



NEW PATIENT INFORMATION

CENTER FOR PODIATRY

Welcome to our CENTER FOR PODIATRY

Thank you for choosing us as the Specialists for your musculoskeletal health care needs. So that we may best serve you, please take some time to fill out this packet. The information you give us helps ensure that we provide you with effective, efficient evaluation and treatment - helping you return to and maintain an active and healthy lifestyle!

EMR - 05/2009, ver 1.1

HOW DID YOU HEAR ABOUT US?

- | | | | | |
|--|---|---|------------------------------------|---------------------------------------|
| <input type="checkbox"/> School Athletic Dept. | <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Magazine | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Hospital Staff | <input type="checkbox"/> Physician Referral | <input type="checkbox"/> Newspaper | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Family Member | <input type="checkbox"/> Patient | <input type="checkbox"/> Seminar | <input type="checkbox"/> Radio | |

Patient's Last Name:	First Name:	Middle Name:
Social Security #:	Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F

Primary Street Address:		
City:	State:	Zip:
County:	Primary Care Physician:	Referring Physician:

Alternate Street Address/Northern Address:		
City:	State:	Zip:

Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced <input type="checkbox"/> Single	Student: <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Phone:	Work (Day) Phone: Place of Employment:		Cell (Alt) Phone:	
Spouse Name/ Parent's Name (if minor):			E-Mail Address:	

Emergency Contact:	Relationship to Patient:
Emergency Contact Phone Number:	Emergency Contact Address:

All professional services rendered are charged to the patient. You need to complete necessary forms to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If you do not have insurance coverage for professional services, it is customary to pay for services when rendered unless other arrangements have been made in advance with our Business Office.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Primary Insured Name:	Policy Number:
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I request that payment of authorized Medicare or Other Insurance Company benefits be made on my behalf to South Florida Orthopaedics & Sports Medicine for any services furnished to me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or any related Medicare claim or other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

Signature of Patient / Parent (if minor)

Date



NEW PATIENT INFORMATION

To Our Patients - Insurance benefits can be very complex, and some plans have very strict rules on when they will pay for medical services. We are here to help you understand your medical benefits coverage. Please provide us with your current insurance information and present your current insurance card(s). This helps ensure that we correctly bill your insurance for you, and so that we both understand what your responsibilities for payment may be.

Thank you for helping us help you!

Patient Name:	Today's Date:
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PRIMARY INSURANCE	
Patient Insurance Information: <input type="checkbox"/> Health Insurance Claim <input type="checkbox"/> Worker's Compensation Claim <input type="checkbox"/> Auto Accident Claim <input type="checkbox"/> None	

Insurance Company:	Policy Number:
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Primary Insured Name:	Relationship to Patient:
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Primary Insured Employer:

Employer Address: Street:
City/State/Zip:

Employer Phone:	
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If NOT the Patient:

Primary Insured Last Name:	First Name:	Middle Name:
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Social Security #:	Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street Address:

City:	State:	Zip:
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Home Phone:	Work (Day) Phone:	Cell (Alt) Phone:
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SECONDARY INSURANCE	
Patient Insurance Information: <input type="checkbox"/> Health Insurance Claim <input type="checkbox"/> Worker's Compensation Claim <input type="checkbox"/> Auto Accident Claim <input type="checkbox"/> None	

Insurance Company:	Policy Number:
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Primary Insured Name:	Relationship to Patient:
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Primary Insured Employer:

Employer Address: Street:
City/State/Zip:

Employer Phone:	
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If NOT the Patient:

Primary Insured Last Name:	First Name:	Middle Name:
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Social Security #:	Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street Address:

City:	State:	Zip:
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Home Phone:	Work (Day) Phone:	Cell (Alt) Phone:
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PATIENT NAME: _____

INSURANCE COMPANY: _____

PROVIDER: South Florida Orthopaedics & Sports Medicine

Dear Patient –

If your visit is related to an **ACCIDENT**, please complete the following details for your insurance company so that they will process your claim for benefits. Please answer all questions in detail, enter “N/A” if not applicable. This sheet will be provided to your insurance company.

WORKERS COMPENSATION **AUTO ACCIDENT** **OTHER TYPE OF ACCIDENT** **NOT AN ACCIDENT**

1. **WHEN** and **WHERE** did the accident occur? Please be specific as to exact date, time, and location.

2. **HOW** did the accident occur? Provide details.

3. Was a **POLICE REPORT** filed? NO YES, and please provide name/address of **POLICE DEPT** that took the report.

4. Are any **ADDITIONAL BENEFITS** payable by other responsible persons as a result of this accident?
For example, Homeowner’s Insurance or Personal Liability Insurance.

5. Do you plan to **FILE SUIT** against any other responsible party involved which may end in a settlement?

Patient Signature / Parent Signature (if minor)

Date



NEW PATIENT INFORMATION

**ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES
PERMISSION TO SHARE HEALTH INFORMATION**

Patient Name: _____ Today's Date: _____

I have **received a copy** of the South Florida Orthopaedics & Sports Medicine "Notice of Privacy Practices" on this day.

