Date _____/_____/_____ 080326

Office use only: Account #_____

PATIENT INFORMATION

Last Name	First Name	Middle Name/Initial	Preferred Name	
				□ Mr □ Ms □ Mrs □ Dr □ Miss □ Other

Date of Birth	Gender	Social Security	Marital Status
_____ /_____ / _____	□ Male □ Female	_____ - _____ - _____ □ Decline to answer	□ Single □ Married □ Separated □ Divorced □ Widow/Widower □ Significant Other

Race	Ethnicity	Preferred Language
□ Black or African American □ Asian □ American Indian or Alaska Native □ White □ Native Hawaiian or Other Pacific Islander □ Other _____ □ Decline to answer	□ Hispanic or Latino □ Not Hispanic or Latino □ Other _____ □ Decline to answer	□ English □ Spanish □ Other _____

Mailing Address		
City	State	ZIP Code

Alternate Address		
City	State	ZIP Code

Home Phone [□ Primary]	Cell Phone [□ Primary]	Work Phone	Email Address

Employer	Occupation

Primary Care Physician	Referred By □ Physician □ Family □ Friend □ Website □ Insurance Plan □ Hospital □ Urgent Care Center □ Other _____

Emergency Contact Name	Relationship to Patient	Primary Phone Number

Is your visit due to an injury/accident? □ YES □ NO **Injury/accident date** _____ / _____ / _____

Is your visit work or auto related? □ YES □ NO **Do you have an attorney for this issue?** □ YES □ NO

Primary Insurance Plan Name _____	Secondary Insurance Plan Name _____
Policy Number_____	**Policy Number**_____
Policy Holder Name_____ **D/O/B**___/___/___	**Policy Holder Name**_____ **D/O/B**___/___/___
Relationship to Insured □ Self □ Parent □ Spouse □ Other	**Relationship to Insured** □ Self □ Parent □ Spouse □ Other

Electronic Communications Consent (Standard Messaging and Data Rates May Apply)

By providing my email address and mobile number above, I authorize Florida Orthopaedic Specialists to send me healthcare communications via email and one-way SMS/text messaging. I understand these communications may include appointment reminders, scheduling updates, patient portal invitations, care instructions, billing notices, or other healthcare updates. I acknowledge standard email and SMS/text messaging are unencrypted and may not be fully secure methods of communication. I understand that consent is not a condition of receiving treatment, and I may opt out of receiving these communications at any time by calling Florida Orthopaedic Specialists directly at (772) 335-4770.

Patient Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Printed Name _____ Relationship _____

Date _____/_____/_____ 080326

Office use only: Account #_____

Patient Name _____

FINANCIAL AGREEMENT / OFFICE POLICIES

Please review your insurance information to stay informed about referrals, deductibles, and copayments, which may be due on the day of your visit.

COPAYMENTS AND BALANCES

Copayments are due at time of check in unless prior arrangements have been made with our Billing Department. Unpaid deductibles, coinsurance, non-covered services, and/or outstanding balances are due at time of check out.

UNINSURED PATIENTS

Payment, based on the services chosen, is due prior to or at time of check in unless prior arrangements have been made with our Billing Department. Payment can be made via our website www.floridaorthopaedicspecialists.com (self-pay pricing) or at reception in the form of cash, Visa, MasterCard, Discover, American Express, or money order. Personal checks are generally not accepted. Payment for services not included in self-pay pricing, such as injectable medications or DME, will be due at time of check out.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits, otherwise payable to me, to the doctor or group indicated on the claim. I understand and agree that I am financially responsible for all charges not covered by my insurance company, including but not limited to deductibles, co-payments, co-insurance, and non-covered services. A copy of my signature is as valid as the original.

GUARANTEE OF ACCOUNT

I, the undersigned, guarantee payment of all charges for services rendered to the named patient. I further understand all applicable charges are due at time of service, excluding charges my insurance company is contractually responsible for. I understand patient accounts not paid promptly are subject to third-party collection and/or legal procedures. If this account should require collection and/or legal procedures, I agree to be responsible for charges associated with the collection process, including reasonable attorneys' fees. My signature will remain valid for the entirety of my care with Florida Orthopaedic Specialists unless I provide a written request to revoke the authorization.

We understand emergencies do arise. If you anticipate a delay in your payment, please contact our Billing Department for assistance.

