Florida Joint Care Institute
2165 Little Road, Trinity, FL 34655
Phone (727)372-6637 Fax (727)375-5044

Thank you for choosing Florida Joint Care Institute for your orthopedic needs. We have prepared a packet of information and forms to make your visit with us an efficient and pleasant experience. We ask that you complete the attached paperwork in its entirety and legibly.

When you come for your appointment please bring the following, without any of the following we will not be able to keep your scheduled appointment:

- Completed new patient paperwork
- Current Medical Insurance Cards (Medicare, primary provider, secondary provider, etc.) A complete list of ALL medications including strengths and dosage
- Photo ID: Driver's license or state issued ID
- X-Rays and MRI's: Imaging report and disc pertaining to the body part will be treating is required before or at your appointment.

Please be prepared to pay via credit/debit card or cash for the following at the time of your visit:

- Co-payments. If your insurance requires co-payment you are responsible for this at the time of your appointment.
- Co-insurance and deductible. If your insurance requires a co-insurance or deductible, you are responsible for that at the time of your appointment.
- If you do not have insurance, payment will be collected at time of service.

Referrals/Authorizations:

Most insurance companies require a referral/authorization from your primary care physician. **Please be sure to contact your primary care physician and let them know that they will need to fax the referral/authorization to (727)375-5044 at least 48 hours prior to your appointment. Without this referral/authorization 48 hours prior to your appointment, we will need to reschedule you. If** you do not have a primary care physician and your insurance requires a primary care physician referral, you will need to establish with a primary care physician before we will be authorized to see you.

Please be sure to check-in 15 minutes prior to you scheduled appointment time to allow our staff to complete the administrative portion of your appointment.

No show fee of $25 is assessed if a patient does not call 24-hours in **advance** to cancel an appointment.

NEW PATIENT REGISTRATION

Patient Information

Last Name: _____First Name: _____Date:_____

Street Address: _____ City/ State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number {day): _____ Phone Number (night): _____

Email Address: _____ Occupation/ Workplace: _____

_____ Emergency Contact (name}: _____

_____ Emergency Contact (number): _____Preferred Language: _____

_____ Race: _____ Ethnic Group: _____

Primary Care Provider: _____ **Referring Physician:** _____

PERMANENT ADDRESS (if different from above)

ADDRES_____ CITY _____ STATE_____ZIP_____

Emergency Contact

Name_____ Phone: _____ Relationship_____

Is the patient the responsible party: Yes / No If no please complete this section

Name _____Relationship_____

ADDRESS (if different from above) _____CITY _____STATE_____ZIP_____

Home Phone: _____Work Phone: _____

(Primary Pharmacy - *default)*

Name: _____Phone Number: _____City or Zip Code: _____

I authorize the physicians and staff of Florida Joint Care Institute to share my protected health information with the following persons:

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

This includes: ____All Medical Records or Specify: _____

This Authorization will remain in effect until revoked.

Patient (or Authorized) Individual: _____

Signature: _____Date: _____

NEW PATIENT REGISTRATION

Select any of the following medical conditions you currently have:

Past Medical History

- ◻ None
- ◻ Asthma
- ◻ Atrial Fibrillation
- ◻ Benign prostatic hyperplasia
- ◻ Cerebrovascular accident
- ◻ Chronic Anemia
- ◻ Chronic obstructive lung disease
- ◻ Coronary arteriosclerosis
- ◻ Deep Venous Thrombosis (Blood Clot)
- ◻ Depressive Disorders
- ◻ Diabetic on Insulin
- ◻ End Stage Renal Disease
- ◻ H/O: hypertension
- ◻ Human immunodeficiency virus infection
- ◻ Hypothyroidism
- ◻ Disease of the liver
- ◻ Leukemia
- ◻ Cancer or Tumor
- ◻ Obstructive sleep apnea syndrome
- ◻ Primary fibromyalgia syndrome
- ◻ Pulmonary Embolism
- ◻ Rheumatoid Arthritis
- ◻ Type 2 diabetes mellitus
- ◻ Other _____

Past Surgical History

- ◻ None
- ◻ Bypass of stomach
- ◻ Heart: Coronary artery bypass graft
- ◻ Excision of basal carcinoma
- ◻ Excision of melanoma
- ◻ Excision of squamous cell carcinoma
- ◻ History of appendectomy
- ◻ History of cholecystectomy
- ◻ History of colectomy
- ◻ History of heat procedures
- ◻ History of tissue graft heart valve replacement
- ◻ Hysterectomy Lumpectomy of breast
- ◻ Mastectomy or left breast
- ◻ Mastectomy or right breast
- ◻ Mechanical heart valve replacement
- ◻ Prostate (Prostatectomy): Prostate Cancer
- ◻ Tonsillectomy
- ◻ Uterus: Total Hysterectomy
- ◻ Joint Surgery
- ◻ Failed Surgery
- ◻ Surgery Infection
- ◻ Surgery Complication
- ◻ Other _____

NEW PATIENT REGISTRATION

Have you had any of the following?

