

Florida Orthopaedic Specialists

9077 S. Federal Highway
 Port Saint Lucie, Florida 34952
 Phone: 772.335.4770 • Fax: 772.335.4133

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Please Print		Present your Photo ID and Insurance card(s) to the receptionist						
Today's Date:				Account Number (office use only):				
PATIENT INFORMATION								
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status: (circle one) Single / Mar / Div / Sep Widow / Life Partner		
Place of Birth:	Race:	Social Security #:		Birth Date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Street Address:					Home Phone Number: ()			
City:		State:	Zip Code:	Cell Phone Number: ()				
Alternate Address:								
Employer:			Occupation:		Employer Phone Number: ()			
Referred by (please check box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital		
<input type="checkbox"/> Urgent Care Center	<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Website	<input type="checkbox"/> Other			
Friend/Family members seen here:					Email Address:			
Name of Parent completing paperwork (Minors Only):								
Parent DOB:		Parent Soc. Sec. #:						
INSURANCE INFORMATION								
<input type="checkbox"/> Please check here if the patient is the primary insurance carrier								
Policy holders name:		Birth date:	Address (if different):			Home phone number: ()		
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No				Social Security number:		
Employer:	Occupation:		Employer address:			Employer phone number: ()		
Accident Date: / /								
Is your injury work or auto related? <input type="checkbox"/> Yes <input type="checkbox"/> No				Do you have an attorney for this issue? <input type="checkbox"/> Yes <input type="checkbox"/> No				
How did your injury occur? _____								
Name of primary insurance: _____								
Name of secondary insurance (if applicable): _____								
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
IN CASE OF EMERGENCY								
Name of relative or friend :			Relationship to patient:		Home phone number: ()		Alt phone number: ()	

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FINANCIAL AGREEMENT:

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize release of information necessary to file a claim with my insurance company, and I assign benefits, otherwise payable to me, to the doctor or group indicated on the claim. I understand that I am financially responsible for any balance not covered by insurance. A copy of my signature is as valid as the original.

GUARANTEE OF ACCOUNT:

This is to certify that I, the undersigned, promise to be responsible for the payment of all charges for services rendered to the named patient. I further understand that all applicable charges are due at the time services rendered *excluding charges that my insurance company is contractually responsible for payment*. If this account should require collection procedures, I, the undersigned, will be responsible for any charges associated with the collection process, including reasonable attorney's fees.

Note to Medicaid patients: Florida Orthopaedic Specialists nor its physicians participate in the Medicaid program. If you are insured through the traditional Medicaid program or Medipass, the person who signs below will be responsible for all charges for services rendered. The undersigned will incur a financial obligation.

Your signature below also represents authorization for treatment of the patients receiving services.

_____	_____	_____
Patient Name (PLEASE PRINT)	Date	Patient Signature
_____		_____
Parent/Guardian (If Minor)		Witness

MEDICARE LIFETIME AUTHORIZATION:

I hereby authorize release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits to the party who accepts assignment.

_____	_____	_____
Patient Name (PLEASE PRINT)	Date	Patient Signature
_____		_____
Parent/Guardian (If Minor)		Witness

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We, at Florida Orthopaedic Specialists, understand that medical information about you and your health is personal. As the custodians of your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures. Please understand that this is not our Notice of Privacy Practices, nor is it a substitute. The actual notice is available to you, as required by law. If you wish to keep a copy of our Privacy Practices, the receptionist will be happy to provide you with it. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient Name (PLEASE PRINT) Date Patient Signature

OPTIONAL:

I hereby authorize Florida Orthopaedic Specialists to disclose my protected health information to the following:
(For example: Family member, Primary Care Physician, Organization)

Name (PLEASE PRINT) Relationship

Name (PLEASE PRINT) Relationship

Name (PLEASE PRINT) Relationship

Check the box if you decline to release your protected health information to anyone. Please note that this includes the release of prescriptions, forms, etc. We will not release anything without their name listed above.

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OFFICE POLICIES:

CO-PAYMENTS AND BALANCES:

Co-payments are due at the time of check in, unless prior arrangements have been made with our Billing Department. This arrangement is part of your contract with your insurance company. Please note that our physicians are specialists and higher co-pays may apply. If you cannot pay your co-payment, you may have to reschedule your appointment. Unpaid deductibles, co-insurance percentages, non-covered services and/or other outstanding balances are due upon check-out.

SELF PAY PATIENTS:

A deposit of \$350 is due at the time of check in, unless prior arrangements have been made with our Billing Department. Payment must be in the form of cash, Visa, MasterCard, Discover or money order. Personal checks are not accepted. All balances will be collected at time of check-out. If applicable, same-day refunds will be made if initial deposit is made with cash. All other refunds will be processed at the end of the month, with checks issued to Guarantor of Account.

