Patient Medical-Information History

Today's Date ____/____ /_____ **Date of Birth____/____/____**

MRN#_____

Last Name _____ First Name _____ Middle Initial_____

Reason for visit_____
Injury Type
(Circle One) **No Injury** **Work Injury** **Car Accident** **Slip & Fall** **Symptoms Start Date_____**

Past Medical History: (Circle all that apply)

Stomach ulcers	Sleep apnea	Diabetes
COPD (Bronchitis or emphysema)	Asthma	Shortness of breath
Kidney Disease	Diarrhea - Constipation	Chest pains or angina
Kidney Stones	Heart Attacks	Dizziness or fainting spells
Irregular Heartbeat, palpitations	Back Pains	History of MRSA
Leg cramps	Migraines	Hepatitis C
GERD	Gout	Thyroid (Hyper-Hypo)
Epilepsy or seizures	Anemia	Joint swelling/Joint pains
AIDS or HIV Positive	Depression	Cancer
High Blood Pressure	Tuberculosis	High Cholesterol
Insomnia	Anxiety	Osteoporosis
Other Medical Conditions	Bipolar	Arthritis

1. _____ 2. _____ 3._____ 4. _____

Past Surgical History: (Circle all that apply)

Partial-Total Hysterectomy	Angioplasty/Stents	Fracture Repair (Surgical)
Right-Left Knee Arthroscopy	Right-Left Total Knee Replacement	Appendix
Right-Left Shoulder Arthroscopy	Right-Left Total Shoulder Replacement	Hernia Repair
Colonoscopy	Right-Left Total Hip Replacement	Adenoids-Tonsils
Ileostomy	Gall Bladder	Tubal Ligation
Mastectomy	Prostate Surgery	Cesarean Section
Heart Surgery	Pacemaker	Eye Surgery

Cosmetic _____
Other_____

Family History: (Parents and or Sibling Suffered from any of the following)

Heart Attack Stroke High Blood Pressure High Cholesterol Diabetes

Heart Disease Cancer Kidney Disease Other_____

Social History: (YES-NO)
Tobacco Use_____ Alcohol Use_____ Last Menstrual Period _____ Currently Nursing_____

LEGAL MARTIAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEPERATED
Allergies to Medication: (NKDA)
1. _____ 2._____ 3._____

Current Medication (even over the counter): PROVIDE LIST IF NEEDED

1. _____ 2._____ 3._____

***PATIENT SIGNATURE_____Date_____ Time_____**

OFFICE USE ONLY
[ ] NEW PATIENT [ ] ESTABLISHED PATIENT [ ] W/C [ ] AUTO [ ] LOP [ ] H&P

Blood Pressure ____________ Temperature _____ Height _____'_____" Weight _____

FINANCIAL AGREEMENT

____ On behalf of the patient receiving services from Hill Orthopedic Center LLC, I accept responsibility to ensure that all services are paid in full within 60 days according to the following guidelines:

- In the event the patient does not have health insurance coverage, I will make payment when services are rendered or I will establish a budget plan with the Center's Patient Financial Services Department.
- In the event the Insurance Company does not have a contractual arrangement with Hill Orthopedic Center LLC, I assume full responsibility for payment of charges not covered by insurance.
- In the event the Insurance Company has a contractual arrangement with Hill Orthopedic Center LLC, I agree to pay the applicable co-payments, deductibles, and co-insurance.

RELEASE OF INFORMATION

____ I authorize Hill Orthopedic Center LLC to release any information acquired in the course of my medical examination and treatment (including drug use, alcoholism and HIV positive test results), to my insurance company, third party payers, case utilization and managed care review companies, the Health Care Financing Administration and its agents which may be necessary in order for the Clinic to determine benefits, to obtain authorization or to receive payment for my care. I further authorize information to be released to all other Hill Orthopedic Center LLC agencies, affiliated institutions, or individuals who will be providing healthcare or social services to me.

ASSIGNMENT OF BENEFITS

____ I authorize payment directly to Hill Orthopedic Center LLC for the surgical and/or medical benefits otherwise payable to me under the terms of the policy but not to exceed the balance due to physicians, and/or other providers for services provided during my treatment. In making this assignment, I understand and agree that I may be financially responsible to Hill Orthopedic Center LLC for charges not paid by my insurance policy(ies). I permit a copy of this authorization to be used in place of the original.

