Key West Orthopedics, P.A

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New Patient Registration form

CHART#_____

Preferred Language: □English □Spanish □Other Race/Ethnicity: _____

Patient name

(Please Print) **LAST** **FIRST** **MI**

Last 4 SS# _____ **Date of Birth** _____/_____/_____ Age: _____ Sex: M F

Billing Address: _____

City State Zip

Local Address: _____

City State Zip

Home Phone: _____ **Cell Phone:** _____

Email: _____

Marital Status □ Single □ Married □ Divorced □ Separated □ Widowed

Student Status □ Full time □ Part time □ Not applicable

Employment Status: □ Full time □ Part time □ Unemployed □ Retired □ Disabled

Employer's Name Occupation

Address

City State Zip

Work number

Emergency contact Relationship to patient

Emergency contact number

PATIENT SIGNATURE **TODAY'S DATE**

NEW PATIENT MEDICAL HISTORY

Patient name: _____ Referred by? _____
What is the reason for your visit? _____
What is your profession? _____
Hand Dominance (check one) □ Right □ Left □ both
Activities (i.e. running, surfing, swimming, basketball, golf, etc.)

_____
_____

Is your visit the result of an injury Y / N
Date of injury: _____ Place of injury: _____
City: _____ State: _____
Describe your injury _____
If this was not an injury, how long have you had symptoms? _____
Did you have any treatment for this problem? Y / N
What treatment did you have? _____
Did it help? Y / N

Was this a work related injury? Y / N
Claim#: _____ AdjustersName: _____
Phone#: _____ Fax#: _____
Address: _____

Was this Auto related? Y / N
Claim#: _____ AdjustersName: _____
Phone#: _____ Fax#: _____
Address: _____

Do you have an Attorney? Y / N
Name of Attorney: _____
Phone#: _____ Fax#: _____
Address: _____

Medical History (Please check if you have any of the following)

□ High blood pressure	□ Cancer	□ Ulcers	□ Osteoporosis
□ Diabetes	□Blood clots	□ Kidney disease	□ irreguiar heart beat
□ Heart disease	□Gout	□ Stroke	□ Arthritis

Body Part(s) _____
Other Medical Problems (please specify)

_____
_____

Past surgical history (Please check all that apply)

□ No significant past surgical History	□ Shoulder/Rotary Cuff	□ Gallbladder
□ Hip Replacement	□ Fracture surgery	□ Prostate
□ Knee replacement	□ Appendix	Do you have a Pacemaker? Y / N
□ Arthroscopy	□ Kidney	□ Hysterectomy □ Caesarian

Patient History

Mother □Alive □Deceased □Unknown □Healthy
Medical history _____
Father □Alive □Deceased □Unknown □Healthy
Medical history _____

Are you currently taking or within the past 6 months have you taken an opioid, including buprenorphine, methadone or a benzodiazepine (such as Xanax or Klonopin)? □ yes □ no

Medications List your present medication and supplements along with the dose and frequency.
□See Attached List

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Allergies Are you allergic to any medications □ yes □ no
If yes, please list and describe what happens _____

Height: _____ **Weight:** _____

Do you Smoke? □ Never □Quit when_____ □Current Smoker # packs per day_____
Do you drink alcohol? □Never □Rarely □Moderate □Daily
Illegal Drug use □Never □Type & frequency_____

Review of Symptoms

Do you have any of these problems?
Mark all that apply in each group. If no symptoms, please mark "none" for that category.

