and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place, and stead to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and said Florida Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order. Furthermore, the undersigned allows Florida Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care or any of its agents to sign any paper that will be necessary to enhance, expedite and or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements. **The undersigned by these presents does give and grant Florida Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other document. Additionally, if the undersigned is involved in litigation, the undersigned directs their attorney to withhold the full amount of the outstanding balance of medical bills due to Florida Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care from any recovery obtained from an insurance company and/or responsible party(ies) via settlement, arbitration, trial, or court determination and, within 30 days of receipt, to send payment directly to Florida Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care.**

Initials_____

IN WITNESS WHEREOF, the undersigned have here unto set their hands, this _____ day of _____, _____

Patient's Signature _____ Print Patients Name _____

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OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

_____ _____ _____

Name *(PRINT or TYPE)* Signature Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

_____ _____ _____

Name *(PRINT or TYPE)* Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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AUTHORIZATION OF USE / DISCLOSURE OF HEALTH INFORMATION

I_____ have read this AUTHORIZATION and understand what information will be used or disclosed, who may use and disclose the information, and the recipients of that information. I specifically authorize any current employee or owner of Florida Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care and staff, or any other person listed below, to disclose my protected health information as described in this form to the recipients listed below. I understand that when the information is used or disclosed in accordance with this authorization, it may be subject to further disclosure by the recipient and may already be medical information is not protected. In addition, I understand that I reserve the right to revoke this authorization, if I do so in accordance with the steps detailed below.

The protected health information published in this document is specifically as follows:

* All Medical Records
* All Entry Forms
* All Diagnostic Reports
* All Medical Billing Records

The following entities may receive the information as published earlier:

* A referral to another doctor or Imaging Center
* insurance company of the 1st, 2nd 3rd payers, or life disability Insurance companies
* pharmacies for durable medical supply
* workers' compensation: By workers' compensation guidelines all your consultations, labs and injury-related test results are required to be released to your employer workers' compensation company and are lawyers and you, the patient who refuses to sign, do not apply to work-related injuries lawyer:

Attorney: _____ Phone: _____
Relative: _____ Relationship: _____
Translator:_____ Company:_____

The patient has the right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization: initials____

The patient has the right to withdraw this authorization in writing. Except if there is a legal case in connection with this authorization. Florida Orthopedics and Neurosurgery d/b/a University of Orthopedics Care and staff must receive in writing the following:

*patient's name and address and the number of patients if any
* the effective date of this authorization on recipients of protected health information in accordance with this authorization
* date of revocation the patient's signature

Florida Orthopedics and Neurosurgery d/b/a University Orthopedic Care and staff will accept written withdrawal of this authorization by U.S. Certified Mail and/or Fax to this number (772) 467-2621 All revocations must be sent to Florida Orthopedics and Neurosurgery d/b/a University Orthopedic Care and staff to the attention of the medical records department and are not effective until the Privacy Officer receives them.

This authorization will expire at [_____] or [_____] at the close of the case. After this date Florida Orthopedics and Neurosurgery d/b/ a University Orthopedic Care may no longer use or disclose the patient's protected health information without first obtaining a new authorization form. · I understand and accept the terms of this authorization.

I would like to be contacted as follows (check all that apply)

Home phone_____ [__]You can leave a message [__] Callback number only
Work Phone _____ [__] You can leave a message [__] Callback number only

In case of emergency:
Contact name_____ Phone_____
Address _____ Relationship: _____

Patient Signature _____ Date: _____
Signature of the legal Guardian _____ Relationship to the patient _____ Witness_____

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Request for Medical Records

Patient Name: _____ **DOB:** _____

FROM:

Doctor/Hospital_____

Address _____.

City_____ **State**_____ **Zip**_____

Phone_____ **Fax** _____

I hereby authorize the release of my medical records and/or x-rays, or copies of such and request that they be transferred to:

To: **Florida Orthopedics and Neurosurgery, LLC. d/b/a University Orthopedic Care**
Phone:(866) 961-1744 Fax: (855) 270-7447

Patient Name:_____ Patient Signature_____Date: _____