Florida Orthopaedic Associates, P.A.

PATIENT REGISTRATION Date_____

Patient Name_____ SSN _____

Home Address_____ City, St., Zip _____

Date of Birth_____ Age _____ Male/Female Married/Single

Phone _____ Home/Work/Cell Phone _____ Home/Work/Cell

Employer_____ Occupation _____

Next of Kin _____ Relationship _____ Phone _____

Primary Care Physician_____ Referring Physician _____

Is an Attorney Involved Regarding this Accident? _____ If so, Name of Attorney _____

Attorney Address and Phone _____

E-Mail Address_____ Ethnicity _____

Race_____ Preferred Language _____

INJURY INFORMATION

Reason for today's visit _____ Date of Injury/Accident _____

How did the Injury occur _____

If seen in the ER, Give the date seen and the hospital's name _____

GUARANTOR INFORMATION (Fill out if the patient is under 18 years of age)

Financially Responsible Party's Name _____ Phone _____

Date of birth _____ SSN _____ Relationship to patient _____

Home Address _____ City, St, Zip _____

Would you like to authorize Florida Orthopaedic Associates to release information to any other person(s) on your behalf? If yes, list name below.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

HEALTH INSURANCE INFORMATION

Insurance Co. Name _____ Phone _____

Policy Holder's Name _____ D.O.B _____

Policy Number _____ Group Number _____

Secondary Health Insurance

Insurance Co. Name _____ Phone _____

Policy Holder's Name _____ D.O.B _____

Policy Number _____ Group Number _____

ACCIDENT INSURANCE Date of Injury _____

Worker's Compensation _____ Auto _____ Other _____

Employer Name _____ Address _____

Insurance Carrier Name _____

Billing Address _____

Claim Number _____

Authorized By _____ Case Manager/Adjuster/Other

Phone Number _____ Fax Number _____

ACKNOWLEDGEMENTS

Please **Read and initial** each item below indicating acknowledgment and acceptance.

_____ I hereby authorize Dr. _____, or a physician designated by him/her, or whomever he/she may designate as assistant to render medical care to me. I Consent to care and treatment that may encompass laboratory, diagnostic, or medical treatment that my physician or his/her assistant may deem necessary for my health and well being.

_____ I hereby assign to Florida Orthopaedic Associates, PA (hereinafter "Assignee") any medical payment benefits available to me under the policy affording coverage to me. I authorize Assignee to release any information acquired in the course of my examination and treatment to my insurance company. If I am being treated as a result of an automobile accident, I further assign any and all rights, claims, benefits, and cause of action for personal injury protection benefits and medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services, and medical claims resulting from the accident. In the event I do not have insurance coverage, or that my insurance coverage only covers a portion of my medical bills, I understand that I remain personally responsible for payment of any remaining balance.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I Hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Dated _____

Patient or Patient's Representative _____

Print Patient's Name _____

If Signed by Representative, State Name of Representative _____

Relationship to Patient _____

In accordance with Florida Statute 458.348(5), when scheduling the initial examination after a referral from another practitioner, the patient may decide to see the physician or any other licensed practitioner supervised by the physician. **By identifying and signing below, I am indicating my choice of practitioner for this initial examination.**

Circle one: Physician P.A.

Signed: _____ Dated: _____

Authorization to Disclose Health Information

FLORIDA ORTHOPAEDIC ASSOCIATES

I, the undersigned, authorize

FL440: FLORIDA ORTHOPAEDIC ASSOCIATES
740 West Plymouth Avenue
Deland, FL 32720

to release my health information as noted below:

Patient Information:

Patient Full Name: _____ Email Address: _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone #: _____

Release Information To:

-This box must be complete in order for request to be processed-

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason _____ ☐ Other _____

Charges outlined below will be applied for all copies released directly to patient . The charge does not apply when the records are sent directly to a healthcare provider for ongoing treatment purposes.

Information to be Released:

Unless otherwise specified, only the following information will be released:

Abstract includes most recent, up to 2 years: Medical History, Progess Notes, Lab Reports , and Diagnostic Testing.

☐ Please provide an abstract of my records
Copy fee capped at **$15.00** for up to 2 years

☐ Other - please be specific under comments
*Over 2 yrs, will be charged per Florida Statute. See below ↘

Comments: _____
_____
_____

PAYMENT OPTIONS:

CHECK: Please make checks available to BACTES Imaging Solutions.

CREDIT CARD: Please provide an email address (above) to have an invoice emailed. If you do not have an email address, an invoice will be sent to your mailing address .

*Florida Statute Copy Fee: $1.00 per page for the first 25 pages. $.025 for any pages over 25, plus postage.

Authorization to Release Protected:

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

	Check one	*Initial each line below*
I ☐ DO	☐ **DO NOT** want information about ***Mental Health** released	_____
I ☐ DO	☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released	_____
I ☐ DO	☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released	_____
I ☐ DO	☐ **DO NOT** want information about _____ released	_____
	"Other sensitive information?"	

STOP Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature _____ **Date:** _____

(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian _____ **Date:** _____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by Florida Orthopaedic Associates and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*

PATIENT NAME _____ TODAY'S DATE_____

Primary Care Physician _____ Referring Physician_____

Occupation _____ Name of Employer_____

PHARMACY & ADDRESS _____

PHARMACY PHONE # _____

CURRENT MEDICATION

MEDICATION AND DOSE DIRECTIONS DATE STARTED

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

Height_____ft _____in Weight _____