ADVANCED ORTHOPEDICS & SPORTS MEDICINE OF SWFL

PATIENT INFORMATION

Please print clearly

PATIENT'S NAME *(First, Middle Initial, Last)*:		☐ Mr. ☐ Ms. ☐ Miss	☐ Mrs. ☐ Dr.
DATE OF BIRTH:	**AGE:**	**SEX:** ☐ MALE ☐ FEMALE	
EMAIL ADDRESS:	**SOCIAL SECURITY #:**	**MARITAL STATUS:** ☐ SINGLE	☐ MAR ☐ WID ☐ DIV

PERMANENT ADDRESS *(Street, City, State, Zip):*

FOR PART-TIME RESIDENTS

WINTER ADDRESS *(Street, City, State, Zip)*:

OUT-OF-AREA PHONE#:

PREFERRED PHONE #:	☐ CELL ☐ HOME ☐ OTHER
ALTERNATE PHONE #:	☐ CELL ☐ HOME ☐ OTHER
WORK PHONE#:	**EMPLOYER:**
EMPLOYER'S ADDRESS:	

IF STUDENT, SCHOOL NAME:

PRIMARY CARE PHYSICIAN:

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	☐ PRIMARY CARE PHYSICIAN ☐ HOSPITAL: ☐ OTHER PHYSICIAN: ☐ FRIEND OR RELATIVE: ☐ OTHER:	*Please provide us with your pharmacy information.* **PHARMACY:**__________________________ **PHONE:**______________________________ **LOCATION:**__________________________

PLEASE DESCRIBE WHY YOU ARE HERE:	**DATE OF INJURY** *(if applicable)*:

GUARANTOR

Please complete this section: (1) If the patient is a minor by providing parent or guardian information or (2) your spouse, or other individual, is the insured party on your insurance policy.

GUARANTEER'S NAME *(First, Middle Initial, Last)*:		**RELATIONSHIP TO PATIENT:** ☐ SPOUSE ☐ PARENT/GUARDIAN ☐ OTHER
DATE OF BIRTH:	**SOCIAL SECURITY #:**	

ADDRESS:	**CONTACT PHONE #:**
EMPLOYER:	**EMPLOYER PHONE #:**

EMPLOYER ADDRESS *(Street, City, State, Zip):*

ADVANCED ORTHOPEDICS & SPORTS MEDICINE OF SWFL

FINANCIAL RESPONSIBILITY & PAYMENT POLICY

We are committed to providing you with the best possible orthopedic care. If you have medical insurance, we would like to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, understanding and consent of our payment policy.

Your insurance is a contract between you and your insurance company. To understand your benefits, we recommend that you call the customer service number on the back of your insurance card or read the explanation of benefits (EOB) provided by your insurance carrier. Make sure you understand what your personal financial responsibilities and pre-authorization requirements are. Our staff will file claims with your health insurance carrier for reimbursement and payment will be made directly to Advanced Orthopedics & Sports Medicine of SWFL from your insurance company. However, deductibles, co-pays, co-insurance, and non-covered treatments are due at the time services are rendered. Any charges for returned checks will be passed along to you. If this account is referred to an attorney or collection agency, you are responsible for paying attorney's fees, collection expenses, court costs and recording fees. We accept cash, personal checks, and all major credit cards.

Depending on your insurance policy, certain medical services may require pre-authorization. It is your responsibility to obtain the appropriate authorization either from your primary care physician or from your insurance carrier. The staff at Advanced Orthopedics & Sports Medicine will assist you with the process. If services are not authorized in advance, you are responsible for the payment of those services. Furthermore, it is your responsibility to notify the staff at Advanced Orthopedics & Sports Medicine if your insurance changes during the course of your treatment.

CANCELLATION & NO-SHOW POLICY

We strive to meet and exceed the expectations of all our patients and to serve you on time. In order to do so, we ask all our patients to show cooperation by arriving at their scheduled time and to provide adequate notice when they need to reschedule. If you miss your appointment, without a 24-hour advance notice, you will be subject to a $25 no-show fee. This fee is not covered by insurance and must be paid before you are seen for your next appointment.

GENERAL CONSENT FOR TREATMENT

I do hereby voluntarily consent to medical treatment deemed as appropriate by the physician, physical therapist and any assistants for the above mentioned as necessary, in his/her professional judgement. I grant permission to voluntarily undergo any necessary tests, examinations, treatments, and other procedures required for the study, diagnosis and treatment by the medical and therapy staff of Advanced Orthopedics & Sports Medicine for my illness or injuries. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of examination and/or treatments by the staff Advanced Orthopedics & Sports Medicine.

RELEASE OF MEDICAL RECORDS

I hereby authorize A Kagan & T Atkinson Orthopedics, its employees or agents, to release medical information regarding myself and my current condition to my insurance company for purpose of payment and/or quality reviews; and to referring, consulting, treating physicians, or other medical providers as needed to support continuity of care; all student athletes and their parents, by signature below, hereby grant consent for Advanced Orthopedics & Sports Medicine to release information and communicate with consulting athletic trainers or coaches.

I understand that original x-rays are the property of Advanced Orthopedics & Sports Medicine. Copies of my x-ray films will be provided to me, should I request them, but I am responsible to pay $10 per film when the copies are released.

I HAVE READ THIS CONSENT AND CERTIFY THAT I UNDERSTAND ITS CONTENTS. THIS AUTHORIZATION WILL REMAIN VALID UNLESS REVOKED IN WRITING.

