SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT INFORMATION

06/2016

Welcome to South Florida Orthopaedics & Sports Medicine

Patient's Last Name:	First Name:	Middle Name:
Social Security #:	Birth Date:	Sex: ☐M ☐F

Primary Street Address:		
City:	State:	Zip:
County:	Primary Care Physician:	Referring Physician:

Alternate Street Address/Northern Address:		
City:	State:	Zip:

Race:	Language Spoken: ☐ English ☐ Spanish ☐ Other -	Religion:	Ethnicity: ☐ Non Hispanic/Non-Latino ☐ Hispanic / Latino
Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed		Student: ☐ Yes ☐ No Smoker: ☐ Yes ☐ No	Veteran: ☐ Yes ☐ No

Preferred Method of Contact: ☐ Cell Phone ☐ Primary phone		E-Mail Address:
Primary Phone:	Cell Phone:	Secondary Phone:

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

Patient's Employer Name:		
Employer Street Address:		
Employer City:	Employer State:	Employer Zip:
Employer Phone:	Employer Fax Number (if known):	

By my signature below, I affirm the above information is current and accurate to the best of my knowledge.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT INFORMATION (continued)

06/2016

Patient Name:	Date of Birth:

EMERGENCY CONTACT:	Relationship to Patient:
Emergency Contact Phone Number:	

REASON FOR TODAY'S VISIT:

- ☐ **OTHER (not an Accident or Injury)**
- ☐ **INJURY**
- ☐ **WORKERS COMPENSATION ACCIDENT**
- ☐ **AUTO ACCIDENT**
- ☐ **OTHER TYPE OF ACCIDENT:** _____

If INJURY or ACCIDENT:

WHEN did it occur? Date: Time:	WHERE did it occur?
Was a POLICE REPORT filed? ☐ NO ☐ YES, Police Department Name:	
Do you have ATTORNEY REPRESENTATION for this Injury or Accident? ☐ NO ☐ YES, Attorney Name:	Attorney Phone Number:
Do you have a WORKERS' COMPENSATION ADJUSTER regarding this Injury or Accident? ☐ NO ☐ YES, Adjuster Name:	Adjuster Phone Number:

IF PATIENT IS A MINOR:

Parent's or Legal Guardian's Last Name:	Parent's or Legal Guardian's First Name:	
Relationship to Patient		
Primary Street Address:		
City:	State:	Zip:
County:		
Race:	Language Spoken: ☐ English ☐ Spanish ☐ Other -	Ethnicity: ☐ Non Hispanic/Non-Latino ☐ Hispanic / Latino
Preferred Method of Contact: ☐Cell Phone ☐Email ☐Home phone ☐Work phone	E-Mail Address:	
Home Phone:	Day (Work) Phone:	Cell Phone:

By my signature below, I affirm the above information is current and accurate to the best of my knowledge.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT INSURANCE INFORMATION

05/2018

☐ ***Please provide us with your current insurance card(s).***

☐

Patient Name:	**Date of Birth:**

☐

PRIMARY INSURANCE ☐**None** **Patient Insurance Information:** ☐**Health Insurance Claim** ☐**Worker's Compensation Claim** ☐**Auto Accident Claim**		
Insurance Company:	Policy Number:	Group Number:
Primary Insured Name:	Relationship to Patient:	
Primary Insured Employer:		
Employer Address: Street: City/State/Zip:		
Employer Phone:		
If NOT the Patient:		
Primary Insured Last Name:	First Name:	Middle Name:
Social Security #:	Birth Date:	Sex: ☐M ☐ F
Street Address:		
City:	State:	Zip:
Home Phone:	Work (Day) Phone:	Cell (Alt) Phone:

☐

SECONDARY INSURANCE ☐**None** **Patient Insurance Information:** ☐**Health Insurance Claim** ☐**Worker's Compensation Claim** ☐**Auto Accident Claim**		
Insurance Company:	Policy Number:	Group Number:
Primary Insured Name:	Relationship to Patient:	
Primary Insured Employer:		
Employer Address: Street: City/State/Zip:		
Employer Phone:		
If NOT the Patient:		
Primary Insured Last Name:	First Name:	Middle Name:
Social Security #:	Birth Date:	Sex: ☐M ☐ F
Street Address:		
City:	State:	Zip:
Home Phone:	Work (Day) Phone:	Cell (Alt) Phone:

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT INFORMATION (continued)

06/2016

Patient Name:	Date of Birth:

EMERGENCY CONTACT:	Relationship to Patient:
Emergency Contact Phone Number:	

REASON FOR TODAY'S VISIT:

- ☐ **OTHER (not an Accident or Injury)**
- ☐ **INJURY**
- ☐ **WORKERS COMPENSATION ACCIDENT**
- ☐ **AUTO ACCIDENT**
- ☐ **OTHER TYPE OF ACCIDENT:** _____

If INJURY or ACCIDENT:	
WHEN did it occur? Date: Time:	WHERE did it occur?
Was a POLICE REPORT filed? ☐ NO ☐ YES, Police Department Name:	
Do you have ATTORNEY REPRESENTATION for this Injury or Accident? ☐ NO ☐ YES, Attorney Name:	Attorney Phone Number:
Do you have a WORKERS' COMPENSATION ADJUSTER regarding this Injury or Accident? ☐ NO ☐ YES, Adjuster Name:	Adjuster Phone Number:

IF PATIENT IS A MINOR:

Parent's or Legal Guardian's Last Name:	Parent's or Legal Guardian's First Name:	
Relationship to Patient		
Primary Street Address:		
City:	State:	Zip:
County:		
Race:	Language Spoken: ☐ English ☐ Spanish ☐ Other -	Ethnicity: ☐ Non Hispanic/Non-Latino ☐ Hispanic / Latino
Preferred Method of Contact: ☐ Cell Phone ☐ Email ☐ Home phone ☐ Work phone	E-Mail Address:	
Home Phone:	Day (Work) Phone:	Cell Phone:

By my signature below, I affirm the above information is current and accurate to the best of my knowledge.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

ACKNOWLEDGEMENT OF RECEIPT
HIPAA CONSENT FORM

06/2016

Patient Name:	Date of Birth:

This consent form allows South Florida Orthopaedics & Sports Medicine to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

South Florida Orthopaedics & Sports Medicine has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at South Florida Orthopaedics & Sports Medicine.

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments. ☐ cell phone ☐ e-mail ☐ home phone ☐ work phone

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the clinic while I meet with my healthcare provider(s).

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may disclose my personal health information to the person who I have listed as my emergency contact.

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that South Florida Orthopaedics & Sports Medicine services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that South Florida Orthopaedics & Sports Medicine may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while South Florida Orthopaedics & Sports Medicine is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that South Florida Orthopaedics & Sports Medicine may refuse me services if I refuse to sign this consent.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT ASSIGNMENT OF BENEFITS

06/2016

Patient Name:	Date of Birth:

ASSIGNMENT OF BENEFITS, LIEN, & AUTHORIZATION

I hereby authorize and direct you (my insurance company, liability insurance adjuster, and/or attorney) to pay directly to South Florida Orthopaedics & Sports Medicine ("office"), such as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

If I have a Medigap policy, I request that payment of authorized Medigap benefits be made either to me or on my behalf to South Florida Orthopaedics & Sports Medicine for any services furnished to me by a provider in the group. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

In the event my insurance company obligated to make payments to me upon the charges made by this office for services rendered refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company any authorize this office to prosecute said cause of action either in my name or in the office's name. I further authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as it sees fit.

If my claims are related to an automobile accident, I hereby authorize South Florida Orthopaedics & Sports Medicine to obtain my PIP log showing all payments made by my automobile insurance.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Irrevocable Assignment, Lien, & Authorization does not constitute any consideration for the office to await payments; the office may demand payments from me immediately upon rendering services, at its option. Such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balance due this office, including agency fees and reasonable attorney's fees.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Irrevocable Assignment, Lien, & Authorization. I agree that the above-mentioned office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I, individually, and/or my successors hereby waive any statute of limitation, defense of the time for claims to be filed, any argument of estoppels, or other defenses to the timely filing of a claim by South Florida Orthopaedics & Sports Medicine as they pertain to any claim filed against me beyond any statutory period applicable to any proceeding after services were rendered. A photocopy of this agreement shall be considered as effective and valid as the original.

Signature _____ Date: _____

Witness Signature _____ Date: _____

For Internal Use Only:

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

FINANCIAL POLICY DISCLOSURE

05/2018

Patient Name:	Date of Birth:

South Florida Orthopaedics & Sports Medicine is committed to providing our patients with the best possible medical care while minimizing administrative costs. We have outlined our Financial Policy below to avoid any misunderstanding concerning payment for professional medical services, and to clearly outline your financial responsibilities as our patient, and how our practice will help you.