Orthopedic History

- ☐ NONE
- ☐ Adhesive Capsulitis
- ☐ Ankylosing Spondylitis
- ☐ Bone Infection
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Complex regional pain syndrome
- ☐ History of osteoporosis
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Primary gout
- ☐ Psoriasis with arthropathy
- ☐ Sarcoma of bone
- ☐ Sarcoma of soft tissue
- ☐ Sciatica
- ☐ Secondary malignant neoplasm of bone
- ☐ Other _____

Orthopedic Surgical History

- ☐ NONE
- ☐ Arthroplasty of the carpometacarpal joint
- ☐ Decompression of the lumbar spine
- ☐ Fracture Surgery
- ☐ History of arthroplasty
- ☐ History of repair of musculotendinous cuff of shoulder
- ☐ Lumbar spinal fusion
- ☐ Prosthetic arthroplasty
- ☐ History of arthroplasty of hip
- ☐ Reconstruction of anterior cruciate ligament of the knee joint
- ☐ Release of trigger finger
- ☐ Repair of tendon
- ☐ Achilles Tendon Repair
- ☐ Total shoulder replacement
- ☐ Meniscus Repair
- ☐ Nerve Surgery
- ☐ Reverse Total Shoulder Replacement
- ☐ Other _____

Orthopedic Family History

Is there a history of any of the following? (*Immediate family

- ☐ NONE
- ☐ Charcot Marie Tooth Disease
- ☐ Diabetes
- ☐ Hypertension
- ☐ Multiple Hereditary Exostosis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Other _____

Medications

Please list ALL current medications (or check the box if it applies)

- ☐ Currently not taking any medication(s)

Medication	Dosage	Frequency

Allergies

Please list ALL known allergies (or check the box if it applies)

- ☐ No Known Drug Allergies (NKDA)

_____

_____

_____

_____

NEW PATIENT REGISTRATION

Social History (check all that apply)

- ◻ Smoker:
  - ◻ Current
  - ◻ Former
  - ◻ Never
- ◻ Marijuana use:
  - ◻ Current
  - ◻ Former
  - ◻ Never
- ◻ Alcohol Intake per day:
  - ◻ 0 to 1
  - ◻ 1 to 2
  - ◻ 3 or more
  - ◻ Never
- ◻ Exercise frequency (choose one):
  - ◻ Several times per day
  - ◻ Once per day
  - ◻ Few times per day
  - ◻ Few times per month
  - ◻ Never

Alerts

- ◻ Pacemaker
- ◻ Blood thinners
- ◻ Defibrillator
- ◻ Premedication prior to procedures
- ◻ Rheumatoid Arthritis
- ◻ Nerve Pain
- ◻ Allergy to shellfish/iodine
- ◻ Allergy to latex
- ◻ Allergy to adhesive
- ◻ Under pain management

Review of Systems (Please check all that apply)

Symptom

- ◻ Fever or Chills
- ◻ Rash
- ◻ Visual Changes
- ◻ Neck or Back Pain
- ◻ Nausea or Vomiting
- ◻ Constipation
- ◻ Painful Urination
- ◻ Frequent Urination
- ◻ Numbness or Tingling or burning
- ◻ Anxiety
- ◻ Depression
- ◻ Weight loss
- ◻ Abnormal Bleeding

Authorization and Assignment

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

I request that the payment of authorized Medicare/insurance benefits be made to me or on my behalf for any services furnished by Florida Joint Care Institute. I authorize any holder of medical information about me to release to CMS (Medicare)/insurance carriers and its agents any information needed to determine these benefits for services rendered.

I hereby authorize Florida Joint Care Institute to furnish information to CMS (Medicare)/insurance carriers concerning my medical condition, illness, and treatment to determine the benefits for services rendered. I hereby authorize (assign) my insurance carrier(s)/CMS (Medicare) to make payment directly to Florida Joint Care Institute for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of the professional services rendered. I understand that CMS (Medicare) and/or other insurance carriers do not cover all office services/procedures, and I agree to take full responsibility for any unpaid balances, and that such payment will be made to this physician's office for services rendered.

