Date	Dr.	Account #
Referring Physician:	PCP:	

Patient Demographic Information

Name of Patient: ______________________________ Date of Birth _______________

Address ____

City ______________________ State _____________ Zip ____________

Home phone (___) ____-_____ Work Phone (___)____-_____ Cell Phone (___) ____-_____

Social Security # ____________________ Email address ________________________

Occupation ________________________ Employer ____________________________

Guardian(s) ____

To whom may we release information on your behalf? _____________________________

____

Emergency Contact ____

Phone # ______________________ Relationship __________________________

HEALTH INSURANCE INFORMATION

Primary Insurance Carrier ____

Subscriber _____________________________ Relationship to Patient ___________

Subscriber's DOB: _____-_____-_______ Subscriber's SS # _______-______-________

Policy # ______________________________ Group # _____________________

- -

Secondary Insurance Carrier ____

Subscriber _____________________________ Relationship to Patient ___________

Subscriber's DOB: _____-_____-_______ Subscriber's SS # _______-______-________

Policy # ______________________________ Group # _____________________

Date:	
Account #	Patient:

FAMILY & SOCIAL HISTORY

Family History

Mother's age ____________
Cause of death ___________

Father's age ______________
Cause of death ___________

List any illness that runs in the family:

____
____
____

Social History:

Who else lives in your household? _________________

Do you smoke? _____________
If so, how much?____________
____

Do you drink? ______________
If so, how much? ____________
____
For how long? ______________

Review of Systems:

Check all that apply.

- ☐ Awaken from sleep with difficulty breathing/coughing
- ☐ Respiratory problems
- ☐ Shortness of breath
- ☐ Chest pain or palpitations
- ☐ Irregular heartbeat
- ☐ Bowel/ bladder problems

Medical History

Past Medical History:

Previous Illnesses.
Check all that apply:

☐ Asthma	☐ Gout
☐ Bleeding	☐ Jaundice
☐ Hepatitis	☐ Ulcer/Gerd
☐ Lung blood clot	☐ Hypertension
☐ Diabetes	☐ Phlebitis
☐ COPD	☐ Heart disease/attack
☐ Emphysema	☐ Pneumonia
☐ Stroke	☐ Thyroid disease
☐ Glaucoma	☐ Sleep apnea
☐ Weight loss	☐ Weight gain

- ☐ Kidney or bladder infection
- ☐ Rheumatoid Arthritis
- ☐ Cancer

What kind?________________________
____

☐ Other ___________________________
____
____

Anesthesia History:

Check each type of anesthesia you have had:

☐ General ☐ Local
☐ Regional ☐Spinal

Please list any adverse reactions
____
____
____
____

Past Surgical History

List all operation and dates of surgery:
____
____
____
____
____
____
____
____
____

Date:		
Account #	Patient:	
Referring Physician:		PCP:

Date of Birth ____/ ____ /_______
Age _____ ☐ Male ☐ Female

☐ Single ☐ Married
☐ Widowed ☐ Divorced

How were you referred to our office?
☐ Physician ____________________
☐ Friend ☐ Adjuster ☐ Ad
☐ Phone Book ☐ Internet
☐ Attorney ____________________

Have you missed work? __________

Date last worked? ______________

Describe your injury/condition: ______________
____
____

Is your injury/condition related to:
☐ Employment ☐ Auto Accident
☐ Other (describe)________________________
When did your injury/condition occur? __________
____
Where did your injury occur? ________________
____
Have you seen another physician for this problem?
Who __________________________________
____
Have you have x-rays or an MRI? If so, when/where?
____

Current Medications & Dosage :
____
____
____
____
Preferred Pharmacy____________________
Location: __________________________

Allergies:
☐ None ☐ Aspirin ☐ Codeine
☐ Cortisone ☐ Demerol ☐ Erythromycin
☐ Lidocaine ☐ Penicillin ☐ Sulfa
☐ Tetracycline ☐ Other ______________
____
____

Physician/Medical Staff Notes

History:

Physical:

X-Ray:

Diagnosis:

Plan:

OAWF
ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA

Account #	Patient:

Coordination of Benefits & HIPPA Acknowledgment

Dear Patient,

Your insurance contract(s) may provide for benefits to be coordinated with other medical insurance by which you may be covered. In this case, your primary insurance pays first when there is more than one insurance company. Please complete the portions below if applicable.

