



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 - \$800.00 depending on the level of complexity for the initial office visit and \$150.00 for each follow-up office visit. 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 acknowledge that I have read 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

Acct #: _____

Date: _____

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: _____ 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	Cardiac Disease	Hernia Y N	Reoccurrence Y N	Hemophilia Y N
Osteoporosis Y N	Heart Attack Y N	GI Bleed Y N	Current Treatment Y N	Arthritis Y N
Pulmonary Disease	Angina Y N	Obstruction Y N	Infections	Rheumatoid Y N
Pneumonia Y N	Heart Murmur Y N	Urologic Disease	After Surgery Y N	Osteoarthritis Y N
Asthma Y N	Arrhythmia Y N	Urinary Tract Infection Y N	Venereal Disease Y N	Gout Y N
COPD Y N	Valve Problems Y N	Kidney Stone Y N	Hepatitis Y N	Miscellaneous
Tuberculosis Y N	Psychiatric Disease	Dialysis Y N	AIDS Y N	Blood Clots Y N
	Depression Y N		HIV Positive Y N	Thrombophlebitis 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.**

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: _____



Patient Problem Questionnaire

First Name: _____ MI: _____ Last Name: _____ DOB: _____ Date: _____

1. When (roughly what date) did your present pain start?

2. Area involved (please check):

- | | | |
|--------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Foot | <input type="checkbox"/> Ankle | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Wrist | <input type="checkbox"/> Elbow |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Back | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Right | <input type="checkbox"/> Left | |

3. Symptoms (please check):

- | | | |
|--------------------------------------|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Swelling | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Instability | <input type="checkbox"/> Giving way | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Locking | <input type="checkbox"/> Catching | <input type="checkbox"/> Tingling |

4. Does your pain radiate or move to another body part?

- Yes Where? _____
 No

5. Which statement best describes your level of pain/symptoms?

- Just want to make sure it's nothing serious
 Aggravating, but I can live with it
 Interferes only with strenuous activity
 Moderate
 Severe
 Disabling
 Other _____

6. How did pain start (check all appropriate boxes)?

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Suddenly | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> Gradually | <input type="checkbox"/> Injured at work |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Injured in auto accident |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Hit from behind |
| <input type="checkbox"/> Fall | <input type="checkbox"/> Injured during sports |
| <input type="checkbox"/> Bending | <input type="checkbox"/> No apparent cause |

7. What activities make pain/symptoms worse?

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Bending |
| <input type="checkbox"/> Running | <input type="checkbox"/> Kneeling |
| <input type="checkbox"/> Exercise (during) | <input type="checkbox"/> Squatting |
| <input type="checkbox"/> Exercise (after) | <input type="checkbox"/> Stairs |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Lying in bed | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Other _____ | |

8. What reduces the pain/symptoms?

- | | |
|---|---|
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Pain pills |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Muscle Relaxant pills |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Aspirin or anti-inflammatory pills |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Physical Therapy _____ | |
| <input type="checkbox"/> Nothing _____ | |

9. How long have you had this pain/symptom?

_____ years _____ months _____ weeks

How long have you had similar pain?

_____ years _____ months _____ weeks

10. What other doctors or health care providers have you seen for this condition?

Name	Specialty	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. Have you had any of these diagnostic studies?

	Yes	No	Date
X-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT (computed tomography) scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI (magnetic resonance imaging)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthrogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sonogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Electromyogram (EMG)	<input type="checkbox"/>	<input type="checkbox"/>	_____

12. Have you been hospitalized for your pain problem?

- Yes # of times _____ Dates _____
 No _____

13. Have you had surgery for this problem?

- Yes # of times _____ Type of surgery _____
 No Date _____

14. Are you still working?

- Yes
 No Last day on job _____

15. Do you plan to be at your regular job in 6 months?

- Yes No

16. Do you like your job?

- Yes No

17. Are you under stress at home or work?

- Yes No

18. Please indicate last grade completed in school: _____

19. To be sure paperwork is filled out correctly, please check if appropriate:

- | | |
|---|--|
| <input type="checkbox"/> On Workman's Compensation | <input type="checkbox"/> Receiving disability income |
| <input type="checkbox"/> Report should be sent to:
Name: _____ | <input type="checkbox"/> Legal proceeding pending |
| Address: _____ | |