FORM FEES:

If you require a particular form (ex: FMLA, Disability, AFLAC) to be completed by our physicians, there is a fee of \$25 per form. This fee is to be paid prior to completion. Please allow adequate time, as every physician may not be in the office on a daily basis.

MEDICAL RECORD REQUESTS:

If copies of medical records are needed there will be a fee of \$1.00/page for the first 25 pages, then it is \$0.25/page from page 26 forward. If you need x-ray film copies for any reason, there is charge of \$10/sheet. We are now able to provide our patients with copies of MRI's in the form of a disc at \$10/CD (pick-up only). If you require they be mailed, there is an additional \$3 postage fee. If you still need actual MRI film copies, they are available for \$10/sheet. Please allow 48-72 hours for copies of records/films/CDs. Please be advised the original films must remain in our possession, as required by law, as they are a part of your permanent medical record.

PRESCRIPTION REFILL REQUESTS:

Prescription refill requests must be made Monday through Friday, 9:00 a.m. – 4:00 p.m. Please note that requests made after 4 p.m. will not be processed until the following business day. Please allow 48-72 hours to process your refill request, as every physician may not be in the office on a daily basis.

Patient Name (PLEASE PRINT)

Date

Patient Signature

HEALTH HISTORY QUESTIONNAIRE

Patient Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Age:
Referred By:	Office use only:	
Primary Care Physician:		
Preferred Pharmacy & Location:		

Reason for visit: _____

Indicate on the drawing below where your problem is and how it feels

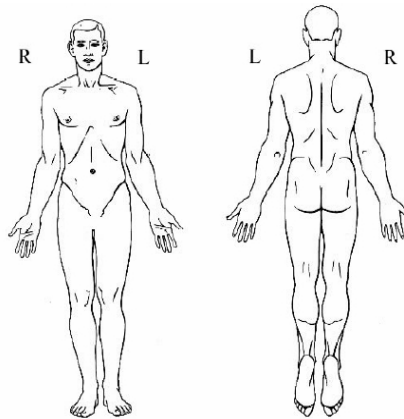
Aching: $\Delta\Delta\Delta$

Burning: XXX

Numbness: ===

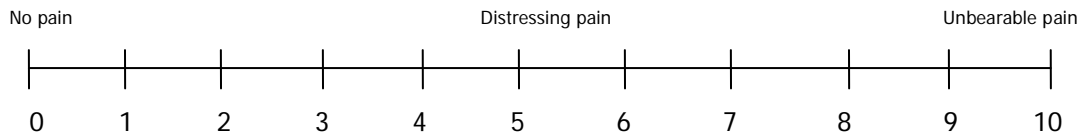
Pins & Needles: 000

Stabbing: ///



How long have you had this problem? _____ Weeks _____ Months _____ Years

Circle a number from 0 to 10 that best describes your pain level:



What increases your pain? _____

What relieves your pain? _____

Accident Date: ____/____/____

Is your injury work or auto related?

Yes

No

Do you have an attorney for this issue?

Yes

No

List previous treatments or surgeries for your current problem and indicate results with an X:

Treatment or Surgery	Improved	Worsened	Unchanged

HEALTH HISTORY QUESTIONNAIRE

PATIENT PAST MEDICAL HISTORY			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Neck/Back Disorder	<input type="checkbox"/> TB/Other
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Other: (list below)
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Phlebitis	<input type="checkbox"/>
<input type="checkbox"/> Bursitis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Pneumonia	<input type="checkbox"/>
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/>
<input type="checkbox"/> COPD	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/>

Explanation of above or similar conditions: _____

Family member with similar health problems: _____

I have NONE of the above listed conditions (check if applicable)

REVIEW OF SYSTEMS			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cold/heat intolerance	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Joint swelling
<input type="checkbox"/> Appetite increase or decrease	<input type="checkbox"/> Depression/sleep disturbance	<input type="checkbox"/> Fevers, chills, night sweats	<input type="checkbox"/> Loss of smell
<input type="checkbox"/> Bone, muscle or joint problems	<input type="checkbox"/> Diarrhea/constipation	<input type="checkbox"/> Hard of hearing	<input type="checkbox"/> Nausea/vomiting
<input type="checkbox"/> Breast Disease	<input type="checkbox"/> Difficult/frequent urination	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Nearsighted/farsighted
<input type="checkbox"/> Breathing difficulties, cough	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Hormonal Disorder	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Burn upon urination	<input type="checkbox"/> Dizziness/headaches/seizures	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Excessive bleeding/clot disorder	<input type="checkbox"/> Joint pain/stiffness	<input type="checkbox"/> Thyroid Disease

Explanation of above or similar conditions: _____

I have NONE of the above listed conditions (check if applicable)

Please list previous admissions into a hospital for illness or trauma.

When:	Where:	Why:

Please list previous major surgeries. Please include cosmetic surgeries.

When:	Where:	Why:	Surgeon:

