

*Orthopaedic Center of South Florida*  
**954-473-6344**

**LIABILITY PATIENT INFORMATION**

PHYSICIAN \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
FIRST MIDDLE LAST

ADDRESS \_\_\_\_\_

CITY/ STATE/ ZIP CODE \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ OTHER: \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_ / \_\_\_ / \_\_\_ MALE \_\_\_ FEMALE \_\_\_ MARITAL STATUS SMWD

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_

YOUR OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

PARENT/SPOUSE NAME \_\_\_\_\_ PHONE \_\_\_\_\_

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**ACCIDENT INFORMATION**

DATE OF ACCIDENT \_\_\_\_\_

PLACE OF ACCIDENT \_\_\_\_\_

SEATING OF PATIENT AT TIME OF ACCIDENT

DRIVER \_\_\_\_\_ FRONT SEAT PASSENGER \_\_\_\_\_ REAR SEAR PASSENGER \_\_\_\_\_

WERE YOU TREATED PREVIOUSLY FOR THIS INJURY? YES \_\_\_\_\_ NO \_\_\_\_\_

HOPSITAL \_\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_

# PAIN MANAGEMENT INTAKE SHEET

Patient Name: \_\_\_\_\_ Chart #: \_\_\_\_\_

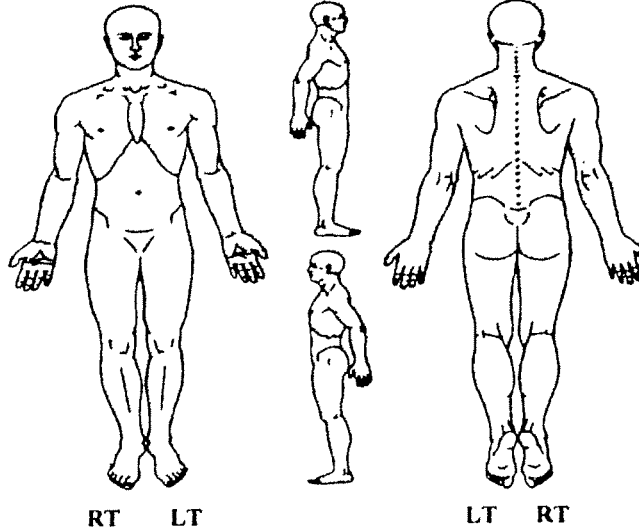
Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

When did the problem begin? \_\_\_\_\_

What activity triggered it? \_\_\_\_\_

### Mark problem areas of pain

XXX= Aching	- - - = Burning	* * * * = Pins & Needles
>> = Shooting	///// = Stabbing	0 0 0 0 = Throbbing



### PAIN SCALE

Rate your pain on the scale from 1-10 with an X  
 NO PAIN    MINIMAL    MODERATE    INTENSE    EMERGENCY  
 0            1-3            4-6            7-9            10

1    2    3    4    5    6    7    8    9    10

**My pain today compared to onset of problem is:**

- The same     Better     Worse

**My pain is improved by:**

- Sitting     Standing     Walking     Laying     Bending forward     Bending back

Describe in detail: \_\_\_\_\_

**My pain is worsened by:**

- Sitting     Standing     Walking     Laying     Bending forward     Bending back  
 Sneeze/cough     Bowel movement

Describe in detail: \_\_\_\_\_

**My pain is described as:**

- Constant     Intermittent     Sharp     Dull     Achy     Burning     Stabbing  
 Searing     Throbbing     Shooting     Cramping     Numbness/Tingling

Describe in detail: \_\_\_\_\_

If you have low back and leg pain please select the statement that best fits:

- \_\_\_\_\_ My back pain is greater than my leg pain.
- \_\_\_\_\_ My leg pain is greater than my back pain.
- \_\_\_\_\_ My back pain is equal to my leg pain.

If you have neck and arm pain select the statement that best fits:

- \_\_\_\_\_ My neck pain is greater than my arm pain.
- \_\_\_\_\_ My arm pain is greater than my neck pain.
- \_\_\_\_\_ My neck pain is equal to my arm pain.

**Previous pain injections:**

- Trigger Points     Epidurals     Facet injections     Discogram
- Other: \_\_\_\_\_

**Other Therapies:**

- Physical Therapy     Chiropractic     Massage Therapy     Acupuncture     Biofeedback
- Surgery (list type & date) \_\_\_\_\_
- Other: \_\_\_\_\_

**Previous Pain Medications Tried and Effect:**

Medications	Dosage	Effect
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Do you now or have you in the past had any of the following?**

