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

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ PHONE: _____

IS INSURANCE THROUGH EMPLOYMENT? ☐ YES ☐ NO

PRIMARY INSURANCE: _____ INSURED: _____

ID #: _____ Group #: _____

SECONDARY INSURANCE: _____ INSURED: _____

ID #: _____ Group #: _____

INSURANCE THROUGH SPOUSE 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.

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

Print: _____

Date: _____

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

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

Print: _____

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.

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: _____ **Dated:** _____

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