20. Do you have any additional information that would be helpful in understanding your problem?

PATIENT PAIN DRAWING

Name: _____ Date: _____

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

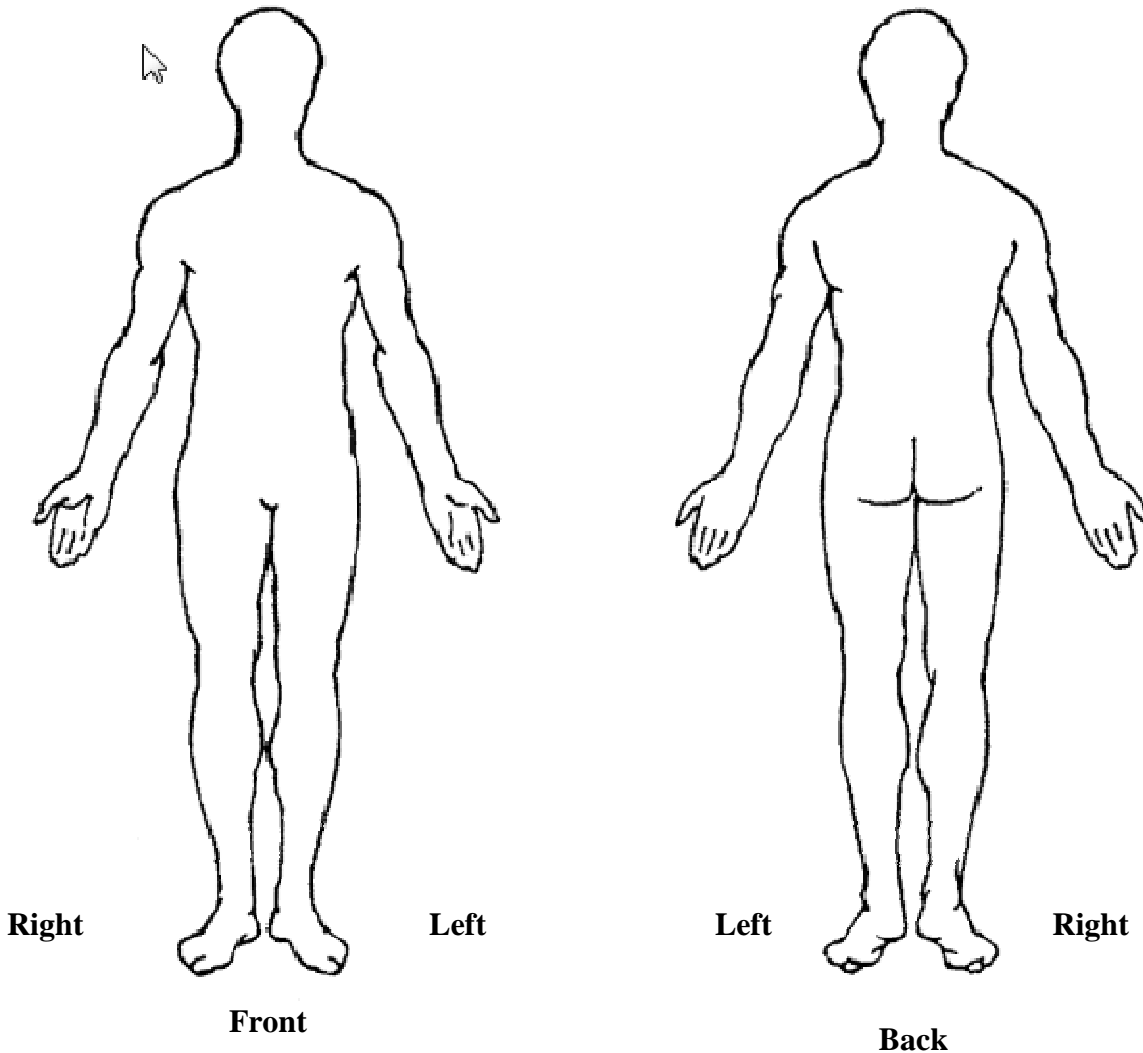
○○○

Burning

xxx

Stabbing

///



How Bad is your pain now?

Please mark with a X on the body from where the pain is worst now.

Please mark on the line below how bad your pain is now.