OFFICE POLICY AND PROCEDURES

____ We now have digital x-rays in our Orlando and davenport locations, should you need a copy of your x-rays the following fees will apply, $25.00 per disk. These fees are not covered by insurance and must be paid prior to receiving your copy.

____ We do not call in new prescriptions, the patient is required to come to our office and obtain a new prescription. Any patient losing a prescription will be required to pay a $5.00 duplication fee. We do not call in refills for any prescriptions on Saturday or Sunday. Please be sure to contact our office, by no later than Thursday before 5:00pm for any refills or medication changes that you may need.

____ This office charges a fee of $25.00 for all forms that you ask the physician and\or staff to complete (ex. Insurance Company, Employer, Attorney and Disability Forms) this fee will be paid when dropping off forms and the completed form may be picked-up in 7 business days. These fees are not covered by insurance and must be paid prior to receiving your copy.

____ Any patient that comes in without a valid referral from physician and\or carrier will be required to pay all office charges in full at time of visit. All co pays and co-insurance will be due at time of visit, if you are unable to pay, your appointment will be rescheduled.

____ There will be a $30.00 charge for all appointments that are not cancelled or rescheduled with our office within 24 hours of appointment.
It is required that you speak to our staff and not leave a voicemail message. Any surgery you schedule and you must cancel ,there will be a 250.00 dollar charge. if cancelled within 2 weeks of the surgery

____ There is a $50.00 fee for all checks that are returned for Non Sufficient Funds and the check will need to be picked up within 15 days from notification of an NSF check or will be turned over to the OCSO for restitution. Payment will need to be in full (service charge) in cash or money order made payable to Hill Orthopedic Center, LLC.

Copies of this is available, please see the office manager for a copy.

Patient Signature _____ **Insured's Signature** _____ **Date** _____
(Parent/Guardian of Minor) **(Parent/Guardian of Minor)**

Witness Signature _____ Date _____Time_____

4125 Hunters Park Lane
Suite 117
Orlando, FL 32837
Phone 407-447-7001

Fax 407-447-7006

40124 U.S. Highway 27
Suite 205
Davenport, Fl 33837
Phone 863-422-1734

Fax 863-421-1975

540 S. Chickasaw Trail
Orlando, Fl. 33837

Phone 407-985-3977

Fax 407-985-1961

NOTICE OF PATIENT PRIVACY PRACTICES
LEGAL FORM AND CONSENT

Form of Written Acknowledgement of Receipt of Hill Orthopedic Center, LLC Notice of Patient Privacy Practices (NPPP)

This will indicate, by signing this Written Acknowledgment of Receipt that I have received the HIPAA Notice of Patient Privacy Practices document (NPPP) issued at Hill Orthopedic Center, LLC

Patient, or Legal Representative, Signature

_____

Printed Name of Patient, or Legal Representative

_____

Date_____

Acknowledgement <u>NOT</u> obtained because:
____ Patient, or legal representative, declined Notice of Patient Privacy Practices (NPPP)

____ Patient treated in emergency room and discharged before obtaining Acknowledgment;

____ Other (briefly describe) _____

Patient Signature _____Date _____

Patient Printed Name _____

Patient Consent Form

Please Read and Sign

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests
- Taking and utilization of cultures
- Performance of other medically accepted laboratory test that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. **This consent will remain in full force until revoked in writing.**

I, the undersigned, authorize that Hill Orthopedic Center, LLC will use and disclose my information for the purpose of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient. Such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which, in the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Healthcare Operations include but not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infections diseases including but not limited to blood-borne diseases.

A photocopy of the consent shall be considered as valid as the original.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed and the State of Florida Health Department and appropriate counseling will be offered.

Medicare Patients: I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Hill Orthopedic Center, LLC.

I acknowledge that I have been given the Hill Orthopedic Center, LLC Notice of Privacy Practices. I understand that if I have questions or complaints, that I should contact the Privacy Official. **Patient Initial: _____**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____	_____
Print Name	**Patient (or Responsible Party) Signature**	**Date**

_____	_____
Witness Signature	**Date**