Orthopaedic Center of South Florida
954-473-6344

MEDICAL HISTORY QUESTIONAIRE

Name: _____ Date of Birth: _____ Age: _____ R/L Handed: _____

Phone #: _____ Height: _____ Weight: _____

Referring Physician: _____ PCP: _____

Is this a work related injury or illness? □ Yes □ No

Is this an accidental injury? □ Yes □ No □ Fall □ Car Accident

If this is a car accident, were you:

wearing your sear belt? □ Yes □ No

the driver? □Yes □ No

the passenger? □ front □ rear

□ rear-ended □ broad-sided □ side-swiped □ head-on collision

Date of injury: _____

Describe what happened (mechanism of injury): _____

When did you first notice the pain? _____

Was the onset of your pain sudden or gradual? _____

Did you go to the Emergency Room? □ Yes □ No

Were you treated? □ Yes □ No

Were any tests performed? □ Yes □ No If yes: _____

What treatment did you receive? _____

List other physicians who have treated you for this problem: _____

Which of the following diagnostic tests have been performed for this problem?

□ X-rays

□ CT Scans

□ MRI Scans

□ EMG/Nerve conduction Studies

□ Discogram or Myelogram

Have you ever had a similar problem with this type of pain? □ Yes □ No

If yes, did you ever completely recover from this problem? □ Yes □ No

Have you had any previous medical or surgical treatment for this condition prior to your current injury? □ Yes □ No

Please describe: _____

_____

Are you currently working? □ Yes □ No

Are you currently working full duty? □ Yes □ No Light duty? □ Yes □ No

How many hours per day do you work? _____

What is your occupation? _____

Have you tried to return to work? □ Yes □ No When? _____

Is there a Rehab Nurse or Counselor or Vocational Specialist working with you? □ Yes □ No

Is there a lawyer involved in your case? ☐ Yes ☐ No Attorney Name: _____

Have you applied for social security disability? ☐ Yes ☐ No

Are you receiving social security benefits? ☐ Yes ☐ No

PAIN DESCRIPTIVES

Pain is: ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Aching ☐ Tingling ☐ Numbness ☐ Pulsating ☐ _____

Pain is: ☐ Constant ☐ Occasional (comes and goes)

How many hours per day do you have the pain? _____

How many days per week do you have the pain? _____

What activities are most affected by your pain? _____

Activity level since the pain began is:

☐ unchanged ☐ pain with manual labor

☐ diminished ☐ unable to perform manual labor

☐ significantly restricted ☐ unable to perform daily household chores

Where is your worst pain? ☐ Neck ☐ Back ☐ Right leg ☐ Left leg ☐ Right arm ☐ Left arm

Please rate your pain (on a scale of 1-10). Please circle appropriately:

	No Pain	Minimal	Moderate	Intense	Emergency
Neck	0	1 2 3	4 5 6	7 8 9	10
Back	0	1 2 3	4 5 6	7 8 9	10
Arm	0	1 2 3	4 5 6	7 8 9	10
Leg	0	1 2 3	4 5 6	7 8 9	10

Pain Diagram: Please make the areas of your pain. You may use the key below to indicate different kinds of pain sensations.

Key: → = shooting

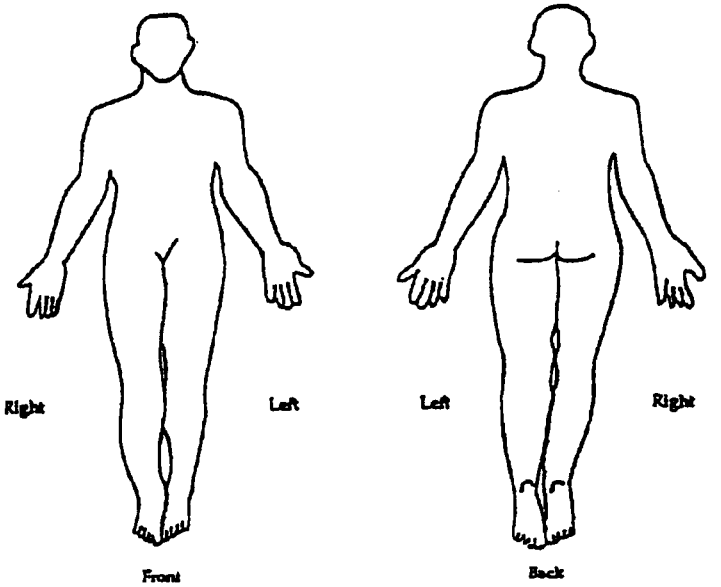
/// = stabbing

xxx = aching

ooo = throbbing

●●● = pins & needles

— = burning



What makes your pain better? *(Please check all that apply)*

☐ lying down	☐ walking	☐ sitting	☐ standing	☐ medication
☐ sleep	☐ heat/ice	☐ massage	☐ exercise	☐ stretching
☐ traction	☐ TENS	☐ forward bending	☐ backward bending	☐ compression