______________________________ Signature of PATIENT or PARENT/GUARDIAN

______________________________ Date

2017.05

THOMAS LAPORTA, MD

MEDICAL HISTORY FORM

PATIENT NAME	DATE

LOCAL PRIMARY CARE PHYSICIAN	OUT OF STATE PRIMARY CARE PHYSICIAN

COMPLAINT OR INJURY

WHY ARE YOU HERE TODAY?

WHAT MAKES THIS PROBLEM WORSE?

WHAT MAKES THIS PROBLEM BETTER?

REVIEW OF SYSTEMS

CARDIOVASCULAR			RESPIRATORY		
Do you ever have chest pain?	Yes	No	Do you have shortness of breath?	Yes	No
Do you ever have palpitations?	Yes	No	Do you have a cough?	Yes	No
Do you ever wake up short of breath?	Yes	No	If yes: Productive or Dry?		
Do you have high blood pressure?	Yes	No	Do you cough up blood?	Yes	No
			Do you have wheezing?	Yes	No
			Do you have asthma?	Yes	No
MUSCULOSKELETAL			**NEUROLOGICAL**		
Do you have muscle pain?	Yes	No	Do you ever faint or pass out?	Yes	No
Do you have joint pain?	Yes	No	Do you have headaches?	Yes	No
Do you have back pain?	Yes	No	Do you have memory changes?	Yes	No
Do you have spasms?	Yes	No	Do you have seizures?	Yes	No
Do you have muscle weakness?	Yes	No	Do you have any problems with balance?	Yes	No
Do you have muscle enlargement?	Yes	No			
Do you have muscle atrophy?	Yes	No	Have you had any TIAs *(mini-strokes)*?	Yes	No
OTHER			Do you have wound healing difficulties?	Yes	No
Do you bruise easily?	Yes	No	Radiation or chemotherapy?	Yes	No
Do you have enlarged lymph nodes?	Yes	No	Are you pregnant?	Yes	No
Do you have painful lymph nodes?	Yes	No	If you are a FEMALE ATHLETE, when was your last menstrual period? ________________________		
Do you bleed easily?	Yes	No			
Are you anemic?	Yes	No			
Do you have any rashes?	Yes	No			

PAST MEDICAL HISTORY

Please circle each one applicable to your personal medical history.

Heart attack	High cholesterol	Bleeding difficulties
Stroke	Chronic obstructive pulmonary disease	Anemia
High blood pressure	Emphysema or chronic bronchitis	Dizziness
Blood clots	Pulmonary disease	Diabetes
Cardiac disease	Abdominal aortic aneurysm	Reflux disease
Mitral valve prolapse	Liver disease	Peptic ulcer disease
Angina	Numbness or tingling arms/legs	Gout
Atrial fibrillation		Rheumatoid arthritis

ANY OTHER PAST MEDICAL HISTORY NOT LISTED?

SURGICAL HISTORY *Please list all surgeries.*	

MEDICATIONS *Please list all medications, including aspirin, NSAIDS, Coumadin, vitamins & birth control pills.*	

ALLERGIES *Please list any allergies to medication and/or metal or jewelry.*

FAMILY HISTORY *Please answer the questions below in reference to your natural parents or relatives.*	
Is your mother alive? Yes No Important medical history: ____________________ ____ Any arthritis, bone, or joint disease in the family? Yes No	Is your father alive? Yes No Important medical history: ____________________ ____

SOCIAL HISTORY		
How many steps do you have at home? ________ What do you do for exercise? ________________ ____	Do you smoke cigarettes? Do you chew tobacco? Do you drink alcohol (beer, wine, liquor)?	Yes No Yes No Yes No
Is there anything else we should know about you?		

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information (PHI) will be used by Advanced Orthopedics & Sports Medicine of SWFL or disclosed to others for the purposes of treatment, obtaining payment, supporting the day-to-day health care operations of this practice and for other purposes required by law.

We are providing you with a copy of our Notice of Privacy practice. This notice describes your rights and how we may use your PHI. We request that you review the notice prior to signing the consent.

You may request a restriction on the use or disclosure of your protected health information.[1] **Please list any person or entity you would like for us to restrict your health information:**

____

[1]If we agree to your request, your restrictions will be binding. Use and disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

With written consent, you may also allow family members or significant others to have access to your protected health information:

I DIRECT MY HEALTH CARE PROVIDERS TO DISCLOSE AND RELEASE MY PROTECTED HEALTH INFORMATION DESCRIBED BELOW TO[2]:

NAME	RELATIONSHIP

*[2]Health information to be disclosed upon the request of the person named above includes disclosure of my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, prescription pick-ups and billing, for all conditions). If I have exceptions to the information I would like disclosed, I will list them here:*______________________________

Advanced Orthopedics & Sports Medicine of SWFL reserves the right to modify the privacy practices outlined in the notice. You may obtain a copy of our Notice of Privacy Practices, including any revisions, by contacting Amber Atkinson at 8710 College Parkway Fort Myers, FL 33919

I understand I have the right to revoke or change this authorization at any time by giving written notice to the contact listed above.

I have reviewed this consent form and the Notice of Privacy Practices. I give my permission to Advanced Orthopedics & Sports Medicine of SWFL to use and disclose my protected health information as outlined in the Notice of Privacy Practices and if applicable, to those names listed in the consent above.

______________________________ ______________________________
Patient's Printed Name Signature

______________________________ ______________________________
Representative's Printed Name *(if signing for patient)* Date