Charlotte Orthopaedic Clinic

New Patient History

Patient Information **Date**______________

Name:____ I Prefer to be called: ______________________
Last First MI Suffix (Jr., Sr., II)

Address:____________________________________City:_____________State:________Zip_____________

Phone (_____)_______________ Work Phone (_____) _____________ Cell Phone (_____)_________________

Northern Address:_____________________________City:_____________State:________Zip_____________

Age:_____ Date of Birth:___________ Social Security Number:____________ E-mail:____________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School_________________________ City/State_________________________

Spouse or Parent/Guardian's Name__________________________

Employer___________________________

Whom may we thank for referring you? ____

Family Doctor_______________________________ Phone______________________

Sports you participate in: ____

I acknowledge that the information provided about my family and medical history is accurate and complete. If there are any changes to this information in the future, I will provide any such change at my next scheduled visit.

______________________________________ ___________________________

Patient or Parent/Guardian Date

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN and TO RELEASE INFORMATION FOR INSURANCE CLAIMS: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible for payment of non-covered services. I hereby authorize the Physician to release any information acquired in the course of my treatment to process insurance claims.

______________________________________ ___________________________

Patient or Parent/Guardian Date

Charlotte Orthopaedic Clinic

Current Orthopaedic Problem (s)

What are you seeing the doctor for today:____

Is this a second opinion ☐ yes ☐ no Are you right or left handed: ☐ right ☐ left

What caused the pain/injury: ☐ car accident ☐ work accident ☐ injury (other) ☐ no injury

How did the injury occur? ____

When did the injury/accident occur? ____

Duration of symptoms: ☐ days ☐ weeks ☐ months ☐ years

Does the pain radiate to: ☐ shoulder ☐ elbow ☐ fingers ☐ groin ☐ buttock ☐ thigh ☐ foot

The pain is getting: ☐ better ☐ worse ☐ unchanged

The pain is: ☐ constant ☐ occasional

Pain level: ☐ intolerable ☐ tolerable

How would you rate the pain (0=no pain through 10=severe): _____

Does the pain prevent you from doing daily activities? ☐ yes ☐ no

What activities increase your symptoms? ____

Do you use a: ☐ cane ☐ walker ☐ nothing

How many blocks can you walk before stopping? ____________

Is the pain improved by: ☐ Aspirin ☐ Tylenol ☐ Advil/Motrin/Ibuprofen ☐ Other: ____________

List of pain medication taken for this problem: ____

Did medication help? ☐ yes ☐ no

Have you had injections for this problem? ☐ yes ☐ no

What type of injection(s) ____

Did the injection help: ☐ yes ☐ no

Have you had physical therapy? ☐ yes ☐ no If yes, when/ how long/ did it help?____________________

Have you had surgery for this problem before? ☐ yes ☐ no If yes, when and where____________________

Was surgery successful? ☐ yes ☐ no Complications: ____________________

Charlotte Orthopaedic Clinic

Past Medical/Surgical History

Do you have a history of any of the following?

Fracture/broken bone	☐ yes	☐ no	Arthritis	☐ yes	☐ no
Gout	☐ yes	☐ no	Bursitis	☐ yes	☐ no
Tendonitis	☐ yes	☐ no	Bone infection	☐ yes	☐ no
Neck pain	☐ yes	☐ no	Back pain	☐ yes	☐ no
Sciatica	☐ yes	☐ no	Osteoporosis	☐ yes	☐ no

Do you have any medical conditions (treated or untreated)?

AIDS	☐ yes	☐ no	Anemia	☐ yes	☐ no
Angina	☐ yes	☐ no	Asthma	☐ yes	☐ no
Emphysema/COPD	☐ yes	☐ no	Bladder/Kidney	☐ yes	☐ no
Bleeding disorder	☐ yes	☐ no	Blood clots	☐ yes	☐ no
Cancer	☐ yes	☐ no	Diabetes	☐ yes	☐ no
Depression/Anxiety	☐ yes	☐ no	Mental disorder	☐ yes	☐ no
Heart Attack	☐ yes	☐ no	Heart disease	☐ yes	☐ no
Atrial fibrillation	☐ yes	☐ no	High Blood Pressure	☐ yes	☐ no
Pacemaker	☐ yes	☐ no	Parkinsons	☐ yes	☐ no
Alzheimer's	☐ yes	☐ no	Gastric Ulcer	☐ yes	☐ no
Phlebitis	☐ yes	☐ no	Prostate disease	☐ yes	☐ no
Pulmonary emboli	☐ yes	☐ no	Stroke	☐ yes	☐ no
Thyroid disease	☐ yes	☐ no	Liver disease	☐ yes	☐ no
Sleep apnea (on CPAP)	☐ yes	☐ no	Peripheral neuropathy	☐ yes	☐ no
Glaucoma	☐ yes	☐ no	Macular degeneration	☐ yes	☐ no

Other illnesses not listed: ______________________________

____

Have you had surgery before?