OUT OF NETWORK

- **Commercial Plans:** Out-of-network care requires payment in full at the time of service. As a courtesy, we will submit a claim if you have out-of-network benefits, but you are responsible for any unpaid balance. S*ubject to federal No Surprises Act consumer protections.*
- **Medicare Advantage:** We are out-of-network with Medicare Advantage. Per CMS guidelines, we do not balance bill. You are only responsible for your plan's designated out-of-network deductible, copayment, or coinsurance.
- **Medicaid:** We do not participate in Florida Medicaid or Medicaid Managed Care. By signing, you choose to pay out-of-pocket instead of using a Medicaid provider. A separate Medicaid Private-Pay Waiver must be signed prior to care.

FORM FEES

If you require a form to be completed by one of our physicians (ex: FMLA, Disability, AFLAC), there is a fee of $50 per form. This fee is to be paid prior to completion. Please allow adequate time, as physicians' office schedules vary.

NO SHOW POLICY

Appointments missed or canceled with less than 24 hours' notice will incur a fee: $50.00 for office visits, and $250.00 for in-office procedures. These fees are your responsibility as insurance does not cover them. We will review emergencies on a case-by-case basis; please contact us as soon as possible.

MEDICAL RECORD REQUESTS

Please allow 48-72 hours for copies of requested medical records/images. Paper reproduction fees are $1.00 per page for the first 25 pages, $0.25 per page for pages 26+. Electronic records sent digitally are charged a flat, reasonable cost-based fee in compliance with HIPAA. Images provided on compact disc (CD) are $20.00, plus $3.00 if mailed.

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. may not be reviewed until the following business day. Please allow 48-72 hours to process your refill request as physicians' office schedules vary.

RETURNED CHECK FEE

I understand that any returned check will result in a service charge added to my account up to the maximum amounts permitted by Florida law.

Patient Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Printed Name _____ Relationship _____

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 Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Printed Name _____ Relationship _____

Date _____/_____/_____ 080326

Office use only: Account #_____

Notice of Privacy Practices Acknowledgement &
Authorization for Release of Information

1. Notice of Privacy Practices Acknowledgement

I acknowledge receipt of Florida Orthopaedic Specialists' *Notice of Privacy Practices*. I understand this notice explains how my protected health information may be used and disclosed, and I understand my rights regarding my health information.

Patient Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Printed Name _____ Relationship _____

2. Authorization for Release of Information

I authorize Florida Orthopaedic Specialists to leave voicemail messages regarding my private medical information at the phone number listed below:

Phone Number _____ □ Home □ Cell □ Other _____

I authorize Florida Orthopaedic Specialists to disclose my protected health information to the following individual(s) for communication regarding my care or billing:

Name	Relationship	Phone Number

I understand I have the right to revoke this authorization in writing at any time. I further understand revocation does not affect information already released.

Patient Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Printed Name _____ Relationship _____

Date _____/_____/_____ 080326

Office use only: Account #_____

HEALTH HISTORY QUESTIONNAIRE

Patient Name:	Age:	Sex: ☐ M ☐ F
Primary Care Physician:	Local Pharmacy & Location:	

Reason for visit: _____

Is your injury the result of an auto or work comp accident? ☐ Yes ☐ No

If yes, please explain: _____

(Type, date of accident, where it occurred, briefly explain how the injury happened)

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

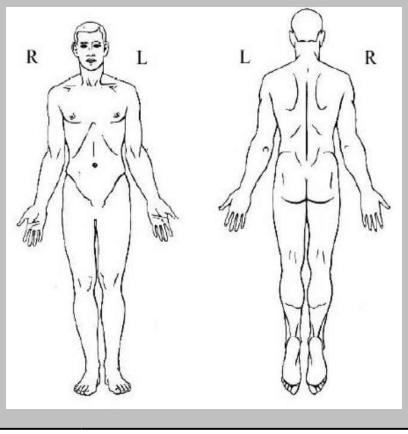
Aching: ΛΛΛ

Burning: XXX

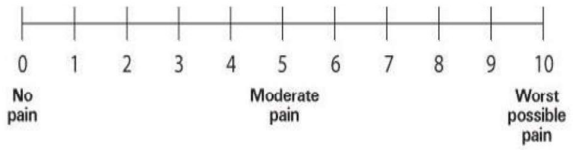
Numbness: = = =

Pins & Needles: 000

Stabbing: ///



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



How long have you had this problem?

