CENTRAL FLORIDA
BONE & JOINT INSTITUTE

2745 Rebecca Lane
Orange City, FL 32763
917 Rinehart Road, Ste 2031
Lake Mary, FL 32746

Phone: 386-775-2012
Fax 368-775-2013

History and Intake Form

Todays Date:_____ Social Security Number: _____

Last Name:_____First Name: _____

Street Address: _____ City/State: _____

Zip Code:_____ Date of Birth: _____

Gender Identity: _____ Birth Assigned Sex: _____

Marital Status: _____

Phone number (day):_____ Phone number (night):_____

Preference for appointment reminder: Text/Call (home or cell) _____

Email address: _____ Occupation: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Emergency Contact (name): _____Emergency Contact (number):_____

If patient is a minor, please list guardian information: Name:_____

Relationship to patient: _____ Phone #_____

Primary Care Provider: _____ Referring Physician: _____

How did you hear about us? _____

Insurance Information

Primary Insurance: _____

Policy#: _____ Group #_____

Secondary Insurance: _____

Policy#: _____ Group #_____

Is the Patient the policy holder?: YES/NO. If no, what is the policy holder name? _____

Policy Holder Date of Birth: _____ Relationship to patient: _____

Problem/Injury Information

Date of Injury/Description of Accident: _____

Was this a Motor Vehicle Accident/Slip and Fall/ Worker's Comp? _____

Were you seen in an ER? If yes, where and when? _____

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HIPAA Authorization Form

I, _____ give permission to Central Florida Bone and Joint Institute to disclose the following protected health information (please check all that apply) to the names listed below:

Name:_____

Name:_____

Name:_____

Information to be disclosed

☐ Medical Records ☐ Diagnostic Reports ☐ Other: _____

☐ Treatment Records ☐ Medications

☐ This authorization expires: _____ ☐ Does not expire

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to the persons listed above and is no longer protected by these regulations.

You may refuse to sign this authorization form. Your refusal to sign this will not affect your ability to obtain treatment or your eligibility benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. Finally, you may revoke this authorization in writing at any time by sending notification to 2745 Rebecca Lane, Orange City, FL 32762. Your notice will not apply to actions taken prior to the date the letter is received.

_____ _____

Signature of patient or patient representative Date

_____

Relationship of patient representative

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Disability/FMLA Form Policy

At Central Florida Bone and Joint Institute, our patients are at the center of all that we do. Our physicians and team members are committed to providing the highest quality of care during all stages of your treatment. With this in mind, we want to share our process for completing disability or FMLA forms.

Our policy regarding completion of all forms is as follows:

- Forms and a signed authorization to release medical information may be delivered directly to the office or faxed to (386)-775-2013
- Our fee to complete **EACH form is $50.00**. This is payable by cash or credit card. This must be paid prior to the completion of the form(s), either at the time of delivery or if faxed it may be paid by phone.
- The patient information portion of the form must be completed prior to processing.
- Once we receive your form(s) and your signed authorization to release your medical records, please allow 7-10 business days for processing of the forms.
- All completed forms will be mailed or faxed to the disability carrier/employer as indicated by the patient or may be picked up at our office by the patient or a designated representative on the patient's HIPPA form.

_____ _____

Signature of patient or patient representative Date

_____

Relationship of patient representative

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Cancellation/No Show Policy

At Central Florida Bone and Joint Institute our goal is to provide quality medical care in a timely manner to our patients. Patients who do not show up to their appointments or fail to cancel in a timely manner prevent us from providing care to other patients in a timely manner. This policy better allows us to utilize available appointments for our patients who need medical care.

In the event you must cancel or reschedule your appointment, you must do so within 24 hours of your scheduled appointment time. Failure to comply with this policy will result in a $40 charge which must be honored prior to rescheduling any future appointments. In the event that you do not show up for 3 consecutive appointments, you may be dismissed from the practice.

Please note that cancellation/no show fees are in addition to the co-pays, deductibles, coinsurance or previous balances.

_____ _____

Signature of patient or patient representative Date

_____

Relationship of patient representative

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Pain Medication Policy

Are you currently under the care of a Pain Management Physician? Yes / No
If Yes, please provide the information below:

NAME OF FACILITY_____ PHONE#_____

During the course of your treatment, you may be prescribed Controlled Substance Medications (also known as narcotic medications) to help treat your pain. Controlled Substance Medications are intended to help relieve your pain during your recovery process.

Controlled Substance Medications have a high potential for misuse and addiction and are therefore closely monitored by the local, state and federal government. State and federal laws prohibit physicians from prescribing these medications for more than 3 days at a time. Here at Central Florida Bone and Joint Institute, we abide by all local, state and federal laws.

If we, here at Central Florida Bone and Joint Institute, prescribe your Controlled Substance Medications, we want to ensure that you fully understand the policies to ensure there are no issues during your postoperative course.