General Issues:	□ NONE	□ Chills □ Fever □ Recent weight gain □ Recent weight loss
Neurological:	□ NONE	□ Tremors □ Dizziness □ Numbness □ Tingling
Eyes:	□ NONE	□ Double vision □ Glaucoma
Ear, Nose & Throat :	□ NONE	□ Difficulty swallowing □ Hoarseness □ Loss of hearing □ Sinus pains
Cardiovascular:	□ NONE	□ Chest pain □ Heart rate is fast □ Heart rate is slow □ Palpitations
Pulmonary:	□ NONE	□ Wheezing □ Frequent Cough □ Shortness of breath
Gastrointestinal:	□ NONE	□ Abdominal pain □ Bloody stools □ Diarrhea □ Nausea □ Vomiting
Genitourinary:	□ NONE	□ Blood in urine □ Difficult Urinating □ Painful Urination
Psychological:	□ NONE	□ Normal □ Depressed □ Anxious □ Claustrophobic
Musculoskeletal :	□ NONE	□ Normal □ Bone □ Joint □ Muscle
Endocrine:	□ NONE	□ Excessive thirst □ Heat/cold tolerance □ Tired/sluggish
Vascular:	□ NONE	□ Pain walking □ Pain resting □ Blood Clot
Integumentary:	□ NONE	□ Rash □ Yes □ No
Bone Density Scan:	□ Yes	□ No Date of Scan:

What is your current pain level: 0 1 2 3 4 5 6 7 8 9 10
(Please circle your current pain level with 0 being least and 10 the worst)

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to Key West Orthopedics (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.
I further authorize the Key West Orthopedics to negotiate, collect and settle any claim with any insurance carrier or other third party pay or with regard to these services, which authorization shall include authority to:

(1) Request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, Key West Orthopedics has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Key West Orthopedics copies of all future notices affecting Key West orthopedics interest in this claim, including, without limitation, any notices of requested medical Examinations or statements.

Key West Orthopedics hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Key West Orthopedics at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.
A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

Patient's Signature _____ Today's Date _____

PATIENT INSURANCE INFORMATION

PHOTO COPY MADE ☐

Primary Insurance

Insurance Company Name _____

Policy/Member I.D Number _____ *Group Number* _____

Secondary Insurance

Insurance Company Name _____

Policy/Member I.D Number _____ *Group Number* _____

Are you the policy holder/Insured? ___ Yes ___ No

IF YOU ARE NOT THE POLICY HOLDER, PLEASE COMPLETE THE SECTION BELOW

Name of Policy Holder/Insured:

Last _____ First _____ MI _____

Relationship to you: _____ Social Security Number of Insured _____

Policy Holder's Address _____ City _____ State _____ Zip _____

Phone Number _____ Date of Birth ____/____/____

PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____
Last First MI

VERIFICATION OF INSURANCE COVERAGE
Please initial.
____ It is my responsibility to know the benefits, limitations, and exclusions of my individual insurance plan. **Verification/Authorization of coverage is not a guarantee of payment and KWO is not responsible if information provided is incorrect.**

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS
Please initial.
____ I am responsible for any unpaid balance, **regardless of any insurance coverage.** I assign all medical benefits to which I am entitled to be paid directly to Key West Orthopedics. In the event that payment is made directly to me, I agree to promptly remit payment to this office. If legal action becomes necessary to collect payment, I am responsible for all costs incurred, including collection agency and legal fees. **MISSED APPOINTMENT** are subject to a no show fee. The fee can be up to $100 for those who do not cancel 24 hours prior to appointment

DEDUCTIBLES, CO-PAYS, AND COINSURANCES
Please initial.
____ **My co-pay is due at the time of service** unless prior financial arrangements have been made. We will bill your insurance for the balance of services provided as a courtesy.

CASH PATIENT
Please initial.
____ **Payment in full is due at the time of service** unless prior financial arrangements have been made. **RETURNED CHECKS** will result in a $50 service charge. The check amount plus the service fee must be paid in cash 10 days of notification or will result in collection through the State Attorney's Office

DELINQUENT ACCOUNTS
Please initial.
____ Accounts are placed for collections 90 days from the date of services were rendered. In the case of an insurance carrier, the account will be placed for collections 90 days after the carrier has paid on the claim.

WORKERS COMPENSATION CLAIMS
Please initial.
____KWO does not accept Work Comp unless KWO fee schedule is accepted and prepayment fees have been met prior to scheduling appointment.

I have read and fully understand the above information and agree to comply as outlined above.

_____ _____
Patient Signature **Date**

(HIPAA)Consent for Disclosure of Medical Information

With my initials below, I authorize Key West Orthopedics to disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to Key West Orthopedics notice of privacy practices for a more complete description of such uses and disclosures. I have the right to review the notice of privacy practices at any time.

