Total Orthopaedic Care - History of Present Issue

Name:_____ Date: _____

Body Part / Reason for Visit:

_____

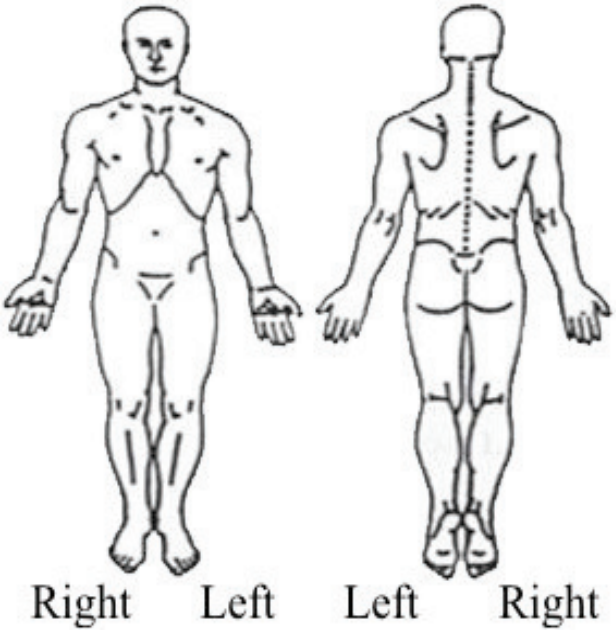
Date of Injury: _____ ❍ None

Duration of Symptoms (How long have you had this problem): _____

On a scale of one to ten, how severe is your pain
❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7 ❍ 8 ❍ 9 ❍ 10

Please describe the symptoms:
❍ Aching ❍ Burning ❍ Cold ❍ Cramping
❍ Electrical ❍ Itchy ❍ Numb ❍ Radiating
❍ Sensitive ❍ Sharp ❍ Shooting ❍ Tingling
❍ Throbbing ❍ Unpleasant ❍ None
❍ Other: _____

Please mark problem area



What is the timing of the symptoms:
❍ Intermittent (Rarely) ❍ Variable (Depends on what you are doing) ❍ Constant (All the time)

****

Where were you when you injured it / noticed the issue? _____

Does it correlate to an event or trauma?_____

Location of the pain on body part (front, back, side): _____

What makes it better? _____

What makes it worse? _____

Have you any treatment (medications, injections, physical therapy, etc) for this problem?

_____

Physician Notes:

Patient Info

Name:_____ Date: _____

Dominant Hand: ❍ Right Hand ❍ Left Hand ❍ Ambidextrous (both)
Race: ❍ Caucasian/White ❍ African American ❍ Asian ❍ Native American / Alaskan
Ethnicity: ❍ Non-Hispanic ❍ Hispanic ❍ Unknown ❍ Decline to Answer
Preferred Language: ❍ English ❍ Spanish ❍ French ❍ Other _____
Referring Physician: _____
Did a physician see you for this problem and send you to our office? ❍ Yes ❍ No
How were you referred to us?
_____

Past Surgical History
Select all previous hospitalizations/surgeries: ❍ None

❍ Aortic Bypass / Vascular Surgery ❍ Lumpectomy
❍ Heart Surgery ❍ Mastectomy
❍ Hysterectomy ❍ Malignancy / Cancer
❍ LAP Band / Gastric Bypass Surgery ❍ Stents

Other Surgery / Orthopaedic or otherwise:
_____
_____
_____

Orthopaedic Surgery	Right	Left
Arthroscopy: Knee	❍	❍
Arthroscopy: Shoulder	❍	❍
Carpal Tunnel Release	❍	❍
Rotator Cuff Repair	❍	❍
Total Hip Replacement	❍	❍
Total Knee Replacement	❍	❍
Total Shoulder Replacement	❍	❍
Spinal Surgery Indicate Level	❍	❍

Medical Questions Mark all that currently apply:
Height: _____ Weight: _____
Females: Pregnant ❍ Yes ❍ No
How old where you when you had your first period?
Date of last Period? _____
_____ (teenage girls only)
Pacemaker ❍ Yes ❍ No
Are you taking blood thinners? ❍ Yes ❍ No
If yes, what is the name of the medication?
❍ Coumadin/Warfarin ❍ Xarelto/Rivaroxaban ❍Pradaxa/Dabigatran ❍ Eliquis / Apixaban
❍ Plavix ❍ Lovenox ❍ Heparin ❍ Other: _____
Do you take Aspirin regularly? ❍ Yes ❍ No

