DATE:_____

MRN:_____

Personal and Contact Information / *Información Personal y Contacto*

Full (Legal) Name: :_____ **Date of Birth:** _____
Nombre legal completo *Last, Full, Middle Initial* *Fecha de nacimiento*

Please circle: **Male** ***or*** **Female** **Social Security #:**_____
circule por favor *Masculino* *o* *Femenino* *Seguro Social:*

Address: _____ **Home Phone:** (_____) _____-_____
dirección _____ *teléfono de casa*

City, State, Zip (ciudad, estado,código postal)

Cell Phone: (_____) _____-_____
celular

Email/ *correo electrónico* **:**_____

Marital Status/ Estado civil : *please circle (circula por favor)*

Single/*soltero* - **Married**/ *Casado* - **Divorced**/ *Divorciado* - **Separated**/ *Separado* - **Widowed**/ *viudo*

Employement History/ *Historia de Empleo*

Are you currently employed? / *Está trabajando actualmente?* **Yes**/ *Si* **No**/ *No*

If Yes, please provide us with the following information.
Si es así , por favor indíquenos con la siguiente información ?

What is your occupation?/ *¿Cuál es su ocupación?:*_____

Who is your employer? *¿Quién es su empleador ?:*_____

Work phone/ *Teléfono del trabajo :* (_____) _____-_____

Emergency Contact Information/ *Información de contacto de emergencia*

Please provide us with the following information in case of an emergency
Por favor proporcione la siguiente información en caso de emergencia

Name/ *Nombre* **:** _____

Phone Number /*número de teléfono* **:**_____

Relationship to patient /*Relación con el paciente* **:** _____

Name/ *Nombre* **:** _____

Phone Number /*número de teléfono* **:**_____

Relationship to patient /*Relación con el paciente* **:** _____

Attorney information / *información del abogado:*

Have you hired an attorney? *Ha contratado a un abogado ?* **YES/** *SI* **NO**

What law firm is your attorney from?/ *Como se llama su firmal de aogado?*

_____

Who is your attorney?/ *¿Quién es tu abogado?* _____

What is your attorney's phone and fax number? *¿Cuál es el número de teléfono y fax de su abogado ?*

Phone: _____ **Fax:**_____

Health Insurance/ *Seguro De Salud:*

Name of insurance/ *Nombre del seguro:* _____

Policy Number/ *número de póliza:*___ _____

Are you the policy holder?/ *Usted es el dueño de la poliza? ?* **Yes/** *Si* **No/** *no*

Policy Holder/ *Due ño de poliza :* _____

Policy holder's FULL legal name/*El nombre del dueño de la póliza* **:**_____

Policy holder's Phone Number/*número de teléfono del dueño de la póliza:*_____

Relationship to patient /*Relación con el paciente* **:** _____

Were you referred to our office? *¿Fue referido a nuestra oficina ?* **Yes/** *Si* **No/** *no*

If YES, whom do we need to thank?_____

En caso afirmativo , ¿a quién tenemos que dar las gracias ? *Name & Number (Nombre y número)*

Accident Information/ *información de accidente*

Date of accident/ *fecha del accidente* **:**_____

Where were you when you injured yourself? *¿Dónde estabas cuando se lesionó ?*

_____

Was an incident report filed?/ *Se presentó un informe de incidente ?* **Yes/** *Si* **No/** *no*

Were you treated at the scene? *¿Fue tratado en la escena?* **Yes/** *Si* **No/** *no*

Were you seen at a Hospital or Urgent Care Center? *¿Fue visto en un Hospital o Centro de Atención Urgente ?*

Yes/ *Si* **No/** *no*

If so, where? *Si es así , ¿dónde?* _____

Were you taken by ambulance? *¿Fue trasladado en ambulancia ?* **Yes/** *Si* **No/** *no*

Course of treatment /*Curso de tratamiento :*

Were radiologic studies performed? *Se realizaron estudios radiológicos?* **Yes/** *Si* **No/** *no*

If so, what? (Please circle ALL that apply)/ *Si es así , ¿qué. (Por favor marque todas las que correspondan)*

X-rays CT Scans MRI Ultrasound

☐**Check here if you have not had any medical treatment.**
Marque aquí si usted no ha tenido ningún tratamiento médico.

Did you have any follow up care? *¿Tuvo alguna atención de seguimiento ?* **Yes/** *Si* **No/** *no*

If so, please choose from below. *Si es así, por favor elegir desde abajo.*

Chiropactor/ *quiropráctico:* **Yes/** *Si* **No/** *no*

Family Doctor */médico de cabecera* **:** **Yes/** *Si* **No/** *no*

Orthopedic */ortopédico* **:** **Yes/** *Si* **No/** *no*

Neurologist, Spinal or Neurosurgeon/ *neurólogo* **:** **Yes/** *Si* **No/** *no*

OTHER/ *otro* **:** _____

_____

Medical History/ *historia médica*

Please place a check beside all that apply to you presently or have in the past.

Por favor, coloque una marca al lado de todo lo que aplique en su caso en la actualidad o en el pasado .

