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TAMPA BAY ORTHOPEDIC SURGERY GROUP

New Patient Intake Information

First Name: _____Last Name_____ Middle Initial_____

Address:_____City&State_____Zip_____

Home Phone_____ Cell Phone _____ Email_____

May we leave messages regarding your appointment or medical condition at the number listed above? □Yes □ No

DOB___/____/____ SSN#:_____/_____/_____ Marital Status: *Married / Single / Widow*

Do you have a DNR on file? Yes/ No -Do you have Advanced Directives in place? Yes / No If yes, may we have a copy? Yes/ No

Employer_____ Work#_____

Emergency Contact Name: _____Phone#_____

Health Insurance

Insurance Company: _____Subscriber ID#:_____Group#_____

Are you the primary insured on this policy? □*YES* □*NO* If No, Insured Name: _____Relation_____

Address if different then above_____City/St_____Zip_____Phone_____

Do you have secondary insurance? *YES / NO*

Pharmacy: _____

Auto Insurance

Date of accident ___/___/____ Insurance Company Name: _____Phone#_____

Policy Number: _____Claim Number: _____

Adjuster Name_____Phone#_____Fax#_____

If you do not have auto insurance, do you live with anyone who does? *YES / NO*

If yes, Name of Insured: _____Address:_____City/St_____Zip_____

Relation to insured _____Insurance Company: _____Policy Number: _____

Workers Compensation

WC Insurance Company: _____Date of injury___/___/____

Employer: _____Phone#_____Claim#_____

Nurse Case Manager: _____Phone#_____Fax#_____

Attorney Information

Do you have an attorney? *YES / NO*

If yes, Office Name_____ Attorney Name_____

Address_____Phone_____Fax_____

I authorize the release of a full report of examination of findings, diagnosis, treatment programs, etc., to any referring or treating physician or dentist. I additionally authorize the release of any medical information to the insurance companies for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of the insurance coverage. I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that ***Tampa Bay Orthopedic Surgery Group****. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to* ***Tampa Bay Orthopedic Surgery Group*** *will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will me immediately due and payable.*

Patient/ Guardian Signature_____Date_____

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Accident/Injury Description
When did the accident or injury occur? Date: _____
What type of accident or injury occurred? (Mark type)
□ *Motor Vehicle* Were you the: □ *Driver* □ *Front Seat Passenger* □ *Rear Seat Passenger* □ *Pedestrian*
□ *Work related* □*Motorcycle* □*Struck by vehicle* □*Slip and Fall* □*Sports/Recreation* □*Other*_____

Briefly describe the accident/injury in your own words:
_____
_____
_____

Seatbelt □ Yes □No Loss of consciousness □ Yes □No Vehicle totaled □ Yes □No
Did you go to the hospital/urgent care? □ Yes □No *If Yes, where?* _____
Have you had an □MRI □X-rays □CT □Other_____ If so where? _____
What treatments have you received for this condition?
□Physical therapy (how many weeks/months): _____
□Chiropractic care (how many weeks/months): _____
□Injections (trigger point, epidural, etc.): How many? _____ When was the last? _____

Are you taking any medications? □ Yes □No If Yes, please list:
_____
_____

Prior Injury History: *(explain):* _____
_____

Surgical History
Have you had any previous surgical operations including spine □Yes *If yes please list below* □No

Date	Physicians Name	Treatment Type

Family Health Information
Many health problems are the result of hereditary spinal weakness, thus information about your family member will give us a better picture of your total health picture. Please list any information you may know about your family members
Father: _____
Mother: _____

Allergies: _____

Social History
Are you pregnant? ☐YES ☐ NO ☐MAYBE If yes, how far along_____ Number of children_____
Smoke: □No, when did you quit smoking? _____ □ Yes; pack per day? _____Smoking time length (yrs): _____
Other (cigars, smokeless tobacco, etc.): _____
Alcohol per week: □None □less than 6 drinks □ 6-12 drinks □ 12-24>drinks
Do you us recreational drugs? □No □Yes If yes, type/how often_____
Occupation: _____