Our practice participates with numerous insurance companies.
For patients who are beneficiaries of one of these insurance companies, our Business Office will submit a claim for all services rendered.
For patients who have insurance in which we do not participate, our Business Office will be glad to submit a claim for all services rendered, upon your request. However, full payment is expected at the time of service.

For patients who do not have insurance, it is the patient's responsibility to pay for all professional medical services at the time of service, unless prior arrangements have been made with us. A discount may apply to charges if paid in full at the time of service.

It is the patient's responsibility to ensure that any required authorizations/referrals for treatment are provided to our Office prior to your visit. Visits should be rescheduled until authorization is received. Otherwise, the patient may be financially responsible for all charges due to lack of authorization/referral.

It is the patient's responsibility to provide our practice with current insurance information. Please bring your insurance card to each visit. In the event we are not provided with current or accurate information, and submitted claims are denied, the patient remains financially responsible for all charges.

It is the patient's responsibility to complete all necessary insurance information, including any special forms, prior to leaving the office.

It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges (as specified by your insurance plan) at the time of visit. It is also the patient's responsibility to pay for any medical services not covered by your insurance plan, and payment in full is due at the time of visit.

Our practice provides for payment by cash, check, or credit or debit card.

Our Business Office staff will be glad to help patients with any insurance questions relating to how a claim was filed, or regarding any additional information your insurance company might need to process your claim. Please keep in mind that some specific coverage issues can only be addressed by the insurance company member services department, and their telephone number is printed on your insurance card.

Thank you for choosing South Florida Orthoapedics & Sports Medicine for your healthcare needs. We're glad to help answer any questions about your financial arrangements and this Financial Policy. Please sign below as your acknowledgement of our Financial Policy.

Signature _____ Date: _____

Witness Signature _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

HEALTH INFORMATION EXCHANGE (HIE)
2018-2019

05/2018

Patient Name:	Date of Birth:

A Health Information Exchange (HIE) allows your medical information to be available and viewed electronically by other physicians and medical team providers. The HIE is designed to provide quick access to medical records so that patient care and treatment is more efficient and effective. Any authorized healthcare provider who agrees to participate in the HIE can electronically access and use your protected health information, if needed, to provide care and treatment to you.

For our patient's convenience, South Florida Orthopaedics & Sports Medicine (SFO) has elected to become an authorized healthcare provider and participate in the HIE.

- Participating in the HIE means that you no longer need to call our office to request your medical records from us be sent to another physician.
- As long as another physician is also participating, you no longer need to call other physicians to request your medical records from another physician be sent to our office.

OPTION 1: - OPT-IN

Patient Signature: _____ Date: _____

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However, you may choose to OPT-OUT of this Health Information Exchange (HIE) service convenience. If you decline to participate, please carefully read and sign the information below. You may change your selection and OPT-IN at any time in the future.

I and/or my legally authorized representative have considered whether to allow my information to be access in HIEs in which South Florida Orthopaedics & Sports Medicine participates. At this time, I have decided to OPT-OUT of this service.

I understand that by choosing to OPT-OUT of the HIEs, I hereby acknowledge and agree:

- This revocation only applies to the sharing of health information through the HIE. Healthcare providers may still have access to my health information using other method, such as fax, telephone or mail.
- By opting out of participant in the HIE, any other physicians involved in my care outside SFO will NOT be able to search, via the HIE, for SFO health information to use while treating me.
- My HIE OPT-OUT election will remain in effect until I notify South Florida Orthopaedics & Sports Medicine in writing, of my willingness to rescind it, and have received notification of receipt of said communication. Communications regarding participation in the HIE should be directed to:
- This OPT-OUT request may take up to seven (7) business days to become effective.
- Any information shared before I submit this HIE OPT-OUT form may remain with providres who accessed information before this went into effect.

☐ I have read and understand this information provided, and wish to be <u>unenrolled</u> in the Health Information Exchange (HIE). **If you OPT-OUT,** please sign below and return this form to the Front Desk.

OPTION 2: - OPT-OUT

Patient Signature: _____ Date:_____

Signature of Parent (if minor)/
Authorized Representative: _____ Date:_____