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

Orlando Orthopædic Center

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. 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: _____ Gender: _____ 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
- Diabetes ☐Y☐N
- High Blood Pressure ☐Y☐N
- Thyroid Disease ☐Y☐N
- Osteoporosis ☐Y☐N

Pulmonary Disease
- Pneumonia ☐Y☐N
- Asthma ☐Y☐N
- COPD ☐Y☐N
- Tuberculosis ☐Y☐N

CNS Disease
- Stroke ☐Y☐N
- Seizure ☐Y☐N

Cardiac Disease
- Heart Attack ☐Y☐N
- Angina ☐Y☐N
- Heart Murmur ☐Y☐N
- Arrhythmia ☐Y☐N
- Valve Problems ☐Y☐N

Psychiatric Disease
- Depression ☐Y☐N
- Schizophrenia ☐Y☐N
- Bipolar Disorder ☐Y☐N

GI Disease
- Ulcer ☐Y☐N
- Gall Bladder ☐Y☐N
- Hernia ☐Y☐N
- GI Bleed ☐Y☐N
- Obstruction ☐Y☐N

Urologic Disease
- Urinary Tract Infection ☐Y☐N
- Kidney Stone ☐Y☐N
- Dialysis ☐Y☐N

Cancer
- Location _____
- Year Diagnosed _____
- Reoccurrence ☐Y☐N
- Current Treatment ☐Y☐N

Infections
- After Surgery ☐Y☐N
- Venereal Disease ☐Y☐N
- Hepatitis ☐Y☐N
- AIDS ☐Y☐N
- HIV Positive ☐Y☐N
- Osteomyelitis ☐Y☐N

Blood Disorders
- Anemia ☐Y☐N
- Clotting Problems ☐Y☐N
- Hemophilia ☐Y☐N

Arthritis ☐Y☐N
- Rheumatoid ☐Y☐N
- Osteoarthritis ☐Y☐N
- Gout ☐Y☐N

Miscellaneous
- Blood Clots ☐Y☐N
- Thrombophlebitis ☐Y☐N
- Prior Blood Transfusion ☐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

Current 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.**

Constitutional	**Cardiovascular**	**Genitourinary**
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
Eye	**Gastrointestinal**	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	**Neurological**
Reading Glasses ☐ Y ☐ N	Abdominal Pain ☐ Y ☐ N	Frequent Headaches ☐ Y ☐ N
Eye Pain ☐ Y ☐ N	Frequent Belching ☐ Y ☐ N	Blackouts ☐ Y ☐ N
Ears / Nose / Throat	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	**Musculoskeletal**	Difficulty Balance / Coordination ☐ Y ☐ N
Nosebleeds ☐ Y ☐ N	Joint Pain / Swelling ☐ Y ☐ N	**Psychiatric**
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
Respiratory	Muscle Cramping / Pain ☐ Y ☐ N	**Women Only**
Morning Cough ☐ Y ☐ N	Loss of Muscle Strength ☐ Y ☐ N	Irregular Periods ☐ Y ☐ N
Shortness of Breath ☐ Y ☐ N	**Skin**	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: _____

Orlando Orthopædic Center

SPINE HISTORY — SRG

Date:_____

INSTRUCTIONS: Please fill out **completely** prior to seeing the doctor.

First Name:_____ **MI:**_____ **Last Name:** _____

AGE:_____ **DOB:** _____ **Gender:**_____

1. My main problem is:
   Neck Pain ☐ Upper Back Pain ☐ Low Back Pain ☐ Scoliosis ☐
   Arm Pain – Left ☐ Right ☐ Leg pain – Left ☐ Right ☐

2. Who requested you visit this office?
   ☐Doctor (Name)_____ ☐Self Referral ☐Attorney_____

3. What date did you problem start? _____

4. Mechanism of pain onset (check ALL that apply):

☐ Suddenly	☐ Pulling
☐ Gradually	☐ Injured at Work
☐ Lifting	☐ Auto Accident
☐ Twisting	☐ Hit in Back
☐ Fall	☐ Sports
☐ Bending	☐ No apparent cause