Signature _____ Date _____

Permission for Treatment

I, the undersigned, hereby voluntarily consent to medical/diagnostic treatment and or minor surgical treatment (for example: Cortisone injections) by Florida Joint Care Institute that is deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and therefore acknowledge that no guarantees have been made to me because of treatment or examination in the office of Florida Joint Care Institute.

Signature _____ Date _____

Doctor-Patient Arbitration Agreement

This agreement is made between Florida Joint Care Institute, including their agents, employees, servants, or any of the foregoing, referred to hereafter as "Physician," and _____ (patient's name), referred to hereinafter as the "Patient." It is the intention of the parties of the agreement to bind themselves, their heirs, personal representatives, guardians, or any person deriving their claims through or on behalf of the patient.

It is understood by the patient that he or she is not required to use any of the Physicians named for orthopedic care, treatment, and surgery, and that numerous other physicians in the state of Florida and West Central Florida are qualified to perform orthopedic care, treatment, and surgery.

It is further understood that in the event of any controversy, dispute, or claim which might arise between the Physician and Patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682 of the Florida Statutes. The arbitration shall be binding and shall be in lieu of and instead of any trial by judge or jury. Each party shall be entitled to the discovery provided for in rule 1.280 of the Florida Rules of Civil Procedure. The panel or arbitrator shall hear and decide the controversy, dispute, or claim, and the decision shall be binding on all parties.

The agreement shall remain in effect for all treatment and surgery provided for the patient presently and at any further date.

Signature _____ Date _____

Florida Joint Care Institute

Patient Name_____

Medical Assignment of Benefits, Authorization for Treatment and Payment Responsibility

1) The undersigned hereby authorizes Florida Joint Care Institute, LLP (Provider) to render treatment to Patient. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of services.

2) The undersigned hereby certifies that all information provided by the undersigned or Patient, including any information in connection with applying for payment under title XVIII of the Social Security Act, is true and accurate in all respects.

3) The undersigned hereby authorizes Provider to disclose any information furnished to Provider or obtained by Provider in connection with the Patient's treatment (including information concerning a related Medicare Claim) to insurance company or health care facility requesting such information.

4) The undersigned hereby assigns *to* Provider all Medicare benefits to which Patient may be entitled for any services rendered by Provider. In addition, the undersigned approves contact with appropriate family members for medical claims management purposes.

5) The undersigned hereby assigns to Provider all private medical insurance benefits (primary and secondary, including medigap Providers) or other benefits to which Patient may be entitled for any services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file all such benefits on behalf of Patient.

6) The undersigned hereby agrees that the undersigned shall be ultimately financially responsible for any portion of Provider's claim that is not paid. The undersigned understands that Medicare or any Health Maintenance Organization (HMO) may deny some charges that the Physician deems necessary. Medicare and other HMO's have been denying payment for some soft goods and services (braces, cast shoes, finger splints, arm slings, elastic bandages, ace wraps, injections, x-rays, fracture treatment, office visits, casting materials and certain blood tests conducted on an outpatient basis). The undersigned agrees to be responsible for payment of these charges should they be denied for payment. Payment of your account is your responsibility regardless of your insurance coverage.

7) The undersigned and Patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned and Patient warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms, or court orders appointing the undersigned as legal guardian of Patient.

8) The undersigned agrees that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; however, the above-mentioned paragraphs 2, 4, 5, and 6 shall survive any such termination.

9) The undersigned grants permission for the Provider to treat the undersigned and/or minor child and/or dependent. If Patient is a minor, the parent/guardian must be present at the time of the visit.

10) The undersigned agrees that treatment by the Provider will not be construed as willingness on the part of the Provider to be a witness in a personal injury ligation case.

11) The undersigned understands that confabulation or fabrication either by commission or omission will be sufficient reason for unilateral discontinuation of treatment and cancellation of any contract either expressed or implied.

12) The undersigned agrees that x-rays and laboratory tests are the property of the Provider and the fees charged for these services are for processing and interpretation. These records or their copies will be released at the discretion of the Provider. A nominal fee may be charged to cover additional expense for their release.

13) The undersigned acknowledges that he/she has received a copy of the Florida Joint Care Institute Privacy Notice (HIPPA Privacy Notice).

Signature _____ Date _____