ORTHO MIAMI

HISTORY FORM

Patients Name: _____ Date of Birth: _____

Date of Accident: _____

Sex: ◯ Male ◯Female Dominant Hand: ◯ Left ◯Right

Reason for Visit: _____

Description of Injury: _____

Were you seen in the Emergency Room for this problem: ◯Yes ◯No

Do you have any allergies: ◯Yes ◯No

If yes what are you allergic to:_____

Are you taking any Mediations? ◯Yes ◯No

If yes, please list medications here: _____

_____ _____

On a scale of 0-10 (10 being the worst) how severe is your pain: _____

What is the Quality of the Pain?

◯ Sharp ◯ Dull ◯ Stabbing ◯Throbbing ◯ Aching ◯ Burning

The Pain is: ◯ Constant ◯ Intermittent (comes & goes)

Does the pain wake you from your sleep? ◯Yes ◯No

I experience: ◯ Swelling ◯ Bruising ◯ Numbness ◯ Tingling ◯ Weakness

Past Medical History (such as heart disease, cancer, arthritis, diabetes etc):

_____

Have you had any prior surgical procedures? If so, please list with date of surgery:

_____

Alcohol Use: ◯Yes ◯No Tobacco Use: ◯Yes ◯No

If yes, # _____/week If yes, # _____/week

7800 SW 87th Avenue, Suite A-110, Miami, Florida 33173
P 305-596-2828 F 305-596-6446
www.orthomiami.com

ORTHO MIAMI

INJURY QUESTIONS

Is this an accident related injury? ◯Yes ◯No

Were you the passenger or the driver: ◯ Passenger ◯ Driver

Where was the impact of the accident: ◯ Front ◯ Rear ◯ Side

Were you wearing your seatbelt? ◯Yes ◯No

Where did the accident occur? ◯ Open Highway ◯ Street light ◯ Stop Sign

◯ Parking Lot ◯ Other _____

Have you begun any type of Therapy:

If yes: Location:_____

Date Therapy Began and Frequency: _____

Have you received any other medical treatment for this injury: ◯Yes ◯No

If yes, please explain: _____

Have you taken any time off from work because of this accident? ◯Yes ◯No

If yes, please explain: _____

Which body part is being treated at this time? _____

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ORTHO
MIAMI

PATIENT RECORD RELEASE AND LETTER OF PROTECTION

I hereby authorize OrthoMiami to furnish my attorney as identified below with full report of any medical records and charges pertaining to my treatment.

I hereby authorize said attorney to pay directly to OrthoMiami such sums that may be due and owing for services rendered to me, and to withhold such sums from any settlement, judgement, or verdict which may be paid to you, my attorney or me as the result of the injury for which I have been treated. I also agree to promptly inform OrthoMiami if any other attorney represents me, and that this release and letter of protection will be immediately executed with my new attorney, if charges occur.

If a new release and letter of protection is not immediately executed upon a change of attorney, I agree that my full charges shall become immediately due and payable.

I fully understand that I am directly responsible to OrthoMiami for all charges and bills submitted by OrthoMiami for services rendered to me. This agreement is made solely for additional protection and consideration of waiting for payment; I also understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

DATE OF ACCIDENT: _____

ATTORNEY NAME: _____

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

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ORTHO MIAMI

CONSENT AND AUTHORIZATION

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I FURTHER ACKNOWLEDGE THAT IN THE EVENT ORTHOMIAMI IS FORCED TO RETAIN THE SERVICES OF A COLLECTION AGENCY AND/OR ATTORNEY; I WILL BE RESPONSIBLE FOR THE COLLECTION AND/OR LEGAL FEES. I HEREBY AUTHORIZE THE MEDICAL PROVIDER TO RELEASE MEDICAL INFORMATION TO MY INSURANCE COMPANY TO SECURE PAYMENT OF BENEFIT. I ALSO AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS AND AS AUTHORIZATION FOR PAYMENT TO BE SENT TO ORTHOMIAMI AT 7800 SW 87TH AVENUE, #A110, Miami, FL 33173 I HEREBY CONSENT TO THE FOLLOWING TREATMENTS: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS, PERFORMANCE OF SUCH PROCEDURES, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TEST AND CULTURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT. PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TEST THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGEMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVE IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS OR TREATMENT. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING. I, THE UNDERSIGNED, ACKNOWLEDGE THAT ORTHOMIAMI WILL USE AND DISCLOSE MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS AS DESCRIBED IN THE NOTICE OF PRIVACY PRACTICE. PHOTOCOPY OF THIS CONSENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL MEDICARE PATIENTS. I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ACKNOWLEDGE THAT I HAVE BEEN GIVEN ORTHOMIAMI'S NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF I HAVE QUESTIONS OR COMPLAINTS, THAT I SHOULD CONTACT THE PRIVACY OFFICIALS. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENTS FULLY AND VOLUNTARILY TO ITS CONTENTS.

Patients Consent – Authorizations – and Assignments of Benefits

I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO ORTHOMIAMI, I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, a/k/a Personal Injury Protect and Medical payments policy of Insurance to the above caption healthcare provider, I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payments at the time services are rendered. I understand this document will allow the provider to file suit against the insurer for payment of the insurance benefits and to seek damages from the insurer per Florida statute 627.428.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of ORTHOMIAMI's Notice of Privacy Practices or have been offered a copy for review. The physicians and staff of ORTHOMIAMI have my permission to speak to any family/friends I designate in writing in reference to my medical care.

Name of Responsible Party: _____

Signature of Responsible Party: _____

Date: _____