

ORTHOPAEDIC SURGERY ASSOCIATES, INC.

DATE: _____

ACCOUNT #: _____

PATIENT NAME: _____
(LAST, FIRST, MIDDLE INITIAL)

LOCAL ADDRESS: _____
(STREET, SUITE/UNIT, CITY, STATE, ZIP)

PERMANENT ADDRESS: _____
(STREET, SUITE/UNIT, CITY, STATE, ZIP)

SEX: MALE FEMALE MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED OTHER

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ AGE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

RACE: _____ ETHNICITY: _____ PRIMARY LANGUAGE: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

NEW PT ESTABLISHED PT REFERRING DR: _____ PRIMARY DR: _____

HOW DID YOU HEAR ABOUT US? NEWSPAPER/MAGAZINE/ INTERNET/LECTURE/BROCHURE/FRIEND/YELLOW PGS/OTHER _____

CHILD STUDENT FULL-TIME EMPLOYEE PART-TIME EMPLOYEE RETIRED

INSURANCE THROUGH EMPLOYMENT? YES NO OCCUPATION: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

PRIMARY INSURANCE: _____ INSURED: _____

ID #: _____ Group #: _____

SECONDARY INSURANCE: _____ INSURED: _____

ID #: _____ Group #: _____

INSURANCE THROUGH SPOUCE OR PARENT? YES NO

SPOUSE / PARENT NAME: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ WORK PHONE: _____

EMPLOYER: _____ OCCUPATION: _____

INSURANCE CO: _____ ID #: _____ GROUP #: _____

PLEASE COMPLETE IF PATIENT IS CHILD OR STUDENT:

FATHER'S NAME: _____ SOCIAL SECURITY #: _____ DOB: _____

ADDRESS (If different from patient) _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

MOTHER'S NAME: _____ SOCIAL SECURITY #: _____ DOB: _____

ADDRESS (If different from patient) _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

AUTHORIZATION FOR TREATMENT:

I hereby give my permission for Orthopaedic Surgery Associates, Inc. to evaluate and treat as deemed medically necessary.

I authorize Orthopaedic Surgery Associates to retrieve medication history information from Surescripts.

Patient Signature: _____
(Parent or Guardian, if patient is a minor.)

Patient Signature: _____
(Parent or Guardian, if patient is a minor.)

Print: _____

Print: _____

Date: _____

Date: _____

ORTHOPAEDIC SURGERY ASSOCIATES, INC.

NAME: _____

DATE: _____

Have you or are you being treated for any of the following?

ENDOCRINE

- Diabetes Yes No
Uses insulin Yes No
Thyroid disorder Yes No

HEMATOLOGIC

- Coagulation disorder Yes No
Anemia Yes No
History of DVT Yes No
History of pulmonary embolism (PE) Yes No
On blood thinning medication (Coumadin, Plavix, Pradaxa) Yes No

SKIN

- History of MRSA infection Yes No

NEUROLOGIC

- Migraines / Headaches Yes No
Seizure disorder Yes No
Stroke Yes No
TIA (mini-stroke) Yes No
Parkinson's disease Yes No
Loss of memory Yes No
Vertigo Yes No
Syncope (fainting) Yes No
Paralysis Yes No
Numbness / tingling in extremities Yes No
Neuropathy Yes No

EYES

- Glaucoma Yes No
Cataracts Yes No
Macular degeneration Yes No
Use glasses / contacts Yes No
Change in vision Yes No

EARS

- Tinnitus (ringing in ears) Yes No
Change in hearing Yes No
Use hearing aids Yes No

NOSE & MOUTH

- Sinus problems Yes No
Bleeding gums Yes No
Epistaxis (nose bleeds) Yes No
Seasonal allergies Yes No
Use dentures Yes No

BREASTS

- Breast cancer Yes No
Breast biopsy Yes No
Lumpectomy / mastectomy Yes No
Cystic disorder Yes No

RESPIRATORY

- Cough Yes No
Coughing up blood Yes No
Asthma Yes No
COPD (Emphysema) Yes No
Tuberculosis Yes No
Pneumonia Yes No
Sleep apnea Yes No
Use CPAP at night Yes No

