

Patient Information



Account #: _____

Today's Date: _____ Primary Care Physician _____ PCP Fax: _____
Patient's Name: _____
(Last) (First) (Middle Initial)
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ email Address: _____
Primary Language Spoken: _____

Age: _____ Date of Birth: _____ Social Security Number: _____
Sex: Male Female Height: _____ Weight: _____ Marital Status: Single Married Other: _____
In Case of Emergency Notify: _____ Relationship: _____
Phone: _____ Cell Phone: _____

Current Employer: _____
Employer's Address: _____
Phone: _____

Area to be treated: _____
Onset of Problem: _____
Detailed description of problem: _____

Condition related to employment: Yes No If yes, please complete the following information:
Date of Injury: _____ Employer at time of injury: _____
Address: _____ Phone: _____

Condition related to automobile accident: Yes No If yes, please complete the following information:
Date of Injury: _____ Insurance Name: _____
Claim #: _____ Address: _____
Policy #: _____
Phone: _____ Adjuster Name: _____

Are you being represented by an Attorney: Yes No If yes, please complete the following information:
Attorney's Name: _____ Phone: _____
Address: _____



Medical History Questionnaire

Please check: Initial Appointment Follow-up Visit

Patient Name: _____

Date: _____

Family Physician: _____

Account#: _____

<p>Allergies</p> <p><input type="checkbox"/> No Change since last visit. <input type="checkbox"/> New info</p> <p>Please list any medication allergies</p> <hr/> <hr/> <hr/> <hr/> <p>Medications</p> <p><input type="checkbox"/> No Change since last visit. <input type="checkbox"/> New info</p> <p>Please list all medications you are taking</p> <p><input type="checkbox"/> Attach List</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <p>Is it possible you may be pregnant?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Are you <input type="checkbox"/> Right Handed? or <input type="checkbox"/> Left Handed?</p> <p>Social History</p> <p><input type="checkbox"/> No Change since last visit. <input type="checkbox"/> New info</p> <p>Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many per day? _____</p> <p>Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many per week? _____</p> <p>Surgical History <input type="checkbox"/> No change since last visit <input type="checkbox"/> New Info</p> <p>Please list any surgeries you have had.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:80%;">Procedure</th> <th style="width:20%;">Year</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Procedure	Year											<p>Medical History</p> <p><input type="checkbox"/> No Change since last visit. <input type="checkbox"/> New Info</p> <p>Have you had any of the following</p> <p>Depression/Anxiety <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Thyroid Disease <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>High Cholesterol <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>High Blood Pressure <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Lung Disease <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Heart Attack <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Rheumatic Fever <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Stroke <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Seizures/Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Asthma <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Emphysema <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Bronchitis <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Liver Disease <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Pancreatitis <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Gout <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Osteoporosis <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Joint Replacement <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>HIV Infection/AIDS <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Hepatitis <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Thrombosis <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Kidney Disease <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Cortisone treatment <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Pace maker <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Others (list):</p> <hr/> <hr/> <hr/> <hr/> <hr/>	<p>Review of Systems</p> <p><input type="checkbox"/> No change since last visit <input type="checkbox"/> New Info</p> <p style="text-align: center;">Do you have any of these symptoms?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;"></th> 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Patient/Guarantor : _____

Date: _____

Physician Signature: _____

Date: _____

Insurance Information



Today's Date: ____/____/____

Patient's Name: _____
(Last) (First) (Middle Initial)

Primary Insurance: _____

Policy Holder Name: _____

Relationship to Patient: _____ Policy Holder's Employer: _____

Social Security #: _____ - _____ - _____ Date of Birth: : ____/____/____

Policy # or Identification #: _____ Group #: _____

Insurance Address: _____

_____ Phone: _____

Secondary Insurance: _____

Policy Holder Name: _____

Relationship to Patient: _____ Policy Holder's Employer: _____

Social Security #: _____ - _____ - _____ Date of Birth: : ____/____/____

Policy # or Identification #: _____ Group #: _____

Insurance Address: _____

_____ Phone: _____

I authorize The Center for Bone & Joint Surgery to release any information acquired in the course of my examination or treatment to my insurance company. I hereby authorize payment directly to The Center for Bone & Joint Surgery of the medical benefits, if any, otherwise payable to me for this service, not to exceed the usual and customary fees. I recognize and accept responsibility for any balance or fee not covered. All information is complete to the best of my knowledge.

