



**William T. Daugherty, MD
South Florida Orthopaedics & Sports Medicine**

Dear Patient –

You have been referred to us for a neurological evaluation. It will consist of either consultation and treatment, or EMG (nerve and muscle) testing. A report of the examination results will be sent to your referring physician.

This practice is restricted to Neurological evaluation and generally does not involve treatment of other medical problems. Also, Dr. Daugherty is not available at all times for questions and/or emergencies. Because of this situation, your primary physician (family doctor, internist, or other referring physician) must continue to be involved in your care.

If a medical emergency having to do with a Neurological condition which arises when Dr. Daugherty is not available, you should seek consultation with your primary physician. If that physician is also not available, you should report to the Emergency Room of Martin Memorial Health Systems for evaluation.

If you have a question having to do with a Neurological condition which arises when Dr. Daugherty is not available, you may leave a message with the office by calling (772) 288-2400, extension 2220. Dr. Daugherty will return your call at the earliest possible time. Or, you may seek consultation with your primary physician.

Sincerely,

William T. Daugherty, MD
Neurologist
South Florida Orthopaedics & Sports Medicine

I have read and understand this notice. I agree to treatment under these restrictions.

Patient Signature / Parent Signature (if minor)

Date



NEW PATIENT INFORMATION

Center for Neurology

Welcome to South Florida Orthopaedics & Sports Medicine

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!

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:		
City:	State:	Zip:

Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <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:	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:	
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:	
Primary Insured Name:		Relationship to Patient:	
Primary Insured Employer:			
Employer Address: Street: City/State/Zip:			
Employer Phone:			
If NOT the Patient:			
Primary Insured Last Name:		First Name:	Middle Name:
Social Security #:		Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:			
City:		State:	Zip:
Home Phone:		Work (Day) Phone:	Cell (Alt) Phone:

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:	
Primary Insured Name:		Relationship to Patient:	
Primary Insured Employer:			
Employer Address: Street: City/State/Zip:			
Employer Phone:			
If NOT the Patient:			
Primary Insured Last Name:		First Name:	Middle Name:
Social Security #:		Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:			
City:		State:	Zip:
Home Phone:		Work (Day) Phone:	Cell (Alt) Phone:



PATIENT NAME: _____

INSURANCE COMPANY: _____

PROVIDER: South Florida Orthopaedics & Sports Medicine

Dear Patient –

If your visit is related to an **AUTO ACCIDENT** or **WORKERS' COMPENSATION 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.

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

Patient's Name: _____	Today's Date: _____
Primary Care Physician: _____	Referring Physician: _____

Chief Complaint: _____

Date of onset, injury or accident: _____

Have you had a previous similar injury? Yes No

Has this injury been treated? Yes No

Is there legal action pending or active? Yes No

Did this occur at work? Yes No
 Was this injury due to an auto accident? Yes No

If yes, when was this treated and by whom?
 Please explain: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____
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PAST MEDICAL HISTORY – mark ONLY if “YES”
 Have you had any of these problems?

YES		YES		YES		YES	
	Aids/HIV		Crohn's disease		Hypertension		Stomach ulcer
	Alcohol Abuse		Joint Disease		Kidney disease		Psoriasis
	Alzheimer's		Depression		Liver disease		Renal disease
	Anemia		Diabetes		Lung problems		Rheumatoid arthritis
	Angina		Drug Abuse		Pneumonia recently		Rheumatic fever
	Arthritis		DVT		Lyme disease		Scoliosis
	Asthma		Fibromyalgia		Migraine headaches		Seizure disorder
	Atrial fibrillation		Gallbladder disease		Multiple Sclerosis		Lupus
	Easy bleeding		Acid Reflux		Muscle Disease		Sickle Cell disease
	Blood Clots		Gout		Obesity		Sleep Apnea
	Cancer, type:		Heart Disease		Osteoarthritis		Spinal Stenosis
			Heart Murmur		Osteoporosis		Spondyloarthropathy
	CVA		Hepatitis		Parkinson Disease		Thyroid disease
	Heart Attack		Hernia		Metal Implants, type:		Valvular disease
	Stroke		Hyperlipidemia				