Past and present medical history. *Historial médico pasado y el present.*

Stomach ulcers	**Sleep Apnea**	**Tuberculosis**	**Thyroid (Hypo or Hyper)**
COPD	**Asthma**	**Diabetes: I or II**	**Cancer:** _____
Bronchitis	**Heart Attack**	**Shortness of breath**	**Osteoporosis**
Emphysema	**Stroke**	**Chest Pains**	**Osteoarthritis**
Kidney Disease	**Migraines**	**Angina**	**Rheumatoid Arthritis**
Kidney Stones	**Gout**	**Dizzy or fainting spells**	**Back Pain**
GERD	**Anemia**	**MRSA**	**Neck Pain**
Depression	**Hep-C**	**Neuropathy**	**Epilepsy/ Seizures**
AIDS OR HIV	**Anxiety**	**Joint pains/swelling**	**Carpal Tunnel**
Bipolar	**High Cholesterol**	**Alzheimer's**	**High Blood Pressure**

Other/ *Otro:* _____

_____

_____

Surgical history /*cirugías pasadas*

Colonoscopy	**Prostate**	**Eye Surgery**	**Hysterectomy: Total or Partial**
Ileostomy	**Pacemaker**	**Cosmetic**	**Knee Arthroscopy: L or R**
Mastectomy	**Appendix**	**Fracture Repair**	**Shoulder Arthroscopy: L or R**
Heart Surgery	**Hernia repair**	**Kidney**	**Total Knee Replacement: L or R**
Angioplasty	**Tonsils-Adenoids**	**Cancer removal**	**Total Hip Replacement: L or R**
Stents	**Tubal Ligation**	**Gall bladder**	**Total Shoulder Replacement: L or R**
C-section			

Other/ *Otro:* _____

_____

_____

Family Medical History: *médico familiar*

Heart Attack	Diabetes	Heart Disease	High Cholesterol
High blood pressure	Cancer	Stroke	Kidney Disease

Other/ *Otro:* _____

_____

_____

Medication:

We have taken the liberty of listing some common medications for common ailments, please mark those that you are currrently taking.

Nos hemos tomado la libertad de enumerar algunos medicamentos comunes para enfermedades comunes , por favor marque los que usted está tomando actualmente .

High Blood Pressure	**Anti-inflammatories**	**Diabetes**	**High cholesterol**	**Psych**
LISINOPRIL	*Naproxen (Aleve)*	*Metformin*	*Simvastatin*	*Zoloft*
ATENOLOL	*Ibuprofen (Motrin)*	*Januvia*	*Lipitor*	*Paxil*
METOPROLOL	*Celebrex*	*Insulin*	*Lovastatin*	*Zanax*
HCLZ	*Anaprox*	*Glimipride*	*Pravastatin*	*Seroquel*
LOSARTAN	*Mobic*	*Glyburide*	*Fenofibrate*	*Depakote*

Please list any other medications you are currently taking . Please include prescriptions, over the counter medications, and/ or vitamins.
Por favor escriba cualquier otro medicamento que esté tomando . Por favor incluya recetas, medicamentos de venta libre , y / o vitaminas .

_____

_____

_____

_____

Por favor enumere todas las alergias conocidas. Si no tienes ninguno, por favor circule NKDA para sin alergias medicamentosas conocidas.

Common Allergies/ *alergias comunes*								
Penicillin	Sulfa	Iodine	Latex	Adhesive	Lidocaine	Codeine	Morphine	NKDA

Please provide us with your pharmacy information so we can e-scribe your medications.
Por favor indíquenos su información de la farmacia para que podamos E-scribe sus medicamentos.

Name of Pharmacy *Nombre de la farmacia* :_____
Phone Number/ *número de teléfono* :_____
Intersection or address/ *Intersección o dirección* : _____

Office Use Only

Height	**Weight**	**Temperature**	**Blood Pressure**

X_____ **Date/** *fecha:*_____
Signature/ Firma

HILL ORTHOPEDIC CENTER,LLC
ORTHOPEDIC SURGERY/FOOT AND ANKLE SURGERY

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.

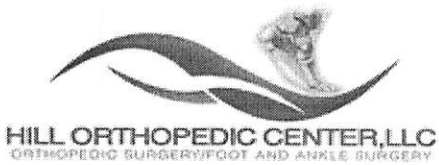
____ There will be a $30.00 charge for all appointments that are not cancelled or rescheduled with our office within 24 hours of appointment.
It is required that you speak to our staff and not leave a voicemail message. Any surgery you schedule and you must cancel ,there will be a 250.00 dollar charge.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

HILL ORTHOPEDIC CENTER,LLC
ORTHOPEDIC SURGERY/FOOT AND ANKLE SURGERY

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**

AUTHORIZATION FOR RELEASE MEDICAL INFORMATION

Hunters Creek	East Orlando	Davenport
4125 Hunters Park Lane, Ste. 117	540 S. Chickasaw Trail	40124 US Hwy 27, Ste.205
Orlando, FL 32837	Orlando, FL 32825	Davenport, FL 33837
P:407-447-7001	**P:**407-985-3977	**P:**863-422-1734
F:407-447-7006	**F:**407-985-1961	**F:**863-421-1975

Re:_____ Date:_____

To Whom It May Concern:

This authorizes the physicians, hospital and all medical attendants to furnish full and complete medical reports and information requested by the undersigned to **Hill Orthopedic Center, LLC**, or any of its representatives. Especially any and all medical reports concerning treatment I had. This authorization also includes examination of all hospital records, x-ray film and furnishing of any information including opinions which will aid to patients treatment.

You are further requested not to disclose such information to any other person with out written authority to do so.

_____ _____

Print Name Sign Name

Patient DOB:_____

Facility:_____

Phone:_____

Fax:_____