_____ Days _____ Weeks

_____ Months _____ Years

Are you currently or have you recently seen a Pain Management Physician? If so, who? _____

What increases your pain? _____

What relieves your pain? _____

Have you received treatment or been to the ER or Urgent Care for this issue? Where/When? _____

What treatments did you receive (injections, medications, etc.)? _____

Did they conduct Imaging (X-ray, MRI, CT, etc.)? _____

Have you previously completed physical therapy for this concern? _____

SURGICAL HISTORY List previous treatments, orthopedic surgeries, and emergency hospitalizations in the last year. (Include orthopedic surgeries i.e. hip, knee, shoulder, etc.)			
When:	What body part:	Why:	Surgeon/Facility Name:

PATIENT MEDICAL HISTORY Check all that apply:			
□ **NONE APPLY**	□ Coronary Artery Disease	□ Kidney Disease	□ Alzheimer's/Dementia
□ Asthma	□ Diabetes I, II	□ Epilepsy/Seizures	□ Stroke/TIA
□ Anxiety	□ Heart Disease	□ Peripheral Artery Disease	□ Coronary Artery Bypass Grafting
□ Auto Implantable Cardo-Defib □ Pacemaker	□ Hepatitis	□ Sleep Disorders	□ Bleeding Disorder
□ Atrial Fibrillation	□ High Blood Pressure	□ Chronic Pain	□ Cancer, Specify Below:
□ Congestive Heart Failure	□ High Cholesterol	□ Phlebitis	□ Chronic Anticoagulation/Blood Thinners
□ COPD	□ HIV/AIDS	□ Thyroid Disease	□ Arthritis/Rheumatoid Arthritis
□ Tuberculosis	□ **Other**	□ **Other**	□ **Other**

FAMILY MEDICAL HISTORY: Have any direct relatives had any of the following? If yes, please specify. (Mother, Father, Sister, Brother, Maternal Grandmother/Grandfather, Paternal Grandmother/Grandfather, Aunt or Uncle)		
□ NO KNOWN FAMILY HISTORY	□ Cancer _____	□ High Blood Pressure _____
□ Arthritis _____	□ Diabetes_____	□ Stroke _____
□ Blood Disorder _____	□ Heart Attack _____	□ Other _____

SOCIAL HISTORY

Alcohol Use: □ None □ Socially □ Frequently □ Daily Drinks/wk._____ Type: _____	Work Status: □ Working □ Not Working □ Disabled □ Retired □ Student	Current/most recent occupation:
Do you use any tobacco products? □ Never Type of tobacco: _____ □ Former Amount used: _____ □ Current some days Age started: _____ □ Current every day Age stopped: _____ Do you currently use any other nicotine products? _____ Are you currently using any illicit/recreational drugs? Yes No If so, which and how often: _____		Highest Level of Completed Education □ Some High School □ High School Graduate □ Some College □ College Graduate □ Master's Degree □ Doctoral Degree
□ Right handed □ Left handed	Number of children: _____	Height: _____ Weight: _____ Blood Pressure: _____ (staff only)
List any hobbies that may be affected by your current injury or problem: _____ Rate your current health: □ Poor □ Fair □ Good □ Very Good □ Excellent		

ALLERGIES/ADVERSE REACTIONS TO MEDICATION

Name of Medication	Reaction

☐ I have no known allergies or adverse reactions to any medications.

☐ I have a LATEX allergy.

CURRENT MEDICATIONS (Include OTC supplements and vitamins)			
Name of Drug	Dosage (mg, mcg)	Frequency	Date Started

☐ I am **NOT** currently taking any medications, supplements, or vitamins.

14 POINT REVIEW OF SYSTEMS **Check all that apply:**			
☐ NONE APPLY	General Constitutional ☐ Fever ☐ Chills ☐ Night Sweats	Eyes, Vision ☐ Visual Changes ☐ Double Vision	Ears, Nose, Throat ☐ Hearing Loss ☐ Difficulty Swallowing
Allergic/Immunologic ☐ Allergic Reactions ☐ Recurrent Infections	Respiratory ☐ Cough ☐ Shortness of breath	Hematologic/Lymphatic ☐ Abnormal Bleeding ☐ Bruise Easily	Psychiatric ☐ Anxiety ☐ Depression
Musculoskeletal ☐ Joint Pain or Swelling ☐ Restricted Motion ☐ Musculoskeletal Pain	Skin, Integumentary ☐ Rashes ☐ Open Wounds ☐ Abnormal Moles	Heart, Cardiovascular ☐ Chest pain ☐ Irregular Heartbeat ☐ Palpitations	Genitourinary ☐ Frequent Urination ☐ Painful Urination ☐ Incomplete Urination
Endocrine ☐ Heat/Cold Intolerance ☐ Excessive Thirst ☐ Unexplained Weight Loss ☐ Unexplained Weight Gain	Gastrointestinal ☐ Abdominal Pain ☐ Heartburn ☐ Diarrhea ☐ Constipation ☐ Bloody Stool	Neurological ☐ Numbness or Tingling ☐ Sensation Loss ☐ Gait/Balance Problems ☐ Unexplained Weakness ☐ Headaches	☐ Other

Patient Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Signature _____ Date _____ / _____ / _____

Parent or Legal Guardian Printed Name _____ Relationship _____

Thank you for taking the time to fill out this questionnaire. The information you present is vital to providing you with optimal and efficient care. Please ask if you need assistance in filling out this form.

