Alexander Orthopaedic Associates
Minor Paperwork

If the patient is under the age of 18, please complete the following:

Patient Name: _____ **Date:** _____
Social Security #_____ **Date of Birth:** _____
Please circle: M or F Race: _____ **Language** _____**Ethnicity** _____
Address:_____
City:_____ State:_____ Zip Code:_____

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

Mother's Name: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____

Father's Name_____ Home Phone: _____
Work Phone: _____ Cell Phone: _____

INSURANCE INFORMATION for the Minor:

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 #_____

I hereby authorize treatment of the above mentioned patient, as the parent or legal guardian. In my absence I authorize the following person's to accompany the patient to his/ her office visits, diagnostic testing, and or physical therapy visits.

_____ _____
Name to accompany minor Relationship to patient

_____ _____
Name to accompany minor Relationship to patient

Signature_____ Printed Name_____
Relationship to patient_____ Date: _____

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

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:
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

12416 66th Street North, Largo, Fl. 33773
2438 9th Street North, Ste. A St. Petersburg, FL 33704
2114 Seven Springs Blvd. New Port Richey, FL 34655
1325 Belcher Road Palm Harbor, FL 34683
(P) 727-547-4700 (F) 727-394-8661

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Alexander Orthopaedic Associates, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Alexander Orthopaedic Associates to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Signature of Patient: _____

Printed Name of Patient: _____

Date: _____

ALEXANDER ORTHOPAEDIC ASSOCIATES

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.

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 _____

Patients' Signature _____ Date: _____

Alexander Orthopaedic Associates
Patient Authorization Form

HIPAA 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_____

ALEXANDER ORTHOPAEDIC ASSOCIATES
HISTORY & PHYSICAL

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

TODAY'S DATE: _____

PATIENT NAME: _____ **Age:** _____ **DOB**: _____

(please circle): **M** **F** Right handed Left handed **HEIGHT:**_____ **WEIGHT:** _____ **BLOOD PRESSURE:**_____

RACE/ETHNICITY (please circle): **WHITE** **HISPANIC** **AFRICAN AMERICAN** **PACIFIC ISLANDER** **OTHER** _____

PRIMARY CARE_____

PREFERRED LANGUAGE (please circle): **ENGLISH** **SPANISH** **OTHER** _____

TODAYS CHIEF COMPLAINT (what body part are you seeking treatment for) _____ ☐ right ☐ left

HISTORY OF PRESENT ILLNESS OR INJURY (when and how did it happen):

EXACT DATE PAIN BEGAN OR INJURY OCCURRED _____

HOW WERE YOU INJURED? ☐ IN A SPORT ☐ ACCIDENT ☐ AUTO ACCIDENT ☐ NEITHER

WERE YOU INJURED AT WORK? ☐ YES ☐ NO **IF YES, WHAT DATE WERE YOU INJURED?**_____

HOW LONG HAVE YOUR SYMPTOMS BEEN PRESENT? _____

ON A SCALE OF 1-10, HOW SEVERE IS YOUR PAIN? _____

WHAT MAKES YOUR SYMPTOMS WORSE? _____

WHAT MAKES YOUR SYMPTOMS BETTER? _____

PREVIOUS INJURY TO THIS AREA: (please circle) **Y** **N**

If yes, explain:

CURRENT MEDICATIONS (name, strength and dose):

1._____ **2.**_____ **3.**_____

4._____ **5.**_____ **6.**_____

7._____ **8.**_____ **9.**_____

PAST MEDICAL HISTORY: (please check all that apply)

- ☐
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders/Blood Clots
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ GERD
- ☐ GI Disorders
- ☐ Heart Attack
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Liver Disease
- ☐ Neurological Disorders
- ☐ Other
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid Disease

PATIENT NAME: _____

ALLERGIES (please circle): **Aspirin Codeine Latex Penicillin Sulfa None Other:** _____
Reaction: _____

LIST ALL PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES: ☐ NONE

1. _____ YEAR _____
2. _____ YEAR _____
3. _____ YEAR _____
4. _____ YEAR _____
5. _____ YEAR _____

FAMILY HISTORY

Have any direct relatives had any of the following disorders? If so, list your relative

☐Diabetes _____ ☐High Blood Pressure _____ ☐Rheumatoid Arthritis _____
☐Difficulty with anesthesia_____ ☐Bleeding Problems_____ ☐None known

SOCIAL HISTORY (please circle): **Smoking** Qty_____ **Drinking** Qty_____ **Drugs** Type/Qty_____

MARITAL STATUS (please circle): **Single Married Divorced Widow Separated Student**

EMPLOYMENT STATUS (please circle): **Employed Unemployed Disabled Retired Occupation _____**

REVIEW OF SYSTEMS

Have you ever had any of these symptoms? If no, mark NONE				**NONE**	**YEAR**	**Details/Comments**
1. **GI**	☐Heartburn, Ulcers	☐Nausea, Vomiting	☐Blood in Stool	☐	____	_____
2. **ENDO**	☐Thyroid Disease	☐Heat or Cold Intolerance		☐	____	_____
3. **CON**	☐Weight Loss	☐Loss of Appetite	☐Fatigue	☐	____	_____
4. **EYE**	☐Blurred Vision	☐Double Vision	☐Vision Loss	☐	____	_____
5. **ENT**	☐Hearing Loss	☐Hoarseness	☐Trouble Swallowing	☐	____	_____
6. **CV**	☐Chest Pain	☐Palpitations		☐	____	_____
7. **RS**	☐Chronic Cough	☐Pneumonia	☐Shortness of Breath	☐	____	_____
8. **GU**	☐Painful Urination	☐Blood in Urine	☐Kidney Problems	☐	____	_____
9. **SK**	☐Frequent Rashes	☐Skin Ulcers	☐Lumps ☐Psoriasis	☐	____	_____
10. **NEU**	☐Headaches	☐Dizziness	☐Seizures ☐Numbness	☐	____	_____
11. **PSY**	☐Depression/Anxiety	☐Drug/Alcohol Addiction	☐Sleep Disorder	☐	____	_____
12. **HEM**	☐Easy Bleeding	☐Easy Bruising	☐Anemia	☐	____	_____

13. **Are you HIV Positive?** ☐Yes ☐No
    Have you ever had Hepatitis A, B, or C? ☐Yes ☐No If yes what type? _____
14. **Are you pregnant?** ☐Yes ☐No
15. **Are you Claustrophobic?** ☐Yes ☐No

PHARMACY NAME _____
ADDRESS/CROSS STREETS _____
PHONE# _____