Section 1

Name of Physician/Provider you are seeing: ____

Is the reason for your visit due to an injury caused by an accident? ☐ Yes ☐ No

If Yes, please indicate the type of accident: ☐ Auto Accident ☐ Work ☐ School ☐ Home

☐ Other Please describe ______________________________

Is a third party responsible for your injury? ☐ Yes ☐ No Who? ______________________________

Section 2 (Please complete if injury is related to an auto accident)

Were you in your own vehicle, or someone else's vehicle? ____________________________________

Name of Auto Carrier? ________________________Adjuster ____________________________

Phone # _________________Claim # ____________________ Date of Injury?______________

Do you have an attorney? ☐ Yes ☐ No If yes, who? ______________________________________

Attorney phone # __________________________ Legal aide/contact _______________________

Section 3 (Please complete if injury is related to a workers comp claim)

Employer at the time of the injury ____

Date of Injury _______________ Work Comp Ins. Carrier _________________________________

Adjuster _________________________________ Phone # _______________________________

Case Manager _____________________________ Phone # _______________________________

Do you have an attorney? ☐ Yes ☐ No If yes, who? ______________________________________

Please read below and sign.

To the best of my knowledge, the statements above are true. Unanswered questions indicate they do not apply. My signature authorizes my insurance carrier to receive any payment and all information concerning claims filed by me or on my behalf to another insurance carrier for the purpose of coordination of benefits.

My signature also serves as acknowledgement that upon request I will be provided a copy of the HIPPA privacy policy.

______________________________ ______________

Signature Date

Account #	Patient:

Financial Policy

This is an agreement between Orthopaedic Associates of West Florida, P.A., a Florida Professional Corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement, the words “you”, “your”, and “yours” means the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “OAWF”, “us”, “our”, and “we” refer to Orthopaedic Associates of West Florida, P.A.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will separately show the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by OAWF in writing, the balance on your statement is due and payable when the statement is issued, and considered past due if not paid within 30 days.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required payments: Any co-payment required by an insurance company must be paid at the time of service.

Payment options: You may choose to pay by cash, credit card, or check on the day services are provided.

Self Pay: Patient is required to pay at the time of service unless other arrangements have been made and agreed to by OAWF in writing prior to the appointment.

Insurance: Insurance is a contract between you and your insurance carrier. We are NOT a party to this contract in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance carrier that makes the final determination of your eligibility and determines payment. You agree to pay the portion of the charges not covered by your insurance carrier. If your insurance carrier requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance carrier, thus increasing the portion you would be responsible for.

As a courtesy, we will be happy to file your secondary insurance. However, it is our policy that should your insurance carrier not pay the claim within 45 days, the balance becomes your responsibility, and is payable at that time. If your insurance carrier makes payment after you have paid, you will be promptly refunded.

Personal Injury: If you are being treated due to a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. Payment of the bill remains the patient’s responsibility unless other arrangements have been agreed to by OAWF in writing prior to the appointment.

Account #	Patient:

Financial Policy cont'

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied or un-authorized services are performed, you will be responsible for payment in full.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the minor patient will be responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt including the possibility of referring the account to a collection agency.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have he option to report your account status to any credit reporting agency such as the credit bureau.

Returned Checks: There is a $25.00 fee for any check returned by the back. The $25.00 fee will be added to your account upon notice from the bank.

Records/Radiology Copies: For copies of either your medical records or radiology films, there may be a charge for copies provided. This may not be covered by your insurance, and will be your responsibility.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collections agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective date: Once you have signed this agreement, you agree to all the terms and conditions contained herein, and the agreement will be in full force and effect.

Patient's Name: ____

Responsible Party
(If not patient) ____

Signature ____ Date __________________________

Co-Signature (if required) ____ Date __________________________

Witness ____ Date __________________________

Witness Signature ____ Date __________________________

BONE DENSITY ORDERS

PATIENT SECTION

Date ______________ Account # _______________ Height _______ Weight _______ Date of Birth _____/______/_______

Patient ______________________________________ ☐ Male ☐ Female PCP _______________________________

Patient Screening

		Yes	No	
1.	Have you had a Dexa (Bone Density) scan in the last 2 years?	☐	☐	When? __________
2.	Are you on any treatment for osteoporosis? If Yes, please list: ____	☐	☐	
3.	Are you postmenopausal or had a hysterectomy?	☐	☐	
4.	Does your family have a history of osteoporosis or bone fractures?	☐	☐	
5.	Do you have a history of bone fracures?	☐	☐	
6.	Do you currently take or have you taken long term steroids?	☐	☐	