Patient/ Guardian Signature_____Date_____

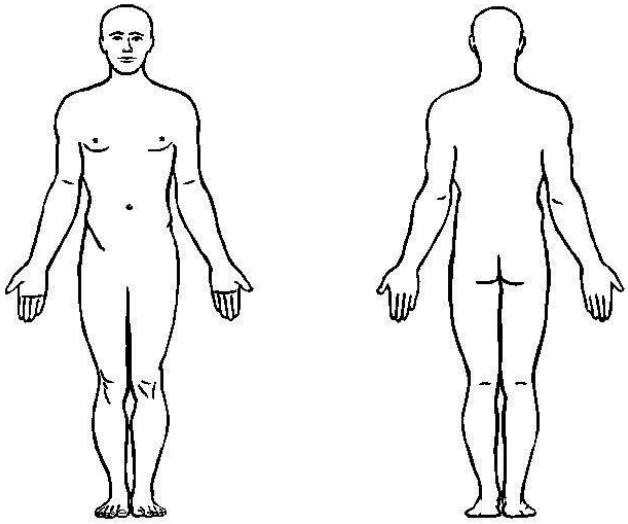
Medical Complication Questionnaire

Age: _____ Sex: *Male Female* Dominant Hand: *Right /Left /Ambidextrous* Height: _____ Weight: _____

Please mark/circle your answers to questions that pertain to your medical complaint. You may select more than one answer.

Mark in the area of your body where your now feel your typical pain. Pain=XXX Numbness =OOO

Right Left Left Right



If you checked more than one region which one is more problematic? _____

Are you experiencing any of the following: □ *Weakness* □ *Numbness* □ *Tingling*

When did this pain start? _____ Have you had and previous neck or back problems? □*Yes*□ *No*

If yes please explain_____

Since the pain began has it □ *Improved* □ *Worsened* □ *Stayed the same*

What time of day is the pain most intense: □ *Morning* □ *Afternoon* □ *Evening* □ *While Sleeping* □ *All Day*

What aggravates your pain? □ *Walking* □ *Standing* □ *Sitting* □ *Laying* □ *Bending/Lifting* □ *Other*_____

Do you have difficulty walking?□ *Yes* □*No* If yes, how far you can walk till you feel pain_____

Does your pain awaken you from sleep? □ *Never* □ *Occasionally* □ *Frequently* □ *Always*

Have you had any problems with bowel, bladder, or sexual functions since this condition began? □*Yes* □ *No*

If yes, please explain_____

Do you exercise regularly? □*Yes* □*No If yes how often?* _____

Does this pain affect your daily living? □*Yes* □ *No If yes explain*_____

Patient/ Guardian Signature_____Date_____

1100 W Kennedy Blvd Tampa FL 33606 P: 813.463.2815 F: 813.463.2857
3830 Tampa Rd. Suite 300 Palm Harbor FL 34684 P: 727.239.0887 F: 727.239.0686
7800 66th St. N. Suite 204 Pinellas Park FL P: 877.703.7171 F: 813.463.2857

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Medical History

Please check the following conditions you currently have, or have had in the past.

Artificial Implant
- _ Heart pace maker
- _ Breast augmentation
- _ Insulin pump
- _ Heart valve
- _ Joint Replacement _____
- _ Other_____

Arthritis
- _ Gout
- _ Osteoarthritis
- _ Rheumatoid Disease
- _ Other_____

Blood
- _ Anemia
- _ Leukemia
- _ Hemophilia
- _ HIV/AIDS
- _ Sickle Cell Anemia
- _ Other_____

Endocrine
- _ Diabetes Type 1
- _ Diabetes Type 2
- _ Thyroid Disease
- _ Hypoglycemia
- _ Parathyroid Disease
- _ Other_____

