

## 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



## 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](http://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	<b>Cardiac Disease</b>	GI Bleed Y N	Current Treatment Y N
<b>Pulmonary Disease</b>	Heart Attack Y N	Obstruction Y N	<b>Infections</b>
Pneumonia Y N	Angina Y N	<b>Urologic Disease</b>	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
<b>Psychiatric Disease</b>	<b>Arthritis</b>	<b>Miscellaneous</b>	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	<b>CNS Disease</b>
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. _____	_____

# 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

### Eye

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

### Respiratory

Morning Cough                                    Y    N  
 Shortness of Breath                                Y    N

### Cardiovascular

Heart or Chest Pain                                Y    N  
 Abnormal Heartbeat                                Y    N  
 Badly Swollen Ankles                              Y    N  
 Calf Cramps while Walking                        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  
 Constipation / Diarrhea                            Y    N  
 Hemorrhoids    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

### Skin

Frequent Rash                                        Y    N  
 Jaundice (Yellow Skin)                            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

### Incontinence

Incontinence                                        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

### Psychiatric

Anxiety / Nervousness                              Y    N  
 Insomnia    Y    N  
 Depression    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 Supplement - SEW/RRP/SXR

Patient Name: \_\_\_\_\_

Chart#: \_\_\_\_\_

Date: \_\_\_\_\_

Physician: \_\_\_\_\_

## 1. Who requested you visit this office?

Doctor (name) \_\_\_\_\_  Self Referral  Attorney \_\_\_\_\_

## 2. Did you bring X-Rays with you? Yes No

## 3. My main reason for this visit is:

Pain  Numbness  Weakness  Other (Chief Complaint) \_\_\_\_\_

## 4. What body part is involved?

<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Back <input type="checkbox"/> Mid <input type="checkbox"/> Lower	<input type="checkbox"/> Arm <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Finger <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Toe <input type="checkbox"/> R <input type="checkbox"/> L

## 5. How long has this problem been present?

Days  Weeks  Months

## 6. The pain is:

Constant  Come and Goes (intermittent)

## 7. The severity of the pain is:

Mild  Moderate  Severe  Extremely Severe

## 8. What is the quality of the pain?

Sharp  Dull  Stabbing  Throbbing  Aching  Burning

Other: \_\_\_\_\_

## 9. Do you have any of the following associated symptoms?

Swelling  Numbness  Weakness

## 10. Since my problem started, it is:

Getting Better  Getting Worse  Unchanged

## 11. Does your pain wake you from sleep?

Yes  No

## 12. What makes your symptoms worse?

Activity  Exercise  Work  Other \_\_\_\_\_

## 13. Which of the following make you feel better?

Rest  Heat  Ice  Elevation  Other \_\_\_\_\_

## 14. What medications have you been taking for this problem?

\_\_\_\_\_

## 15. Which treatments have you tried?

Injections  Brace  Therapy  Cane/Crutch

Patient: \_\_\_\_\_  
Account #: \_\_\_\_\_  
 Yes  No

**16. Have you had a prior problem with this same Orthopaedic condition/problem in the past?**

**17. Have you had prior?**

- Back Pain                       Joint Swelling                       Prior Fracture                       Arthritis                       MRI

**18. Check the box that best fits how your problem started.**

- No Injury (Onset was gradual or sudden)  
Why do you think it started? \_\_\_\_\_
- No Injury (Work Related)  
How did your job cause this problem? \_\_\_\_\_
- Injured in an Auto Accident      Date Injured: \_\_\_\_\_  
How was your car hit? \_\_\_\_\_
- Injured at Work      Date Injured: \_\_\_\_\_  
Where and how did it happen? \_\_\_\_\_
- Injured Playing a Sport      Date Injured: \_\_\_\_\_  
Where and how did it happen? \_\_\_\_\_
- Injured in an Accident (Not an Auto or Work Accident) Date Injured: \_\_\_\_\_  
Where and how did it happen? \_\_\_\_\_

**19. What other doctors have you seen for this problem/injury?**

Doctor	Date Seen	Treatment Provided
_____	_____	_____
_____	_____	_____
_____	_____	_____

**20. Have you had prior surgery to your neck/back?**  Yes  No

Doctor	Date Seen	Type of Surgery	Result (Better/Worse)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**21. Are you presently employed?**  Yes  No

What is your regular job? \_\_\_\_\_

Are you working regular duty?  Yes  NO

If No, describe your work restrictions: \_\_\_\_\_

**22. Records available for review (Physicians to complete)**

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

Patient:  
Account #:

## PATIENT PAIN DRAWING

### Where is your pain now?

Using the appropriate symbol below, mark the areas on your body where you feel the sensations described. Mark the areas of radiation. Include affected areas.

