

Patient or Patient's Representative or Responsible Party

Financial Policy

Patie	ent Name:	Acct #:	Date:
providir	you for choosing Orlando Orthopaedic Center. We striving transparency regarding any financial responsibilities otential costs of services, please alert one of our team n	. If at any time during your visit you hav	
Please	e review the following.		
1.	Orlando Orthopaedic Center verifies your benefits wit with your insurance company is not a guarantee of be expenses as part of your benefit coverage. Be advise out-of-pocket expenses will be covered.	enefits or payment. You are responsible	e for paying any out-of-pocket
2.	As a courtesy, Orlando Orthopaedic Center provides	2 options for you to pay your out-of-poc	ket expenses for services provided.
	Estimate of Cost Pay today an estimate of fees owed for you the end of your visit today. After your insura expenses for which you will be billed or you	ance company processes your claim you	
	Authorized Payment Option Pay your exact out-of-pocket expenses afte secure your credit card information. After your charged the determined amount for any bala is charged.	our insurance company has processed y	our claim your credit card will be
3.	Assignment of Benefits: In consideration of the treatr benefits you have to Orlando Orthopaedic Center for responsible for any services not covered by your insu	services provided to you. You understan	
4.	For Self-Pay patients with no active insurance covera depending on the level of complexity for the initial offi for services not included in the office visit (examples services being rendered.	ice visit and \$150.00 for each follow-up	office visit. Additional charges apply
5.	If your balance is not paid or a payment arrangement may be assessed as a late fee on your account. Any		
6.	There will be a \$35 fee assessed for insufficient funds	s when paying by check.	
7.	A No Show fee of \$50 may be charged for patients w their scheduled appointment.	ho do not cancel or reschedule their app	pointments prior to 24 hours before
8.	There is a charge for completing individual medical for allow five (5) business days to process all form reque	•	er forms, school forms, etc. Please
	There is a cost for other service(s) such as copying x	x-ray images and medical records.	

Date



Consent for Purposes of Treatment, Payment, and Healthcare Operations

Acct #:	Date:
I consent to medical examination and treatment for parent or legally authorized representative. (If a custody, a legal guardian, or a person authorized incompetent, a legal guardian or conservator must	patient is a minor, the parent having legal by them in writing must sign. If a patient is
I consent to the use or disclosure of my protected Center (OOC) for the purpose of diagnosing and for my health care bills, or to conduct health care diagnosis and/or treatment of me by OOC may b my signature on this document.	or providing treatment to me, obtaining payment e operations for OOC. I understand that
My "protected health information" means health information, collected from me and created or reprovider, a health plan, and my employer or a he information relates to my past, present, and/or fu identifies me, or there is a reasonable basis to be	ceived by my physician, another health care alth care clearinghouse. This protected health atture physical or mental health or condition and
I understand I have the right to request a restriction used or disclosed to carry out treatment, payment is not required to agree to the restrictions that I restriction that I request then the restriction is bir	t, or healthcare operations of the practice. OOC nay request; however, if OOC agrees to a
I have the right to revoke this consent, in writing taken action in reliance on this consent.	s, at any time, except to the extent that OOC has
I understand I have the right to review OOC's Not available to me, prior to signing this document. It types of uses and disclosures of my protected heap payment of my bills, and in the performance of heap Privacy Practices for OOC is also posted at each www.orlandoortho.com . This Notice of Privacy duties with respect to my protected health inform	The Notice of Privacy Practices describes the alth information that will occur in my treatment, health care operations of the OOC. The Notice of office location and on the OOC website at Practices also describes my rights and OOC's
OOC reserves the right to change the privacy pra Practices. I may obtain a revised notice of privac calling the office and requesting a revised copy be of my next appointment.	cy practices by accessing the OOC website,
	I hereby authorize the release of my Protected Health
Signature of Patient or Personal Representative	Information to the following individuals (Please Print):
Name of Patient or Personal Representative	
Date	
Description of Personal Representative's Authority	



