CELEBRATION ORTHOPAEDIC & SPORTS MEDICINE INSTITUTE

2954 Mallory Circle, Suite 101 · Celebration, FL 34747

Phone: (321) 939-0222 · **Fax**: (321) 939-0225

BRAD HOMAN, DO
Joint Replacement & Sports Medicine

JOSEPH E. ROBISON, MD
Hand & Wrist Surgery

JOSE AMUNDARAY, MD
Joint Replacement Specialist

J. DOUGLAS McDONALD, MD
Sports Medicine

MATTHEW JOHNSTON, DO
Joint Replacement & Sports Medicine

MAAHIR HAQUE, MD
Spine Surgery

JOSHUA BRITT, DPM
Foot & Ankle Surgery

DAVID LALLI, DO
Joint Replacement & Sports Medicine

MATTHEW WILLEY, MD
Physical Medicine & Rehabilitation

PATIENT INFORMATION

Last Name_____ First Name_____ Middle Initial_____
Apellido *Nombre* *inicial del segundo nombre*

Birthday_____ Phone (_____) _____ Social Security # _____-_____-_____
Cumpleaños *teléfono* *Seguro social*

Address_____ City_____ State_____ Zip_____
Dirección *cuidad* *estado* *código postal*

Email_____ Sex: ☐ M ☐ F
Correo electrónico *género*

Whom may we thank for referring you? _____
Quien lo refirió

Referring Physician (*If Applicable*) _____ Phone: (____) _____
Médico de referencia (si corresponde) *teléfono*

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered
estado civil *solo* *casado* *divorciado* *viudo* *apartado* *asociado*

Who is Responsible for Patient? ☐ Self ☐ Parent ☐ Employer ☐ Other_____
¿Quién es Responsable de Paciente? *Yo* *padre* *empleador* *otro*

_____ _____ (_____) _____
Person to contact in case of emergency / Relationship / Phone
Persona de contacto en caso de emergencia *relación* *teléfono*

*****Who may we share Medical Information with?**
¿Con quién podemos compartir información médica?

_____ _____ (_____) _____
Name / Relationship / Phone
Nombre *relación* *teléfono*

_____ _____ (_____) _____
Name / Relationship / Phone
Nombre *relación* *teléfono*

INSURANCE INFORMATION

Primary Insurance Co. _____
seguro primario

Name of Insured _____
Nombre del Asegurado

Relationship to Patient _____
Relación con el Paciente

Secondary Insurance_____
seguro secundario

Name of Insured _____
Nombre del Asegurado

Relationship to Patient _____
Relación con el Paciente

ACCIDENT INFORMATION

Was the Accident: ☐ Work-Related ☐ Auto-Related ☐ Other _____
¿cuál fue el accidente? relacionados con trabajo auto relacionados otro

Employer _____ Date of Injury _____
Empleador fecha de la lesión

Time of Injury_____ Place of Injury _____
momento de la lesion lugar de la lesión

Do you have notice of Injury on file? ☐ Yes ☐ No W.C. Claim # _____
¿Tiene la notificación de lesiones? Si No numero de reclamo

Attorney Name _____ Insurance Co. _____
nombre del abogado compañía de seguros

Policy Holder _____ I.D. # _____
Tomador I.D. número

Address _____ Zip_____
Dirección código postal

Phone (_____) _____ were X-Rays taken of this Injury? Yes ☐ No ☐
Teléfono fueron radiografías tomadas de esta lesión? Si No

If yes, where were X-Rays taken? _____ Date _____
En caso afirmativo, ¿dónde estaban radiografías tomadas? fecha

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR RECEPTIONIST. PAYMENT FOR PROFESSIONAL SERVICE IS DUE AND PAYABLE WHEN SERVICE IS RENDERED.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Sign: _____ Date: _____
Firma fecha

Relationship (if not signed by patient) _____
Relación (si no es firmado por el paciente)

I wish to provide the following restrictions on disclosure of my health information:
Deseo dar las siguientes restricciones a la divulgación de mi información de salud:

_____

Internal Use ONLY: If patient/patient's representative declines to sign acknowledgement, please document date and time notice as presented to patient and sign below.
Date/Time _____ Name/Title _____

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical, psychiatric, alcohol and HIV testing and/or drug abuse information for insurance carriers or for continuing patient care. I further agree to have my physician maintain my health information data for the purpose of education, research and publication in professional journals and medical books. However, any publication of these will exclude my name so as to protect my identity.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian and/or Responsible Party Date

