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): ____

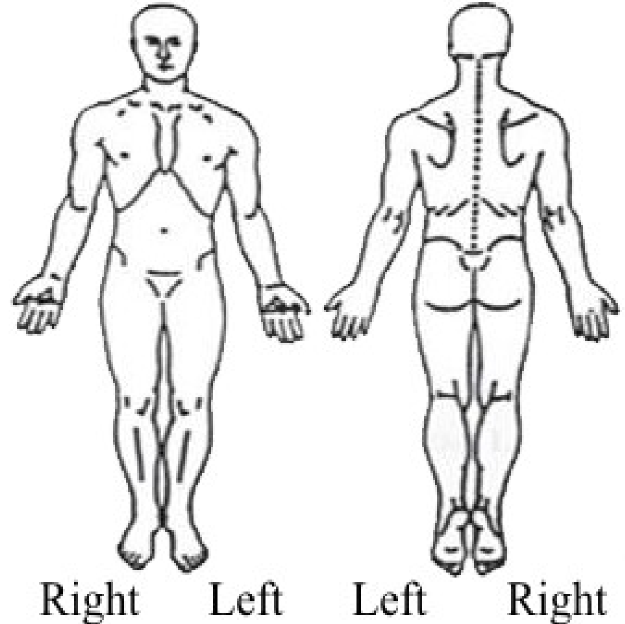
On a scale of one to ten, how severe is your pain

❍ 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
❍ Heart Surgery
❍ Hysterectomy
❍ LAP Band / Gastric Bypass Surgery
❍ Lumpectomy
❍ Mastectomy
❍ Malignancy / Cancer
❍ 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
Date of last Period? ____________
How old where you when you had your first 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 ❍ Change in bowel	❍ Loss of coordination ❍ Change in bladder	❍ Numbness ❍ 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	

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.

<u>Your Rights</u>

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.

<u>Locations:</u>

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