PHYSICIAN SECTION

Diagnosis Code

☐ 733.00 – Osteoporosis, unspecified
☐ 256.31-256.39 – Premature menopause/other ovarian failure

Procedure Code:

☐ 77080 – Bone Density Study ☐ 76077 – Vert. Fx. Assessment

Yes	No		
☐	☐	1)	Has the patient had an x-ray that shows vertebral abnormalities that are indicative of Osteopenia, Osteoporosis, or a vertebral fracture?
☐	☐	2)	Is the patient being monitored to assess the response to, or efficiency of an FDA approved Osteoporosis drug therapy?
☐	☐	3)	Has the patient been on steroid therapy for more than 3 months?
☐	☐	4)	Has the patient had a Bone Density Study (77080) with-in the past 2 years?

If YES to #4, please answer questions below. If NO, move to appointment date.

☐	☐	5)	Is the test necessary to monitor the response to or efficacy of an FDA approved Osteoporosis drug therapy?
☐	☐	6)	Is the test necessary to determine a patient's response to pharmacologic therapy when the therapy has been changed to another family of therapeutic agents?
☐	☐	7)	Is the test necessary to monitor a patient receiving, or expected to receive, steroid therapy of 30 mg cortisone or 5.0 mg prednisone or greater per day, for more than 3 months?

OAWF Physician Standing Order ____________
Date

☐ Patient declines Dexa Scan ___________
Date

☐ Per Physician, Dexa Scan not needed at this time ____________
Date

SCHEDULING AND AUTHORIZATION

Appt. Date _____________ Time _____________ Insurance Carrier ____

Policy # ____ Phone # ____

Auth # ____ Benefits ____

Radiology Department

Date Scan Completed _________________ Technologist _____________________ Documented in chart ________________________________

11/12/09

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

INTRODUCTION:

At Orthopaedic Associates of West Florida (OAWF), we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policy describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit OAWF, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: Ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of OAWF, the information belongs to you. Upon request you have the right to:

- Obtain a paper copy of this Privacy Policy,
- Inspect and copy your health record in accordance with OAWF policies and procedures,
- Amend your health record, according to OAWF procedures,
- Obtain an accounting of disclosures of your health information,
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:

OAWF is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations, to the best of our ability.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will make them available to you at your next appointment, or at your request we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue use or disclosure of your health information after we receive a written revocation of the authorization as described in the authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact the practice's Privacy Officer at (727) 461-6026. If you believe your privacy rights have been violated, you may file a complaint with OAWF's Privacy Officer, and/or with the Office for Civil Rights, U.S.Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him/her in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.

For example: Members of our group practice may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include certain laboratory tests, prosthetic and orthotic manufacturers, transcription services, and a copy service we use when making copies of your health record for authorized requests. When such services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information by signing a "business associate agreement."

Students: We may disclose your protected health information to medical school, radiology, and other healthcare students that may see patients at our offices.

Directory: Unless you notify us that you object, we may use your name outside the examination rooms for purposes of designating an examination room for your visit. We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician.

Continued on back

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Appointment Reminders: We may call you, or notify you by mail, to remind you of your upcoming appointment.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors, consistent with applicable law, to carry out their duties.

Marketing: We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities.

Law Enforcement: We may disclose health information as required by law.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that OAWF or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Notice of Privacy Practices

WWW.OAWF.COM
(727) 461-6026

OAWF
ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA

OFFICE LOCATIONS
(727) 461-6026

430 Morton Plant Street, Suites 301 and 106
Clearwater, FL 33756
FAX # (727) 461-1492

^^^^^^^^^^^^^^^^^^

8839 Bryan Dairy Road, Suite 240
Largo, FL 33777
FAX # (727) 320-0707

^^^^^^^^^^^^^^^^^^

Mease Medical Arts Building
1840 Mease Drive, Suite 409
Safety Harbor, FL 34695
FAX # (727) 796-4345

^^^^^^^^^^^^^^^^^

2044 Trinity Oaks Boulevard
Suite 110
Trinity, FL 34655
FAX # (727) 815-7554

This notice is also posted on our web site at:
www.OAWFWESTFL.COM

08/15/2008