ORTHOONE
JACKSONVILLE
EXCELLENCE IN ORTHOPEDIC CARE

Today's Date: _____

Patient's Name: _____

Address: _____

City:_____State:_____ Zip Code: _____

DOB:_____ SSN:_____

Sex:____Male____Female Marital Status:____Single___Married___Divorced____Widow

Home Phone:_____ Cell Phone: _____

Email:_____

IN CASE OF EMERGENCY

Name:_____Relationship to Patient: _____

Home Phone:_____Cell Phone:_____Work Phone: _____

INJURY INFORMATION

Type Of injury: ___Auto ___Slip & Fall ___Work_____Other Date of Accident: _____
If Auto:____Driver____Passenger

WORKERS COMP

Insurance Name: _____

Claim Number:_____ Case Number: _____

Adjuster:_____Adjusters Phone Number:_____Ext: _____

EMPLOYER INFO

Employee:_____ Contact Person: _____

Address: _____

Phone Number:_____Fax: _____

I authorize the release of medical information necessary to process this and related insurance claims. I authorize the payment of insurance benefits to be made to: ORTHO ONE JACKSONVILLE. To whom the assignment has been made.

Patient Signature:_____ **Date:** _____

PATIENT MEDICAL HISTORY

Patient's Name:_____ **Today's Date:**_____

Date of Birth: _____ **Age:** _____ **Height:**_____ **Weight:**_____

Sex :_____ **Race:**_____ **Ethnicity:**_____ **Preferred Language:**_____

CHIEF COMPLAINT

**Why are you here today? _____

_____

_____

**What Happened? _____

_____

_____

_____

Are you Right or Left Handed?_____Date of Injury or Onset of Symptoms? _____

Is this injury due to one or more of the following: (please circle) ☐ Auto related ☐ Work related ☐ Slip and Fall

Other (please explain)_____

Were you seen in the E.R./or by another physician? _____

Are your symptoms improving/unchanged/or worsening?_____

Are you working now?_____What is your Occupation? _____

HISTORY OF PRESENT ILLNESS

Initial symptoms:

☐ Catching ☐ Locking ☐ Weakness ☐ Numbness

☐ Initial popping sound ☐ Slipping ☐ Pain with overhead activity ☐ Tingling

☐ Giving way ☐ Stiffness ☐ Pain with reaching behind neck/back

☐ Weight bearing: ☐ with pain ☐ with no pain ☐ unable to bear weight ☐ Night Pain

Pain : ***PLEASE ANSWER THE FOLLOWING TO HELP YOU DESCRIBE YOUR PAIN***

Quality - ☐ *Aching* ☐ *Burning* ☐ *Diffuse* ☐ *Dull* ☐ *Knifelike* ☐ *Pounding*

☐ *Sharp* ☐ *Stabbing* ☐ *Tearing* ☐ *Throbbing*

Frequency of your Pain: Intermittent_____ Constant_____ Frequent_____ Infrequent_____

Severity of your pain **at this time**:(Mild--1--2--3) (Moderate--4--5--6--7) (Intense--8--9-10) (Rate pain on a scale from 1 to 10)

Severity of your pain **at its worse**:(Mild--1--2--3) (Moderate--4--5--6--7) (Intense--8--9-10) (Rate pain on a scale from 1 to 10)

Activity Limitations: Please *check* any of the following limitations that apply or write your own personal limitation.

☐ Climbing stairs ☐ In and out of chair ☐ Walking ☐ Lifting

☐ In and out of car ☐ Kneeling ☐ Bending forward ☐ Household chores

☐ Working light duty ☐ Unable to work ☐ Yard work ☐ Getting dressed

My personal limitations: _____

What makes symptoms worse?_____

What makes symptoms better?_____

Therapies tried:

☐ Braces ☐ Crutches ☐ Cold/Heat ☐ Elevation ☐ Physical Therapy ☐ Chiropractor

Medication:

☐ Anti-inflammatory ☐ Narcotics ☐ Steroids ☐ Over-the-counter ☐ Injections

Any previous medical or surgical treatment for this condition? ◯ **Yes** ◯ **No** **If yes, what:**_____

_____

PAST MEDICAL HISTORY

Patient's Name:_____ **Today's Date:**_____

Please list your past illnesses

_____
_____
_____
_____
_____

Please list your past injuries.

_____
_____
_____
_____
_____

CURRENT MEDICATIONS

Medication Name	Dose	Why are you taking this medication?

ALLERGIES: (Please answer Y for yes or N/A if not applicable. **If yes,** please describe the adverse symptoms or reaction.
List medications you are allergic to:_____

_____

Environmental Allergies:_____
Food Allergies:_____
Cosmetic or personal care product Allergies:_____
Plastic Allergy:_____
Latex Allergy:_____

PAST SURGICAL HISTORY:

Surgical Procedure	Date	Name of Surgeon

CHILDHOOD DISEASES:
Asthma_____ Chicken Pox_____ Measles _____ Mumps_____ Rheumatic fever_____ Scarlet fever____

SOCIAL HISTORY:
Marital Status:_____Married _____Single _____Divorced_____Widowed_____Separated
Tobacco use - Current Smoker: Amount and duration_____Former Smoker ☐ Never Smoker ☐
Alcohol - Wine - Occasional_____ 2-3 times per week_____ Daily_____ Socially only_____
Mixed drinks or Hard Liquor - Occasional_____ 2-3 times per week_____ Daily_____ Socially only_____
Beer - Occasional_____ 2-3 times per week_____ Daily_____ Socially only_____
Ancillary aids - Glasses _____ Contacts _____ Dentures _____ Hearing aids _____
Drug use - Never used Drugs_____used Drugs in the past_____Using Drugs now Socially_____
Camping/Hunting - if yes, when & where _____
Scuba diving - if yes, state how often, how deep you dive and for how long: _____
Travel outside of the country, if so_____where_____when

FAMILY HISTORY:
Father Status_____living_____deceased
Illness_____
Cause of death_____;_____age at death

Mother Status_____living_____deceased
Illness_____
Cause of death_____:_____age at death

REVIEW OF MEDICAL SYSTEMS

Patient's Name:_____ **Today's Date:**_____

General/Constitutional:

Yes No
- Y N Decreased Activity
- Y N Change in appetite
- Y N Fever
- Y N Chills
- Y N Tires easily
- Y N Lost Weight
- Y N Gained Weight

Eyes:

Yes No
- Y N Recent vision changes
- Y N Double Vision

Ears Nose Throat:

- Y N Earaches
- Y N Hearing loss
- Y N Ear pain
- Y N Ear Ringing
- Y N Dizziness
- Y N Congestion
- Y N Nose Bleeds
- Y N Bleeding gums
- Y N Full Dentures
- Y N Partial Upper Dentures
- Y N Partial Lower Dentures
- Y N Difficulty swallowing
- Y N Hoarseness
- Y N Sore throat

Respiratory:

Yes No
- Y N Asthma
- Y N Bronchitis
- Y N Cough
- Y N Shortness of Breath
- Y N Bronchitis
- Y N Coughing up blood
- Y N Recent Respiratory Infection
- Y N Sleep Apnea

GI:

Yes No
- Y N Abdominal pain
- Y N Nausea
- Y N Vomiting
- Y N Diarrhea
- Y N Heartburn
- Y N Indigestion

Musculoskeletal:

Yes No
- Y N Joint pain
- Y N Tenderness
- Y N Weakness
- Y N Swelling
- Y N Redness
- Y N Stiffness
- Y N Cramping
- Y N Loss of motion

Neurological:

Yes No
- Y N Abnormality of walk
- Y N Balance
- Y N Blackouts
- Y N Burning sensations
- Y N Confusion
- Y N Coordination
- Y N Dizziness
- Y N Fainting
- Y N Headaches
- Y N Lightheadedness
- Y N Loss of consciousness
- Y N Loss of sensation
- Y N Memory loss
- Y N Numbness
- Y N Paralysis
- Y N Speech difficulty
- Y N Tingling
- Y N Tremor
- Y N Weakness

Skin:

Yes No
- Y N Lesions
- Y N Itching
- Y N Discoloration
- Y N Rash
- Y N Ulceration

Psychiatric:

Yes No
- Y N Compulsive behavior
- Y N Mood swings

Hematologic/lymphatic:

Yes No
- Y N Easy bruising
- Y N Swollen lymph node
- Y N History of transfusion

GU:

Yes No
- Y N Pain with urination
- Y N Blood in Urine
- Y N Abnormal Urine test
- Y N Frequent urination
- Y N Kidney stones
- Y N Prostate surgery

Females

Yes No
- Y N Normal Menstruation
- Y N Menopause
- Y N Ovaries removed
- Y N Birth control pills

Cardiac:

Yes No
- Y N Chest pain
- Y N Heart murmur
- Y N Hypertension
- Y N Abnormal EKG
- Y N Cold hands & feet
- Y N Palpitations
- Y N Abnormal stress test
- Y N Edema

ORTHOONE
EXCELLENCE IN ORTHOPEDIC CARE

PRIMARY CARE PHYSICIAN:
DOCTOR'S NAME:_____
FACILITY:_____
PHONE NUMBER: _____

RIVERSIDE
1045 Riverside Ave # 200
Jacksonville, FL 32204
Fax: (904) 619-5753
Phone: (904) 619-3048

KENNERLY
6100 Kennerly Rd # 202
Jacksonville, FL 32216
Fax: (904) 619-5753
Phone: (904) 619-3048

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Standard Disclosure and Acknowledgement Form
Workers Compensation / DOL - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were actually rendered. This means that those services have already been provided.

2. I have the right and the duty to confirm that the services have already been provided.

3. I was not solicited by any person to seek any services from the medical provider of the services described above.

4. The medical provider has explained the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name (PRINT or TYPE)	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have not solicited or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.

C. The accompanying statement or bill is properly completed in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to truthfully, accurately, and in a substantially complete manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been upcoded, unbundled, or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (Signature by his/ her own hand):

Name (PRINT or TYPE)	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Kennerly: 6100 Kennerly Road, Suite 202 Jacksonville, FL 32216
Riverside: 1045 Riverside Avenue, Suite 100 Jacksonville, FL 32204
Ph: (904) 619-3048 Fax: (904) 619-5753

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ASSIGNMENT OF INSURANCE BENFITS, RELEASE & DEMAND

Insurer and Patient Please Read the following in its Entirely Carefully!

I, the undersigned patient/insured knowingly; voluntarily and intentionally assign the rights and benefits on my automobile insurance, A/K/A/ Personal Injury Protection (hereinafter PIP), Uninsured Motorist, 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 §626.428 damages from insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, and overdue 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, 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 attest 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 patients name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance including resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the names 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 suite 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 refund, 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 contest and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited bythe 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. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. 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 specific attention of the Office Manager. See Fla,Stat. §673.311.

EUO'S And IME'S If the insurer schedules a defense examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send copy of said notification to provider. The provider or 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 or the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even 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 in any check for services rendered by the provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release Of Information: I authorize this provider to: Furnish the insurer, insurer's intermediary, the patient's other medical providers, and the patient's attorney, via mail, fax, or E-mail, 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 (EOB's) for all providers and non-redacted PIP pay-out sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer, obtain copies of the entire claim file, the incident and property damage file, and all medical records, including but not limited to, documents, reports, scans, notes,

bills, opinions, x-rays, IME's, and MRI's, from any other medical provider or any insurer. The provider is not 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; the insurer is not authorized to provide these medical records to anyone without the patients and the provider's prior 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 pay-out 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 providers bill to the deductible. If the 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.

Guarantee of payment: I understand and agree, I am personally responsible for all services received at ORTHO ONE JACKSONVILLE, and promise to pay regardless of my health insurance benefits and/or possible future payment from any judgement or verdict on my behalf I understand that if my account at ORTHO ONE JACKSONVILLE. is past 60 days overdue, it may be subject to 1.5% per month (18% year) finance charge. If the default amount is referred to a collection agency and/or for legal action, I agree to pay for reasonable court costs of collections.

Consent of Treatment: I give ORTHO ONE JACKSONVILLE. Permission to perform on myself (Or minor child who I declare I am the parent or legal guardian) such general procedures as they deem necessary in the diagnosis and/ or treatment of my (their) condition. My signature below verifies my full understanding of this consent and upon my request and possible risks regarding or assurance as to my results I may obtain from services received.

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 providers prices for medical services, treatments and supplies are reasonable, usable and customary

ATTENTION: Please read, before signing. 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 terms..

Patient (Print)_____ DOB: _____

Signature:_____ **Date**: _____

Witness:_____Date: _____