Family History
Have any direct relatives had any of the following disorders? ❍ None for all

Father:	❍ None	❍ Rheumatoid Arthritis	❍ Cancer	❍ Bleeding Problems
Mother:	❍ None	❍ Rheumatoid Arthritis	❍ Cancer	❍ Bleeding Problems
Siblings:	❍ None	❍ Rheumatoid Arthritis	❍ Cancer	❍ Bleeding Problems

Social History

Do you smoke tobacco?	❍ Never	❍ Occasionally	❍ Daily	❍ Former Smoker	❍ Unknown
Do you drink alcohol?	❍ Never	❍ Rarely	❍ Occasionally	❍ Daily	
Do you have a history of drug abuse?	❍ No	❍ Yes			
Marital History:	❍ Married	❍ Single	❍ Divorced	❍ Widowed	❍ Domestic Partnership
Are you currently working?	❍ Yes	❍ No	❍ Retired	❍ Disables	❍ Student

Occupation: _____
Employer: _____

Patient Info

Name:_____ Date: _____

Medical Conditions:

Do you have any allergies? ❍ Yes ❍ No

If yes, please list: _____

Latex Allergy: ❍ Yes ❍ No

Do you have a personal history of any of the following? ❍ None

❍ Arthritis – ❍ Osteo ❍ Rheumatoid
❍ Asthma
❍ Bleeding Disorders Type: _____
❍ Bone or Joint Infection
❍ Cancer Type: _____
❍ Diabetes ❍ Insulin ❍ Pills ❍ Both
❍ Heart Disease Type: _____
❍ Hepatitis Type ❍ A ❍ B ❍ C
❍ HIV/AIDS
❍ High Cholesterol
❍ Hypertension
❍ Kidney Disease Type: ____
❍ Lung Disease Type: _____
❍ MRSA Infection
❍ Neurological Disorder Type: _____
❍ Osteoporosis
❍ Psychological Issues
❍ Anesthesia Reaction Type: _____
❍ Active Ulcer
❍ Seizures
❍ Thyroid Disease

Other: _____

Review of Systems

Please indicate if you have experienced any of the following symptoms in the **last 6 months**? ❍ None for All

1)	❍ Weight loss	❍ Loss of appetite	❍ Fatigue
2)	❍ Blurred vision	❍ Double vision	❍ Vision loss
3)	❍ Hearing loss	❍ Hoarseness	❍ Trouble swallowing
4)	❍ Chest pain	❍ Palpitations	
5)	❍ Chronic cough	❍ Pneumonia	❍ Shortness of breath
6)	❍ Heartburn, ulcers	❍ Nausea, vomiting	❍ Blood in stool
7)	❍ Painful urination	❍ Blood in urine	❍ Kidney problems
8)	❍ Frequent rashes	❍ Skin ulcers	❍ Lump ❍ Psoriasis
9)	❍ Frequent falls	❍ Loss of coordination	❍ Numbness
	❍ Change in bowel	❍ Change in bladder	❍ Dizziness
10)	❍ Depression/Anxiety	❍ Drug/Alcohol Addiction	❍ Sleep disorder
11)	❍ Fever	❍ Heat or Cold Intolerance	❍ Night sweats
12)	❍ Easy bleeding	❍ Easy bruising	❍ Anemia
13)	❍ Joint pain	❍ Neck pain	❍ Back pain
14)	❍ Hay fever	❍ Drug allergies	

TOTAL ORTHOPAEDIC CARE, PA
4850 W OAKLAND PARK BLVD, SUITE 201, LAUDERDALE LAKES, FL 33313 (Tax ID: 65-0557162)

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. The patient agrees, before the services are provided, that the amount the provider charges for services are reasonable, usual and customary. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days**. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the**

Office Manager. See Fla. Stat. §673.3111. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

EUOs and IMEs: If the insurer schedules a defense physical examination (hereinafter an IME) or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. The provider is authorized and entitled to copy of the IME report and the EUO.

Payment agreement: I agree to pay: for all services; any applicable deductible or co-payment; for services rendered after the policy of insurance exhausts; and for any other services unrelated to the automobile accident in a timely fashion.

