SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT INFORMATION

Center for Podiatry

02/2019

Welcome to South Florida Orthopaedics & Sports Medicine

Patient's Last Name:	First Name:	Middle Name:
Social Security #:	Birth Date:	Sex: ☐M ☐ F

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

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

Race:	Language Spoken: ☐ English ☐ Spanish ☐ Other -	Religion:	Ethnicity: ☐ Non Hispanic/Non-Latino ☐ Hispanic / Latino
Marital Status: ☐ Single ☐ Married ☐Domestic Partner ☐ Divorced ☐ Widowed	Student: ☐ Yes ☐ No Smoker: ☐ Yes ☐ No	Veteran: ☐ Yes ☐ No	

How do you want to receive Appointment Notifications? ☐ Text message ☐ Call - Cell Phone ☐ Call – Home phone	E-Mail Address:	
What is your preferred number for contacting you? ☐ Cell Phone ☐ Home phone	Cell Phone Number:	Home Phone Number**:**

_____ I hereby authorize that South Florida Orthopaedics & Sports Medicine may text or leave a voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.
Initial

Patient's Employer Name:		
Employer Street Address:		
Employer City:	Employer State:	Employer Zip:
Employer Phone:	Employer Fax Number (if known):	

By my signature below, I affirm the above information is current and accurate to the best of my knowledge.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT INSURANCE INFORMATION

02/2019

☐ ***Please provide us with your current insurance card(s).***

☐

Patient Name:	**Date of Birth:**

☐

PRIMARY INSURANCE ☐**None** **Patient Insurance Information:** ☐**Health Insurance Claim** ☐**Worker's Compensation Claim** ☐**Auto Accident Claim**		
Insurance Company:	Policy Number:	Group 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: ☐M ☐ F
Street Address:		
City:	State:	Zip:
Home Phone:	Work (Day) Phone:	Cell (Alt) Phone:

☐

SECONDARY INSURANCE ☐**None** **Patient Insurance Information:** ☐**Health Insurance Claim** ☐**Worker's Compensation Claim** ☐**Auto Accident Claim**		
Insurance Company:	Policy Number:	Group 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: ☐M ☐ F
Street Address:		
City:	State:	Zip:
Home Phone:	Work (Day) Phone:	Cell (Alt) Phone:

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT INFORMATION (continued)

02/2019

Patient Name:	Date of Birth:

EMERGENCY CONTACT:	Relationship to Patient:
Emergency Contact Phone Number:	

REASON FOR TODAY'S VISIT:

- ☐ **OTHER (not an Accident or Injury)**
- ☐ **INJURY**
- ☐ **WORKERS COMPENSATION ACCIDENT**
- ☐ **AUTO ACCIDENT**
- ☐ **OTHER TYPE OF ACCIDENT:** _____

If INJURY or ACCIDENT:	
WHEN did it occur? Date: Time:	WHERE did it occur?
Was a POLICE REPORT filed? ☐ NO ☐ YES, Police Department Name:	
Do you have ATTORNEY REPRESENTATION for this Injury or Accident? ☐ NO ☐ YES, Attorney Name:	Attorney Phone Number:
Do you have a WORKERS' COMPENSATION ADJUSTER regarding this Injury or Accident? ☐ NO ☐ YES, Adjuster Name:	Adjuster Phone Number:

IF PATIENT IS A MINOR:

Parent's or Legal Guardian's Last Name:	Parent's or Legal Guardian's First Name:	
Relationship to Patient		
Primary Street Address:		
City:	State:	Zip:
County:		
Race:	Language Spoken: ☐ English ☐ Spanish ☐ Other -	Ethnicity: ☐ Non Hispanic/Non-Latino ☐ Hispanic / Latino
Preferred Method of Contact: ☐ Cell Phone ☐ Email ☐ Home phone ☐ Work phone	E-Mail Address:	
Home Phone:	Day (Work) Phone:	Cell Phone:

By my signature below, I affirm the above information is current and accurate to the best of my knowledge.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

ACKNOWLEDGEMENT OF RECEIPT
HIPAA CONSENT FORM

02/2019

Patient Name:	Date of Birth:

This consent form allows South Florida Orthopaedics & Sports Medicine to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

South Florida Orthopaedics & Sports Medicine has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at South Florida Orthopaedics & Sports Medicine.