With my consent (please initial ONLY ONE of the following paragraphs):

____ (Initials) Key West Orthopedics may call my home and/or cell phone to leave a message on my answering machine/ voice mail. Key West Orthopedics may also send mail or email to me in reference to any items that assist the practice, Key West Orthopedics, in carrying out treatment, payment or operations such as appointment reminders, billing information, insurance items and any call pertaining to my clinical care including examination and test (laboratory, etc.) results.

____(Initials) I direct that Key West Orthopedics not leave any voice mail messages on my answering machine or speak to anyone in my household other than myself. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations.

I understand and can be provided with a notice of patient privacy handout that provides a more complete description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the office and I must agree on the use and disclosure of my protected health information. A photocopy or fax of this consent is as valid as this original. I understand that I may revoke this consent, in writing, except where disclosures have already been made in reliance.

Printed Name_____ Date of Birth____/____/_____

Signature of Patient_____ Date ____/____/____

Who may we speak to regarding your treatment?

I give permission to Key West Orthopedics to release my private health information, including appointment day/time, to the following person(s); spouse, family member, etc.: ☐ **only disclose to me**

Individual authorized to receive your health information _____

Relationship/Telephone Number _____

Individual authorized to receive your health information _____

Relationship/Telephone Number _____

May we leave a message on your voicemail? YES/NO Phone # _____
May we leave message at place of work? YES/NO Phone #_____

EMAIL CONSENT: Standard email correspondence is not a secure means of communication. There is a risk that any PHI contained in standard email may be intercepted by or misdirected to unauthorized 3rd parties. By signing below, the patient or legal guardian acknowledges these potential risks and gives Key West Orthopedics authorization to correspond via email as needed or as initiated by the patient.
Email Address_____

Patient Signature_____**Date**____/____/_____

Opioid and Controlled Substance Agreement and Consent

Opioid Prescription Contract Opioid and Controlled Substances Agreement and Informed Consent Opioid medications are used judiciously in the treatment of benign or malignant pain conditions. The following is an agreement and explanation of issues related to treatment of painful disorders through the use of opioid medications and/or other controlled substances. These medications include, but are not limited to, morphine (e.g. MS Contin, Kadian, MS IR), oxycodone (e.g. Percocet, Oxycontin, Roxicodone), hydromorphone (Dilauded), hydrocodone (e.g. Vicodin, Lortab, Norco), propoxyphene (e.g. Darvocet), fentanyl (e.g. Duragesic patch, Actiq), methadone, codeine (e.g. Tylenol No. 3), benzodiazepines (e.g. Valium, Xanax), stimulants (e.g. Adderall, Ritalin), barbiturates (e.g. Floricet, Florinal), etc.

Side Effects & Risks: Because these medications are potentially dangerous, as are all medications, the side effects and risks are discussed with you at the beginning of the treatment and periodically thereafter. Side effects/risks include, but are not limited to, allergic reactions, sedation, somnolence, respiratory depression (i.e. slow breathing), dizziness, confusion, nausea, vomiting, urinary retention, suppression of menstrual cycle, hormonal imbalance, constipation, itching, physical dependence, tolerance, addiction, or death.

Caution: Opioid medications may cause drowsiness. Alcoholic beverages are prohibited while using opiate/narcotic pain medications. Driving a car or operating machinery is not initially allowed while under the influence of these medications. Please notify your physician immediately if these medications affect your ability to drive or work safely. Usually, most side effects of opioid use disappear over time and with continued use, expect constipation. Bowel maintenance should be addressed seriously and treated if necessary. If the decision is made to terminate opioid therapy, a weaning schedule rather than an abrupt discontinuation of treatment should be exercised to prevent withdrawal symptoms (e.g. increased pain, agitation, nausea, diarrhea, etc.)

The following conditions must be followed and agreed upon as long as the patient is receiving treatment at KEY WEST ORTHOPEDICS. Noncompliance with any one of these conditions may result in discharge from the practice.