Express Consent and Release of information: For the next seven years, I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, the patient's attorney and hired experts via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. For the next seven years, the provider is permitted to produce my medical records to its attorney and experts in connection with any pending lawsuits. The patient's other medical providers are authorized to sign affidavits and testify justifying the patient's care and treatment. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide the patient's medical records to anyone without the patient's and the provider's prior express written permission. The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider and to request a copy of any medical records, statements or examinations under oath given by the patient.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute and when the policy is exhausted.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. **If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____ (3-17)

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Authorization / Release Form

Total Orthopaedic Care, P.A.

Notice of Privacy Practices (HIPAA)

_____ I acknowledge I have received a copy of Total Orthopaedic Care, P.A. Notice of Privacy Practices
(initials)

Medical Information Release

I authorize the physicians of T.O.C. to release any information including diagnosis acquired in the course
_____ of my exam to any health care facilities, physicians, insurance carriers, or collection agencies.
(initials)

Assignment of Benefits

I authorize my insurance carrier to pay directly to T.O.C. the medical benefits otherwise payable to me for their services, but not exceed the charges of those services. I further understand that I am fully responsible for service provide that are not covered by my insurance. I hearby irrevocably assign to T.O.C. any benefits under any policy Of insurance, indemnity agreement, or any other collateral source as defined in the Florida statues for any service and/
_____ charges provided by T.O.C.
(initials)

Communication

I agree to receive emails and texts to the numbers listed on file and understand I may be subject to the text messaging rates of my cellular plan. The staff at T.O.C. is authorized to call me at the above listed numbers. If I am not
_____ available, they are permitted to leave a message with whomever answers or an answering machine / voice mail.
(initials)

Patient Financial Responsibility

As a courtesy to our patients, TOC verifies insurances in advance. However it is ultimately the patient's responsibility to be aware of all co-payments, co-insurances, and deductibles. Any quote of patient responsibility by TOC is an **estimate** and may not reflect the actual amount due from the patient for services rendered. Any additional amounts due will be billed to the patient upon receipt of the EOB from the insurance company. These amounts are solely the patient's responsibility, regardless of any quote previously provided by TOC.

It is the policy of this office to collect all co-payments, deductibles, and co-insurances indicated as the patient's responsibility by their insurance company. We can not waive or reduce any patient's responsibility as per our contract with your insurance company.

It is the policy of this office to charge a $35.00 no show fee for any appointments missed and not canceled or rescheduled 24 hours in advance to the appointment time. I understand the above and that I am responsible to cancel or reschedule my appointments 24 hours in advance or pay the $35.00 No Show fee for missed appointments. I understand the above and
_____ that I am solely responsible for any amounts deemed due by me according to my insurance plan and agree to pay promptly.
(initials)

Consent for Treatment

I consent to and authorize a physician and/or health care professional of T.O.C. to perform a physical examination, procedures, diagnostic procedure, and to prescribe a therapeutic regimen. I acknowledge implicit permission for T.O.C. to import my prescription history from the medication / pharmacy database into my account when an appointment was made
_____ on my behalf.
(initials)

Total Orthopaedic Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Records Release

By my signature below, I hereby authorize the release of my diagnostic imaging results, medical records, hospital records, consultations, lab work, or any other pertinent medical information from any medical provider, hospital, attorney or insurance company upon receipt of a copy of this form, to:

Total Orthopaedic Care Phone: 954-735-3535, Fax: 954-484-7000

_____ _____ _____

Name (Print) **Signature** **Date**

HIPAA Omnibus Notice of Privacy Practices - Total Orthopaedic Care

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

•Complaints

If you believe your privacy rights have been violated by us, you may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint. You may also complain to us or to the Secretary of Health and Human Services.

HIPAA Compliance Officer: Linda Sacco

Phone: 954-735-3535 Email: lsacco@toc.md

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care
• Share information in a disaster relief situation
• Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

• Marketing purposes
• Sale of your information
• Most sharing of psychotherapy notes

In the case of fundraising:

• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

• Preventing disease
• Helping with product recalls
• Reporting adverse reactions to medications
• Reporting suspected abuse, neglect, or domestic violence
• Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

• For workers' compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will never share any substance abuse treatment records without your written permission.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site, www.toc.md.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Locations:

Total Orthopaedic Care
4850 W Oakland Park Blvd Suite 201 Lauderdale Lakes Fl 33313
10794 Pines Blvd Suite 104 Pembroke Pines Fl 33026

3-2017