Please list any SURGERIES you have had:	Please list any ALLERGIES you have:
	Allergy: _____
	Reaction: _____

Please list any current MEDICATIONS you are taking:	Have TESTS been done for your CURRENT problem:
Medication: _____	YES _____
Dosage: _____	YES _____
	X-Ray
	MRI
	CT Scan
	Bone Scan
	Nerve Conduction test
	Bone Density test
	Ultrasound or Doppler
	Blood or other lab tests

FAMILY MEDICAL HISTORY – mark ONLY if “YES”
 Has anyone in your family (excluding your spouse) had any of these problems?

YES		YES		YES		YES	
	Alzheimer's disease		Stroke		Kidney disease		Osteoporosis
	Anemia		Diabetes		Liver disease		Parkinson's Disease
	Asthma		Gout		Muscle disease		Vascular disease
	Blood Disease		Heart Disease		Obesity		Renal disease
	Bone Cancer		Hodgkin's disease		Osteoarthritis		Seizure disorder
	Cancer, type:		Hypertension				



NEW PATIENT INFORMATION

Patient's Name:	Today's Date:
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SOCIAL HISTORY

Children: Number of Sons = _____ Number of Daughters = _____	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Single
Tobacco Use: <input type="checkbox"/> None <input type="checkbox"/> Former: Year Quit _____ <input type="checkbox"/> Yes <input type="radio"/> Chew <input type="radio"/> Cigar <input type="radio"/> Cigarette <input type="radio"/> Pipe How much per day _____	Caffeine Use: <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="radio"/> Chocolate <input type="radio"/> Coffee <input type="radio"/> Soda <input type="radio"/> Tea How much per day _____
Alcohol Use: <input type="checkbox"/> None <input type="checkbox"/> Former: Year Quit _____ <input type="checkbox"/> Yes How much per week _____	Education: <input type="checkbox"/> Grade School <input type="checkbox"/> Some College <i>Check all that apply</i> <input type="checkbox"/> High School/GED <input type="checkbox"/> College Graduate <input type="checkbox"/> Tech/Trade School <input type="checkbox"/> Advanced Degree

Are you: Working _____hours/week Retired Full-time Student Disabled Veteran

Occupation:

REVIEW OF SYSTEMS – mark ONLY if “YES”

Have you had any of these problems in the past 6 months?

YES	CONSTITUTIONAL	YES	GASTROINTESTINAL	YES	GENITOURINARY
	Fatigue		Vomiting		Painful / burning urination
	Fever/Chills		Diarrhea		Blood in urine
	Night Sweats		Constipation		Urgency
	Weight Loss		Abdominal pain		Loss of urinary control
	Weight Gain		Difficulty swallowing		Increased urination
	Increased Thirst		Change in appetite		
			Blood in stool		
			Tarry stool		
			Nausea		
YES	EYES	YES	EARS	YES	HEMATOLOGIC
	Vision loss – right eye		Hearing loss		Easy bruising
	Vision loss – left eye		Drainage		Easy bleeding
	Discharge				Swollen glands
	Double vision				
YES	NOSE & SINUS	YES	SKIN	YES	IMMUNOLOGICAL
	Discharge		Rash		Food Allergies
			Itching		Environmental Allergies
YES	RESPIRATORY	YES	CARDIOVASCULAR	YES	MUSCULOSKELETAL
	Shortness of breath		Chest pain		Joint / Bone pain
	Cough		Heart palpitations		Weakness
	Wheezing				Leg Swelling
	Difficulty breathing on exertion				
	Coughing up blood				
YES	NEUROLOGICAL	YES	OTHER PROBLEMS NOT IDENTIFIED ABOVE		
	Dizziness / light-headedness				
	Emotional problems				
	Anxiety				
	Depression				
	Change in sleep patterns				



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 waiver 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