- |                                       |  |                          |   |
|---------------------------------------|--|--------------------------|---|
| <b>Yes</b>                            | <b>No</b>  | <b>Yes</b>               | <b>No</b>   |
| <input type="checkbox"/>              | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> | <input type="checkbox"/> Bleeding Disorders/Clotting Problems |
| <input type="checkbox"/>              | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> | <input type="checkbox"/> High Cholesterol                     |
| <input type="checkbox"/>              | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> | <input type="checkbox"/> Urinary Disorders                    |
| <input type="checkbox"/>              | <input type="checkbox"/> Thyroid                   | <input type="checkbox"/> | <input type="checkbox"/> Arthritis                            |
| <input type="checkbox"/>              | <input type="checkbox"/> Stomach Ulcer             | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy                             |
| <input type="checkbox"/>              | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> | <input type="checkbox"/> Lung/Breathing Problems              |
| <input type="checkbox"/>              | <input type="checkbox"/> Rashes/non-healing lesion | <input type="checkbox"/> | <input type="checkbox"/> Could you possibly be pregnant?      |
| <input type="checkbox"/> Other: _____ |  |                          |   |

**Have you had any surgery in the past? If yes, list type and date of surgery:** \_\_\_\_\_

**Have you been hospitalized for a problem other than listed above? If yes, please specify condition:** \_\_\_\_\_

**Have you had any complications with anesthesia? If yes, please explain:** \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

**Current Medications:**

Medications	Dosage	Doctor Prescribing

Do you take any blood thinners? (Coumadin, Plavix, Lovenox, etc.)  YES  NO

**Allergies:**

None  Penicillin  Sulfa  Iodine  IVP dye / contrast  Latex  Eggs  
 Other: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced  Separated

Do you smoke?  Yes  No \_\_\_\_\_ packs per day for \_\_\_\_\_ years

Do you drink alcohol?  Yes  No Amount per week \_\_\_\_\_

Recreational drug use?  Yes  No

If yes, please list what and when last used \_\_\_\_\_

Are you currently employed?  Yes  No If yes, what is your occupation? \_\_\_\_\_

If no, how long have you been unemployed? \_\_\_\_\_

Family Member	Alive/Deceased	Age	If deceased, what was the cause?
Father	A / D	_____	_____
Mother	A / D	_____	_____

**Review of Systems:**

		Yes	No
Constitutional	Unintended Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
	Fever/Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	Change in vision	<input type="checkbox"/>	<input type="checkbox"/>
ENT	Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>
	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	Swelling of legs/ankles	<input type="checkbox"/>	<input type="checkbox"/>
	Calf cramps while walking	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal		<input type="checkbox"/>	<input type="checkbox"/>
Integumentary	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Heme/Lymphatic	Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	Numbness of arms/legs	<input type="checkbox"/>	<input type="checkbox"/>
	Bladder/Bowel Incontinence	<input type="checkbox"/>	<input type="checkbox"/>

## **OCSF FINANCIAL POLICY & ASSIGNMENT OF BENEFITS**

The purpose of this form is to help our patient(s) understand Orthopaedic Center of South Florida, PA (OCSF) Financial Policy.

### **PAYMENT IS EXPECTED AT TIME OF SERVICE**

OCSF accepts the following Types of Payments: Cash, Personal Checks, Major Credit Cards (i.e. American Express, Discover, MasterCard and Visa), and Care Credit with No interest for 6 months. There will be a \$25 fee for all returned checks.

All patients are required and responsible for the following:

- To bring any Referral and/or Authorization required by their health insurance, either Primary or Secondary, for services rendered;
- To provide OCSF with current home address and updated insurance;
- To pay for the co-payment, deductible and/or coinsurance at the time of service as designated by the insurance company;
- To pay for any previous balance at the time of service;

### **MEDICARE PATIENTS:**

If patient is a Medicare member, patient will be responsible to review and sign the Medicare "ABN" Advanced Beneficiary Notice for services non-covered or not deemed Medically Necessary by Medicare, including orthotics, injections, etc. If patient has no secondary insurance, 20% coinsurance is required to be paid at time of service. The patient must notify OCSF if enrolled with any HMO/PPO.

### **MOTOR VEHICLE ACCIDENT PATIENTS:**

If related to MVA accident, patient is to report accident to their own Automobile insurance within time limit and provide our office with the claim number. If patient does not have Automobile insurance, they need to report accident to the Automobile insurance in their household. If we file patient's health insurance, co-payment, deductible, and/or coinsurance is expected at the time of service.

### **WORKER'S COMP PATIENTS:**

Patient will be treated for Worker's Comp. accident as long as we are the authorized treating physician(s). Once patient reaches MMI (Maximum Medical Improvement), patient shall be responsible for co-payment designated by Worker's Comp. If case is settled, we cannot file future claims to Worker's Comp., therefore, patient shall provide us with their health insurance information.

