



## Financial Policy

Patient Name: \_\_\_\_\_ Acct #: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for choosing Orlando Orthopaedic Center. We strive to offer the best healthcare services to our patients. Part of that service is providing transparency regarding any financial responsibilities. If at any time during your visit you have questions or concerns regarding your potential costs of services, please alert one of our team members.

Please review the following.

1. Orlando Orthopaedic Center verifies your benefits with your insurance company prior to each visit. Verification of your benefits with your insurance company is not a guarantee of benefits or payment. You are responsible for paying any out-of-pocket expenses as part of your benefit coverage. Be advised having more than one insurance policy is not a guarantee that all of your out-of-pocket expenses will be covered.
2. As a courtesy, Orlando Orthopaedic Center provides 2 options for you to pay your out-of-pocket expenses for services provided.
  - Estimate of Cost  
Pay today an **estimate** of fees owed for your visit. A team member will review your estimated out-of-pocket expenses at the end of your visit today. After your insurance company processes your claim you may have additional out-of-pocket expenses for which you will be billed or you may be due a refund.
  - Authorized Payment Option  
Pay your **exact** out-of-pocket expenses after your insurance company processes your claim. This process requires us to secure your credit card information. After your insurance company has processed your claim your credit card will be charged the determined amount for any balance owed. You will be notified of the exact amount before your credit card is charged.
3. Assignment of Benefits: In consideration of the treatment being rendered, you hereby irrevocably assign any and all insurance benefits you have to Orlando Orthopaedic Center for services provided to you. You understand you remain personally financially responsible for any services not covered by your insurance benefits or plan.
4. For Self-Pay patients with no active insurance coverage, Orlando Orthopaedic Center offers a flat rate of \$250.00 for the initial office visit and \$150.00 for each follow-up office visit. Please note separate fees apply for tumor consultations. Additional charges apply for services not included in the office visit (examples include DME, MRI, EMG, therapy, surgery). Payment is required prior to services being rendered.
5. If your balance is not paid or a payment arrangement has not been made after two (2) attempts to collect, a **\$25 service charge** may be assessed as a late fee on your account. Any unpaid balance may be turned over to an outside collection agency.
6. There will be a \$35 fee assessed for insufficient funds when paying by check.
7. A No Show fee of \$50 may be charged for patients who do not cancel or reschedule their appointments prior to 24 hours before their scheduled appointment.
8. There is a charge for completing individual medical forms, disability, work restriction, employer forms, school forms, etc. Please allow five (5) business days to process all form requests.
9. There is a cost for other service(s) such as copying x-ray images and medical records.

**By signing below I understand and accept the financial policy of Orlando Orthopaedic Center.**

\_\_\_\_\_  
Patient or Patient's Representative or Responsible Party

\_\_\_\_\_  
Date



## Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to medical examination and treatment for myself or for the patient for whom I am the parent or legally authorized representative. (If a patient is a minor, the parent having legal custody, a legal guardian, or a person authorized by them in writing must sign. If a patient is incompetent, a legal guardian or conservator must sign.)

I consent to the use or disclosure of my protected health information by Orlando Orthopaedic Center (OOC) for the purpose of diagnosing and/or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations for OOC. I understand that diagnosis and/or treatment of me by OOC may be conditional upon my consent, as evidenced by my signature on this document.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, and my employer or a health care clearinghouse. This protected health information relates to my past, present, and/or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. OOC is not required to agree to the restrictions that I may request; however, if OOC agrees to a restriction that I request then the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that OOC has taken action in reliance on this consent.

I understand I have the right to review OOC’s Notice of Privacy Practices, which has been made available to me, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, and in the performance of health care operations of the OOC. The Notice of Privacy Practices for OOC is also posted at each office location and on the OOC website at [www.orlandoortho.com](http://www.orlandoortho.com). This Notice of Privacy Practices also describes my rights and OOC’s duties with respect to my protected health information.