Signature: _____ Date: ____/____/____

For Office Purposes Only. Please Do Not Write Below This Line

Send claims to: _____

Address: _____

Claim #: _____

Adjuster's Name: _____

Phone: _____ Fax: _____

Nurse Case Manager's Name: _____

Phone: _____ Fax: _____

Privacy Release, Medical Release, Financial Authorization



PATIENT CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

A. I understand that as part of my health care, The Center for Bone and Joint Surgery of the Palm Beaches originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- o A basis for planning my care treatment
- o A means of communication among the many health professionals who contribute to my care
- o A source of information for applying my diagnosis and surgical information to my bill
- o A means by which a third party payer can verify that services billed were actually provided
- o A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

B. I understand and have been provided with a NOTICE OF PRIVACY POLICIES that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- o The right to review the notice prior to signing this consent
- o The right to object to the use of my health information for directory purposes
- o The right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment or healthcare operations

C. I understand that The Center for Bone and Joint Surgery of the Palm Beaches is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal regulations.

D. I further understand that The Center for Bone and Joint Surgery of the Palm Beaches reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of federal regulations. Should The Center for Bone and Joint Surgery of the Palm Beaches change their notice, they will send a copy of any revised notice to the address I've provided (whether US postal mail or email).

E. I wish to have the following restrictions to the use or disclosure of my health information:

F. I understand that as part of this organizations treatment, payment or healthcare operations, it may become necessary to disclosure my protected health information to another entity

and I consent to such disclosure for the above permitted uses, including disclosures via facsimile.

G. I understand that The Center for Bone and Joint Surgery of the Palm Beaches may charge me or the interested third party a fee for the copies as set forth on the fee schedule at Medical Records Department from The Center for Bone and Joint Surgery of the Palm Beaches. I also understand that I may be required to pay the fee in full before I can obtain the copy.

HOW TO REVOKE YOUR AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective The Center for Bone and Joint Surgery of the Palm Beaches must receive the revocation in writing. The letter should be mailed to the following address via Certified US Mail:

10131 W. Forest Hill Blvd. Ste. 230,
Wellington, FL 33414

The revocation letter must include:

- o The patient's name, address, and telephone number
- o The effective date of this authorization and the recipients of the protected health information
- o The patients desire to revoke this authorization, date of the revocation and patients signature

All revocations must be sent to the attention of the Privacy Officer. This authorization shall expire five (5) days after received by the Privacy Officer. After this date, The Center for Bone and Joint Surgery of the Palm Beaches can no longer use or disclose the patients protected health information without first obtaining a new authorization form.

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Notice of Privacy Policies for The Center for Bone and Joint Surgery of the Palm Beaches.
Privacy Notice effective April 14, 2003.

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

A. Known by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint The Center for Bone and Joint Surgery of the Palm Beaches and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said The Center for Bone and Joint Surgery of the Palm Beaches which checks, drafts or money orders are made payable for services which have been made by The Center for Bone and Joint

Surgery of the Palm Beaches at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

B. Furthermore, the undersigned allows The Center for Bone and Joint Surgery of the Palm Beaches or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

C. The undersigned by these presents does give and grant the said The Center for Bone and Joint Surgery of the Palm Beaches as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other documents.

MEDICAL RELEASE

A. A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me to release true copies of same to The Center for Bone and Joint Surgery of the Palm Beaches or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

B. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney do or cause to be done by virtue of these present.

C. I hereby authorize my insurance carrier (s) to pay directly to:

The Center for Bone and Joint Surgery of
the Palm Beaches
10131 W. Forest Hill Blvd. Ste. 230,
Wellington, FL 33414

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services, I hereby IRREVOCABLY ASSIGN to The Center for Bone and Joint Surgery of the Palm Beaches any rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by The Center for Bone and Joint Surgery of the Palm Beaches.

I fully understand and accept the terms of this authorization. IN WITNESS WHEREOF the undersigned have hereunto set their hands:

Patient or Guardian Signature

date



Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand that *The Center for Bone and Joint Surgery of the Palm Beaches* is authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner of *The Center for Bone and Joint Surgery of the Palm Beaches* or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this information, it may be subject re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (Please check all that apply):

The Patient's Entire Medical Record:

NOTE: This requires an explanation why the entire medical record may be disclosed.

The Patient's Demographic Information:

Name Address Telephone Date of Birth

Medical Data:

Appointment(s) Date and Time Medication(s) Lab and Test Results

Attorney authorized by this form that may use and disclose the patient's protected health information:

Attorney's Name: _____

Attorney's Address: _____

Attorney's Telephone: (____) _____ - _____ Attorney's Fax Number: (____) _____ - _____

Other Recipient: _____

Name(s) or class of person(s) authorized by this form to which the patient's protected health information will be disclosed:

Check only if applicable. This authorization permits *The Center for Bone and Joint Surgery of the Palm Beaches* to send the protected health information ONLY to this address and/or fax number:

***The Center for Bone and Joint Surgery of the Palm Beaches* shall send information ONLY as authorized above. Any disclosure of the patient's protected health information to another information not mentioned will require a separate authorization.**

Signature of Patient

Date



Financial Agreement

I. In consideration of the services to be rendered to me, I **HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF THE CENTER FOR BONE AND JOINT SURGERY OF THE PALM BEACHES IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF THE CENTER FOR BONE AND JOINT SURGERY OF THE PALM BEACHES.** Should the account be referred to an attorney or licensed collections agency for collections, I shall pay reasonable attorney's fees and collections expenses. All delinquent accounts (those not paid within sixty (60) days from the date of service) shall bear interest at the legal rate.

