Orthopaedic Center of Venice, P.L.

Patient Registration

Date:______________ **Chart #:**________________________

PATIENT INFORMATION

SSN# ____________________________ GENDER:_____ DATE OF BIRTH _____/______/_______ AGE________

FIRST NAME __________________ MIDDLE: ______________ LAST NAME _________________________________

LOCAL ADDRESS ____

CITY _________________________ STATE ________ ZIP ___________ EMAIL ______________________________

NORTHERN ADDRESS ____

CITY _________________________ STATE ________ ZIP ___________ EMAIL ______________________________

HOME PHONE (___)____________ WORK PHONE (___)____________ CELL PHONE (___)__________________

MARITAL STATUS: ______MARRIED ______SINGLE ______DIVORCED ______ WIDOWED

CHECK ONE: ________ EMPLOYED ______RETIRED ________ FULL/TIME STUDENT

EMPLOYER NAME: ____

REFERRING PHYSICIAN ______________________ **PRIMARY CARE PHYSICIAN:**______________________

HOW DID YOU HEAR OF US? ____

Circle & notify the staff if applicable: currently incarcerated, under supervised release, on medical furlough, resident of mental health facility, resident of halfway house, under home detention.

INSURANCE INFORMATION

PRIMARY INS. CO. & ID #:____

SECONDARY INS. CO. & ID#: ____

INSURED/CARD HOLDER'S NAME:____

RELATIONSHIP____ D.O.B. ______________________________

****ARE YOUR INJURIES AUTO/ACCIDENT RELATED:**____

PHARMACY:

PHARMACY INSURANCE:_____________________________ ID#: ____________________________________

ADDRESS:____ PHONE NUMBER:____________________________

PREFERRED PHARMACY:______________________________ PHONE NUMBER: ___________________________

EMERGENCY CONTACT

FIRST NAME: __________________ MIDDLE: ______________ LAST NAME: _______________________________

PATIENT'S RELATIONSHIP TO CONTACT: ____

HOME PHONE: (___)___________________________ WORK PHONE: (___)_____________________________________

AUTHORIZATION: I hereby authorize payment directly to the Physicians of Orthopaedic Center of Venice, P.L. I am responsible to pay all non-covered services, co-insurances, co-pays, and deductibles. I hereby authorize the Physicians of Orthopaedic Center of Venice, P.L. to release any information acquired in the course of my treatment necessary to process insurance claims.

____

SIGNATURE (Patient or Parent if Minor) **DATE**

SELF INSURANCE

Dear Patient:

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Dr. Julio Gonzalez and Orthopaedic Center of Venice, P.L. HAVE DECIDED TO NOT CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

______________________________ ______________________________

PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

______________________________ ______________________________

PRINT NAME DATE OF BIRTH

Notificacion de la Cancelacion del Seguro de la Negligencia Medica

Querido Paciente,

Bajo las leyes de la Florida, los proveedores requiren tener sequro medico de negligencia, o demostrar la responsabilidad financiera para cubrir los gastos hacia los reclamos echos por negligencia. El Dr. Gonzalez y Orthopaedic Center of Venice, P.L. han decidido no tener este seguro de negligencia. Bajo las leyes de la Florida es permitido no tener este seguro sujeto a ciertas condiciones. La ley de la Florida impune penalidades a los proveedores sin este seguro, hacia proveedores que fallen satisfacer los reclamos de juicos adversos a causa de la negligencia. Este anuncio esta provido por la ley de la Florida.

______________________________ ______________________________

Firma del Paciente Persona Respondable Fecha

______________________________ ______________________________

Firma en molde Fecha de nacimiento

ASSIGNMENT OF BENEFITS AND MEDICAL RELEASE

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Orthopaedic Center of Venice, P.L., and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are payable to the undersigned alone or to the undersigned and the said Orthopaedic Center of Venice, P.L. , which checks, drafts, or money orders are made payable for the services which made by at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order. Furthermore, the undersigned allows Orthopaedic Center of Venice, P.L. or any of its agents to sign any paper that will be necessary to enhance, expedite and or allow payment to said provider.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Orthopaedic Center of Venice, P.L. insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.
The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by the virtue of these present.

ASSIGNMENT OF BENEFITS

I,____ hereby authorize my third party payor to make medical benefit payments
(Name of Insured/Patient)

otherwise payable to me for the services rendered by Orthopaedic Center of Venice, P.L. but not to exceed the charges of those services, payable to and mailed directly to:

Orthopaedic Center of Venice, P.L.
241 Nokomis Ave. S., Ste. B
Venice, FL 34285

I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of unpaid benefits claimed by Orthopaedic Center of Venice, P.L. is to be set aside and not disbursed until the dispute is resolved. Furthermore, I hereby IRREVOCABLY ASSIGN to Orthopaedic Center of Venice, P.L. the rights and benefits and any and all causes of action resulting from non-payment under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Orthopaedic Center of Venice, P.L. or Dr. Julio Gonzalez/Dr. Tracy Ng.

I understand that if I have fees that are incurred by me for services rendered by Orthopaedic Center of Venice, P.L. that are not paid for by my insurance company or by me, that these fees will then be sent to a collection agency or legal entity with their own charges to be paid by me at that point. Sending these charges to a collection agency can affect my credit report or rating in the future.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of ______________, 2019.

____ ________________________________
PATIENT SIGNATURE PATIENT NAME (PLEASE PRINT)

This notice is to advise you that we have contacted your insurance company for benefits on your policy prior to your visit at Orthopaedic Center of Venice. The benefits that are quoted to Orthopaedic Center of Venice are not a guarantee of payment by your insurance company. The quote you are given by Orthopaedic Center of Venice is not a guarantee of insurance payment. If there is a balance after insurance payment, this is your responsibility and is due at that time.

_______________________________ _______________________________

PRINT PATIENT NAME TODAY'S DATE

_______________________________ _______________________________

PATIENT SIGNATURE PATIENT DATE OF BIRTH

Orthopaedic Center of Venice, P.L.

ORTHOPEDIC HISTORY

Name: ______________________ SS#: ______________________ Date: ______________

Height: ____________ Weight: ____________ Date of Birth: ______________________ Age:_____

Chief Complaint

Why are you seeing the doctor today? ____

Past Medical History

Medical Problem(s):

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Surgical History:

Date(s):	Procedure(s):
1.	
2.	
3.	
4.	
5.	

Allergy to Medication(s):

1. ____________ 4. ____________
2. ____________ 5. ____________
3. ____________ 6. ____________

Medication(s):

1. ____________ 4. ____________
2. ____________ 5. ____________
3. ____________ 6. ____________

Review of Systems

Are you currently having or have you had problems with your:

	Circle		Describe All Yes Responses
Eyes	No	Yes	
Ears, Nose, Throat	No	Yes	
Lungs, Breathing	No	Yes	
Digestion	No	Yes	
Bowel movement	No	Yes	
Bladder Problem	No	Yes	
Diabetes	No	Yes	
Heart Disease	No	Yes	
High blood pressure	No	Yes	
Bleeding problems	No	Yes	
Balance problems	No	Yes	
Numbness/tingling	No	Yes	
Blackout/fainting	No	Yes	
Psychological problems	No	Yes	
AIDS	No	Yes	
Cancer	No	Yes	
Arthritis	No	Yes	
Polio	No	Yes	
TB	No	Yes	
Epilepsy	No	Yes	

Social History

Occupation: ______________________

Tobacco: **(Packs/day)**

❑ 0 ❑ 1/2 ❑ 1 ❑ 2 ❑ 3

Alcohol:

❑ None ❑ Light ❑ Moderate ❑ Heavy

Social Drugs: ❑ Yes ❑ No

Physical Activity **Frequency**

____

____

____

Marital Status: Married Divorced Widowed Single

Children: **Sex** **Age**

(e.g.) F 7, ___ ___, ___ ___, ___ ___

Family History (significant medical problems in blood relatives):

Relationship (e.g. Mother)	Problem

Have you had a Bone Density Scan? Yes No If yes, when? ______________________

Patient Signature: ______________________ Date: ____________

Reviewed By: ______________________, M.D. Date: ____________

PF-1000 NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, the results of your laboratory tests and procedures will be available in your medical record to all health care professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurers, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of the Orthopaedic Center of Venice, P.L. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to public health agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Use and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION

Appointment reminders.
Your health information will be used by our staff be members to send you appointment reminders.

Information About treatments.
Your health information may be used to send information on the treatment and management of your medical condition that you may find of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Fund Raising. Unless you request us not to, we will use your name and address to support our fund raising efforts. If you do not want to participate in fund raising efforts, please check off the following box.

☐ **Please do not use my information for fund raising efforts.**

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

· The right to request restrictions on the use and disclosures of your protected health information.
· The right to receive confidential communications concerning your medical condition and treatment.
· The right to inspect and copy your protected health information.
· The right to receive an accounting of how and to whom your protected health information has been disclosed.
· The right to receive a printed copy of this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. These revised policies and practices will be applied to all protected health information that we maintain.

REQUEST TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Ms. Kara Andrews

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practice's, you can do so by sending a letter outlining your concerns to :

Ms. Kara Andrews
Orthopaedic Center of Venice, P.L.
241 Nokomis Ave. S. , Ste. B
Venice, FL 34285

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated for filling a complaint.

CONTACT PERSON

The name and address of the person you can contact for further information concerning our privacy practice's is:

Ms. Kara Andrews
Orthopaedic Center of Venice, P.L.
241 Nokomis Ave. S., Ste. B
Venice, FL 34285

ORTHOPAEDIC CENTER OF VENICE, P.L. DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices W are also required to abide by the privacy policies and practices that are outlines in this notice.

EFFECTIVE DATE : April 26, 2004

______________________________ Signature

__________ Date