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may text me or leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the clinic while I meet with my healthcare provider(s).

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may disclose my personal health information to the person who I have listed as my emergency contact.

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may disclose my personal health information, including release of printed documents and pick-up prescriptions, to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that South Florida Orthopaedics & Sports Medicine services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that South Florida Orthopaedics & Sports Medicine may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while South Florida Orthopaedics & Sports Medicine is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that South Florida Orthopaedics & Sports Medicine may refuse me services if I refuse to sign this consent.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

FINANCIAL POLICY DISCLOSURE

02/2019

Patient Name:	Date of Birth:

South Florida Orthopaedics & Sports Medicine is committed to providing our patients with the best possible medical care while minimizing administrative costs. We have outlined our Financial Policy below to avoid any misunderstanding concerning payment for professional medical services, and to clearly outline your financial responsibilities as our patient, and how our practice will help you.

As a patient of South Florida Orthopaedics & Sports Medicine…

It is the patient's responsibility to provide a current address, telephone number, email address, and insurance information at EACH visit.

It is the patient's responsibility to provide our practice with current insurance information. Please bring your insurance card to each visit. In the event we are not provided with current or accurate information, and submitted claims are denied, the patient remains financially responsible for all charges.

It is the patient's responsibility to complete all necessary insurance information, including any special forms, prior to leaving the office.

It is the patient's responsibility to pay any coinsurance, copayment, or any portion of the charges (as specified by your insurance plan) at the time of visit. It is also the patient's responsibility to pay for any medical services not covered by your insurance plan, which often happens if a deductible is not yet satisfied. Payment in full is due at the time of visit.

This practice may deny service for failure by a patient to pay for their responsibility for charges (coinsurance, co-pay, deductible) and/or an outstanding balance at the time of service.

The patient is ultimately responsible for payment of charges for services received from this practice including those covered by their insurance. As a convenience, this practice will submit claims for reimbursement with insurance providers; however, all payment responsibility is ultimately the patient's.

For patients who do not have insurance, it is the patient's responsibility to pay for all professional medical services at the time of service, unless prior arrangements have been made with us.

It is the patient's responsibility to ensure that any required authorizations/referrals for treatment are provided to our office prior to your visit. Visits should be rescheduled until authorization is received. Otherwise, the patient may be financially responsible for all charges due to lack of authorization/referral.

Our practice provides for payment by cash, check, or credit or debit card. If warranted, our practice may offer the option of paying the patient's share of cost via an automated payment plan.

Our Business Office staff will be glad to help patients with any insurance questions relating to how a claim was filed, or regarding any additional information your insurance company might need to process your claim. Please keep in mind that some specific coverage issues can only be addressed by the insurance company member services department, and their telephone number is printed on your insurance card.

Signature _____ Date: _____

Witness Signature _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT ASSIGNMENT OF BENEFITS

02/2019

Patient Name:	Date of Birth:

ASSIGNMENT OF BENEFITS

I hereby authorize and direct you (my insurance company, liability insurance adjuster, and/or attorney) to pay directly to South Florida Orthopaedics & Sports Medicine ("office"), such as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand as a patient of South Florida Orthopaedics & Sports Medicine that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Irrevocable Assignment, Lien, & Authorization does not constitute any consideration for the office to await payments; the office may demand payments from me immediately upon rendering services, at its option. Such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balance due this office, including agency fees and reasonable attorney's fees.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Irrevocable Assignment, Lien, & Authorization. I agree that the above-mentioned office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I, individually, and/or my successors hereby waive any statute of limitation, defense of the time for claims to be filed, any argument of estoppels, or other defenses to the timely filing of a claim by South Florida Orthopaedics & Sports Medicine as they pertain to any claim filed against me beyond any statutory period applicable to any proceeding after services were rendered. A photocopy of this agreement shall be considered as effective and valid as the original.

In the event my insurance company obligated to make payments to me upon the charges made by this office for services rendered refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company any authorize this office to prosecute said cause of action either in my name or in the office's name. I further authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as it sees fit.

If my claims are related to an automobile accident, I hereby authorize South Florida Orthopaedics & Sports Medicine to obtain my PIP log showing all payments made by my automobile insurance.