1. Your KWO physician must be the only source for the medications that were reviewed above. The patient may not obtain these medications from any other source or physician except when it is explicitly allowed and approved by your KWO physician.
2. The patient understands that the treatment goal is to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine benefits of opioid therapy and adjust the dosage accordingly.
3. The patient understands that he/she must take the medications as instructed and prescribed. Any change in dosing must be approved by your KWO physician.
4. The patient agrees to use only one pharmacy whose contact information and address the patient would provide to your KWO physician. If for any reason another pharmacy is to be used (e.g. unavailability of a certain medicine), the patient should notify your KWO physician.
5. **Lost or stolen prescriptions or medications will NOT be replaced.** It is the patient's responsibility to ensure that prescriptions are filled correctly at the pharmacy. If the patient realizes a medication is lost, stolen, or misplaced, a police report must be filed, and the case number should be given to your KWO physician.
6. To ensure efficacy of treatment and monitoring purposes, the patient should keep all recommended appointments.
7. Controlled substance prescriptions will not be given over the phone, after hours, during weekends, or holidays. If there is a need to change any controlled substance prescription, a new appointment needs to be made.
8. Your KWO physician has the right to directly communicate with other healthcare providers and pharmacies regarding the patient's use of controlled substances.
9. Opioid therapy usually is only part of the overall treatment plan. The patient shall comply with all other treatments as outlined by their physician at KWO.
10. The patient maybe asked for urine and/or blood screening tests as well as random pull count. Failure to comply with this results in immediate discharge from the practice.
11. The patient understands that it is illegal and absolutely forbidden to share, sell, or trade any medication with anyone.
12. Patient understands that the results of urine/blood testing can be given to the patient's other healthcare providers, insurance company, or other reimbursing agencies. The patient also authorizes any other healthcare provider, pharmacy, law enforcement, or judiciary body to release any pertinent information regarding the patient's prescription or urine/blood screen results.
13. The patient understands to notify KWO physician immediately if there is a chance you could be pregnant or nursing now, or if you become pregnant in the future.
14. The patient understands our staff expects to be treated with respect and courtesy. Rudeness and/or abusive behavior toward our staff will not be tolerated and may result in dismissal.
15. The patient understands any time you receive an increased dose if your opiate (narcotic) medications, you will be expected not to drive or operate machinery for 7 days.
16. Patient agrees that any use of illicit substances (marijuana, cocaine, etc.) during treatment is strictly prohibited, and if identified during a urine test will result in discharge of patient from the clinic.
17. Patient agrees to inform KWO physician of any signs of becoming/being drug dependent.
18. Controlled substance prescriptions will not be authorized more than (2) two days before due date.

_____(Initials) **Patient will need to be seen by Doctor for reevaluation every 3 month for continuation of prescription.**

I, the undersigned, attest that the above was discussed with me, and I fully understand and agree to all of the above requirements and instructions. I also understand that failure to comply with the above can result in my discharge from your KWO physician.

Pharmacy:_____Telephone: _____

_____ _____

Patient Signature **Date**

(Office use only)
I have verified that paperwork is correct and completed.

_____ _____

Signature of employee ***Date***

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kworecords@gmail.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Key West Orthopedics to release my records

To: _____

Phone: _____ Fax: _____

The following information from my medical record:

____ Entire Medical Record ____ Problem List ____ History & physical

____ Progress Notes ____ Medication List ____ H.I.V. Records

____ Operative List ____ Pathology Report ____ Dx Test Results (Lab or Radiology)

____ Other (Specify) _____

Printed Patient Name: _____

Date of Birth: _____

The purpose or need for the information is:

____ Continuity of care ____ Reimbursement

____ Other (Specify) _____

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Email: _____

PatientSignature _____ **Date**____/____/_____

I understand that this authorization is valid for 90 days (Note: subject to legal counsel and State Law) after the date of my signature. I also understand that this authorization can be revoked, except to the extent that action has already been taken to comply with it. Information documented in my record after the date of my signature will not be released.

_____ _____
Date Signature of patient

_____
Legal representative's relationship to patient

_____ _____
Pulled/Copied Date & Initials Date of pick up/fax/mailed & Initials