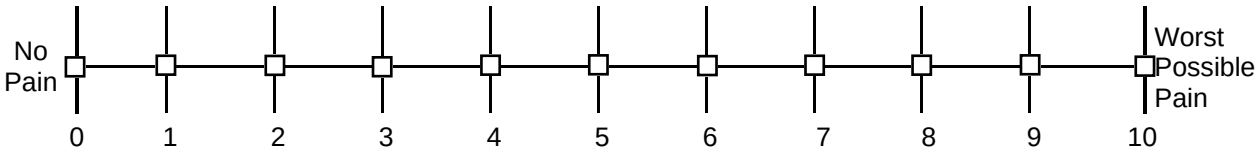
5. Was there an injury? _____ If so, describe:_____

   _____

   _____

6. Since the onset of your pain, has your pain been the
   Same ☐ Increased ☐ Decreased ☐

7. How bad is your pain now?
   a. Please check on the line below how bad your pain is now:



   b. Is the pain constant? _____

   c. Does the pain come and go (intermittent)? _____

   d. Does the pain awaken you from sleep at night? Yes☐ No☐

8. Describe the type of pain. (i.e. Sharp, Dull, Achy, Stabbing, etc.) _____
_____

9. What activities make the pain worse (check ALL that apply):

☐ During Exercise	☐ Bending Forward
☐ After Exercise	☐ Bending Backward
☐ Sitting	☐ Coughing
☐ Standing	☐ Sneezing
☐ Walking	

10. What reduces your pain:

☐ Lying Down	☐ Pain Pills
☐ Sitting	☐ Walking
☐ Standing	☐ Nothing

11. Do you have numbness (tingling) in your:

Right Arm	☐ Yes	☐ No	if yes, where? _____
Left Arm	☐ Yes	☐ No	if yes, where? _____
Right Leg	☐ Yes	☐ No	if yes, where? _____
Left Leg	☐ Yes	☐ No	if yes, where? _____

12. Have you noticed weakness (loss of strength) in your:

Right Arm	☐ Yes	☐ No	if yes, where? _____
Left Arm	☐ Yes	☐ No	if yes, where? _____
Right Leg	☐ Yes	☐ No	if yes, where? _____
Left Leg	☐ Yes	☐ No	if yes, where? _____

13. How far can you walk before you must stop because of pain?

☐ Less than a half of block	☐ One or two city blocks
☐ ½ to one block	☐ More than 3 city blocks

14. Is your bowel and bladder control normal? Yes ☐ No ☐ If No, please explain_____

15. Have you ever had any previous back or neck problem for which you sought treatment with any other doctor or chiropractor? Yes ☐ No ☐
Explain Problem: _____

Explain Type of Treatment: _____

16. Have you had prior back or neck surgery? Yes ☐ No ☐
    a. Symptoms before operation: _____
    b. Surgery performed: _____
       Date of surgery: _____
    c. Did you improve? Yes ☐ No ☐
    d. How much did you improve (%)? _____

17. What doctors have you seen regarding this problem?

Name	Specialty	Dates Treated	Type of Treatment

18. Please check the following regarding diagnostic studies.

	Yes	No	Date	Where
X-Rays:	☐	☐		
CT Scan:	☐	☐		
Myelogram:	☐	☐		
EMG:	☐	☐		
MRI:	☐	☐		
Bone Scan:	☐	☐		

19. Which of the following treatments have you received?

a. Physical Therapy - ☐ Yes ☐ No How many _____ Response (☐ Better ☐ Worse ☐ No Effect)

b. Medicine - ☐ Yes ☐ No How Long _____ Response (☐ Better ☐ Worse ☐ No Effect)

Meds: _____

c. Injections: _____ Where? _____

WORK HISTORY:

1. Are you currently employed? Yes ☐ No ☐
   If so, for whom?_____
2. Are you now working? Yes ☐ No ☐
   Full Time, Regular Duties? Yes ☐ No ☐
   Light Duty? Yes ☐ No ☐
   What restrictions?_____
3. If not working, date last worked: _____
4. What type of work do you, or did you do? _____
5. Describe in detail your work responsibilities: _____