Tonsillectomy	☐ yes	☐ no	Appendectomy	☐ yes	☐ no
Hysterectomy	☐ yes	☐ no	Prostate	☐ yes	☐ no
Cardiac Stent	☐ yes	☐ no	Cardiac Bypass	☐ yes	☐ no
Vascular surgery	☐ yes	☐ no	Laparoscopy	☐ yes	☐ no
Shoulder/Rotator cuff	☐ yes	☐ no	Knee arthroscopy	☐ yes	☐ no

Other surgery not listed: ______________________________

____

Date of last Dental Visit: ____________ Dental Problems: ______________________________

Medication Allergies: ☐ Penicillin ☐ Sulfa ☐ Morphine ☐ Codeine ☐ Aspirin

☐ Tylenol ☐ Latex ☐ Betadine ☐ Other:____________

Charlotte Orthopaedic Clinic

List of Current Medications:

Name	Dosage	Quantity/Frequency	Name	Dosage	Quantity/Frequency

Social History:

Present Occupation: ________________ Hobbies: ________________

Do you smoke: ☐ no ☐ cigarettes ☐ cigars How many per day/how long: ________________

Do you drink alcohol: ☐ no ☐ socially ☐ daily How many drinks per week: ________

Do you use recreational drugs? ☐ no ☐ yes If yes, what kind/how often: ________________

Do you exercise: ☐ yes ☐ no How often/what type? ________________

Family History: Father: ☐ alive ☐ deceased Age: ___ Cause of death: ________________

Mother: ☐ alive ☐ deceased Age: ___ Cause of death: ________________

☐ Rheumatoid ☐ Stroke ☐ Cancer ☐ Diabetes ☐ Heart disease

☐ Other: ________________

Do you now have (or have you had) any problems related to the following systems? Circle if yes...

Constitutional:	Fever	Chills	Headache	Other: ________
Eyes:	Blurred vision	Double vision	Pain	Other: ________
Immunologic:	Hay fever	Drug allergies	Seasonal allergies	Other: ________
Neurologic:	Tremors	Dizzy spells	Seizures	Other: ________
Endocrine:	Excessive thirst	Too hot/cold	Tired/sluggish	Other: ________
Gastrointestinal:	Abdominal pain	Nausea/Vomiting	Heartburn	Other: ________
Cardiovascular:	Chest Pain	Palpitations	High blood pressure	Other: ________
Integumentary:	Skin rash	Boils	Persistent itching	Other: ________
Musculoskeletal:	Swollen joints	Painful joints	Neck/Back pain	Other: ________
Ear/Nose/Throat:	Ear infection	Sore throat	Sinus problem	Other: ________
Genitourinary:	Painful urination	Frequent urge	Discharge	Other: ________
Respiratory:	Wheezing	Frequent cough	Short of breath	Other: ________
Hematologic:	Swollen glands	Blood clots	Bruising	Other: ________
Psychologic:	Depression	Anxiety	Difficulty sleeping	Other: ________

PATIENT INFORMED CONSENT

Please make sure YOU are informed of your insurance benefits!

1. NOTICE TO OUR PATIENTS REGARDING PAYMENT:
   If you are ***self-pay***—full payment of services rendered is required at the time of service.
   CURRENT INSURANCE CARDS MUST BE PRESENTED AT THE TIME OF SERVICE
   If we ***are*** *contracted with your insurance*—full payment of co-pay's, co-insurance, or deductibles are required at the time of service. We will bill your insurance—*as a courtesy to you*. Please understand any balance is ultimately your responsibility.
   If we* ***are not* *contracted with your insurance*—full payment of services is required at the time of your visit. We will provide you with the appropriate paperwork so that you may file your claim with your insurance carrier for reimbursement.
   OB patients: We will bill your insurance, whether we are contracted or not, for your global package— *as a courtesy to you*. The above information does apply to services not covered in your OB contract. Please be familiar with what this includes. Non-global problem visits are billed separately.

2. **Preauthorization Requirements:** I accept the responsibility to obtain *all referrals from other physicians*, or *preauthorizations from insurance* to be in compliance with my insurance or medical coverage. This includes finding out whether my insurance company needs preauthorization for ultrasounds, procedures, D.E.X.A. scan's (bone density), or medications. If I have questions, I will contact my insurance for clarification. *If any procedures do need to be preauthorized, I take responsibility to do that, or ask my nurse for assistance. If this is not done, I will be responsible for payment.*

3. **Annual Exams:** Some insurance companies do not cover preventive care visits. Due to insurance fraud issues, we cannot change the reason for your visit AFTER you have left the office. We contract with many insurance carriers to offer you discounted services and specialty care, but we do not know what your specific plan covers. Our office will not make calls to your insurance company for this purpose. Please let us know whether you are being seen for a problem or a routine physical exam, so that we may provide you with appropriate care and avoid insurance disappointments.