Patient Medical History

N N

N N N

N N N

Patient Name:							Cha	art #	t:		_ [Oate:	
Date of Birth:			Age:	_	Sex	:: Primary (Care	Ph	ysician:				
How were you referr	ed t	to u				☐ Work Comp Syste			_		rima	ary Care Physician	
What is the main rea	asor	n foi											
						our pain today?				4-6 m	ode	rate, 7-10 severe)	
PAST HEALTH HIST	OR	ΥO	F PATIENT - Pleas	e ch	eck	Y or N for each condition	n lis	ted	below. Do not leav	e any	blaı	nks.	
Metabolic Disease			CNS Disease			GI Disease			Cancer			Blood Disorders	
Diabetes	Υ	Ν	Stroke	Υ	Ν	Ulcer	Υ	Ν	Location		_	Anemia	Υ
High Blood Pressure	Υ	Ν	Seizure	Υ	Ν	Gall Bladder	Υ	Ν	Year Diagnosed			Clotting Problems	Υ
Thyroid Disease	Υ	Ν	Cardiac Disease			Hernia	Υ	Ν	Reoccurrence	Υ	Ν	Hemophilia	Υ
Osteoporosis	Υ	Ν	Heart Attack	Υ	Ν	GI Bleed	Υ	Ν	Current Treatment	Υ	Ν	Arthritis	Υ
Pulmonary Disease			Angina	Υ	Ν	Obstruction	Υ	Ν	Infections			Rheumatoid	١
Pneumonia	Υ	Ν	Heart Murmur	Υ	Ν	Urologic Disease			After Surgery	Υ	Ν	Osteoarthritis	Υ
Asthma	Υ	Ν	Arrhythmia	Υ	Ν	Urinary Tract Infection	Υ	Ν	Venereal Disease	Υ	Ν	Gout	Υ
COPD	Υ	Ν	Valve Problems	Υ	Ν	Kidney Stone	Υ	Ν	Hepatitis	Υ	Ν	Miscellaneous	
Tuberculosis	Υ	Ν	Psychiatric Disea	se		Dialysis	Υ	Ν	AIDS	Υ	Ν	Blood Clots	Υ
			Depression	Υ	Ν				HIV Positive	Υ	Ν	Thrombophlebitis	Υ
			Schizophrenia	Υ	Ν				Osteomyelitis	Υ	Ν	Prior Blood Transfusion	Υ
Have you ever had a	a pro	bblei	m with anesthesia?		□ N	o □ Yes If yes, ex	фlai	n					
			ONE			5							
Medicat	tion	/ 01	her			Reaction		Mil	_		cırcı Seve	e level of severity Intolerant	
							-	IVIII			OCVC		
							-	Mil	d Moderate		Seve	ere Intolerant	
							-	Mil	d Moderate		Seve	ere Intolerant	
							_	Mil	d Moderate	,	Seve	ere Intolerant	
								Mil	d Moderate		Seve	ere Intolerant	
Reaction	on E	xan	nples: Unknown, Bre	eath	ing	Difficulty, Nausea, Rash	- ı, An						
CURRENT MEDICA Medication &						cations prescribed by a phy			ver-the-Counter (OTC on & Dosage	t), Herb		upplements and Vitamins. Prescribing Physician	-
													_