The policies include:

- Controlled Substance Medications will only be prescribed in the Post-Operative Period.
- Controlled Substance Medications can only be prescribed for a 3 day period at a time.
- All refill requests for Controlled Substance Medications should be called in 24 hours prior to you needing them. Any refill requests called in on Friday will be filled on Monday.
- The patient is responsible for his/her Controlled Substance Medication and if any medication is lost, stolen or misplaced, it cannot be refilled until the proper period of time has passed.
- Controlled Substance Medications CAN NOT BE CALLED INTO THE PHARMACY OR MAILED TO YOU. You or a person you have designated on our paperwork as an acceptable alternative must come into the office to pick up the prescription in person with a valid photo ID.
- If you obtain a prescription for a Controlled Substance from another physician during the same time you are receiving medication from Central Florida Bone and Joint, you will be in breach of contract and will no longer receive any pain medications from our group.

PATIENT SIGNATURE _____ DATE _____

PRINTED PATIENT NAME _____

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Central Florida Bone and Joint Financial Policy

Thank you for choosing us as your health care provider. We are committed to the quality care and treatment of all of our patients. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

Regarding Insurance

Medicare - We accept Medicare assignment. We also accept SOME Medicare replacement plans. Please check with your insurance company before seeing the provider to ensure that your Replacement Plan is one that we accept. This means that we have agreed in contract to accept fees and bill according to Medicare allowed amount. The patient is responsible for the annual deductible and 20% of the approved amount at the time of service except when there is a supplemental policy to pay these amounts.

Medicaid - We only accept certain Medicaid insurances. Please check with your insurance company before seeing the provider to ensure that your Medicaid Plan is one that we accept.

Share of Cost - It is our policy that the patient will be responsible for any charges incurred at the time of service. Upon payment, a receipt will be given with detailed charges that can be turned into the case worker for reimbursement.

Private Insurance - It is the **patient's responsibility** to verify with the insurance company that their insurance is one that we accept prior to seeing the provider. Failure to do so will make the patient responsible for 100% of the charges incurred. All co-pays, deductibles , and co-insurances are due at the time of service. In the event that there is a remaining balance on your account after insurance has paid, payment is due within 30 days of the insurance payment. If payments are not made within 30 days of the insurance payment, then the account may be submitted for collections. The balance is the patient's responsibility whether your insurance company pays or not. Your insurance policy is a contract between yourself and your insurance company. We are not party to that contract. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable or necessary under your insurance policy contract.

Referral/Authorizations - In the case that we are out-of-network with your insurance plan that require referral and/or authorizations, you will be responsible for all charges at that time of service. Your insurance will be billed out of courtesy if a written authorization is obtained. **You are responsible for obtaining any authorizations necessary for your visit or testing prior to the date of your appointment.** Authorizations must be in writing from your PCP or authorized insurance representative. You will be responsible for charges if **written** authorization has not been obtained prior to the date of service.

Self Pay - If you do not fall within any of the categories listed above, we require **FULL PAYMENT AT THE TIME OF SERVICE.** You will be considered a Self Pay Patient and upon the first visit will be required to pay the advance amount of $250.00. We **DO NOT ACCEPT** checks or partial payments for your first visit. After the first visit you may pay by cash, check, CareCredit, Visa, Discover or MasterCard. If there are any additional charges you will be asked to pay the remaining balance at checkout. Please be advised that $250.00 is an estimate and charges may be more than $250.00 depending on the services received.

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Surgery Patients - It is the patient's responsibility to check **PRIOR** to surgery to make financial arrangements for surgery costs that exceed $500.00.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

For your convenience we accept **CASH, CHECKS, CARECREDIT, CREDIT CARDS AND DEBIT CARDS.** Thank you for understanding our financial policy. Please let us know if there are any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

PATIENT/RESPONSIBLE PARTY SIGNATURE _____ DATE _____

PRINTED PATIENT NAME _____

Please be aware that you may receive a questionnaire from your insurance company regarding whether or not your visit(s) is Workers-Compensation or Motor Vehicle Accident related. In the event that you do not return the questionnaire to your insurance company, you will be solely responsible fo all charges due to Central Florida Bone and Joint Institute. _____(please initial)

I authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of medical benefits to my physician at Central Florida Bone and Joint Institute for services rendered to me. I understand I am responsible for all deductibles, co-pays, and non-covered services. I hereby acknowledge that I have read and completely understand the authorization above.