4. **Extra Paperwork:** There may be a fee if you need your doctor to fill out extra paperwork, such as, forms for your employer, more intensive physical exams, disability forms, work releases, or extensive insurance forms.

5. **Record Release:** We do charge a fee to release records, unless one of our doctors has referred you elsewhere. We **only** release records for visits and tests done here at this office.

6. **Account Balances:** All past due balances or collection accounts must be paid in full at the time you come in for your appointment. You may call to set up payment arrangements, but these must be reasonable and paid in a timely manner. All arrangements MUST be made in advance!

7. **Cancellations**: In order to provide the best possible service and availability to ALL our patients, should you need to cancel your appointment; we ask that you please do so at least 24-hours in advance.

Signature (Patient/Parent of Minor): ____

Patient DOB: ______________

Today's Date: _______/_______/_______

Revised 09/12/06

Contract of Financial Responsibility

In agreeing to be responsible for your medical care, Charlotte Orthopaedic Clinic, P.A. requires that you be responsible for your *financial obligations to us.*

Please read each paragraph and sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18 years of age), your parent or legal guardian must accept financial responsibility on your behalf

1. I agree that I will pay for all services provided to me by Charlotte Orthopaedic Clinic at the time of service, unless my services are covered by a contracted insurance.

2. I understand that my insurance company or health plan may require me to pay co-payments, co-insurance or deductibles. I agree to pay these in full at the time of service.

3. I understand that if, upon 60 days after billing and/or insurance filing, my contracted insurance has not paid, I will be required to contact them to find out why the claim has not been paid.

4. I understand that if, 60 days after billing, I fail to pay any balance due on my account (unless this balance is still out to a contracted insurance), further action may be taken on my account, unless other previous arrangements have been made and approved by Charlotte Orthopaedic Clinic, P.A.

5. If my account is sent to collections, I am responsible for all amounts due *plus* all costs of collection, including:

- A handling charge of $50.00 may be added to my account if it must be sent to collections;
- All collection expenses charged by the collection agency;
- Court costs;
- Reasonable attorneys' fees; and
- Any discounts I may have received on my account will be reversed.

6. I also understand that at the discretion of Charlotte Orthopaedic Clinic, P.A., I may be taken to small claims court for full reimbursement of all fees and balances.

7. If further action must be taken on my account, Charlotte Orthopaedic Clinic, P.A. may require me to permanently seek further care elsewhere, in accordance with guidelines set forth by the **Florida State Board of Medical Examiners.**

Thank you very much.

SIGNATURE (Patient or Parent of Minor): ____

PLEASE PRINT NAME: ____ DOB __________

TODAY'S DATE: _______/_______/_______

ADVANCED IMAGING OF PORT CHARLOTTE, LLC
4161 Tamiami Trail, Unit 101
Port Charlotte, FL 33952
Phone 941-625-0984 Fax 941-235-4655

Authorization for Care and Release of Health Information

X Patient ____________________ Date of Birth ______________ SS#________________

X Address ______________________________ Telephone____________________

X City & Zip ______________________________Cell Phone ____________________

I authorize ______________________________ to release my information to:

____

This authorization for release of information is valid for 90 days from the date of signature, unless revoked by written notice to the providing institution. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once the information is disclosed pursuant to this authorization, the recipient may re-disclose it and the authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

I grant permission to the employees of Advanced Imaging of Port Charlotte to render care to me and expedite the orders of the physicians and/or physician extender. I further authorize release of this information to other healthcare providers associated with my care.

I agree that I will be financially responsible for any reasonable and customary charges should my treatment not be covered by my insurance company or responsible party due to denial, deductible or co-pay.

Patient Signature: X ____________________________ Date ____________________

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this section indicates that you have received a copy of our Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in our Notice of Privacy Practices, please do not hesitate to contact our Patient Privacy Officer at 941-235-4646.

Patient Signature: X ____________________________Date ____________________

If Patient Representative, Name (printed): ______________________________

Patient Representative Signature: ______________________________

Charlotte Orthopaedic Clinic, P.A.
4161 Tamiami Trail, Unit 101
Port Charlotte, Florida 33952

Notice of Privacy Practices

We are required to provide you with our "Notice of Privacy Practice" upon request. Please notify the receptionist if you would like a copy.

Please provide the information below.

Your Name (please print) ____

Date of Birth _____________________

Do you want to give us permission to discuss your medical and financial information with family members and/or friends?

_____ Yes ______ No

If yes, please let the friends/family members that you would like to authorize us to speak to:

Name Relationship Phone Number

Name Relationship Phone Number

Name Relationship Phone Number

Name Relationship Phone Number

The 'Notice of Privacy Practices" was made available to me.

Your signature_________________________ Today's date____________