Patient Name:							_ Cł	nart #:	Page 2			
SOCIAL HISTORY												
Most Recent Occupation	:											
Married □ Single		Div	vorced 🗆	Widowed □	Domes	tic Par	rtnersh	ір□				
Number of Children Livir	ıg:			Presently Living Alone?	□Y	'es	□ No					
Smoking / use of tobacco	o prod	lucts:	□ Never	□ Quit □ Yes If Y	/es / Qu	it, # ye	ears _	#	Packs/Products per Day L	ast Us	se	
Alcohol Use: ☐ None				☐ Rarely (< 12 drinl	ke/vear)			reacion	nally (< 12 drinks/month)			
	lv (4. 1	1 drin	ıks/week)	☐ Often (> 2 drinks	-			ast Pro				
	iy (4-1	4 uiiii	iks/week)	□ Often (> 2 dilliks/	ruay)		шга	151 110	DIEIII			
Drug Use: ☐ None		Prese	ently [Past Problem								
FAMILY HISTORY - Plea					our Moti	ner (M), Fath	er (F),	or Grandparents (G) have or had.			
Stroke	M	F	G	Arthritis	М	F	G		Kidney Trouble or Stones	M	F	G
Heart Trouble	M	F	G	Gout	М	F	G		Cancer	M	F	G
High Blood Pressure	M	F	G	Seizures	М	F	G		Bleeding Disorders	M	F	G
Diabetes	M	F	G	Mental Illness	М	F	G		Alcoholism	M	F	G
Anesthesia Problems	M	F	G									
Other:												
Check this box if your	Moth	er, Fat	ther, or G	randparents do not have	or neve	r had	any of	the co	nditions listed above			
REVIEW OF SYSTEMS -	Pleas	se circ	le Y or N		pelow.	Do no	t leave	e any				
Constitutional			., .,	Cardiovascular			.,		Genitourinary		.,	
Recent Weight Change	S		Y N	Heart or Chest Pain			Y	N	Frequent Urination		Y	N
Chills or Fever			Y N	Abnormal Heartbea			Y	N	Burning on Urination		Y	N
Fatigue			Y N	Badly Swollen Ankle			Y	N	Difficulty Starting Urination		Y	N
Hot or Cold Spells			Y N	Calf Cramps while V Gastrointestinal	vaiking		Y	N	Difficulty Stopping Urination		Y	N
Change of Vision			Y N				Υ	N	Get Up Every Night to Urinate Incontinence)	Y Y	N N
Change of Vision Double / Blurred Vision			Y N	Poor Appetite Nausea / Vomiting			Υ	N	Neurological		ī	IN
Reading Glasses			Y N	Abdominal Pain			Ϋ́	N	Frequent Headaches		Υ	N
Eye Pain			Y N	Frequent Belching			Ϋ́	N	Blackouts		Υ	N
Ears / Nose / Throat			I IN	Black Stools / Blood	l in Stoo	ı	Y	N	Seizures		Ϋ́	N
Loss of Hearing			Y N	Constipation / Diarrh			Y	N	Tremors		Υ	N
Ear Pain			Y N	Hemorrhoids	ica		Y	N	Loss of Bowel / Bladder Cont	rol	Υ	N
Hoarseness			YN	Musculoskeletal			'	11	Difficulty Balance / Coordinat		Ϋ́	N
Nosebleeds			Y N	Joint Pain / Swelling	1		Υ	N	Psychiatric	011	•	.,
Difficulty Swallowing			Y N	Joint Stiffness	1		Y	N	Anxiety / Nervousness		Υ	N
Toothache			Y N	Limited Use of a Jo	int		Y	N	Insomnia		Y	N
Gum Trouble			Y N	Bone Deformities			Y	N	Depression		Υ	N
Respiratory				Muscle Cramping /	Pain		Y	N	Women Only		•	•
Morning Cough			Y N	Loss of Muscle Stre			Y	N	Irregular Periods		Υ	N
Shortness of Breath			Y N	Skin	J		-	. •	Vaginal Disorder		Υ	N
			• •				Υ	N	_			N
					kin)				· · · · · ·			N
(For Office Use On		nplet	eness b	Frequent Rash Jaundice (Yellow Sk	<u>, </u>		Y	N N	Frequent Spotting Pregnant		Y Y	



Patient Problem Questionnaire

Da	ite:	Provid	der:	Chart #	:
Fir	st Name:	MI:	Last Name:		
Ag	e: Date of Birth:				
If c	currently attending school:				
	Name of School:		Sport	s Played:	
1.	What part of the body are you (please specify – R				
	ShoulderElbow	Wrist	Hand	Hip	
	Knee Ankle	Foot	Neck	Back	Other
2.	Are you right or left-handed?				
3.	Is your problem a result of an	ı injury? Y	es No (If "N	No", then procee	d to #8)
4.	What is the date of your injury	y?			
5.	How were you injured?	Sports – ple	ease specify the s	port:	
	_	Car Accider	nt Motorcy	cle Accident	A Fall
6.	Where were you injured?	_ Work	_School	HomeC	Other:
7.	How did the injury occur?				
8.	How long have you had this p	oroblem (Pleas	se specify a numb	er) Days	Weeks
				Mont	hs Years
9.	What types of treatment have Anti-Inflammate Cortisone Inject Physical Thera	ory Medication ctions	s Surgery No Trea		
10.	. How were you referred to us? Primary Care F Emergency Ro	Physician	High Sc _ Other:	chool	
11	. Who is your primary care phy	/sician?			