I hereby **authorize** South Florida Orthopaedics & Sports Medicine to disclose my health information to the following persons:

NAME	ADDRESS	PHONE #	RELATIONSHIP to Patient

I hereby request the following **restrictions** on the use and disclosure of my health information. The Practice is not required to agree to my requests.

1. _____
2. _____
3. _____

By my signature below, I affirm the above information.

Signature of Patient / Parent (if minor) / Authorized Representative

Date



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW THIS NOTICE CAREFULLY AND ACKNOWLEDGE RECEIPT.

We are required by law to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. We are required to follow the practices described in this Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time. If we change our notice, we will post the revised notice in the facility and will have them available upon request. You can receive a copy of the current notice at any time. This Notice describes how we extended certain protections to your PHI and how, when, and why we may use and disclose your PHI. With certain exceptions, we will use or disclose your PHI in the minimum necessary manner to accomplish the intended purpose of the use or disclosure. We will share PHI as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. To the extent there is stricter Ohio or federal law regulating the privacy of your PHI, we will comply with the more strict provisions of the law. You may view this Notice or any new notices on our website: www.southflaortho.com

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We are committed to maintaining the confidentiality of your health information. Your health information may be used and disclosed for purposes of treatment, payment, and health care operations. Outside of these permitted uses, we must have your written and signed authorization unless the law permits or requires the use or disclosure without your authorization. You have the right to revoke that authorization in writing except to the extent any action has been taken in reliance on the authorization.

Treatment, Payment, and Health Care Operations. Except as otherwise provided, we may use and disclose your health information for purposes of treatment, payment, and as otherwise necessary and permitted by law, for our health care operations. This may include disclosure to another health care provider who, at the request of your physician, becomes involved in your treatment, for purposes of approval of reimbursement from your health plan, or for audit purposes, we may disclose to our accountant or attorney.

Business Associates. It may be necessary for us to provide your health information to certain outside persons or entities that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your health information.

Appointments and Services. We may contact you to provide appointment reminders, information about treatment alternative, or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate your reasonable requests, to receive communications regarding your health information from us by alternative means or at alternative locations. You may request such confidential communication by providing your written request to us.

USES AND DISCLOSURES REQUIRING YOU TO HAVE THE OPPORTUNITY TO OBJECT

Family and Friends. With your approval and using our professional judgment, your health information may be disclosed to designated family, friends, and others who are directly involved in your care or in the payment for your care. If you are unavailable, incapacitated, or in an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited medical information with such individuals without your approval.

Patient Directories. Unless you object, your name, location, and general condition may be put into our patient directory for disclosure to callers or visitors who ask for you by name. Your religious affiliation may be shared with clergy.

USES AND DISCLOSURE OF PHI

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, accrediting organizations, required abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donations, workers' compensation purposes and emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders. We may use or disclose your medical information for research purposes but only with your prior authorization or a proper waive of authorization from the IRB or Privacy Board.



NOTICE OF PRIVACY PRACTICES

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Restrictions on Use and Disclosure of Individual Health Information. You have the right to request that we restrict how we use and disclose your health information. These restrictions must be made in writing and signed by you or your representative. We are not required to agree to your restrictions. We cannot agree to limit uses/disclosures that are required by law. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination. You may terminate, in writing or orally, any agreed-to restriction.

Access to Individual Health Information. You have the right to inspect and receive a copy of your health information. All such requests must be made in writing and signed by you or your representative. A reasonable per page fee will be assessed if you request a copy of the information. There will also be a charge for postage if you request a mailed copy and, if requested, for preparation of a summary of the requested information. You may obtain a Request form from our Medical Information department or Privacy Officer. We will respond within 30 days unless an extension is taken. In certain circumstances, you may not be permitted access. Depending upon the circumstances, you may request a review of the decision to deny access. If we deny your request, you will be given written notice that will explain the basis and your right to appeal.

Amendments to Individual Health Information. You have the right to request that your health information be amended or corrected. We will respond within 60 days unless an extension is taken. In certain cases, we may deny your request for amendment and you will be given written notice that will explain the basis and your right to appeal, which will be appended to your health information. You may also submit a statement of disagreement and we may prepare a rebuttal that will be provided to you. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment. If we make an amendment, we may notify others who work with us and have copies of the un-amended record if we believe that such notification is necessary. You may obtain a Request for Amendment form from the Privacy Officer.

Accounting for Disclosures of Individual Health Information. You have the right to receive an accounting of certain disclosures of your health information made by us after April 14, 2003. Requests must be made in writing and signed by you or your representative. Request for Accounting forms are available from the Privacy Officer. This first accounting in any 12-month period is free; you will be charged a reasonable fee for each subsequent accounting within the same 12-month period. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Confidential Communications. You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of a specific way or location for us to use to communicate with you.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with our Privacy Office listed above. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Ave., SW, Washington D.C. 20201, or call 1-877-696-6771. There will be no retaliation for filing a complaint.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR PRIVACY OFFICER:

South Florida Orthopaedics & Sports Medicine
ATTN: Privacy Officer
1050 S.E. Monterey Road, Suite 400
Stuart, FL 34994
(772) 288-2400