Eye
- _ Glaucoma
- _ Ocular Herpes
- _ Other:_____

Lung/Respiratory
- _ Asthma
- _ Emphysema
- _ Lung Cancer
- _ COPD
- _ Shortness of Breath
- _ Tuberculosis
- _ Other_____

Nerve /Other
- _ Cerebral Palsy
- _ Epilepsy
- _ Neuralgia
- _ Multiple Sclerosis
- _ Parkinson's Disease
- _ Stroke
- _ Headaches /Migraines
- _ Dizziness
- _ Vertigo
- _ Anxiety
- _ Depression
- _ Bipolar Disorder
- _ Other_____

Stomach/Intestinal
- _ Ulcerative Colitis
- _ Gallbladder issues
- _ IBS
- _ Other:_____

Heart/Circulatory
- _ Arteriosclerosis
- _ Congenital Heart Disorders
- _ Parathyroid Disease
- _ Heart attack
- _ Coronary Artery Disease
- _ Heart Murmur
- _ High/Low Pressure
- _ Rheumatic fever
- _ Congestive Heart Failure
- _ Poor circulation
- _ Heart palpitations
- _ Other_____

Kidney/Urinary
- _ Bladder Infection
- _ UTI
- _ Blood in Urine
- _ Kidney Disease
- _ Sugar in urine
- _ Other:_____

Liver Disease
- _ Cirrhosis of the liver
- _ Hepatitis A
- _ Hepatitis B
- _ Other:_____

Review of Systems

Have you **RECENTLY** experienced any of the following?

General/Constitutional
- __Fever
- __Fatigue
- __Chills
- __ Night Sweats
- __Weight Gain
- __Weight Loss

Skin
- __Change in moles
- __ Breast Lumps
- __Lesions

Eyes
- __Loss of Vision
- __Double Vision

ENT
- __Hearing loss
- __Nose Bleeds
- __ Difficulty Swallowing

Gastrointestinal
- __Decrease appetite
- __Nausea
- __ Vomiting
- __ Change in Bowel
- __ Heartburn

Respiratory
- __Shortness of breath
- __ Coughing Blood
- __ Wheezing
- __Difficulty Breathing

Cardiovascular
- __Chest Pain
- __Palpitations
- __Fainting
- __High Blood Pressure
- __Swelling in the Legs
- __Emboli (clots)

Genitourinary
- __Frequent Urination
- __ Difficulty with Urination
- __Blood In Urine
- __Unable to hold Urine
- __Sexual difficulties

Musculoskeletal
- __Muscle/Joint Weakness
- __Muscle/Joint Pain
- __Joint Swelling

Psychiatric
- __Depression
- __Suicidal thoughts
- __Anxiety
- __Memory Loss

Patient/ Guardian Signature_____Date_____

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Consent for Treatment

I hereby authorize your practice and whomever the doctor may designate as his/her assistant to perform examination, physiotherapy, and physical therapy and to perform non-invasive diagnostic tests. This may include any unforeseen condition that arises in the course of the procedures which may call for judgment for procedures in addition to or different from those non-complicated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications have been fully explained to me. I acknowledge that no guarantee has been made to me as to the result that may be obtained.

Patient/ Guardian Signature_____Date_____

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-rays, physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the auto personal injury protection law. (Chapter 71-252f)

Patient/ Guardian Signature_____Date_____

Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that you respect the healthcare provider's or healthcare facility's right to expect certain behavior on the parts of patients. You may request a copy of the full text of this law from your healthcare provider or health facility. A Summary of your rights and responsibilities are as follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his/her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his/her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his/her conduct.
- A patient has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the healthcare provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive a copy of a reasonable clear and understandable, itemized bill and upon request, to have the charges explained.
- A patient has the right to receives, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for the purpose of experimental research and to give his/her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his/her rights, as states in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served him/her and to the appropriate states licensing agency.

- A patient is responsible for providing to the healthcare provider, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.

