



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

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	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G	Arthritis	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G	Kidney Trouble or Stones	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G
Heart Trouble	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G	Gout	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G	Cancer	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G
High Blood Pressure	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G	Seizures	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G	Bleeding Disorders	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G
Diabetes	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G	Mental Illness	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G	Alcoholism	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> G
Anesthesia Problems	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 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	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart or Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Urination	<input type="checkbox"/> Y <input type="checkbox"/> N
Chills or Fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal Heartbeat	<input type="checkbox"/> Y <input type="checkbox"/> N	Burning on Urination	<input type="checkbox"/> Y <input type="checkbox"/> N
Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N	Badly Swollen Ankles	<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty Starting Urination	<input type="checkbox"/> Y <input type="checkbox"/> N
Hot or Cold Spells	<input type="checkbox"/> Y <input type="checkbox"/> N	Calf Cramps while Walking	<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty Stopping Urination	<input type="checkbox"/> Y <input type="checkbox"/> N
Eye		Gastrointestinal		Get Up Every Night to Urinate	<input type="checkbox"/> Y <input type="checkbox"/> N
Change of Vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Poor Appetite	<input type="checkbox"/> Y <input type="checkbox"/> N	Incontinence	<input type="checkbox"/> Y <input type="checkbox"/> N
Double / Blurred Vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Nausea / Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N	Neurological	
Reading Glasses	<input type="checkbox"/> Y <input type="checkbox"/> N	Abdominal Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N
Eye Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Belching	<input type="checkbox"/> Y <input type="checkbox"/> N	Blackouts	<input type="checkbox"/> Y <input type="checkbox"/> N
Ears / Nose / Throat		Black Stools / Blood in Stool	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Loss of Hearing	<input type="checkbox"/> Y <input type="checkbox"/> N	Constipation / Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Tremors	<input type="checkbox"/> Y <input type="checkbox"/> N
Ear Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of Bowel / Bladder Control	<input type="checkbox"/> Y <input type="checkbox"/> N
Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N	Musculoskeletal		Difficulty Balance / Coordination	<input type="checkbox"/> Y <input type="checkbox"/> N
Nosebleeds	<input type="checkbox"/> Y <input type="checkbox"/> N	Joint Pain / Swelling	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric	
Difficulty Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N	Joint Stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety / Nervousness	<input type="checkbox"/> Y <input type="checkbox"/> N
Toothache	<input type="checkbox"/> Y <input type="checkbox"/> N	Limited Use of a Joint	<input type="checkbox"/> Y <input type="checkbox"/> N	Insomnia	<input type="checkbox"/> Y <input type="checkbox"/> N
Gum Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N	Bone Deformities	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Respiratory		Muscle Cramping / Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Women Only	
Morning Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of Muscle Strength	<input type="checkbox"/> Y <input type="checkbox"/> N	Irregular Periods	<input type="checkbox"/> Y <input type="checkbox"/> N
Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin		Vaginal Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N
		Frequent Rash	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Spotting	<input type="checkbox"/> Y <input type="checkbox"/> N
		Jaundice (Yellow Skin)	<input type="checkbox"/> Y <input type="checkbox"/> N	Pregnant	<input type="checkbox"/> Y <input type="checkbox"/> N

(For Office Use Only)

Reviewed for completeness by: _____ Date: _____

PAIN HISTORY

Patient Name: _____

Chart#: _____

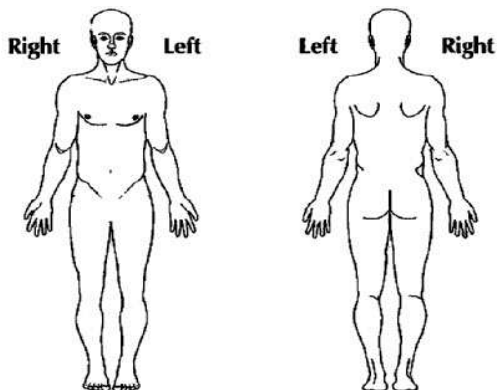
Date: _____

Referred By? Physician _____

Other _____

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:

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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Lumbar (low back) | <input type="checkbox"/> Sacral (buttocks) | <input type="checkbox"/> Thoracic (mid-back) | <input type="checkbox"/> Cervical (neck) |
| <input type="checkbox"/> Cranial (head) | <input type="checkbox"/> Chest | <input type="checkbox"/> Abdomen | |
| <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Arm <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Leg <input type="checkbox"/> R <input type="checkbox"/> L |

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

- | | | | | | |
|-----------------------------------|------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Heaviness | <input type="checkbox"/> Sharp | <input type="checkbox"/> Exhausting | <input type="checkbox"/> Numb | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Gnawing | <input type="checkbox"/> Raw | <input type="checkbox"/> Tightness | <input type="checkbox"/> Cramping | <input type="checkbox"/> Tingling | _____ |
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Cold | <input type="checkbox"/> Penetrating | <input type="checkbox"/> Soreness | _____ |
| <input type="checkbox"/> Stinging | <input type="checkbox"/> Burning | <input type="checkbox"/> Nagging | <input type="checkbox"/> Shooting | <input type="checkbox"/> Agonizing | |
| <input type="checkbox"/> Drilling | <input type="checkbox"/> Hot | <input type="checkbox"/> Shock-like | <input type="checkbox"/> Crushing | <input type="checkbox"/> Stabbing | |

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? Yes No
- 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: _____ c. Your pain at its worst over the last 30 days: _____
- b. Your typical or average pain over the last 30 days: _____

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

- | | |
|--|--|
| <input type="checkbox"/> Constant (90%-100% of the time) | <input type="checkbox"/> Frequent (75% of the time) |
| <input type="checkbox"/> Intermittent (25-50% of the time) | <input type="checkbox"/> 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)

- | | |
|---|---|
| <input type="checkbox"/> None (I do all of my activities) | <input type="checkbox"/> Mild (I do all my activities, but I have discomfort) |
| <input type="checkbox"/> Moderate (I can't do most of my activities due to pain) | <input type="checkbox"/> Severe (I can't do all my activities due to pain) |
| <input type="checkbox"/> Very Severe (I can't do any of the things I normally do due to pain) | |

Patient : _____
Account #: _____

9. Please list three specific activities (bowling, emptying dishwasher, etc.) that your pain currently prevents you from doing:

1) _____ 2) _____ 3) _____

10. List previous recent treatments (within the last 6 months) you have had for the current pain problem:

Treatment	Yes / No	Start Date	End Date	# of Sessions	Helpful? Yes / No
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	__/__/__	__/__/__	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chiropractic	<input type="checkbox"/> Yes <input type="checkbox"/> No	__/__/__	__/__/__	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home Exercise Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	__/__/__	__/__/__	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Massage Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	__/__/__	__/__/__	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acupuncture/Biofeedback	<input type="checkbox"/> Yes <input type="checkbox"/> No	__/__/__	__/__/__	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain Counseling	<input type="checkbox"/> Yes <input type="checkbox"/> No	__/__/__	__/__/__	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	__/__/__	__/__/__	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

11. Medications tried for pain (list specific medications): _____

12. Have you had previous accident, injury, or pain in this region prior to this episode that required visits to a doctor, testing, or treatment? Yes No

If yes, please explain: _____

13. Do you take any doctor-prescribed blood thinning medications or herbal supplements? Yes No

If yes, please list: _____

14. Do you have any liver, kidney, or blood clotting disorders or problems? Yes No

If yes, please explain: _____

15. Do you have any allergies to local anesthetics (numbing medicines), steroid preparations, or medical contrast agents (IVP dye, etc)? Yes No

If yes, please list: _____

16. What is your current activity level? Light Moderate Vigorous

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