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

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			
Do you have enlarged lymph nodes?	Yes	No	Radiation or chemotherapy?	Yes	No
Do you have painful lymph nodes?	Yes	No	Are you pregnant?	Yes	No
Do you bleed easily?	Yes	No	If you are a FEMALE ATHLETE, when was your last menstrual period?		
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: _____

_____

Is your father alive? Yes No

Important medical history: _____

_____

Any arthritis, bone, or joint disease in the family? Yes No

SOCIAL HISTORY

How many steps do you have at home? _____

What do you do for exercise? _____

_____

Do you smoke cigarettes? Yes No

Do you chew tobacco? Yes No

Do you drink alcohol (beer, wine, liquor)? 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

HIPAA NOTICE OF PRIVACY PRACTICES

ADVANCED ORTHOPEDICS & SPORTS MEDICINE OF SWFL

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by our physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

- **Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination and management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
- **Payment:** Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.
- **Healthcare Operations:** We may use or disclose your PHI in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee performance reviews, training of staff or medical students, business planning, development and administration. It may also include conducting or arranging for medical reviews, audits or legal services, including abuse detection and compliance programs.
- **As Required by Law:** We may use or disclose your PHI: to public health authorities authorized by law to collect or receive information to prevent or control disease and injury, or other government authorities authorized to receive reports of child abuse and neglect; to the Food and Drug Administration; to individuals that may have been exposed to communicable disease, as required by law; to employers, regarding employees, when concerning a work-related illness or injury, because such information is needed by the employer to comply with OSHA or other state laws; to health oversight agencies; to the court in a judicial or administration proceeding; to law enforcement officials for purposes covered under the law; to coroners, medical examiners and funeral directors, as needed; to facilitate the donation of organs; for research purposes as covered by law; for essential government functions; and as necessary to comply with workers' compensation laws.

  Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object, unless required by law.

HIPAA NOTICE OF PRIVACY PRACTICES

ADVANCED ORTHOPEDICS & SPORTS MEDICINE OF SWFL

YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information (PHI).

1. **You have the right to inspect and receive copies of your PHI.** Under Federal law, however, you may not inspect or receive copies of the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.
2. **You have the right to request a restriction of your PHI.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You have the right to restrict disclosures of your PHI to your health plan if you pay out-of-pocket in full for a healthcare item or service. You may request to opt out of receiving fundraising communications. Your authorization is required for disclosure of your PHI for marketing purposes and disclosures that constitute a sale of PHI. You may also request that any or part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare provider.
3. **You have the right to request and receive confidential communications from us by alternative means or at an alternative location.** You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
4. **You may have the right to have your physician amend your PHI.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy.
5. **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided with this notice. Uses and disclosures of your PHI not described in this Notice of Privacy Practices will be made only with your authorization. You will be notified following any breach of unsecured PHI.
6. **Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
7. **You may revoke this authorization** at any time, in writing, except to the extent that your physician or the practice has taken action in reliance on the use or disclosure indicated in this authorization.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to your protected health information (PHI). If you have any objections to this form, or need additional HIPAA information, please ask to speak with our HIPAA compliance officer in person or by phone at (239) 482-8788.

Your signature below is only an acknowledgement that you have received this NOTICE OF PRIVACY PRACTICES.

Printed Name	Signature	Date