CONSENT FOR EVALUATION OR TREATMENT

Undersigned hereby consents to whatever evaluation or treatment the assigned physician deems necessary to the above named patient.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian and/or Responsible Party Date

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to **Celebration Orthopaedic & Sports Medicine Institute** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named physician may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian and/or Responsible Party Date

MEDICARE/MEDIGAP AUTHORIZATION

Patient Name: _____ Date of Birth: _____

Medicare #: _____ Patient ID #: _____

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **Celebration Orthopaedic & Sports Medicine Institute**, for any services furnished to be by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare or Medicaid Services, any Medigap insurer, and their agents any information needed to determine these benefits and related services.

_____ _____
Signature of Patient, Patient Guardian, or Personal Representative Date

_____ _____
Print name of Parent/Guardian and/or Representative Relationship to Patient

FINANCIAL AGREEMENT

Thank you for choosing Celebration Orthopaedic & Sports Medicine Institute as your healthcare provider. We are committed to your treatment being successful and we appreciate your trust in us. The following is a statement of our Financial Policy which you are required to read and sign. Our staff will address any questions that you may have but you will need to agree to and sign prior to your treatment being rendered:

- **Self pay patients** - Payment in full is due at the time of service.
- **Patients with Insurance** - We will file your insurance claim for you. However, in order to work with your insurance company, we must have complete and current information, a copy of your insurance card and your signature on file.
- **Insurance benefits** – It is your responsibility to know your insurance benefits. Please contact your insurance company with any questions that you may have regarding coverage of orthopaedic services.
- **Co-payments, co-insurances and deductibles** – All patient balances are due at time of service. We accept cash, checks as well as Visa, MasterCard, Discover and American Express credit cards.
- **Non Covered Charges** - Please understand there may be some charges for our services which your insurance company considers non-covered and may be excluded from your policy. Accordingly, you will be responsible for these charges.
- **Denied Claims** - You will be responsible for any charges that are denied by your insurance company which result from your failure to provide our office with complete and current information in a timely manner.
- **Medicare** - We are a participating Medicare provider. We will bill Medicare, as well as any secondary insurance that you may have, for you. However, that does not mean that all services are covered. Additionally, you are responsible for any copayments, usually 20% of the allowed amount, as well as any unmet annual deductible. Please realize that Medicare may allow a service but your secondary may not so you will be responsible for that portion.
- **Missed appointments** - Failure to cancel an appointment within 24 hours will be subject to a $10 patient charge. ($50 will be charged for MRI's and Laser's) This is an internal charge and cannot be billed to your insurance company.
- **Returned checks** – Any returned check is subject to a $25 bank fee.
- **Special financial arrangements** – We offer monthly payments plans with balances to be paid off in 4 consecutive payments. Also, we offer financial hardship discounts but these required the patient to complete a Financial Evaluation Form with proper supporting documentation that shows the patient's income.
- **Past due accounts** – All past due accounts are subject to collection proceedings. All fees including but not limited to the maximum interest that is allowable by law, a 35% collection agency fee and awarded court fees will become your responsibility in addition to the patient balance should you be placed with an external collection agency.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY

_____ _____

Signature of Patient, Patient Guardian, or Personal Representative | Date

_____ _____

Print name of Parent/Guardian and/or Representative | Relationship to Patient

CELEBRATION ORTHOPAEDIC & SPORTS MEDICINE INSTITUTE

Clinical History - Please Complete

Name: _____ Age: _____ Date: _____

Primary Physician: _____ Last Physical Date: _____

Please Note, items left blank indicate a negative response

PAST MEDICAL HISTORY

☐None Indicate **all** medical conditions you have experienced.

☐ Bleeding disorders	☐ High blood pressure	☐ Liver disorder	☐ Osteoporosis
☐ Blood clots/DVT	☐ Heart disease	☐ Stomach ulcers	☐ Rheumatoid arthritis
☐ Stroke	☐ Arrhythmia	☐ Kidney problems	☐ Gout
☐ Seizures	☐ Anemia	☐ Blood transfusion	☐ Fibromyalgia
☐ Sleep apnea	☐ Diabetes	☐ Cancer	☐ Psoriasis
☐ Asthma/Emphysema	☐ Thyroid disorders	☐ Glaucoma	☐ Other (list below)

_____

_____

SURGICAL PROCEDURES

☐None Indicate **all** surgical procedures (include approximate date)