I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that I will not receive a copy of any such invoice via U.S. Mail. I understand that it is my responsibility to maintain a current email address on file with the practice at all times.

This authorization will remain in effect until I provide written notice of cancellation to the practice. I understand that I can cancel the authorization only for future services. Authorization for services already rendered cannot be cancelled or refunded.

Signature _____ Date: _____

Witness Signature _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

HEALTH INFORMATION EXCHANGE (HIE)

02/2019

Patient Name:	Date of Birth:

A Health Information Exchange (HIE) allows your medical information to be available and viewed electronically by other physicians and medical team providers. The HIE is designed to provide quick access to medical records so that patient care and treatment is more efficient and effective. Any authorized healthcare provider who agrees to participate in the HIE can electronically access and use your protected health information, if needed, to provide care and treatment to you.

For our patient's convenience, South Florida Orthopaedics & Sports Medicine (SFO) has elected to become an authorized healthcare provider and participate in the HIE.

- Participating in the HIE means that you no longer need to call our office to request your medical records from us be sent to another physician.
- As long as another physician is also participating, you no longer need to call other physicians to request your medical records from another physician be sent to our office.

OPTION 1: - OPT-IN

Patient Signature: _____ Date: _____

• • • • • •

OPT-OUT SUMMARY: However, you may choose to OPT-OUT of this Health Information Exchange (HIE) service convenience. If you decline to participate, please carefully read and sign the information below. You may change your selection and OPT-IN at any time in the future.

I and/or my legally authorized representative have considered whether to allow my information to be access in HIEs in which South Florida Orthopaedics & Sports Medicine participates. At this time, I have decided to OPT-OUT of this service.

I understand that by choosing to OPT-OUT of the HIEs, I hereby acknowledge and agree:

- This revocation only applies to the sharing of health information through the HIE. Healthcare providers may still have access to my health information using other method, such as fax, telephone or mail.
- By opting out of participant in the HIE, any other physicians involved in my care outside SFO will NOT be able to search, via the HIE, for SFO health information to use while treating me.
- My HIE OPT-OUT election will remain in effect until I notify South Florida Orthopaedics & Sports Medicine in writing, of my willingness to rescind it, and have received notification of receipt of said communication. Communications regarding participation in the HIE should be directed to:
- This OPT-OUT request may take up to seven (7) business days to become effective.
- Any information shared before I submit this HIE OPT-OUT form may remain with providres who accessed information before this went into effect.

☐ I have read and understand this information provided, and wish to be <u>unenrolled</u> in the Health Information Exchange (HIE). **If you OPT-OUT,** please sign below and return this form to the Front Desk.

OPTION 2: - OPT-OUT

Patient Signature: _____ Date:_____

Signature of Parent (if minor)/
Authorized Representative: _____ Date:_____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT INFORMATION

07/2016

Patient's Name:	Date of Birth:	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 ant by whom?

Please explain:

AGE:_____ HEIGHT: _____ WEIGHT: _____

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:	**Dosage:**	**YES**		**YES**	
			X-Ray		Nerve Conduction test
			MRI		Bone Density test
			CT Scan		Ultrasound or Doppler
			Bone Scan		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				

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT INFORMATION

07/2016

Patient's Name:	Date of Birth:	Today's Date:

SOCIAL HISTORY

Children: Number of Sons = _____
Number of Daughters = _____

Marital Status: ☐ Married ☐ Divorced ☐ Widow ☐ Single

Tobacco Use: ☐ None ☐ Former: Year Quit _____ ☐ Yes ○Chew ○Cigar ○Cigarette ○ Pipe How much per day _____

Caffeine Use: ☐ None ☐ Yes ○Chocolate ○Coffee ○Soda ○ Tea How much per day _____

Alcohol Use: ☐ None ☐ Former: Year Quit _____ ☐ Yes How much per week _____

Education: *Check all that apply* ☐ Grade School ☐ High School/GED ☐ Tech/Trade School ☐ Some College ☐ College Graduate ☐ 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		
			Abdominal Pain		

YES	EYES	YES	EARS	YES	SKIN
	Vision loss – right eye		Hearing loss		Rash
	Vision loss – left eye		Drainage		Itching
	Discharge				