OOC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the OOC website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative’s Authority

**I hereby authorize the release of my Protected Health Information to the following individuals (Please Print):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Patient Medical History

Patient Name: \_\_\_\_\_ Chart #: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

How were you referred to us?  Urgent Care  Work Comp System  High School  Primary Care Physician  
 Other: \_\_\_\_\_

What is the main reason for this visit? \_\_\_\_\_

On a scale of 0 to 10 what number would you give your pain today? \_\_\_\_\_ (0 no pain, 1-3 mild, 4-6 moderate, 7-10 severe)

**PAST HEALTH HISTORY OF PATIENT** - Please check **Y** or **N** for each condition listed below. **Do not leave any blanks.**

Metabolic Disease	CNS Disease	GI Disease	Cancer	Blood Disorders	
Diabetes Y N	Stroke Y N	Ulcer Y N	Location _____	Anemia Y N	
High Blood Pressure Y N	Seizure Y N	Gall Bladder Y N	Year Diagnosed _____	Clotting Problems Y N	
Thyroid Disease Y N	<b>Cardiac Disease</b>	Hernia Y N	Reoccurrence Y N	Hemophilia Y N	
Osteoporosis Y N		Heart Attack Y N	Current Treatment Y N	<b>Arthritis</b> Y N	
<b>Pulmonary Disease</b>	Angina Y N	Obstruction Y N	<b>Infections</b>	Rheumatoid Y N	
	Pneumonia Y N	Heart Murmur Y N		After Surgery Y N	Osteoarthritis Y N
Asthma Y N	Arrhythmia Y N	<b>Urologic Disease</b>	Venereal Disease Y N	Gout Y N	
COPD Y N	Valve Problems Y N		Urinary Tract Infection Y N	Hepatitis Y N	<b>Miscellaneous</b>
Tuberculosis Y N	<b>Psychiatric Disease</b>	Kidney Stone Y N	AIDS Y N	Blood Clots Y N	
		Depression Y N	Dialysis Y N	HIV Positive Y N	
		Schizophrenia Y N		Osteomyelitis Y N	Prior Blood Transfusion Y N
	Bipolar Disorder Y N				

Explain any other conditions not listed above that you have been diagnosed with: \_\_\_\_\_

**SURGICAL PROCEDURES (include approximate dates):**  NONE

_____	_____
_____	_____
_____	_____

Have you ever had a problem with anesthesia?  No  Yes If yes, explain \_\_\_\_\_

**ALLERGIES:**  NONE

Medication / Other	Reaction	Severity of Allergy - circle level of severity			
_____	_____	Mild	Moderate	Severe	Intolerant
_____	_____	Mild	Moderate	Severe	Intolerant
_____	_____	Mild	Moderate	Severe	Intolerant
_____	_____	Mild	Moderate	Severe	Intolerant
_____	_____	Mild	Moderate	Severe	Intolerant

*Reaction Examples: Unknown, Breathing Difficulty, Nausea, Rash, Anaphylaxis, Vomiting, Diarrhea, Hives, Dizziness*

**CURRENT MEDICATIONS:**  NONE *Include medications prescribed by a physician, Over-the-Counter (OTC), Herbal Supplements and Vitamins.*

Medication & Dosage	Prescribing Physician	Medication & Dosage	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SOCIAL HISTORY**

Most Recent Occupation: \_\_\_\_\_

Married  Single  Divorced  Widowed  Domestic Partnership

Number of Children Living: \_\_\_\_\_ Presently Living Alone?  Yes  No

Smoking / use of tobacco products:  Never  Quit  Yes If Yes / Quit, # years \_\_\_\_\_ # Packs/Products per Day \_\_\_\_\_ Last Use \_\_\_\_\_

Alcohol Use:  None  Rarely (< 12 drinks/year)  Occasionally (< 12 drinks/month)  
 Socially (4-14 drinks/week)  Often (> 2 drinks/day)  Past Problem

Drug Use:  None  Presently  Past Problem

**FAMILY HISTORY** - Please check each condition listed below that either your **Mother (M)**, **Father (F)**, or **Grandparents (G)** have or had.