☐ Tonsils _____	☐ Heart _____	☐ Uterus _____	☐ Prostate _____
☐ Appendix _____	☐ Colon _____	☐ Breast _____	☐ Hernia _____
☐ Thyroid _____	☐ Gall Bladder_____	☐ Vascular _____	☐ Other (list in space below)

FAMILY HISTORY

☐None Indicate **all** medical conditions experienced by any parent, sibling, or child

☐ Cancer	☐ High Blood Pressure	☐ Kidney Problems	☐ Osteoporosis
☐ Stroke	☐ Heart Disease	☐ Bleeding Disorders	☐ Birth defects
☐ Seizures	☐ Diabetes	☐ Blood clots/DVT	☐ Anesthesia complications

SOCIAL HISTORY

Occupation: _____ ☐ Student ☐ Retired ☐ Disabled

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Do you smoke or use tobacco? ☐ Yes ☐ No If Yes, How Much? _____

Do you drink alcohol? ☐ Yes ☐ No If Yes, How Much? _____

Do you exercise regularly? ☐ Yes ☐ No If Yes, how often? _____

REVIEW OF SYSTEMS ☐ None Indicate **all** symptoms you are currently experiencing

☐ Fevers/Night sweats	☐ Shaking/Chills	☐ Recent weight loss	☐ Bleeding gums
☐ Frequent headaches	☐ Depression	☐ Shortness of breath	☐ Coughing up blood
☐ Nausea/Vomiting	☐ Heartburn	☐ Blood in stools	☐ Loose stools
☐ Rashes	☐ Anxiety	☐ Bruising/Bleeding easily	☐ Calf cramps
☐ Frequent nosebleeds	☐ Visual problems	☐ Hearing problems	☐ Dizziness/Fainting
☐ Hoarseness	☐ Chest pain	☐ Abnormal heartbeat	☐ Ankle or foot swelling
☐ Loss of appetite	☐ Difficulty with urination	☐ Pain/Burning on urination	☐ Blood in urine
☐ Joint pain	☐ Joint swelling	☐ Loss of height	☐ Irregular periods

MEDICATIONS ☐ None List **all prescription** and **non-prescription** medications and supplements.

Name of Medication	Strength/Dose	Frequency

ALLERGIES ☐ None Indicate **all** allergies you have to **medications** and **foods.**

Allergy	Reaction

CONFIDENTIAL INFORMATION ☐ None Indicate **all** conditions for which you have received treatment

☐ Mental health conditions (depression, anxiety, etc.)
☐ Substance abuse (alcohol, narcotics, etc.)
☐ Illegal drug use
☐ HIV / AIDS
☐ Sexually transmitted diseases (STD's)
☐ Minor pregnancies (pregnancy under the age of 18)

If you have indicated any of the conditions above, **please initial** the corresponding categories listed below which will authorize **Celebration Orthopaedic & Sports Medicine Institute** to disclose that information to third parties for treatment or payment purposes in the event that it is requested by said third parties or required by law.

Initials: _____ Mental health information

Initials: _____ HIV/AIDS information

Initials: _____ Substance abuse information

Initials: _____ STD information

Initials: _____ Illegal drug use information

Initials: _____ Minor pregnancy information

Are you pregnant or could you be pregnant? ☐ No ☐ Yes If yes, due date: _____

****I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I AM THE PATIENT OR AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE TERMS.**

_____ _____
Signature of Patient, Patient Guardian, or Personal Representative Date

_____ _____
Print name of Parent/Guardian and/or Representative Relationship to Patient

Consent for Electronic Prescribing

Patient Name: _____

Patient Portal Number: _____

Celebration Orthopaedic & Sports Medicine Institute is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to give them the best possible treatment.

By signing this form, you are consenting to allow Celebration Orthopaedic & Sports Medicine Institute to retrieve electronic prescribing information from other providers through the Sure Scripts database.

**I agree that Celebration Orthopaedic & Sports Medicine Institute may request and use my prescribing medication history from other healthcare providers.

_____ _____

Patient Signature Date of Consent

Pharmacy Name: _____

Address: _____

Phone Number: _____

OFFICE POLICY FOR PRESCRIPTION REFILL REQUESTS

We require a 48 hour notice for all prescription refill requests.
Please leave the following information on the Medical Assistant's voice mail when calling:

- **Your Name & Telephone Number**
- **Your Physician's Name**
- **Pharmacy Telephone Number**
- **Medication Name & Strength**

Please Initial: _____ Today's Date: _____