YES	NOSE & SINUS	YES	HEMATOLOGIC	YES	IMMUNOLOGICAL
	Discharge		Easy bruising		Food Allergies
			Easy bleeding		Environmental Allergies

YES	RESPIRATORY	YES	CARDIOVASCULAR	YES	MUSCULOSKELETAL
	Shortness of breath		Chest pain		Joint / Bone pain
	Cough		Heart palpitations		Weakness
	Wheezing				

YES	NEUROLOGICAL	YES	OTHER PROBLEMS NOT IDENTIFIED ABOVE
	Dizziness / light-headedness		
	Emotional problems		

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

ver 7

PATIENT PORTAL Instructions

You're about to find out just how easy it can be to communicate with your physician at South Florida Orthopaedics & Sports Medicine!

Through our secure Patient Portal, you can:

- Access your SFO patient record – view, download and print test results and notes from your office visits
- Send a secure message to your SFO physician
- Request or change an appointment
- Request a medication refill
- Update your medical record (medical history, medications, and other health information)

As a patient of our practice, you are enrolled in our Patient Portal. Just follow the quick steps below to complete your log-in to the Patient Portal for the first time.

---

1. Go to https://www.nextmd.com/ud2/Login/Login.aspx.
2. Enter your temporary username in lowercase.
   A) Your temporary username will be:
      i) 1st letter of your first name.
      ii)Your full last name.
      iii) Last 2 digits of the year you were born.
      iv) Lowercase letters "sfo"
3. For example, if your name is John Smith and your year of birth 1972 as a patient at South Florida Orthopaedics (SFO), then your temporary username will be "jsmith72sfo"
4. Enter your temporary password in lowercase.
   A) Your temporary password will be:
      i) 1st letter of your first name.
      ii)1st letter of your last name.
      iii) 2-digit month and 2-digit day you were born.
      iv) Add the lowercase letters "sfo"
   B) For example, if your name is John Smith and your DOB is 08/24/1972, then your temporary password will be"js0824sfo"
5. Click LOG IN.
6. Please read the "Terms and Conditions" and, if you accept them, click I Accept.
7. The next window is where you will create the secure and private Username and Password of your choice. This information must be created by you and not shared with anyone. Please make sure you follow the requirements that are specified for both the Username and Password.
8. Once you have filled in all the fields, click the NEXT button.

9. Next pick 5 Security Questions and supply your answers and click SUBMIT.
10. You can choose to use the "Google Authenticator" if you would like but are not required to.
11. When you are done, click Continue and you should see you Patient Portal Welcome Screen.

Congratulations!
You Are Enrolled & You Can Begin Accessing Your Patient Portal

☐ **I wish to be unenrolled in the Patient Portal at this time.** If you decline coverage, please sign below and return this form to the Front Desk.

Patient Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

If you need help with your Patient Portal, please feel free to contact our
Patient Portal HELPDESK during normal business hours at: *(772) 419-0152*

ver 7

❖ How to Access your Patient Record

Log-in to the Patient Portal via www.NextMD.com/ud2
You may receive an email notifying you that there are documents in your Portal to view. From the top right tabs, click on "My Chart", click "View My Chart."

❖ How to Send a Secure Message to Your Physician

From the center left section called "Inbox", click on the blue "Compose an Email". Type your message just like a regular e-mail. When finished, click "Submit". Replies from your physician will also appear in your "Inbox"

❖ How to Request an Appointment

From the center section called "Upcoming Appointments", click on the blue "Schedule An Appointment." Select your parameters. When finished, click "Submit". You will receive a call within one (1) business day to arrange your appointment. Replies from our Appointment Schedulers will appear in your "Inbox"

❖ How to Request Medication Refills

From the top right tabs, click on "Renew Medications". Select your parameters. When finished, click "Submit". You will see all active medications prescribed by your healthcare provider. The application to Renew Medication is currently not available for our Patient Portal. For medication refill requests, please contact your pharmacy.

❖ How to Update your Medical Record (medications, medical history, and other information about your health)

This is done by sending a message to your physician. From the center left section called "Inbox", click on the blue "Compose an Email". Type your message just like a regular e-mail. When finished, click "Submit". Replies from your physician will also appear in your "Inbox"