Other: _____

_____

What makes your pain worse? *(Please check all that apply)*

☐ standing	☐ sitting	☐ walking	☐ bending	☐ driving
☐ lack of sleep	☐ lying down	☐ lifting	☐ weather	☐ housework activity
☐ reaching overhead	☐ coughing	☐ sneezing	☐ tension	☐ arising from chair

Other: _____

_____

Do you have severe night time pain? ☐ Yes ☐ No

Do you wake up in the middle of the night because of pain? ☐ Yes ☐ No If yes, how many times? _____

Do you experience any associated symptoms such as:

☐ weakness in arms or legs	☐ problems with sexual functions	
☐ numbness/tingling of arms or legs	☐ headaches	
☐ leg pain with walking	☐ depression	
☐ leg pain not relieved by rest	☐ anxiety	
☐ balance disturbance	☐ bladder dysfunction	☐ bowel dysfunction

Which of the following treatments have you had for this condition?

- ☐ Physical Therapy *(including ultrasound, hot packs, traction, electrical stimulation, massage, exercise)*
- ☐ TENS Unit
- ☐ Traction
- ☐ Biofeedback
- ☐ Chiropractic
- ☐ Chiropractic Adjustments
- ☐ Psychological Supports
- ☐ Braces / supports
- ☐ Back School Education
- ☐ Work Hardening
- ☐ Injections *(including tigger points, facet blocks, epidural steroids, stellate ganglion blocks, BIER blocks)*
- ☐ Acupuncture
- ☐ Medications *(including anti-inflammatories, muscle relaxants, pain medications)*
- ☐ Hospitalization
- ☐ Surgery

Which treatment(s) provide(s) the most relief? _____

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, provide consent for treatment and accept financial responsibility for services rendered by OCSF.

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.

Electronic Check Conversion: When you provide a check as payment, you authorize OCSF to use the information from your check to make a one-time 'electronic fund transfer' (EFT) from your account or to process the payment as a check transaction. Please note that when we use this information to process an EFT, funds may be withdrawn from your account as soon as the same day we received your payment.

Returned Check Fee: The return of a paper check/EFT issued to OCSF will result in a returned check fee determined at the time of processing. The fee will be assessed on the account of the patient who the check was presented for, no matter the reason. Each patient account will ONLY be allowed two returned checks/EFTs, after which payment by check/EFT will no longer be accepted. Written notification on how to resolve the returned check/EFT will be sent to the maker of the check/EFT and to the person whose account was affected. Additionally, a hold will be placed on the patient account until the returned check/EFT has been resolved.

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 orthotic, 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 their policy 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. If patient is not insured by any insurance policy, he may qualify to pay Self Pay fees. However, at the time an attorney is hired, OCSF expects full charges to be paid from any Settlement and a Letter of Protection may be requested. If attorney fails to pay OCSF, patient will be responsible for the balance up to OCSF full charge(s).

LIABILITY ACCIDENT PATIENTS:
If related to Slip & Fall accident, patient's health insurance shall be filed and patient is responsible for co-pay, coinsurance and/or deductible at the time of service. If patient is not insured by any insurance policy, he may qualify to pay Self Pay fees. However, at the time an attorney is hired, OCSF expects full charges to be paid from any Settlement and a Letter of Protection may be requested. If attorney fails to pay OCSF, patient will be responsible for the balance up to OCSF full charge(s).

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. OCSF 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 10th 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
Outpatient Surgical Services
ParkCreek Surgery Center
The Surgery Center of Ft Lauderdale
Weston Outpatient Surgery Center

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 held responsible for any referral of a non-participating facility.

ASSIGNMENT OF BENEFITS:
The undersigned patient assigns the insurance benefits to OCSF 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 OCSF directly for services rendered. In the event health insurance pays the patient directly, the patient agrees to endorse and turn payment over to OCSF immediately.

RELEASE OF INFORMATION: The undersigned patient authorizes OCSF 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.

CONSENT TO TREAT:
I accept treatment from any physician(s) at OCSF and/or any provider on staff. If patient is under 18, I hereby give my permission and consent for patient to be treated by a physician part of OCSF.

FINANCIAL RESPONSIBILITY:
I certify that I have read, understand and agree to the terms and conditions indicated on this form, and I further agree to accept financial responsibility for services and/or items rendered or dispensed by OCSF.

_____
Patient's Name

_____ _____
Patient's Signature (if minor, Parent or Guardian) Date