

Patient Information		
PATIENT'S NAME: (last)	First	M. Init.
LOCAL ADDRESS... Street		Unit/Apt. #
City	State	Zip Code
SEX... <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
EMPLOYER		
EMPLOYER's Address... Street		Suite/Unit
City	State	Zip Code
PRIMARY LANGUAGE		
HOME PHONE Area Code ()	WORK PHONE Area Code ()	
DATE OF BIRTH	AGE	
DRIVERS LIC. #	ST	
SOCIAL SECURITY #		
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW(ER) <input type="checkbox"/> CHILD/STUDENT		
PERMANENT ADDRESS: (if different from local above)		Unit/Apt. #
City	State	Zip Code
PHONE NUMBER for Permanent Location Area Code ()	EMERGENCY CONTACT... Area Code ()	
REFERRED By?	FAMILY PHYSICIAN:	

Spouse's Information		
NAME: (Last)	First	M. Init.
SOCIAL SECURITY #		DATE OF BIRTH:
EMPLOYER:		
EMPLOYER's Full Address...		
WORK PHONE Area Code ()	OCCUPATION:	

Spouse's Insurance Coverage	
NAME & ADDRESS OF INSURANCE COMPANY:	
CERT. #	GROUP #
INSURANCE THROUGH EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
INSURED'S NAME & Relationship to Patient?	Date of Birth

Complete If Patient Is Child or Student		
FATHER'S Full Name: (Last)	First	M. Init.
SOCIAL SECURITY #		DATE OF BIRTH:
ADDRESS (If different from child/student)...		
EMPLOYER:		
EMPLOYER's Full Address...		
HOME PHONE Area Code ()	WORK PHONE Area Code ()	
MOTHER'S Full Name: (Last)	First	M. Init.
SOCIAL SECURITY #		DATE OF BIRTH:
ADDRESS (If different from child/student)...		
HOME PHONE Area Code ()	WORK PHONE Area Code ()	

Primary Insurance Coverage	
NAME & ADDRESS OF INSURANCE COMPANY:	
CERT. #	GROUP #
INSURANCE THROUGH EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
INSURED'S NAME & Relationship to Patient?	Date of Birth

Secondary Insurance Coverage	
NAME & ADDRESS OF INSURANCE COMPANY:	
CERT. #	GROUP #
INSURANCE THROUGH EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
INSURED'S NAME & Relationship to Patient?	Date of Birth

If Patient Is A Minor:
I hereby give my permission for Orthopaedic Surgery Associates, Inc. to evaluate and treat my child.
X SIGNED: _____ (Parent or Guardian)

Name: _____ Date: _____

Have you/ or are you being treated for the following: Include dates

1. ENDOCRINE:

- Diabetes
- Thyroid disorders
- Fever
- Weakness
- Chills
- Night sweats
- Recent change in weight or appetite

2. SKIN AND HEMATOLOGIC:

- Skin color
- Texture
- Frequent infections
- Varicosities
- Coagulation disorders
- Anemia

3. CNS:

- Unusual headaches
- Migraines
- Loss of consciousness
- Epilepsy
- Head trauma
- Seizure disorders
- Stroke
- Loss of memory
- Vertigo
- Syncope
- Paralysis
- Numbness/tingling in extremities

4. EYES:

- Glaucoma
- Cataracts
- Change in vision
- Use of glasses for reading

5. EARS:

- Buzzing or ringing in ears (tinnitus)
- Change in hearing
- Use of hearing aid
- Earache
- Discharge from ears

6. NOSE AND MOUTH:

- Airway obstruction
- Difficulty Speaking
- Sinus problems
- Unusual bleeding
- Dentures

7. BREASTS:

- Masses
- Cystic condition
- Past biopsy or surgery

8. RESPIRATORY:

- Cough
- Coughing up blood
- Asthma
- Bronchitis
- Shortness of breath at night
- Emphysema
- Pneumonia
- Tuberculosis
- Congestive failure

9. CARDIOVASCULAR:

- Anginal chest pain
- Heart attack
- Murmurs
- Hypertension
- Stroke
- Palpitations
- Peripheral edema
- Claudication
- Poor circulation
- Congestive heart failure
- Phlebitis
- Cramping of legs when walking

10. GASTROINTESTINAL:

- Constipation
- Nausea
- Vomiting
- Diarrhea
- Enteritis
- Vomiting blood
- Melena
- Bright red blood per rectum
- Jaundice
- Abdominal hernias
- Hepatitis
- Diverticulitis
- Gallbladder disease
- Yellow jaundice
- Peptic or duodenal ulcer disease
- Abdominal pain

11. UROLOGY:

- Pain on urination
- Frequency
- Urgency
- Decreased stream
- Blood in urine
- Incontinence
- Kidney stones
- Bladder infections
- Syphilis
- Gonorrhea
- Difficulty with urination
- Burning during urination

12. MUSCULOSKELETAL:

- Joint pain
- Swelling
- Stiffness
- Muscle pain
- Arthritis
- Gout
- Deformities
- Cramps or weakness
- Prior fractures
- Decreased range of motion



ORTHOOPAEDIC SURGERY ASSOCIATES

COMPREHENSIVE MUSCULOSKELETAL CENTERS

BOCA RATON:

1401 N.W. 9th Avenue • BOCA RATON, FL 33486
Tel: (561) 395-5733 • FAX: (561) 395-3098

BOYNTON BEACH:

2828 S. Seacrest Boulevard, Suite 204 • BOYNTON BEACH, FL 33435
Tel: (561) 734-5080 • FAX: (561) 369-1332

ARTHROSCOPY • FOOT SURGERY • HAND SURGERY • JOINT REPLACEMENT • PAIN MANAGEMENT • SPINAL SURGERY • SPORTS MEDICINE

PATIENT'S FINANCIAL AGREEMENT

Patient's Name: _____ Date: _____

IMPORTANT: THIS IS NOT AN APPLICATION FOR CREDIT. CHARGES FOR ALL SERVICES RENDERED BY ORTHOPAEDIC SURGERY ASSOCIATES (HEREINAFTER, "OSA") ARE DUE AND PAYABLE IN FULL FORTY-FIVE (45) DAYS FROM THE DATE SERVICES WERE RENDERED. OSA will assist the Patient in the processing of insurance claims as a courtesy only. OSA accepts no responsibility for any processing procedures, acts, omissions and/or neglect. PATIENT, RESPONSIBLE PARTY AND/OR INSURANCE CARRIER ARE SOLELY RESPONSIBLE TO PAY FOR ALL SERVICES PROVIDED.

IN CONSIDERATION of the provision of services to the Patient named above, the Patient and the Responsible Party understand and agree that:

1. Payment for services rendered is due in full forty-five (45) days from the date services were rendered, or as otherwise might be stipulated through a contract between OSA and Patient's health plan or as stipulated by any state prompt payment laws. Any balance unpaid after sixty (60) days from the date services were rendered will be considered "delinquent".
2. **FOR PATIENTS WITH INSURANCE:** In the event that services rendered are not covered or are deemed as not medically necessary, Patient and/or Responsible Party shall be responsible for payment in full for those services. Patient and/or Responsible Party shall also be responsible for any cost sharing, such as co-payments, coinsurance and/or deductibles.
3. In the event that any unpaid balance remains delinquent and has been placed for collection, the Patient and/or Responsible Party must pay all costs of collection, including reasonable attorney's fees, if the delinquent balance is referred to an attorney for collection.
4. In the event the Patient submits payment by check and that check is returned for INSUFFICIENT FUNDS by the Bank, OSA will add a bank charge to the balance owed by the Patient or Responsible Party.
5. No statement by an employee or agent of OSA will contradict, void or nullify this Agreement, nor shall the Patient rely on any statements or opinions made by OSA that Patient's insurance carrier will pay the bill.
6. Patient also assigns to the Physicians accepting this assignment of medical benefits their rights under policy of insurance, including the right to receive information concerning benefits available and the right to file a lawsuit to recover unpaid medical benefits for the Physician's regular charges.

X-RAYS: Original X-rays are a part of the patient's permanent medical chart and remain in our office. If you would like a copy of your X-rays, there is a nominal charge to cover the cost of duplication.

LIFETIME AUTHORIZATION - MEDICARE AND MEDICAID PATIENT CERTIFICATION - PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Authorization is hereby given to OSA to submit my claim directly to my insurance on my behalf. I understand that by signing this form, my signature is not needed each time a claim is submitted on my behalf. I further authorize my insurance carrier to forward payment directly to OSA.

I HEREBY AUTHORIZE OSA TO RELEASE ALL MEDICAL AND BILLING INFORMATION NECESSARY TO SECURE PAYMENT FROM MY DESIGNATED INSURANCE CARRIER ON MY BEHALF. I have read and fully understand all of the above conditions. Once I sign this Agreement, I am responsible for all payments, charges, and if necessary, costs of collection as stated above. I acknowledge receipt of a copy of this Agreement.

Patient: X _____

Dated: _____

Responsible Party (if other than Patient): _____

Witness: _____

Relationship to Patient _____ PatFinAgree _____

ORTHOPAEDIC SURGERY ASSOCIATES

1401 NW. 9th Avenue, Boca Raton, FL 33486 (561) 395-5733
2828 S. Seacrest Boulevard, , Boynton Beach, FL 33435 (561) 734-5080

AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Medical Record #: _____

1. I authorize Orthopaedic Surgery Associates to disclose my health information specific to the following date or time period:

2. Individual or entity authorized to receive my health information: _____

3. Purpose for which disclosure is to be made:

4. Information to be disclosed:
- | | | |
|--|--|--|
| <input type="checkbox"/> Practitioner Summary | <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> X-ray Records |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Office Chart Notes | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Rx |

I understand that this will include health information relating to (check if applicable):

- | | |
|---|--|
| <input type="checkbox"/> HIV (Human Immunodeficiency Virus) infection | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Treatment for alcohol and/or drug abuse | <input type="checkbox"/> Genetic Testing |

5. I understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore, I release **Orthopaedic Surgery Associates**, its employees, and my physicians from all liability arising from this disclosure of my health information.

6. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 180 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revocation request.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

_____ Signature: Patient or Legal Representative	_____ Date	_____ Signature of Witness	_____ Date
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **Orthopaedic Surgery Associates'** health care operations. The Notice of Privacy Practices also describes my rights and **Orthopaedic Surgery Associates'** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the office of **Orthopaedic Surgery Associate's** at 2828 S. Seacrest Blvd. Boynton Beach, Florida 33435 and on **Orthopaedic Surgery Associates'** website at www.Ortho-Surgeon.com.

_____ Signature of Patient or Personal Representative	_____ Name of Patient or Personal Representative
_____ Date	_____ Description of Personal Representative's Authority HIPAA Compliance