- A patient is responsible for reporting unexpected changes in his/her condition to the healthcare provider.
- A patient is responsible for reporting to the healthcare provider whether he/she comprehends a contemplated course of action and what is expected for him/her.
- A patient is responsible for following the treatment plan recommended by the healthcare provider.
- A patient is responsible for keeping appointments and, when he/she is unable to do so for any reason, for notifying the healthcare provider for healthcare facility.
- A patient is responsible for his/her actions if he/she refuses treatment or does not follow the healthcare provider's instructions.
- A patient is responsible for assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible.
- A patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

I have read and understand the summary of the Florida patient's bill of rights and responsibilities.

Patient/guardian Signature_____**Date**_____

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HIPAA Privacy Authorization Form

This is an authorization for use or Disclosure of Protected Health Information.(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

This is an authorization for release of health information that covers all past, present, and future periods of my medical record. I, _____ ____/____/_____ _____/____/_____
Patient Name *Date of Birth* *SS#*
authorize the use or disclosure of the health information as described below to the following person or organization_____ _____
Name /Facility *City/St*

□ Entire Medical Record
□ ER Record
□ Operative Reports
□ Diagnostic Imaging
□ Demographic Information
□ Consultations
□ Laboratory results
□Other_____

I authorize the disclosure of the following information marked above to the following organization:

Tampa Bay Orthopedic Surgery Group
□ 1100 W. Kennedy Blvd Tampa Fl 33607 | P:813.463.2815 |F:813.463.2857
□ 3830 Tampa Rd. Suite 300 Palm Harbor Fl 34684 | P:727.239.0887 I F:727.239.0686

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that the information in my medical record may include information relating to mental healthcare, and treatment of alcohol or drug abuse. I also understand that the information may include information relating to sexually transmitted disease, AIDS or HIV. I also understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance policy. Unless otherwise revoked, this authorization will expire in one year.

Patient /Guardian Signature: _____

*If signed by Legal Rep., relation to Patient*_____

Witness_____**Date**_____

Patient Name: _____DOB_____

Address: _____City/St_____Zip_____

Date of Loss: _____ Insurance Carrier _____Claim#_____

Assignment of Benefits

I hereby assign from any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title and interest *to* ***Tampa Bay Orthopedic Surgery Group LLC*** ("Assignee") for payment for services rendered unto me both by reason of accident or illness. In the event my insurance company fails to pay Assignee the full amount owed to Assignee after proper statutory notice, I hereby also assign by this instrument, all rights and causes of action in tort, in contract and the laws of Florida, against the personal injury protection carrier for the above named insured/patient, for its failure to pay for services rendered unto Assignee in relation to my accident or illness. This assignment may only be rescinded /reassigned by the mutual constant of the patient/insured/assignor and the healthcare provider/assignee.

Reservation of Benefits

Please be advised that I am here by placing you on notice pursuant to Florida case law that should you deny, reduce or fail to pay either part or an entire bill, which was submitted on my behalf from this healthcare provider. I am requesting you reserve, or hold aside, that same amount until this dispute is resolved. Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, or if my benefits should become exhausted, please notify me and this healthcare provider of the fact immediately.

Direction of Payment/Release of Information

I hereby authorize any insurance company or attorney to pay direct to *Assignee* the amount of this and/or any future bills for services rendered unto me. I also agree to pay in a current manner any difference between the total charges and the amount pain by the insurance company directly to the *Assignee.* I hereby authorize *Assignee* to release any information requested that is pertinent to my case to any insurance company or attorney involved in this case. *Pursuant to FS 627.4137*, I hereby request a copy of this PIP payment log and any available policy insurance or declaration sheet, which reflects the applicable policy limits available at the time of this accident, to be provided by the insurance company to the *Assignee.* I hereby authorize *Assignee* permission to request and receive a current copy of my PIP payment log periodically as they deem necessary. A photocopy of this assignment shall be considered as valid and effective as the original

Patient/Guardian Signature_____***Date***_____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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