II. I hereby authorize direct payment to *The Center for Bone and Joint Surgery of the Palm Beaches* of any insurance benefits otherwise payable to me for the services rendered at a rate not to exceed *The Center for Bone and Joint Surgery of the Palm Beaches* regular charges. It is agreed that payment to *The Center for Bone and Joint Surgery of the Palm Beaches*, pursuant of this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this agreement.

I understand that *The Center for Bone and Joint Surgery of the Palm Beaches* shall have the right at any time to reuse to provide medical care or treatment to me. I certify that I am a patient or am dully authorized by the patient as the patient's general agent to execute this document and accept its terms.

III. I understand that, as a courtesy, *The Center for Bone and Joint Surgery of the Palm Beaches* will file my primary insurance. If after sixty (60) days from the date of service and/or surgery insurance has not paid, the total balance will be considered due and payable.

THIS REFERS TO MEDICARE PATIENTS ONLY:

IV. Regarding **MEDICARE ASSIGNMENT**: This means *The Center for Bone and Joint Surgery of the Palm Beaches* will accept payment in full for what MEDICARE allows not what MEDICARE pays. It is the patient's responsibility for the 20% of the MEDICARE allowable for which MEDICARE does not pay. I fully understand that I agree to be responsible for this 20%.

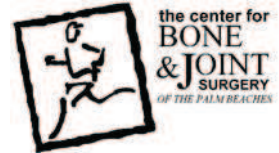
Lifetime Authorization

I certify that the information given by me in applying for payment under Title XVII 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 intermediaries or carriers any information needed for this or a related MEDICARE claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to MEDICARE for payment to me.

Signature of Patient

Date

FOR USE ON LEGAL CASES ONLY



Medical Reports and Doctor's Lien

Patients Name: _____ SSN: _____

Acct. No. _____ D/A: _____

Dear _____:

I do hereby authorize *The Center for Bone and Joint Surgery of the Palm Beaches ("CBJ")* to furnish you, my attorney, with copies of all medical records relating to treatment received by me from doctors, physician assistants, nurses or any other clinical member employed by "CBJ" in regard to the accident in which I was involved.

I further authorize and direct you, my attorney, to pay directly to "CBJ" such sums as may be due and owing for medical services rendered to me both by reason of this accident and by reason of any other bills, including interest on the unpaid balances of my account, that are due "CBJ" and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect "CBJ". In addition, I hereby give a lien on my case to "CBJ" against all proceeds from any settlement, judgment or verdict which may be paid to my attorney and/or I as a result of the injuries and damages claimed in connection with my case. Expect that, as the sole and only exception to a lien on the proceeds of my case are the fees and costs due my attorney as a result of any settlement, judgment or verdict obtained by my attorney.

I fully understand that I am directly responsible to "CBJ" for all medical bills submitted for services rendered to me and that this agreement is made solely for "CBJ" additional protection and in consideration of "CBJ" awaiting payments on its medical bills until a settlement, judgment, verdict or a dismissal of my case is obtained. I further understand that such payment is not contingent on any settlement, judgment or verdict from which I may eventually recover funds to pay "CBJ" bills for services rendered to me. Furthermore, I hereby agree and consent to "CBJ" entitlement to intervene in any action, suit or claim which may be filed by me or my attorney for this injuries treated by "CBJ". In addition, I hereby acknowledge that the covenants and agreements made herein do not pertain to any health or managed care contracts between my health care insurer and "CBJ" to which I may be a direct or third party beneficiary.

In the event suit is initiated for collection of medical bills due to "CBJ" in accordance with this agreement, I agree to pay, in addition to the medical bills, all expenses necessitated by the collection of said medical bills including but not limited to reasonable attorney's fees and costs incurred by "CBJ".

Signature of Patient: _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from my settlement, judgment or verdict, excluding attorney's fees and cost due me, as may be necessary to adequately protect "CBJ" as above stated.

Signature of Attorney: _____ Date: _____

Please return copy to "CBJ". Keep one copy for your records.

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

Any alterations to this document will be deemed as null and invalid