HIPAA Notice of Privacy Practices

Effective as of April 14, 2003 - Revised February 16, 2026

Florida Orthopaedic Specialists

9077 South US-1, Port St Lucie, FL 34952 ● 1151 SE Indian Street, Stuart, FL 34997

Phone: 772-335-4770 ● Fax: 772-335-4133

Email: Fosofficemanager@bellsouth.net

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out Treatment, Payment or Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Please review it carefully. By signing the Acknowledgement form you are only acknowledging that you received, or have been given the opportunity to receive, a copy of our Notice of Privacy Practices.

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also obtain your own copy by accessing our website at https://www.floridaorthopaedicspecialists.com/or calling the Privacy Officer at 772-398-7335.

Some examples of Protected Health Information include information about your past, present or future physical or mental health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information such as your name, address, social security number or phone number.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

Treatment: We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Healthcare Operations: We may use or disclose, as needed, your Protected Health Information in order to support the business activities of our practice, for example: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.

Appointment Reminders and Health-related Benefits and Services: We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for **fundraising activities**, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Friends and Family Involved in Your Care: If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

Business Associate: We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

Proof of Immunization: We may disclose proof of immunization to a school about a student or prospective student of the school, as required by State or other law. Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of your health information.

Emergencies or Public Need:

We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you.

We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Research: We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

SUD RECORDS DISCLOSUE AND PROTECTIONS

The confidentiality of your substance use disorder (SUD) treatment records maintained by this facility is protected by federal law and regulations (42 CFR Part 2 and the HIPAA Privacy Rule). Generally, we cannot disclose information that identifies you as a person with a substance use disorder to anyone outside the facility without your written consent. With your written consent, we may use and disclose your SUD information for treatment, payment, and health care operations. You may revoke your consent at any time in writing, except to the extent that we have already relied on it.

Use and Disclosure for Legal Proceedings: SUD treatment records from programs subject to 42 CFR Part 2 generally cannot be used or disclosed in legal proceedings against the patient unless there is specific written consent or a court order.

Redisclosure of SUD Records: If SUD records are disclosed with patient consent, the recipient can re-disclose them to contractors or legal representatives for specified TPO activities if a written agreement is in place that maintains confidentiality. Otherwise, redisclosure is prohibited.

SUD Counseling Notes: SUD counseling notes require a separate, specific consent for their use or disclosure and cannot be used or disclosed based on a general TPO consent.

Fundraising Communications: If SUD records are used or disclosed for fundraising, patients must be given a clear opportunity to opt out.

Exceptions: We may share information without your consent in a medical emergency, to report suspected child abuse as required by law, or to law enforcement if you commit a crime on our premises.

Stricter State Laws: If state law offers greater protection, the more stringent state law applies.

REQUIREMENT FOR WRITTEN AUTHORIZATION

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Most Uses of Psychotherapy Notes, when appropriate.

Marketing: We may not disclose any of your health information for marketing purposes if our practice will receive direct or indirect financial payment not reasonably related to our practice's cost of making the communication.

Sale of Protected Health Information: We will not sell your Protected Health Information to third parties.

You may revoke the written authorization, at any time, except when we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our practice. You may also initiate the transfer of your records to another person by completing a written authorization form.

PATIENT RIGHTS

Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of your health information, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the practice. We may charge a fee for the costs of copying, mailing or other supplies. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested. In some limited circumstances, we may deny the request. Under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information related to medical research where you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Right to Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

Right to an Accounting of Disclosures. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Right to Receive Notification of a Breach. You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

Right to Request Restrictions. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket.

Right to Request Confidential Communications. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

Right to Have Someone Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

Right to Obtain a Copy of Notices. If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

Right to File a Complaint. If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at 772.398-7335, or with the U.S. Department of Health and Human Services, Office of Civil Rights. You may email the OCR at OCRMail@hhs.gov or call the U.S. Department of Health and Human Services, Office for Civil Rights toll-free at: 1-800-368-1019, TDD: 1-800-537-7697. We will not withhold treatment or take action against you for filing a complaint.

Use and Disclosures Where Special Protections May Apply. Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.