ORTHOPAEDIC CARE SPECIALISTS
733 US HIGHWAY ONE
NORTH PALM BEACH, FL 33408

NAME ____

STREET ______________________ APT ______________________

CITY ______________________ STATE __________ ZIP __________

DO YOU HAVE AN NORTHERN ADDRESS? ____YES ______NO (if so please provide on reverse side)

AGE ______________ SEX ________ DATE OF BIRTH ______________

HOME PHONE______________ CELL ______________ WORK PHONE ______________

EMAIL ADDRESS ____

PHARMACY NAME ______________________ PHONE ______________

SOCIAL SECURITY______________________ MARITAL STATUS: M S W D

SPOUSE'S NAME ______________________ SPOUSE DATE OF BIRTH ____________

NAME OF EMPLOYER____

IS INJURY A RESULT OF:

MOTOR VEHICLE ACCIDENT? DATE ______________

WORK RELATED ACCIDENT? DATE ______________

OTHER ACCIDENT? DATE ______________

(Please describe)

DO YOU HAVE MEDICAL INSURANCE? ______________________________

(Please provide us with your card)

WHO IS YOUR MEDICAL DOCTOR? ______________________________

MEDIGAP AUTHORIZATION

(FOR MEDICARE PATIENTS ONLY)

I request that payment of authorized MEDIGAP benefits be made on my behalf to ORTHOPAEDIC CARE SPECIALISTS for services furnished to me. I authorize any holder of medical information about me to release to my Medigap insurance company any information needed to determine these benefits or the benefits payable for related services.

____

Signature Date

LIFETIME AUTHORIZATION

(FOR ALL PATIENTS)

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim.
I understand that I am financially responsible for all charges to the extent permissible under law.

____

Signature Date

MEDICAL QUESTIONAIRE

Patient ______________________________ Date _______________

Do you have any allergies to medications? Yes No

If yes, which medications? ______________________________

WEIGHT ________________________ **HEIGHT** _______________

Do you have any medical problems?

Diabetes	Yes	No
Hypertension	Yes	No
Heart Disease	Yes	No
Peptic Ulcer Disease	Yes	No

When was your last check?

Mammography ____________

Colonoscopy ______________

Pap Smear ________________

Please list your medications:

____

____

Have you ever had surgery? Yes No

Date _________ Operation _____________________________________

Date _________ Operation _____________________________________

Have you ever been involved in a previous accident with injuries? Yes No

Date _________ Injury ________________________ Work related? _____

Date _________ Injury ________________________ Work related? _____

Do you smoke? Yes No

If yes, how much? _____________________ How long? _________

Do you drink alcohol? Yes No

If yes, how much? _______________________________________

AGREEMENT OF PAYMENT FOR NON-PARTICIPATING PROVIDER AND PERSONAL FINANCIAL GUARANTEE

Patient's Name ____

Insured Name ____

Insurance Company ____

I understand that the doctors at Orthopaedic Care Specialists are not participating providers for my insurance plan. I agree that any insurance checks received by me (or insured/guarantor) for any services rendered, will be endorsed to Orthopaedic Care Specialists and sent within 10 business days.

I authorize Orthopaedic Care Specialists to be paid out of any settlement, judgement or verdict as it is necessary to adequately and completely reimburse provider for all medical treatment provided to me by any physician at Orthopaedic Care Specialists. I understand that I will remain responsible to the extent permissible under Florida law for the full amount of any balance on my account after partial payment from any source, such as, but not limited to PIP carriers, workers' compensation and any other insurance billed by Orthopaedic Care Specialists on behalf of the patient.

I realize that the balance of my medical bills is my responsibility whether or not my insurance company pays and is to be paid in full by me to the extent permissible under Florida law. For any services rendered by Orthopaedic Care Specialists arising out of an accident or event for which I receive any settlement, award or monetary recovery of any kind related to the injuries or conditions for which I am treated by Orthopaedic Care Specialists ("Recovery"), I agree and instruct any claims representative, attorney, adjuster, or insurance company to withhold from the proceeds of any Recovery sufficient funds to pay all outstanding medical charges of Orthopaedic Care Specialists. I understand and agree that I remain personally responsible for the full amount of my entire bill whether or not any Recovery is made. If partial payment is made to Orthopaedic Care Specialists for any Recovery, I agree that I am personally responsible to Orthopaedic Care Specialists for payment of the entire balance remaining on my medical bill after any partial payment from any source, to the extent permissible under Florida law. I agree that this personal financial guarantee and obligation to pay shall be binding upon myself, my heirs, executors, administrators, or personal and legal representatives of mine.

I hereby guarantee payment of all collection charges, including reasonable attorney's fees and court costs incurred in the event that collection action is necessitated due to the default of payment of said charges. If enforcement is necessary, I agree and acknowledge that this agreement shall be governed by the laws of the state of Florida and venue shall be the appropriate court of competent jurisdiction located in Palm Beach County Florida.

Patient/Guarantor Signature ________________________________ Date ____________

ORTHOPAEDIC CARE SPECIALISTS
733 US HIGHWAY ONE
NORTH PALM BEACH, FL 33408
PHONE: (561) 840-1090 FAX (561) 840-0791

CONSENT TO DISCUSS OR RELEASE INFORMATION
&
ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I, ____ hereby

give consent to ***Orthopaedic Care Specialists*** to discuss or release my private health care information to:

____

❑ who is related to me ❑ is my care giver, unrelated to me

I fully understand and accept the terms of this consent. I have been informed of my rights according to HIPAA Regulations. I have reviewed and have had the opportunity to receive a copy of *The Notice of Privacy Practices at Orthopaedic Care Specialists*.

Signature _________________________________ Date _____________