Stroke	M	F	G	Arthritis	M	F	G	Kidney Trouble or Stones	M	F	G
Heart Trouble	M	F	G	Gout	M	F	G	Cancer	M	F	G
High Blood Pressure	M	F	G	Seizures	M	F	G	Bleeding Disorders	M	F	G
Diabetes	M	F	G	Mental Illness	M	F	G	Alcoholism	M	F	G
Anesthesia Problems	M	F	G								

Other: \_\_\_\_\_

Check this box if your Mother, Father, or Grandparents do not have or never had any of the conditions listed above

**REVIEW OF SYSTEMS** - Please circle **Y** or **N** for each symptom listed below. **Do not leave any blanks.**

<b>Constitutional</b>				<b>Cardiovascular</b>				<b>Genitourinary</b>			
Recent Weight Changes	Y	N		Heart or Chest Pain	Y	N		Frequent Urination	Y	N	
Chills or Fever	Y	N		Abnormal Heartbeat	Y	N		Burning on Urination	Y	N	
Fatigue	Y	N		Badly Swollen Ankles	Y	N		Difficulty Starting Urination	Y	N	
Hot or Cold Spells	Y	N		Calf Cramps while Walking	Y	N		Difficulty Stopping Urination	Y	N	
<b>Eye</b>				<b>Gastrointestinal</b>				Get Up Every Night to Urinate	Y	N	
Change of Vision	Y	N		Poor Appetite	Y	N		Incontinence	Y	N	
Double / Blurred Vision	Y	N		Nausea / Vomiting	Y	N		<b>Neurological</b>			
Reading Glasses	Y	N		Abdominal Pain	Y	N		Frequent Headaches	Y	N	
Eye Pain	Y	N		Frequent Belching	Y	N		Blackouts	Y	N	
<b>Ears / Nose / Throat</b>				Black Stools / Blood in Stool	Y	N		Seizures	Y	N	
Loss of Hearing	Y	N		Constipation / Diarrhea	Y	N		Tremors	Y	N	
Ear Pain	Y	N		Hemorrhoids	Y	N		Loss of Bowel / Bladder Control	Y	N	
Hoarseness	Y	N		<b>Musculoskeletal</b>				Difficulty Balance / Coordination	Y	N	
Nosebleeds	Y	N		Joint Pain / Swelling	Y	N		<b>Psychiatric</b>			
Difficulty Swallowing	Y	N		Joint Stiffness	Y	N		Anxiety / Nervousness	Y	N	
Toothache	Y	N		Limited Use of a Joint	Y	N		Insomnia	Y	N	
Gum Trouble	Y	N		Bone Deformities	Y	N		Depression	Y	N	
<b>Respiratory</b>				Muscle Cramping / Pain	Y	N		<b>Women Only</b>			
Morning Cough	Y	N		Loss of Muscle Strength	Y	N		Irregular Periods	Y	N	
Shortness of Breath	Y	N		<b>Skin</b>				Vaginal Disorder	Y	N	
				Frequent Rash	Y	N		Frequent Spotting	Y	N	
				Jaundice (Yellow Skin)	Y	N		Pregnant	Y	N	

**(For Office Use Only)**

Reviewed for completeness by: \_\_\_\_\_ Date: \_\_\_\_\_

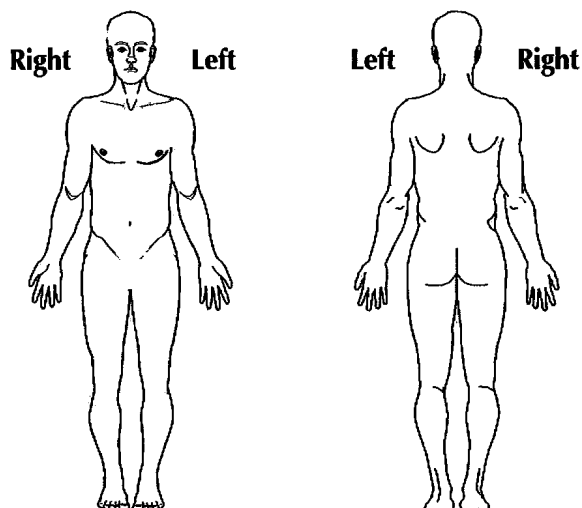
## PAIN HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Chart #: \_\_\_\_\_ Physician: \_\_\_\_\_

INSTRUCTIONS: Please **PRINT**. Fill out all items **completely** prior to seeing the physician.

