

Financial Policy

Patient Name: _____

Chart #: _____

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

Patient: _____

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.

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

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Orlando Orthopaedic Center

Patient: _____ Account #: _____

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 circle 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 select Y or N for each symptom listed below. Do not leave any blanks.

Constitutional

Recent Weight Changes Y N
 Chills or Fever Y N
 Fatigue Y N
 Hot or Cold Spells Y N

Cardiovascular

Heart or Chest Pain Y N
 Abnormal Heartbeat Y N
 Badly Swollen Ankles Y N
 Calf Cramps while Walking Y N

Genitourinary

Frequent Urination Y N
 Burning on Urination Y N
 Difficulty Starting Urination Y N
 Difficulty Stopping Urination Y N
 Get Up Every Night to Urinate Y N

Eye

Change of Vision Y N
 Double / Blurred Vision Y N
 Reading Glasses Y N
 Eye Pain Y N

Gastrointestinal

Poor Appetite Y N
 Nausea / Vomiting Y N
 Abdominal Pain Y N
 Frequent Belching Y N
 Black Stools / Blood in Stool Y N

Neurological

Frequent Headaches Y N
 Blackouts Y N
 Seizures Y N
 Tremors Y N
 Loss of Bowel / Bladder Control Y N
 Difficult Balance/Coordination Y N

Ears / Nose / Throat

Loss of Hearing Y N
 Ear Pain Y N
 Hoarseness Y N
 Nosebleeds Y N
 Difficulty Swallowing Y N
 Toothache Y N
 Gum Trouble Y N

Musculoskeletal

Joint Pain / Swelling Y N
 Joint Stiffness Y N
 Limited Use of a Joint Y N
 Bone Deformities Y N
 Muscle Cramping / Pain Y N
 Loss of Muscle Strength Y N

Psychiatric

Anxiety / Nervousness Y N
 Insomnia Y N
 Depression Y N

Respiratory

Morning Cough Y N
 Shortness of Breath Y N

Skin

Frequent Rash Y N
 Jaundice (Yellow Skin) Y N

Women Only

Irregular Periods Y N
 Vaginal Disorder Y N
 Frequent Spotting Y N
 Pregnant Y N

(For Office Use Only):

Reviewed for completeness by: _____

Date: _____

Spine History

Patient: _____ Account #: _____
Date: _____

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

1. My main problem is:

- Neck Pain Upper Back Pain Low Back Pain Scoliosis
Arm Pain Right Left Bilateral Leg Pain Right Left Bilateral Sacrum/Coccyx

2. Who requested you visit this office?

- Doctor (Name): _____ Self Referral Work Comp Attorney (Name): _____

3. Which is worse?

- Neck pain OR Back pain OR Equal
 Back pain OR Leg pain OR Equal
 Right leg pain OR Left leg pain OR Equal
 Neck pain OR Arm pain OR Equal
 Right arm pain OR Left arm pain OR Equal

4. What date did your problem start?

Date: _____

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

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Suddenly | <input type="checkbox"/> Fall | <input type="checkbox"/> Auto Accident |
| <input type="checkbox"/> Gradually | <input type="checkbox"/> Bending | <input type="checkbox"/> Hit in Back |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Pulling | <input type="checkbox"/> Sports |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Injured at Work | <input type="checkbox"/> No apparent cause |

6. Was there an injury?

- Yes No If yes, describe: _____

7. Since the onset of your pain, has your pain been the:

- Same Increased Decreased

8. How bad is your pain now?

No Pain < ----- > Worst Possible Pain

- 0 1 2 3 4 5 6 7 8 9 10

If you have neck pain: 0 1 2 3 4 5 6 7 8 9 10

If you have back pain: 0 1 2 3 4 5 6 7 8 9 10

8a. Is your pain constant or intermittent?

- Constant Intermittent

8b. Does the pain awaken you from sleep at night?

- Yes No

9. Describe the type of pain:

- Sharp Stabbing Dull Achy Throbbing Burning Shooting

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

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

11. What reduces your pain:

- Lying Down Standing Walking
- Sitting Pain Pills Nothing

12. 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? _____

13. 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? _____

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

- Less than 1/2 block 1/2 to 1 block 1 or 2 city blocks More than 3 city blocks No Limitation

15. Have you had any recent loss of bowel/bladder function?

- Yes No

If yes, please explain.

16. Do you have any unsteadiness or loss of balance with walking?

- Yes No If yes, please explain. _____

17. Any recent fever or chills or infections?

- Yes No If yes, please explain. _____

18. Have you ever had any previous back or neck problem for which you sought treatment with any other doctor or chiropractor?

- Yes No

a. Explain Problem: _____

b. Explain Type of Treatment: _____

19. Have you had prior back or neck surgery?

- Yes No

a. Symptoms before operation: _____

b. Surgery performed: _____

c. Date of surgery: _____

d. Did you improve? Yes No

e. How much did you improve (%)? _____

20. What doctors have you seen regarding this problem? (List name, specialty, dates treated and type of treatment)

21. Please check the following regarding diagnostic studies:

	Yes	No	Date	Where
Xrays:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
CT Scan:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Myelogram:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
EMG:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MRI:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bone Scan:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

22. Which of the following treatments have you received?

Physical Therapy Yes No How many _____ Response: Better Worse No Effect

Medicine Yes No How long _____ Response: Better Worse No Effect

Meds: _____

Injections: _____ Where: _____

Work History

1. Are you currently employed?

Yes No If yes, for whom? _____

2. Are you now working?

Yes No

a. Full time, regular duties?

Yes No

b. Light duties?

Yes No If yes, what restrictions? _____

3. If not working, date last worked:

Date: _____

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

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