Orlando Orthopædic Center
OrlandoOrtho.com

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. At your request, a Good Faith Estimate will be provided prior to your visit. 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.
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 $270.00 - $864.00 depending on the level of complexity for the initial office visit and $162.00 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

Orlando Orthopædic Center
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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 Medical History

Patient: **Chart:** **Date:** _____

Gender: **AGE:** **DOB:** **Primary Care Provider:** _____

Pharmacy Name: _____ **Phone:** _____ **Address:** _____

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 circle **Y** or **N** for each condition listed below. Do not leave any blanks.

Metabolic Disease	**Blood Disorders**	**GI Disease**	**Cancer**
Diabetes Y N	Anemia Y N	Ulcer Y N	Location _____
High Blood Pressure Y N	Clotting Problems Y N	Gall Bladder Y N	Year Diagnosed _____
Thyroid Disease Y N	Hemophilia Y N	Hernia Y N	Reoccurrence Y N
Osteoporosis Y N	**Cardiac Disease**	GI Bleed Y N	Current Treatment Y N
Pulmonary Disease	Heart Attack Y N	Obstruction Y N	**Infections**
Pneumonia Y N	Angina Y N	**Urologic Disease**	After Surgery Y N
Asthma Y N	Heart Murmur Y N	Urinary Tract Infection Y N	Venereal Disease Y N
COPD Y N	Arrhythmia Y N	Kidney Stone Y N	Hepatitis Y N
Tuberculosis Y N	Valve Problems Y N	Dialysis Y N	AIDS Y N
Psychiatric Disease	**Arthritis**	**Miscellaneous**	HIV Positive Y N
Depression Y N	Rheumatoid Y N	Blood Clots Y N	Osteomyelitis Y N
Schizophrenia Y N	Osteoarthritis Y N	Thrombophlebitis Y N	**CNS Disease**
Bipolar Disorder Y N	Gout Y N	Prior Blood Transfusion Y N	Stroke Y N
			Seizure 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? ☐ Yes ☐ No If yes, explain _____

ALLERGIES: ☐ NONE

Medication / Other	**Reaction**	**Severity of Allergy**			
_____	_____	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**
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

*** PLEASE CONTINUE AND COMPLETE PAGE 2 OF THE PATIENT MEDICAL HISTORY ***

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			**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**			Difficult 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: _____

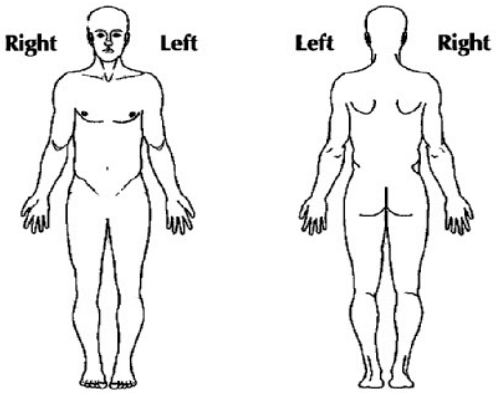
PAIN HISTORY

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)

☐ Lumbar (low back) ☐ Sacral (buttocks) ☐ Thoracic (mid-back) ☐ Cervical (neck)
☐ Cranial (head) ☐ Chest ☐ Abdomen
☐ Shoulder ☐ R ☐ L ☐ Hip ☐ R ☐ L ☐ Arm ☐ R ☐ L ☐ Leg ☐ R ☐ L

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

☐ Aching ☐ Heaviness ☐ Sharp ☐ Exhausting ☐ Numb ☐ Other_____
☐ Gnawing ☐ Raw ☐ Tightness ☐ Cramping ☐ Tingling _____
☐ Pressure ☐ Throbbing ☐ Cold ☐ Penetrating ☐ Soreness _____
☐ Stinging ☐ Burning ☐ Nagging ☐ Shooting ☐ Agonizing
☐ Drilling ☐ Hot ☐ Shock-like ☐ Crushing ☐ 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: _____
b. Your typical or average pain over the last 30 days: _____
c. Your pain at its worst over the last 30 days: _____

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

☐ Constant (90%-100% of the time) ☐ Frequent (75% of the time)
☐ Intermittent (25-50% of the time) ☐ 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)

☐ None (I do all of my activities) ☐ Mild (I do all my activities, but I have discomfort)
☐ Moderate (I can't do most of my activities due to pain) ☐ Severe (I can't do all my activities due to pain)
☐ Very Severe (I can't do any of the things I normally do due to pain)

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	☐ Yes ☐ No	__ / __ / ____	__ / __ / ____	_____	☐ Yes ☐ No
Chiropractic	☐ Yes ☐ No	__ / __ / ____	__ / __ / ____	_____	☐ Yes ☐ No
Home Exercise Program	☐ Yes ☐ No	__ / __ / ____	__ / __ / ____	_____	☐ Yes ☐ No
Massage Therapy	☐ Yes ☐ No	__ / __ / ____	__ / __ / ____	_____	☐ Yes ☐ No
Acupuncture/Biofeedback	☐ Yes ☐ No	__ / __ / ____	__ / __ / ____	_____	☐ Yes ☐ No
Pain Counseling	☐ Yes ☐ No	__ / __ / ____	__ / __ / ____	_____	☐ Yes ☐ No
Other: _____	☐ Yes ☐ No	__ / __ / ____	__ / __ / ____	_____	☐ Yes ☐ 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