List the main pain condition or symptom for today's visit: \_\_\_\_\_



In the diagram to the left shade the area(s) that are painful.

Briefly describe your pain problem:

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1. Where are you experiencing pain? (Check ALL that apply)

- Lumbar (low back)     Sacral (buttocks)     Thoracic (mid-back)     Cervical (neck)  
 Cranial (head)     Chest     Abdomen  
 Shoulder \_\_\_R \_\_\_L     Hip \_\_\_R \_\_\_L     Arm \_\_\_R \_\_\_L     Leg \_\_\_R \_\_\_L

2. Describe the quality of your pain: (Check ALL that apply)

- Aching     Drilling     Burning     Cold     Cramping     Crushing     Numb  
 Gnawing     Heaviness     Hot     Nagging     Penetrating     Tingling     Agonizing  
 Pressure     Raw     Sharp     Shock-like     Shooting     Soreness     Stabbing  
 Stinging     Throbbing     Tightness     Exhausting     Other \_\_\_\_\_

3. How long has the current condition been present? \_\_\_ Years    \_\_\_ Months    \_\_\_ Days    Date of onset: \_\_\_\_\_

4. How did the problem begin?

- Gradual onset     Sudden onset     After illness     After surgery  
 Accident/Injury: Date \_\_\_\_\_ Was the accident/injury work related? \_\_\_Y \_\_\_N  
 Describe the accident/injury: \_\_\_\_\_

5. Rate your pain on a scale of 0 to 10 where 0 is no pain and 10 is the worst possible pain:

- a. Your pain today: \_\_\_\_\_  
 b. Your typical or average pain over the last 30 days: \_\_\_\_\_  
 c. Your pain at its worst over the last 30 days: \_\_\_\_\_

6. How often does your pain occur? (Check ONLY one)

- Constant (90-100% of the time)     Frequent (75% of the time)  
 Intermittent (25-50% of the time)     Occasional (10-25% of the time)

7. Is your pain worse at a certain time of the day? If so, when? \_\_\_\_\_
8. Check the box that best fits how your pain affects your daily activities (CHECK ONE)
- None (I do all of my activities)                       Mild (I do all my activities, but I have discomfort)
- Moderate (I can't do all my activities due to pain)                       Severe (I can't do most of my activities due to pain)
- Very Severe (I can't do any of the things I normally do due to pain)
9. List three activities affected by your pain:
- 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_
10. Indicate what effect the following activities have on your pain:

Activity	Better	Worse	No Change
Sitting			
Standing			
Walking			
Laying			
Bending			
Squatting/Kneeling			
Pushing/Pulling			
Reaching/Climbing			
Lifting			
Sneeze/Cough			
Turning Head			
Looking Up or Down			
Rising from Sitting/Lying			
Massaging Area			
Applying Cold/Heat			
Changing Position			

11. What prior pain treatments have you tried?       Physical Therapy       Chiropractor       Exercise       TENS unit
- Medications (list specific medications) \_\_\_\_\_
- Other \_\_\_\_\_
12. What is the highest level of education attained?
- High school       Some college       College graduate       Some post graduate
- Graduate degree       Masters degree       Doctorate       Other \_\_\_\_\_
13. What is your present exercise level?
- None     Exercises regularly     Once/wk     Twice/wk     Three times/wk     Other \_\_\_\_\_
14. What is your home living situation?
- Lives alone                       Lives with spouse/child(ren)       Lives with roommate/significant other
- Lives with mother/father       Assisted living residence       Nursing home

I certify that the answers and explanations that I have provided on this form are true and accurate to the best of my knowledge.

X \_\_\_\_\_  
Signature of Patient or Personal Representative

(For Office Use Only)  
Reviewed for completeness by \_\_\_\_\_ Date: \_\_\_\_\_