### **BILLING & COLLECTION PROCEDURES:**

If eligible for Insurance benefits, it should be understood that the agreement is between the patient and their health insurance. Patient is responsible to pay for our services regardless of the status with their insurance company. Orthopaedic Center of South Florida, PA files claims promptly to the insurance company for services rendered as a courtesy to the patient. If there is a patient balance, statements are mailed monthly, around the 10<sup>th</sup> of every month, for a period not to exceed three (3) months. Any balance due beyond 30 days is subject to interest of 1.5%, which accumulates every month thereafter until balance is paid in full. OCSF may use an outside collection

agency in an attempt to collect any outstanding patient balance, and collection fees may be added.

**OTHER ENTITIES:**

During the course of your treatment, patient may be referred to other institutions for diagnostic testing, lab work, durable medical equipment and/or therapy. These Referrals are based solely on medical necessity and our affiliation with these institutions is based on providing our patients with the highest quality and professional medical care possible. Comments on patient's experience of these institutions will be used to modify and improve the Referral process. This notice will serve to advise our patient(s) that OCSF participates as a partner in the Centers listed below and that patient's signature acknowledges that he/she has been apprised of this information. The Centers are as follows:

- Coral Springs Surgical Center
- Memorial Same Day Surgery Center East
- Memorial Same Day Surgery Center West
- The Surgery Center of Ft Lauderdale

OCSF will make every attempt possible to refer our patient(s) to a facility participating with the patient's insurance plan; however, it is ultimately the patient's responsibility to find out if the facility is participating with their insurance company. OCSF will not be help responsible for any referral of a non-participating facility.

**ASSIGNMENT OF BENEFITS:**

The undersigned patient assigns the insurance benefits to Orthopaedic Center of South Florida, PA for services rendered. The medical provider agrees to accept the irrevocable assignment benefits for services rendered to the patient. A photocopy of this assignment is to be considered valid as an original.

**DIRECTION TO PAY:** The undersigned patient directs their Health Insurance to pay Orthopaedic Center of South Florida, PA directly for services rendered. In the event health insurance pays the patient directly, the patient agrees to endorse and turn payment over to Orthopaedic Center of South Florida immediately.

**RELEASE OF INFORMATION:** The undersigned patient authorizes Orthopaedic Center of South Florida, PA to furnish insurance and/or business associates with any and all information that may be necessary for treatment, for payment or for health care operations.

I certify that I have read, understand and agree to the terms and conditions indicated on this form. If Patient is under 18, I hereby give my permission and consent for patient to be treated by any physician part of Orthopaedic Center of South Florida, P.A.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Signature (if minor, Parent or Guardian)

\_\_\_\_\_  
Date

*Orthopaedic Center of South Florida*  
*954-473-6344*

**Patient Acknowledgement & Receipt of Privacy Practices**

**\*\*\*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT\*\*\***

I, \_\_\_\_\_, have read and received a copy of the  
Aforementioned practice's Notice of Privacy Practices.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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For Office Use Only

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

\_\_\_\_\_ Individual refused to sign

\_\_\_\_\_ Communication barriers prohibited obtaining the acknowledgement

\_\_\_\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_\_\_\_ Other: \_\_\_\_\_

*Orthopaedic Center of South Florida*  
**954-473-6344**

**CONSENT FOR USE AND DISCLOSURE  
OF HEALTH INFORMATION**

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**Section A: Patient Giving Consent**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

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**Section B: To the Patient – Please read the following statements carefully**

**Purpose of Consent:** By signing this form, you will consent to our use of your Protected Health Information to carry out treatment, payment activities and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your Protected Health Information, and of other important matters regarding your Protected Health Information. A copy of our notice accompanies the consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our Protected Health Information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person: Robin Fielding, CEO

Address: 600 South Pine Island Road, Suite 300, Plantation, FL 33324

Telephone: (954) 473-6344 Fax: (954)476-9077

**Right to Revoke:** You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect our action we took in reliance of this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

**Signature:**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by reading this consent form, I am giving my consent to your use and disclosure of my Protected Health Information to carry out treatments, payment activities and healthcare operations.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Orthopaedic Center of South Florida*  
954-473-6344

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect on April 15, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations; for example:

**Treatment.** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment.** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization.** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends.** We must disclose your health information to you, as described in the Patient Rights of this Notice. We may disclose your health information to a family member, friend or any other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved in Care.** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

**Marketing Health-Related Services.** We will not use your health information for marketing communications without your written authorization.

**Required by Law.** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect.** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders.** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

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## **PATIENT RIGHTS**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses, such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you what is reasonable and customary for Broward County for each page and hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

**Notice of Privacy Practices**  
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**Disclosure Accounting.** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a twelve (12) month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction.** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

**Electronic Notice.** If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Orthopaedic Center of South Florida, P.A.

Address: 600 South Pine Island Road, Suite 300, Plantation, Florida 33324

Telephone: (954) 473-6344 Fax: (954) 476-9077