PATIENT/RESPONSIBLE PARTY SIGNATURE _____ DATE _____

PRINTED PATIENT NAME _____

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Past Medical History

- ☐ None
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hyperplasia
- ☐ Bipolar Disorder
- ☐ Cerebrovascular accident
- ☐ Chronic Anemia
- ☐ Chronic Obstructive Lung Disease
- ☐ Chronic Pain
- ☐ Coronary Disease
- ☐ Deep Venous Thrombosis
- ☐ Depressive Disorder
- ☐ Diabetic on Insulin
- ☐ Disease Caused by Covid 19
- ☐ End Stage Renal Disease
- ☐ Epilepsy
- ☐ Essential Hypertension
- ☐ Gastroesophageal reflux
- ☐ Hypertension
- ☐ Primary Hyperparathyroidism
- ☐ History of radiation therapy
- ☐ HIV
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory disease of liver
- ☐ Ischemic heart disease
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Breast Cancer
- ☐ Lung Cancer
- ☐ Prostate Cancer
- ☐ Morbid Obesity
- ☐ Multiple Myeloma
- ☐ Obesity
- ☐ Sleep Apnea
- ☐ Fibromyalgia
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Type 2 diabetes
- ☐ Other _____

Past Surgical History

- ☐ None
- ☐ Abdominoperineal resection
- ☐ Bypass of stomach
- ☐ Cesarean hysterectomy
- ☐ Coronary artery bypass
- ☐ Kidney transplant
- ☐ Skin cancer excision
- ☐ Colostomy
- ☐ Tubal ligation
- ☐ Appendectomy
- ☐ Mastectomy
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Liver excision
- ☐ Angioplasty
- ☐ Heart valve replacement
  - ☐ Tissue
  - ☐ mechanical
- ☐ Prostatectomy
- ☐ Hysterectomy
- ☐ Joint replacement surgery
  - ☐ Shoulder
  - ☐ Knee
  - ☐ Hip
- ☐ Spine Surgery
  - ☐ Decompression
  - ☐ Laminectomy
  - ☐ Kyphoplasty
  - ☐ Fusion
- ☐ Arthroscopy
  - ☐ Shoulder
  - ☐ Knee
  - ☐ Hip
  - ☐ Ankle
- ☐ Hip fracture surgery
- ☐ Other

_____

_____

_____

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Preferred Pharmacy

Name:_____ Phone Number:_____

Address:_____

Medications

Please list ALL current medications (including over the counter medications) as well as the dose and frequency.

☐ Currently not taking any medication

Medication	Dose	Frequency

Allergies

Please list ALL known allergies including the type of reaction and severity

☐ No known drug allergies

Allergy	Reaction (ie anaphylaxis, hives, swelling)	Severity (ie mild, moderate, severe)

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Vitals

Height: _____ (Feet and inches) Weight: _____ (pounds)

Social History

Please choose one from each category

Smoking Status :

☐ Current Smoker
- Packs per day _____

☐ Former Smoke
- How long ago did you quit? _____

☐ Never Smoker

Alcohol Intake :

☐ None

☐ Current
- How many times per year do you drink more than 5 drinks in a day? _____

☐ Former

Exercise Frequency:

☐ None

☐ Few times a month

☐ Few times a week

☐ Once a day

☐ Never

Family History

Please list any medical conditions any of your first-degree relatives have or had before passing (mother, father, grandparents, siblings).

Example: Mother- Diabetes and Hypertension

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Review of Systems

- ☐ None
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Unsteady gait
- ☐ Numbness
- ☐ Tingling
- ☐ Dizziness
- ☐ Headaches
- ☐ Tremors
- ☐ Fatigue
- ☐ Unexpected weight loss
- ☐ Fever
- ☐ Chills
- ☐ Weight gain
- ☐ Poor healing wounds
- ☐ Redness
- ☐ Rash
- ☐ Itching
- ☐ Scarring/keloids
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Immunosuppression
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Heart murmur
- ☐ Leg cramps
- ☐ Excessive thirst
- ☐ Heat/cold intolerance
- ☐ Nose bleeds
- ☐ Ringing in the ears
- ☐ Hoarseness
- ☐ Glasses/contact lenses
- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody/tarry stolls
- ☐ Frequent urination
- ☐ Difficult/painful urination
- ☐ Incontinence
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough/ hurts to breath
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Blood thinners
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Premedication prior to procedure
- ☐ Rheumatoid arthritis
- ☐ RSD
- ☐ Allergy to shellfish or iodine
- ☐ Allergy to latex
- ☐ Allergy to adhesive
- ☐ Under pain management
- ☐ Pregnant/planning to become pregnant
- ☐ Recent international travel
- ☐ Other: _____

_____

_____

Patient Screening Questionnaire

Today's Date_____

Name_____ **Date of Birth**_____

1. What is your height and weight?

   Height _____ Weight _____

2. Are you currently a smoker? (Please circle one) Yes / No

   If Yes, how many packs per day? _____

   Did you use to smoke, but quit? (Please circle one) Yes / No

   If Yes, when did you quit? _____

3. Do you use alcohol? Yes / No

   If Yes, how many times per year would you say you drink more than 5 drinks per day?

   _____

4. If 65 years old or older, do you have an advanced directive? Yes / No

   Living will? Yes / No

   Health Care Proxy? Yes / No

   If Yes, what is the name of your health care proxy? _____

5. Please see the list of medications we printed for you and review to make sure you are still taking all these. If there are any new medications you are on that are not listed or changes to the medications listed, please add the new medication on the blank lines below. If there are any meds on this list that you are no longer taking, please cross them out.

Medication	Dose	Frequency