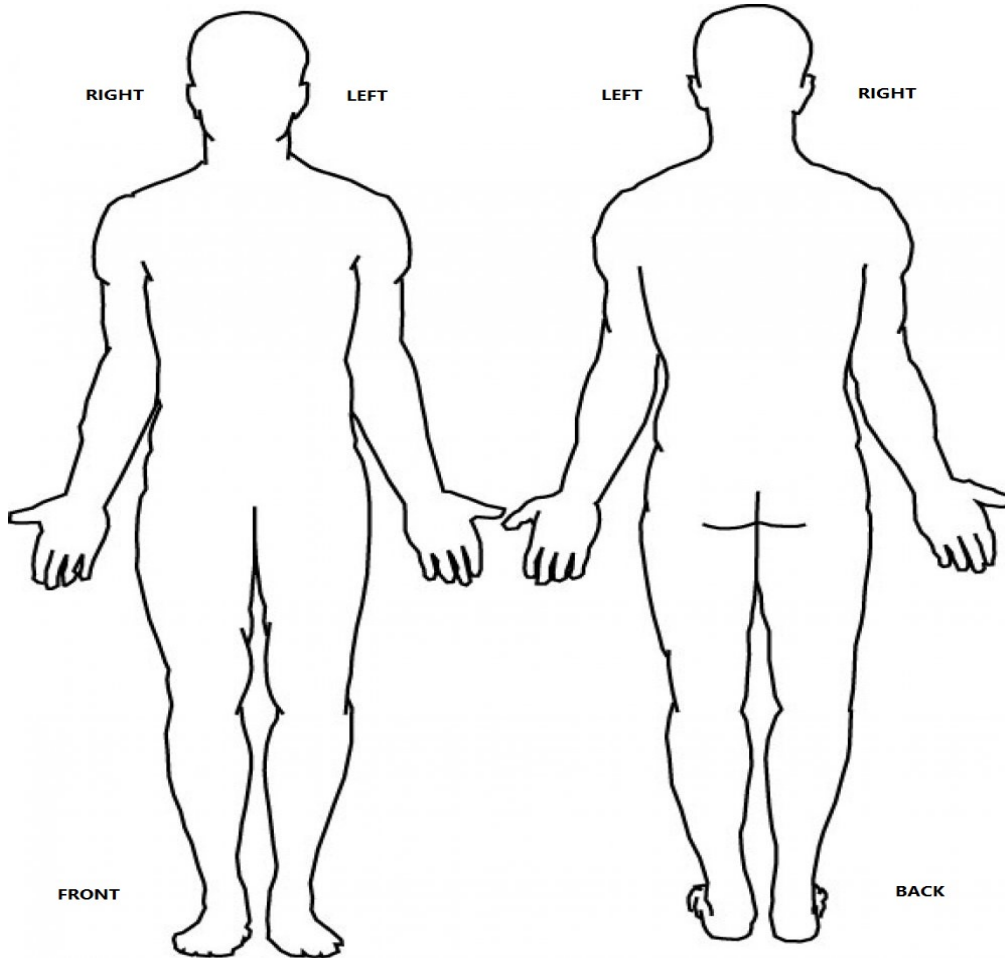
Aching  
▲ ▲ ▲

Numbness  
= = =

Pins and Needles  
o o o

Burning  
x x x

Stabbing  
/ / /



### How bad is your pain now?

Please mark with a X on the body from where the pain is worst now?

Please mark with a check in the box below how bad your pain is now:

No Pain    0    1    2    3    4    5    6    7    8    9    10   Worst Possible Pain