Orthopaedic Center of South Florida
954-473-6344

WORKERS' COMPENSATION PATIENT INFORMATION

PHYSICIAN ____________________

NAME ______________________________ DATE ________________
FIRST MIDDLE LAST

ADDRESS ______________________ CITY _________ STATE___ ZIP _____

PHONE ________________ AGE _________ DATE OF BIRTH ____/____/____

SOCIAL SECURITY # _____-_____-_____ DRIVERS LICENSE # ____________

YOUR OCCUPATION ____

MALE ______ FEMALE _______ MARITAL STATUS: S M W D

HOW DID THE ACCIDENT HAPPEN? ______________________________

____

EMPLOYER ____

EMPLOYER ADDRESS ____

EMPLOYER PHONE NUMBER ___________________________________

ATTORNEY INFORMATION

ATTORNEY NAME ____

ATTORNEY ADDRESS ____

ATTORNEY PHONE ____

PAIN MANAGEMENT INTAKE SHEET

Patient Name: ______________________________ **Chart #:** ____________

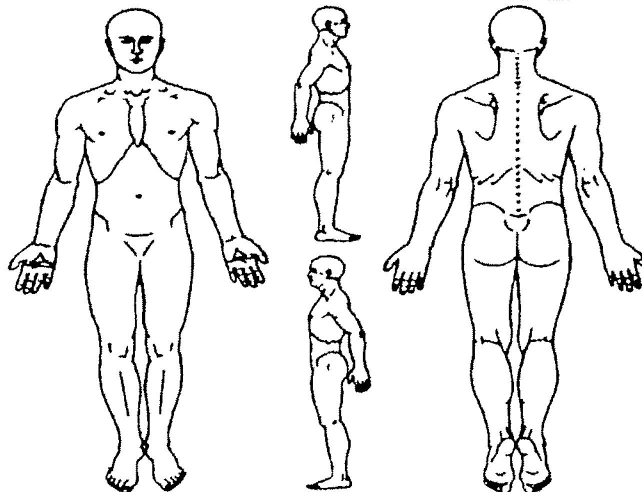
Date of Birth: ______________________________ **Date:** ____________

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



RT LT LT RT

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 that 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?

Yes	No		Yes	No	
☐	☐	Heart Disease	☐	☐	**Bleeding Disorders/Clotting Problems**
☐	☐	High Blood Pressure	☐	☐	High Cholesterol
☐	☐	Diabetes	☐	☐	Urinary Disorders
☐	☐	Thyroid	☐	☐	Arthritis
☐	☐	Stomach Ulcer	☐	☐	Epilepsy
☐	☐	Cancer	☐	☐	Lung/Breathing Problems
☐	☐	Rashes/non-healing lesion	☐	☐	Could you possibly be pregnant?

☐ 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	☐	☐
	Fever/Night sweats	☐	☐
Eyes	Change in vision	☐	☐
ENT	Loss of hearing	☐	☐
	Difficulty Swallowing	☐	☐
	Hoarseness	☐	☐
Cardiovascular	Swelling of legs/ankles	☐	☐
	Calf cramps while walking	☐	☐
Respiratory	Shortness of breath	☐	☐
Gastrointestinal	Nausea/Vomiting	☐	☐
Musculoskeletal		☐	☐
Integumentary	Skin rash	☐	☐
Heme/Lymphatic	Enlarged lymph nodes	☐	☐
Neurological	Numbness of arms/legs	☐	☐
	Bladder/Bowel Incontinence	☐	☐

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 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
- 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