CARDIOVASCULAR

- Hypertension Yes No
Angina / chest pain Yes No
Atrial fibrillation Yes No
Palpitations Yes No
Murmur Yes No
Heart attack Yes No
Stents / angioplasty Yes No
Bypass surgery (CABG) Yes No
High cholesterol Yes No
Valve replacement Yes No
Congestive heart failure (CHF) Yes No
Lower extremity edema Yes No
Poor circulation Yes No
Pain / cramping in legs with walking Yes No

GASTROINTESTINAL

- Abdominal pain Yes No
Nausea / vomiting Yes No
Vomiting blood Yes No
Constipation Yes No
Diarrhea Yes No
Blood in stool Yes No
Melena (black, tarry stool) Yes No
Hepatitis Yes No
Diverticulosis / Diverticulitis Yes No
Gallbladder disease Yes No
Hernia Yes No
Ulcers (stomach or intestine) Yes No
Heartburn / reflux (GERD) Yes No

UROLOGY

- Pain / burning with urination Yes No
Frequency of urination Yes No
Urgency of urination Yes No
Blood in urine Yes No
Frequent bladder infections (UTI) Yes No
STI: syphilis, gonorrhea, chlamydia Yes No
Incontinence Yes No
Decreased stream Yes No
Kidney disease Yes No
On dialysis Yes No

RHEUMATOLOGIC

- Rheumatoid arthritis Yes No
Lupus (SLE) Yes No
Fibromyalgia Yes No

MUSCULOSKELETAL

- Joint pain Yes No
Joint swelling Yes No
Joint stiffness Yes No
Arthritis (OA) Yes No
Muscle pain Yes No
Gout Yes No
History of fracture Yes No
If yes, where? _____
Osteoporosis Yes No
Last bone density: _____

CANCER

- History of cancer: Yes No
If yes, type? _____

ORTHOPAEDIC SURGERY ASSOCIATES, INC.

NAME: _____ DATE: _____

HISTORY OF PRESENT ILLNESS

HEIGHT: _____ WEIGHT: _____ RIGHT HAND DOMINANT LEFT HAND DOMINANT

REASON FOR VISIT: RIGHT LEFT BODY PART: _____

HOW DID THIS PROBLEM OCCUR? _____ WHEN? _____ WHERE? _____

WILL YOU BE CLAIMING THIS INJURY UNDER WORKER'S COMPENSATION? YES NO

IS THIS A LIABILITY CASE? NO YES

HAVE YOU HAD TREATMENT FOR THIS? NO PHYSICAL THERAPY CORTICOSTEROID INJECTION OTHER INJECTION

BRACE ASSISTIVE DEVICE (CANE / WALKER / CRUTCHES / WHEELCHAIR / OTHER)

HAVE YOU TRIED ANY MEDICATIONS FOR THIS PROBLEM? NO YES, _____

STUDIES ALREADY PERFORMED FOR THIS PROBLEM: X-RAY MRI CT SCAN BONE SCAN MYELOGRAM OTHER

WHEN? _____ WHERE? _____

PAST SURGICAL HISTORY: NONE

TYPE:	DATE:	DOCTOR:	FACILITY/STATE

PHARMACY: _____ Pharmacy Phone #: _____

ALLERGIES: NONE IODINE/BETADINE ADHESIVE MYELOGRAM DYE OTHER: _____

MEDICATION / VITAMIN / SUPPLEMENT:	DOSAGE:	REASON FOR TAKING MEDICATION:

FAMILY HISTORY: Please list age, general health, deceased or living.

MOTHER:	FATHER:
BROTHER(S):	SISTER(S):

SMOKING STATUS: NO QUIT _____ YEARS AGO YES, # OF PACKS/DAY _____ AND # OF YEARS _____

ALCOHOL USAGE: None Infrequent 1-2 drinks / week 3-7 drinks / week 7+ drinks / week

ORTHOPAEDIC SURGERY ASSOCIATES, INC.