   _____

   _____
6. Do you have a lawyer? Yes ☐ No ☐
7. Are legal proceedings pending? Yes ☐ No ☐

Orlando Orthopædic Center

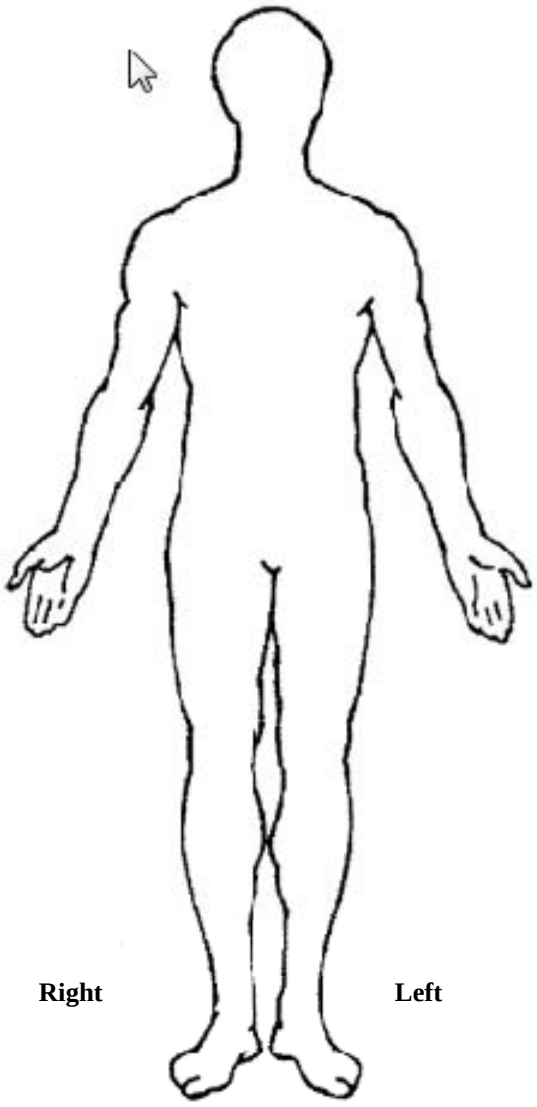
PATIENT PAIN DRAWING

Date:_____

Name:_____ DOB: _____

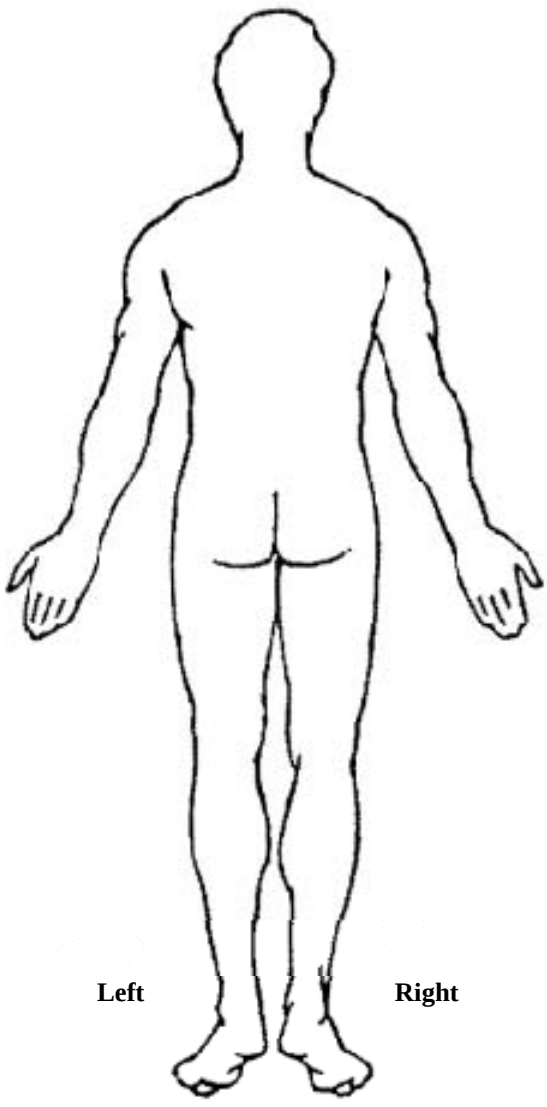
Where is your pain now?
Using the appropriate symbol below, mark the areas on your body where you feel the sensations described. Mark the areas of radiation. Include affected areas.

Aching	Numbness	Pins and Needles	Burning	Stabbing
▲▲▲	= = =	o o o	**x x x**	/ / /



Right **Left**

Front



Left **Right**

Back