Alexander Orthopaedic Associates

New Patient Information:

Patient Name: _____ **Date:** _____
Social Security #_____ **Date of Birth:** _____
Please circle: M or F **Race:** _____ **Language** _____
Ethnicity _____ Single Married Divorced Widowed
Primary Home Address: _____
City: _____ **State**: _____ **Zip Code**: _____
Occupation: _____ Employer: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Secondary Home Address: -_____
City: _____ **State**: _____ **Zip Code:** _____

Primary Care Physician: _____ **Phone#:**_____
Referring Physician: _____ **Phone#**:_____

EMERGENCY CONTACTS:

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
If you have a spouse:
Name: _____ Date of Birth: _____
Social Security #_____ Employer: _____
Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Effective Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone # _____
Name of Insured: _____Relationship to patient: _____
ID #_____ Group #_____
Subscribers SS#:_____ Subscribers DOB: _____
Please Circle: **HMO** **PPO** **Other**

Secondary Insurance: _____Effective Date: _____

Address: _____
City: _____ State: _____ Zip Code: _____
Telephone # _____
Name of Insured: _____Relationship to patient: _____
ID #_____ Group #_____
Subscribers SS#:_____ Subscribers DOB: _____
Please Circle: **HMO** **PPO** **Other**

Did your injury occur at work? (Please circle) **Yes** **No** if yes, Date of injury_____
Is your injury from an auto accident? (Please circle) **Yes** **No** if yes, Date of injury_____
Are you being represented by an attorney? (Please circle) **Yes** **No**
if yes, Name of attorney_____ Phone #_____

MRI REFERRAL DISCLOSURE

In the course of your treatment, an x-ray, MRI, CT, bone scan, bone density scan, or other ancillary studies may be necessary and ordered. Alexander Medical Group, LLC, dba Alexander Orthopaedic Associates in accordance with the Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010, ("PPACA") Section 6003, informs you that it is your choice to have the study done at our facility or at the facility of your preference.

A written list of such facilities in the area is provided below.

Advanced Medical Imaging	**727-398-5999**	**Palms of Pasadena**	**727-341-7890**
Bardmoor Imaging	**727-461-8555**	**Pinellas High Field Imaging**	**727-347-4674**
Central MRI	**727-381-4674**	**Rose Radiology**	**727-531-5444**
Largo Medical Center	**727-588-5850**	**St. Petersburg General**	**727-341-4808**
National PET Scan	**727-471-1000**	**Tampa Bay Imaging (TBI)**	**727-545-9674**
Gateway	**727-525-2121**	**Westcoast Radiology**	**727-446-6760**
Northside Hospital	**727-528-5900**		

Please print and sign your name below to acknowledge your understanding of the above statements.

Print Name	Signature	Date

ALEXANDERORTHOPAEDICASSOC.

Alexander Orthopaedic Associates Disclosure of Policies

Financial Policy:

Alexander Orthopaedic Associates participates with many forms of health insurance, such as HMO's, PPO's, Workman's Compensation and Medicare. However, few insurance carriers cover all medical costs and a balance on your account may result from co-payments, co-insurance, deductibles, or non-covered services. The patient is responsible for full payment of any and all balances deemed "patient responsibility" by their insurance carrier. We will file medical insurance claims as a courtesy to our patients.

Motor Vehicle and Worker's Compensation: In order for our office to submit your claims for you, you must provide us with the following information: insurance company name, address and telephone number, as well as your claim number, date of accident and claims adjuster's name. In the event that your insurance denies or terminates your benefits, you will be responsible for full payment for services rendered. Please note for all Workers' Compensation patients, your initial appointment must be scheduled by your nurse case manager or Worker's Compensation adjustor. Authorization must be received prior to the initial office visit. Motor Vehicle patients, please note prior to your initial office visit your auto benefits must be confirmed and verified by our office.

Payment Policy:

All co-payments, co-insurance, and deductibles are paid at the time of service to help control costs of medical care. Payments may be made by cash, check, Visa, MasterCard, American Express, and Discover. For larger amounts, such as surgical fees not covered by insurance, AOA will work with you to arrange a payment plan. Self pay patients and Surgical Pre-pay patient's payments will only be accepted via credit card, cash payment, and/or money orders.

Treatment of Patients:

Throughout your treatment at AOA, the medical providers may order diagnostic testing to help determine your diagnosis or create a better treatment plan for you, the patient. These tests include lab work, x-rays, MRI's, CT scans, Bone Scan's, etc. Failure to schedule or obtain the recommended diagnostic studies in a timely manner or to schedule a follow up appointment to review the diagnostic tests in a timely manner; will constitute as a breech of our recommendations and is Against Medical Advice (AMA). Therefore, AOA employees and medical providers will not be held responsible for lack of patient responsibility and purposeful disregard of our medical recommendations. Non- compliance may result in an adverse complication to the patient's medical result/ outcome.

Alexander Orthopaedic Associates notifies you that our providers may be involved in education, research, development and/ or consulting with regards to Orthopaedic products and the Orthopaedic industry; therefore the providers may benefit directly or indirectly from such educational, research, development and/ or consulting relationships. This will not conflict with the best interest of the patient and/or their medical condition/ diagnoses.

Alexander Orthopaedic Associates notifies you that some or all providers may or may not carry Medical Malpractice Insurance.

AUTHORIZATION FOR
RELEASE OF
CONFIDENTIAL INFORMATION
(PURSUANT TO 45.C.F.R.164.508)
(T) 727-547-4700 (F) 727-394-8661

Patient Name: _____ DOB:_____
Last 4 digits of Social Security Number: _____ MR#: _____
Patient Phone Number: _____ (Personnel to Fill out)

I authorize to release **medical, psychiatric, alcohol and/or drug abuse, HIV testing, ARC and/or AIDS diagnosis, eating disorder information** or any other medical records of a sensitive nature:(Pursuant to 42.C.F.R.2.31)

This will authorize:_____(Name of facility/entity to provide records)

To Release To: **To Release To:**

Alexander Orthopaedic Associates
12416 66th Street No Suite A
Largo, FL. 33773

For the purpose of_____

Please disclose the exact information selected below:
Entire Medical Record, excluding _____
Date(s) of Service:

Check all that apply:

_____ Laboratory Reports	**_____ Medication Sheets**	**_____ Operative Reports**
_____ Radiology Reports	**_____ Facesheet**	**_____ Pathology**
_____ Progress Notes	**_____ History and Physical**	**_____ Emergency Report**
_____ Physician Orders	**_____ Discharge Summary**	**_____ EKG Report**
_____ Nurses Notes	**_____ Consultations**	**_____ Other (Specify):**

Note: X-ray films must be obtained from Radiology Dept.

To be completed by the patient or personal representative:

I hereby authorize the use or disclosure of my protected health information as described above.

This authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign the form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.

I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected.

I understand that I have a right to revoke this authorization by sending written notifications to: Alexander Orthopaedic Associates 12416 66th Street No Suite A Largo, FL. 33773

Any revocation will not affect disclosures made prior to Alexander Orthopaedic Associates receipt or knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form.

Signature of patient or patient's representative/Power of Attorney_____

Printed name of patient's representative/Power of Attorney_____

Relationship to the patient:

Date: _____ Expiration Date of this Authorization: **One Year**

Alexander Orthopaedic Associates
Patient Authorization Form

HIPPA Privacy Notice

I have received and read a copy of Alexander Orthopaedic Associates Notice of Privacy Practices (Notice).

*By initialing I have read and understand the above*_____

Authorization to Release Information

I consent to the use or disclosure of my protected health information by Alexander Orthopaedic Associates (AOA) for the purpose of diagnosing or providing treatment to me, obtaining payment for my Health care bills or to conduct health care operations of AOA. As mentioned in (*sections I, II, III, V*) of the Notice.

*By initialing I have read and understand the above*_____

AOA Disclosures

I acknowledge that I have been notified that some or all of the providers at AOA may or may not carry Medical Malpractice Insurance. I also acknowledge that I have been notified that the providers at AOA may be involved in education, research, development, and/ or consulting with regards to Orthopaedic products and the Orthopaedic industry; therefore, the providers may benefit directly or indirectly from such educational, research, development, and or consulting relationships. The above does not conflict with my best interest as a patient at AOA. I desire to enter into a doctor-patient relationship with a provider at AOA. As mentioned in (*section VI*) the Notice.

*By initialing I have read and understand the above*_____

Financial Agreement & Payment Policy

I understand that I am financially responsible for services rendered by AOA providers.
I also understand that few insurance carriers cover all costs for services rendered. AOA will submit claims to your insurance carrier. I will be responsible for the balance on my account that my insurance company does not cover. I will pay any co-payments, co-insurance, and deductibles at the time of service at AOA. As mentioned in (*section VII, VIII*) in the Notice.

*By initialing I have read and understand the above*_____

Authorization for treatment

Throughout your treatment at AOA the medical providers may order diagnostic testing (lab work, bone scan's, x-rays, MRI's, CT scans… etc) that will help determine your diagnosis and future treatment. Failure to schedule or obtain the recommended diagnostic studies or failure to schedule a follow up visit in a timely manner to review the diagnostic studies and discuss the results will constitute as a breech of our recommendations. AOA employees and medical providers will not be held accountable for your lack of responsibility and purposeful disregard of our medical recommendations. As mentioned in (section IX) in the Notice.

*By initialing I have read and understand the above*_____

I hereby authorize the medical staff of AOA to render medical services and treatments as deemed necessary. I understand that failure to comply with our medical recommendations is against medical advice. (AMA)

*By initialing I have read and understand the above*_____

By signing, I have read, understand and agree to comply with AOA policies so noted in the Notice of Privacy Practices (Notice).

Signature _____Date _____
Printed Name_____

If patient is a minor (under 18):

Minor's Name_____ Guardian's Name (printed) _____
Signature_____ Relationship _____ Date_____

Consent for the Release of Protected Health Information to Personal Representatives

I, _____, give my written consent for Alexander Orthopaedic Associates to share information regarding my protected health information and care to the following listed persons: I understand that these persons will be treated as personal representatives of myself.

Personal Representatives that Alexander Orthopaedic Associates may share my Protected Health Information with:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

_____Do not discuss my Protected Health Information with anyone other than myself at any time.

Alexander Orthopaedic Associates may leave a message:

At Home _____ At Work _____ On Answering machine _____

Patients' Signature _____ Date: _____

Patient's Account Number:

Alexander Orthopaedic Associates
Form Fee Agreement

Please note: The completion of informational/insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs, especially when multiplied over the large number of patients our practice serves. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of the forms as follows:

NO Charge:

- Workers Compensation requested Disability and Work Status forms
- Auto Insurance Carrier requests for Work Status and Treatment Plans

$15.00:

- Disabled Parking Applications

$35.00/ form:

- Credit Card deferment forms
- Private Disability Insurance Forms
- School Educational Disability or Limitation Forms

$35.00/form

- Family Medical Leave Act (FMLA) forms

$150.00- $300.00

- For completion of any dictated letter describing medical care and limitations
- For any narrative report detailing diagnosis, treatment, and future medical care including work capacity statements. Functional Capacity Evaluation testing may be necessary prior to, or in addition to the narrative report. The fee for the FCE test is determined by the facility that the testing is completed at.

I have read and understand the above. By signing I agree to comply with the Form Fee policy of AOA. Fees subject to change without notice.

_____ _____ _____

Patient Name (printed) Signature Date

Revise 9/7/10

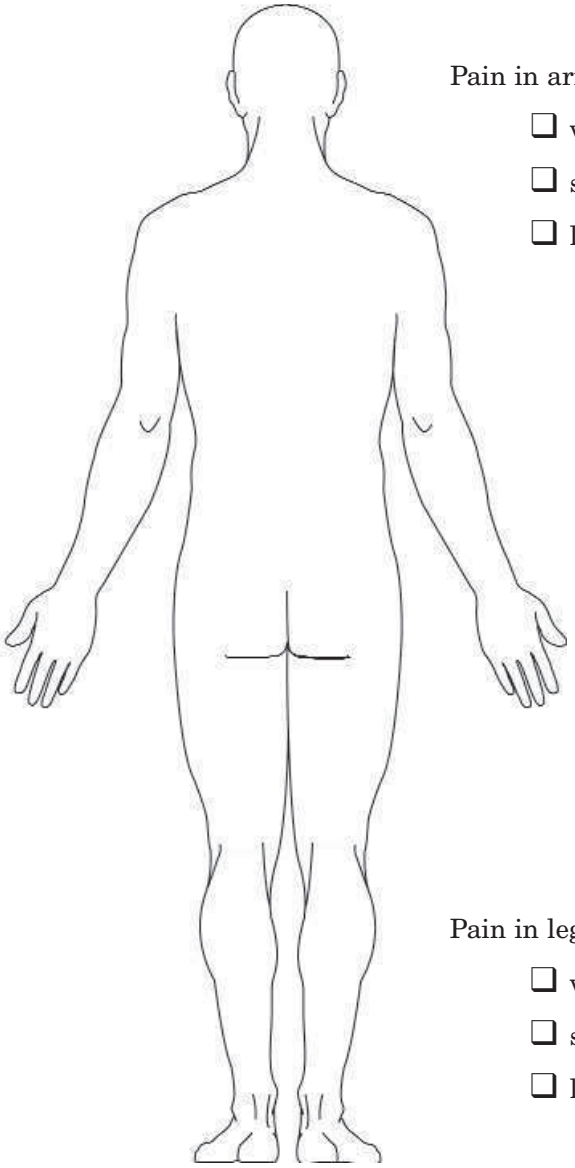
Patient Pain Drawing

Patient name:_____ Date: _____

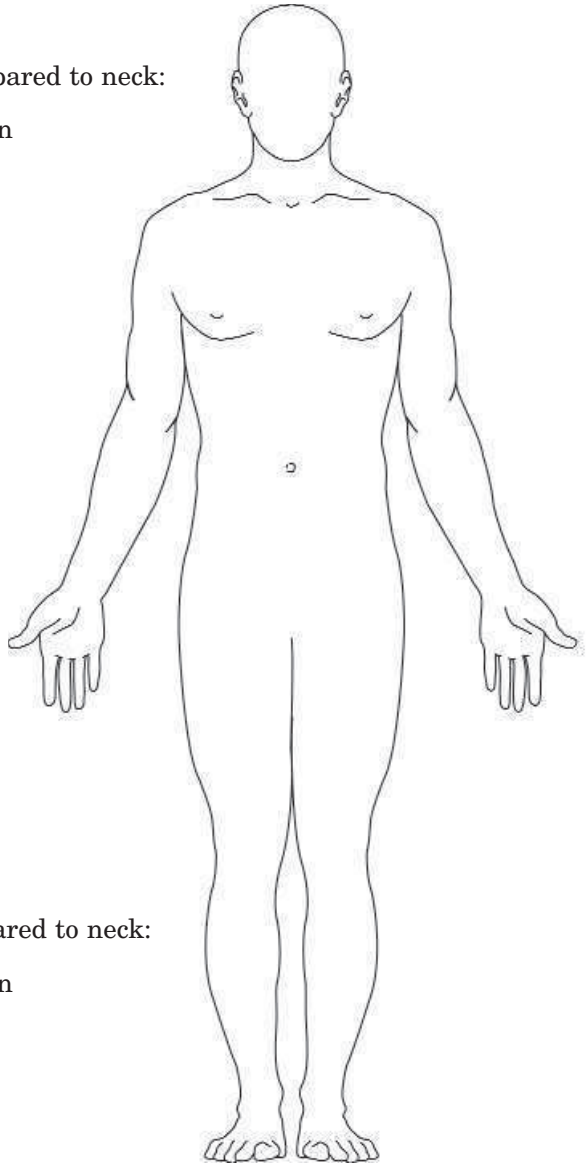
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas. Just to complete the picture, please draw in your face.

Ache	Numbness	Pins and needles	Burning	Stabbing
ΔΔΔΔΔ	======	oooooo	xxxxx	//////

Back



Front



Pain in arm(s) compared to neck:

- ❑ worse than
- ❑ same as
- ❑ less than

Pain in leg(s) compared to neck:

- ❑ worse than
- ❑ same as
- ❑ less than

Signature:_____ Date:_____

Room # _____
Provider _____
X-ray taken _____
XR/MRI brought yes no
Facility _____
(for office use only)

Neil Brown, MD
NEUROSURGERY HISTORY FORM

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

Reason for Referral (Neck pain, Low back pain) _____

Date of Injury or when Problem Onset _____

Type of Injury if Applicable

1. Slip & Fall: Yes No

2. Work-Related Injury: Yes No

3. Motor Vehicle Accident: Yes No

Driver Passenger: front / rear seat Pedestrian

Seat belt Yes No

Did you strike any part of your body in the vehicle?: Yes No

If Yes, Where? Steering wheel, windshield, head rest, side window, dash

Did someone get a ticket ? Yes No Your vehicle Other Driver

How fast was the vehicle going when it hit your vehicle / you? _____ mph

Was anyone else injured? _____

How much damage was done to your vehicle (estimate$/description): _____

_____

Briefly describe how the accident/injury occurred or when problem started:

_____

_____

_____

_____

_____

Did you have any loss of consciousness: Yes No If yes, how long? _____

What problems/symptoms did you have *immediately* after the injury?

_____

_____

Where were you *initially* seen? (Name of hospital, clinic or location) _____

_____

Date of *Initial* Visit_____

How did you get there? Ambulance other vehicle _____

What treatments (examination, x-rays, medications) were *initially* rendered?

_____

Name of Clinic and/or Physician which you *followed up* with _____

_____

Did you see any other physicians? If so, who, when and where? _____

_____

_____

Have you been prescribed any medications for your injury? By Whom?

_____

_____

Describe any treatments you have received for this injury (Chiropractic treatment, Physical Therapy, Massage, Acupuncture, Epidural Steroid Injections, etc.)_____

_____

_____

Are you still receiving therapy? Yes No

If yes, How often?_____

Are you experiencing any pain in any other areas besides your neck or back? If so, where?_____

_____

_____

Do you have **low back pain**: Yes No

If yes, is pain: constant intermittent seldom

How long has pain been present: _____

Rate pain: ____/10 (good day) – ____/10 (bad day)

(0 = no pain; 10 = extreme pain)

Is the pain improving with treatment: Yes No

Is there associated **leg pain** Yes No

Which leg: right left both

Is the leg pain the same as, worse or less than the back pain

Do you have any numbness or tingling in your legs: Yes No

Do you have any leg weakness Yes No

Do you have any bowel or bladder problems: Yes No

Does your low back pain affect your sex life Yes No

Circle the activities that make the pain worse: bending forward/ extension / squatting/ kneeling coughing/ prolonged standing/ prolonged sitting/ walking/ all of the above

What makes the pain better?

_____

_____

Do you have **neck pain**: Yes No

If yes, is pain: constant intermittent seldom

How long has pain been present: _____

Rate pain: ____/10 (good day) – ____/10 (bad day)

(0 = no pain; 10 = extreme pain)

Is the pain improving with treatment: Yes No

Is there associated **arm pain** Yes No

Which arm: right left both

Is the arm pain the same as, worse or less than the neck pain

Do you have any numbness or tingling in your arms: Yes No

Do you have any arm weakness: Yes No

Do you have associated headaches: Yes No

If yes, how often? _____

Do you have any dizziness Yes No

Circle the activities that make the pain worse: bending/ extending head/ turning head to either side/ coughing/ prolonged standing/ prolonged sitting/ walking/ reaching above head/ all of the above

What makes the pain better? _____

_____

Prior Injuries or Symptoms to Same Area Yes No

If so, what and when?

_____

_____

_____

Describe any prior work-related injuries, automobile injuries or slip & fall injuries that you were involved in, when and how? _____

_____

_____

Social History

Marital Status: single married divorced widowed

Smoker No / Yes If Yes, how much daily _____years _____

Alcohol Intake No / Yes If Yes, how much daily _____ years_____

What is your occupation? _____

Are you Currently Working?_ Yes No

Do you have any workplace restrictions? Yes No

If so, describe work restrictions:

_____

_____

Medical History: Are you being treated for any medical conditions

_____

_____

List All Prescription Medications you are currently taking

_____

_____

_____

List All Non-Prescription Medications you are currently taking

(i.e. vitamins, aspirin, Tylenol, Motrin, Advil)

_____

_____

_____

Medication Allergies_____

_____

PHARMACY _____
ADDRESS/CROSS STREETS _____
PHONE # _____

Family Medical History:

_____

_____

_____

Previous Surgeries _____

_____

_____