PATIENT NAME: _____

DATE: _____

IMPORTANT: THIS IS NOT AN APPLICATION FOR CREDIT. CHARGES FOR ALL SERVICES RENDERED BY ORTHOPAEDIC SURGERY ASSOCIATES (HEREINAFTER, "OSA") ARE DUE AND PAYABLE IN FULL FORTY-FIVE (45) DAYS FROM THE DATE SERVICES WERE RENDERED. OSA will assist the Patient in the processing of insurance claims as a courtesy only. OSA accepts no responsibility for any processing procedures, acts, omissions and/or neglect. PATIENT, RESPONSIBLE PARTY AND/OR INSURANCE CARRIER ARE SOLELY RESPONSIBLE TO PAY FOR ALL SERVICES PROVIDED.

IN CONSIDERATION of the provision of services to the Patient named above, the Patient and the Responsible Party understand and agree that:

1. Payment for services rendered is due in full forty-five (45) days from the date services were rendered, or as otherwise might be stipulated through a contract between OSA and Patient's health plan or as stipulated by any state prompt payment laws. Any balance unpaid after sixty (60) days from the date services were rendered will be considered "delinquent."
2. **FOR PATIENTS WITH INSURANCE:** In the event that services rendered are not covered or are deemed as not medically necessary, Patient and/or Responsible Party shall be responsible for payment in full for those services. Patient and/or Responsible Party shall also be responsible for any cost sharing, such as co-payments, coinsurance and/or deductibles.
3. In the event that any unpaid balance remains delinquent and has been placed for collection, the Patient and/or Responsible Party must pay all costs of collection, including reasonable attorney's fees, if the delinquent balance is referred to an attorney for collection.
4. In the event the Patient submits payment by check and that check is returned for INSUFFICIENT FUNDS by the bank, OSA will add a bank charge to the balance owed by the Patient or Responsible Party.
5. No statement by an employee or agent of OSA will contradict, void or nullify this Agreement, nor shall the Patient rely on any statement or opinions made by OSA that Patient's insurance carrier will pay the bill.
6. Patient also agrees to assign to OSA the rights under their policy of insurance, including medical benefits, the right to receive information concerning benefits available, and the right to file a lawsuit to recover unpaid medical benefits for OSA's charges.
7. All patients who fail to arrive for their scheduled appointments or who cancel with less than 24 hours advance notice will be charged a missed appointment fee of \$25.00.

X-RAYS: Original X-rays are a part of the patient's permanent medical chart and remain in our office. If you would like a copy of your X-rays, there is a nominal charge to cover the cost of duplication.

LIFETIME AUTHORIZATION - MEDICARE AND MEDICAID PATIENT CERTIFICATION - PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Authorization is hereby given to OSA to submit my claim directly to my insurance on my behalf. I understand that by signing this form, my signature is not needed each time a claim is submitted on my behalf. I further authorize my insurance carrier to forward payment directly to OSA.

I HEREBY AUTHORIZE OSA TO RELEASE ALL MEDICAL AND BILLING INFORMATION NECESSARY TO SECURE PAYMENT FROM MY DESIGNATED INSURANCE CARRIER ON MY BEHALF. I have read and fully understand all of the above conditions. Once I sign this Agreement, I am responsible for all payments, charges, and if necessary, cost of collection as stated above. I acknowledge receipt of copy of this Agreement.

Patient: _____
Responsible Party (if other than Patient): _____

Dated: _____
Witness: _____

ORTHOPAEDIC SURGERY ASSOCIATES, INC.

Relationship to Patient

AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ACCOUNT #: _____

1. I authorize Orthopaedic Surgery Associates to disclose my health information specific to the following date or time period: _____

2. Individual or entity authorized to receive my health information: _____

3. Purpose for which disclosure is to be made: _____

4. Information to be disclosed:

Practitioner Summary

Emergency Room Report

X-ray Records

History & Physical Exam

Laboratory Report

Consultation

Office Chart Notes

Radiology Report

Rx

5. I understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore, I release **Orthopaedic Surgery Associates**, its employees, and my physicians from all liability arising from this disclosure of my health information.

6. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revocation request.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

Signature: Patient or Legal Representative

Date

Signature of Witness

Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **Orthopaedic Surgery Associates'** health care operations. The Notice of Privacy Practices also describes my rights and **Orthopaedic Surgery Associates'** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the office of Orthopaedic Surgery Associates at 2828 South Seacrest Boulevard, Suite 204, Boynton Beach, FL and on **Orthopaedic Surgery Associates'** website at www.ortho-surgeon.com.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority