

INSTITUTE FOR NON-SURGICAL ORTHOPEDICS

DATE: _____

Referred By: Dr.: _____ -Yellow Pages—Patient—Internet—Other _____

Last Name: First: Middle:

Address: City: State: Zip:

Home Phone: Cell: Other:

Date of Birth: Age: Sex:

Social Security # Marital Status: S M W D SEP

Employer: Phone:

Emergency Contact: Relationship: Phone:

Current Medical Problem: Primary Care Physician:

_____-YES _____-NO Date of Onset/Injury: _____
Was This an Accident

-Auto- -Work Comp- -Slip/Fall- _Other: _____

Responsible Party Name: Address: Phone:

Primary Insurance: ID# Group#

Secondary Insurance: ID# Group#

“Any person who, knowingly and within intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Florida Statute 817.234.”

Patient Signature: Date:

EMAIL ADDRESS: _____

FINANCIAL POLICY

The purpose of this form allows Institute for Non-Surgical Orthopedics to treat you, and bill any insurance's you may have, share information with other health care offices/facilities, and collect on your account.

Regarding Insurance: Our office participates with Medicare and many managed care companies, including Auto and Workers Comp. As a courtesy we will bill all insurances. However, Co-payments, Co-insurances, Deductibles, and Non-covered services are the responsibility of the patient/guarantor and expected at the time of service. Any amounts not paid at time of service are subject to additional administrative fees as outlined below.

I authorize treatment by the providers of Non-Surgical Orthopedics. I authorize the release of any information requested by insurance companies or liable third parties and I assign all benefits or injury benefits to Non-Surgical Orthopedics. If the correct insurance is not provided or the proper referral is not obtained, then patient acknowledges full responsibility for the bill.

I acknowledge that I received or read a copy of the Notice of Privacy Practices, which are posted in the waiting room.

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay all reasonable Attorney's Fee, Collection Agencies Fee, court costs and any other collection related fees incurred on my account. I also understand that my employer may be contacted to verify employment status.

Special Needs: There are times when making a payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise staff prior to receiving treatment. Co-pays are exempt as required by law and your insurance company. You are required to notify us if this is worker's comp or accident to avoid additional financial costs. If you are not covered by any insurance, let us know you are a self-pay and ask about our same day discounts.

Note our Fees for the following:

Returned check fee \$30.00.

Any forms such as FMLA, Disability, etc. range from \$15.00-\$35.00 each.

There may be a \$25.00 fee for any appointment not kept without 24-hour notice.

Co-pays, Coinsurance, Deductibles and Non-Covered services not paid at time of service will result in an additional \$10.00 monthly service fee.

If a referral is required and not obtained, you will be responsible for payment for those services. Incorrect insurance information provided or changes in policies will be patient responsibility.

Patient/Guardian Signature/Date

Relationship to Patient

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), 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 and I authorize and request such litigation. 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. 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.

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. 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 attention of the **Office Manager**. See 673.3111.

EUOs and IMEs: If the insurer schedules a defense examination 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.

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. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. 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 and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney 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 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. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

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.

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. Please ask to view a copy of our charges. 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 _____

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the below from to the best of your ability.

Patient's Name: _____ Birth Date: _____ Date: _____

Chief Complaint: _____

History of Present Illness:

Location: _____
(where is pain or problem)

Quality: _____
(example: normal vs. abnormal, color, etc)

Severity: _____
(how severe is pain on scale 1-5, 5 being the most severe start?)

Duration: _____
(how long have you had pain/problem, when did it start?)

Timing: _____
(does pain/problem occur at a specific time)

Context: _____
(where were you at the onset of pain/problem)

Associated Symptoms: _____

Modifying Factors: _____

(what other associated problems have you been having)

(what makes the pain/problem better or worse)

Past Medical History:

Have you ever had the following: (Circle yes or no, leave blank if uncertain)

Measles	yes	no	Anemia	yes	no	Back Trouble	yes	no	Hepatitis	yes	no
Mumps	yes	no	Bladder Infection	yes	no	High blood pressure	yes	no	Ulcer	yes	no
Chicken pox	yes	no	Epilepsy	yes	no	Low blood pressure	yes	no	Kidney disease	yes	no
Whooping cough	yes	no	Migraines	yes	no	Hemorrhoids	yes	no	Thyroid disease	yes	no
Scarlet fever	yes	no	Tuberculosis	yes	no	Date of last chest x-ray	_____	Bleeding	yes	no	
Diphtheria	yes	no	Diabetes	yes	no	Asthma	yes	no	Any other disease:	_____	
Small pox	yes	no	Cancer	yes	no	Hives or Eczema	yes	no		_____	
Pneumonia	yes	no	Polio	yes	no	Aids or HIV	yes	no		_____	
Rheumatic fever	yes	no	Glaucoma	yes	no	Infectious mono	yes	no		_____	
Heart Disease	yes	no	Hernia	yes	no	Bronchitis	yes	no		_____	
Arthritis	yes	no	Blood/Plasma	yes	no	Mitral valve prolapse	yes	no		_____	
Venereal disease	yes	no	Transfusion	yes	no	Stroke	yes	no		_____	

Previous Hospitalizations/Surgeries/Serious Illness:	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: _____

Medications: (Include non-prescription)

Medication:	Dosage:	How Taken:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History:

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____
 Use of alcohol: Never _____ Rarely _____ Moderate _____ Daily _____
 Use of tobacco: Never _____ Previous but quit/date _____ Current # of packs per day _____

Family Medical History: Age Disease If Deceased, Cause of death

Father: _____

Mother: _____

Sibling: _____

Sibling : _____

Children: _____

Spouse: _____

Review of Systems: Please indicate any personal history below:

--Constitutional Symptoms		--Genitourinary		--Psychiatric	
Good general health lately	yes no	Frequent urination	yes no	Memory loss or confusion	
Recent weight change	yes no	Painful urination	yes no	Nervousness	yes no
Fever	yes no	Blood in urine	yes no	Depression	yes no
Fatigue	yes no	Change in force of strain		Insomnia	yes no
Headaches	yes no	when urinating	yes no		
		Incontinence or dribbling	yes no		
--Eyes		Kidney Stones	yes no	--Endocrine	
Eye disease or injury	yes no	Sexual difficulty	yes no	Glandular or hormone problem	yes no
Wear glasses or contact lenses	yes no	Male-Testicular pain	yes no	Excessive thirst or urination	yes no
Blurred or double vision	yes no	Female-Pain with period	yes no	Heat or cold intolerance	yes no
		Female-Irregular periods	yes no	Skin becoming dryer	yes no
--Ears/Nose/Mouth/Throat		Female-Vaginal discharge	yes no	Change in hat or glove size	
Hearing loss or ringing	yes no	Female-# of pregnancies _____			
Earaches or drainage	yes no	Female-# of miscarriages _____		--Hematologic/Lymphatic	
Chronic sinus problems	yes no	Female-Date of last pap smear _____		Slow to heal after cut	yes no
Nose bleeds	yes no			bleeding or bruising tendency	yes no
Mouth sores	yes no	--Musculoskeletal		Anemia	yes no
Bleeding gums	yes no	Joint pain	yes no	Phlebitis	yes no
Bad breath or bad taste	yes no	Joint stiffness or swelling	yes no	Past transfusion	yes no
Sore throat or voice change	yes no	Weakness of muscle/joint	yes no	Enlarged glands	yes no
Swollen glands in neck	yes no	Back pain	yes no		
		Cold extremities	yes no	--Date of last:	
--Cardiovascular		Difficulty walking	yes no	Mammgram: _____	
Heart trouble	yes no			Pap Smear: _____	
Chest pain or angina pectoris	yes no	--Integumentary (Skin/Breast)		PSA: _____	
Palpitation	yes no	Rash or itching	yes no	Colonoscopy: _____	
Shortness of breath when walking or lying flat	yes no	Change in skin color	yes no	Other Tests: _____	
Swelling of feet,ankles or hands	yes no	Change in hair or nails	yes no		
		Varicose veins	yes no		
--Respiratory		Breast pain	yes no		
Chronic or frequent cough	yes no	Breast lump	yes no		
Spitting up blood	yes no	Breast discharge	yes no		
Shortness of breath	yes no				
Wheezing	yes no	--Neurological			

		Frequent or recurring headaches	yes	no	
--Gastrointestinal		Light headed or dizzy	yes	no	
Loss of appetite	yes	no	Convulsions or seizure	yes	no
Change in bowel movements	yes	no	Numbness or tingling		
Nausea or vomiting	yes	no	sensation	yes	no
Frequent diarrhea	yes	no	Tremors	yes	no
Painful bowel movement	yes	no	Paralysis	yes	no
Constipation	yes	no	Head injury	yes	no
Rectal bleeding or blood in stool	yes	no			
Abdominal pain	yes	no			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Signature of Patient, Parent, or Guardian

Date

INSTITUTE FOR NON-SURGICAL ORTHOPEDICS
Pain Management Agreement

The purpose of this agreement is to prevent misunderstandings about certain medications you may be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled substances.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and my doctor undertakes to treat me based on this agreement.

I understand that if I break this agreement, my doctor will stop prescribing these pain controlling medications.

In this case, my doctor will taper off the medication's over a period of several days, as necessary, to avoid with-drawl symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication helps to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication's with anyone.

I will not attempt to obtain any controlled medication's, including opiod pain medication's, controlled stimulant's, or anti-anxiety medication's from any other doctor.

I will safeguard my medication's from loss or theft. I understand lost or stolen medication's will not be replaced.

I agree that refills for pain medication's will only be made at time of an office visit during regular business hours. No refills will be available during weekends or after normal business hours.

I agree to use _____ Pharmacy

located at _____

telephone number is _____, for filling prescriptions for all of my pain medications.

I authorize the doctor and my pharmacy to cooperate fully with any, city, state or federal law enforcement agency, including this state's Board of Pharmacy in the investigation of my possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respects to these authorizations.

I agree to submit to blood or urine test if requested by my doctor to determine my compliance with my program of pain control medications.

I agree to use my medication's as directed and understand use greater than as directed may result in being without medication.

I agree to bring unused medications to each office visit.

I agree to follow these guidelines, which have been fully explained to me. I also acknowledge that all of my questions and concerns have been adequately answered and I have received a copy of this agreement.

Patient Signature/Date

Physician Signature/Date

Witness/Date

WORKERS COMPENSATION INFORMATION SHEET

DATE: _____ EMPLOYEE: _____

NAME OF EMPLOYER: _____

WORK ADDRESS: _____

TELEPHONE-Home/Cell: _____

CONTACT NAME/PHONE: _____

DATE OF ACCIDENT: _____

BODY AREA OF COMPLAINT: _____

LOCATION OF ACCIDENT: _____

DID YOU GO TO HOSPITAL: NAME/ADDRESS: _____

TRANSPORTED BY AMBULANCE: _____

HAVE YOU BEEN TREATED BY A DOCTOR, NAME/ADDRESS: _____

DID YOU HAVE X-RAYS, CT SCAN, OR MRI, WHERE: _____

DESCRIBE HOW ACCIDENT HAPPENED:

“Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Florida Statute 817.234.”

Patient Signature/Date: _____