PATIENT INFORMATION FORM FOR MINORS

Patient Name:_____
LAST FIRST INITIAL

Patient Address:_____
NUMBER & STREET CITY STATE ZIP

Phone: (_____)_____ Birthdate:_____Age:_____Sex:_____

☐ Father's Name:_____ Phone: ( )_____

Father's Address:_____
NUMBER & STREET CITY STATE ZIP
Father's Social Security #:_____

☐ Mother's Name:_____ Phone: ( )_____

Mother's Address:_____
(If different from Father's) NUMBER & STREET CITY STATE ZIP
Mother's Social Security #:_____

☐ Legal Guardian's Name:_____ Phone: ( )_____
Guardian's Address:_____
(If guardian is different from parents) NUMBER & STREET CITY STATE ZIP

Is today's visit related to an AUTO ACCIDENT? YES NO
SCHOOL RELATED INJURY? YES NO Date of injury?_____
Are you involved in litigation b/c of this accident? YES NO

Name of Family Physician:_____
Who may we thank for referring you to us?_____
Nearest Relative not living with you?_____Relationship to child:_____
Phone number of relative: ( )_____

REGARDLESS OF WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL.
I understand payment is due at the time services are rendered unless arrangements have PREVIOUSLY been made with the office manager. I will be paying by:
CASH_____ CREDIT CARD_____ CHECK_____
PRIMARY INSURANCE:_____
SECONDARY INSURANCE:_____

I have read all of the information on the patient information sheets and hae answered all of the questions. I certify this information is true and correct to the best of my knowledge. I will notify you of ant changes in my child's health status or the above information.

_____ _____
SIGNATURE DATE

If this form is being filled out by someone other than the patient, what is your relationship:_____

PLEASE PLACE AN X IN THE BOX IN FRONT OF THE PERSON WHO IS DESIGNATED TO BE CONTACTED IN CASE OF AN EMERGENCY

PRESENT ALL INSURANCE INFORMATION AND DRIVER'S LICENSE TO RECEPTIONIST FOR COPYING

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

We are committed to providing you with the best possible care. If you have medical insurance, we will be glad to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. Payment is due at the time services are rendered. We accept CASH, CHECKS, MASTERCARD, OR VISA. In SPECIALcircumstances such as fractures or surgeries, we may accept assignment of insurance benefits. Returned checks will be subject to a $20 fee. Balances older than 30 days will be subject to interest charges at 1.5%/month. We will gladly discuss your proposed treatment and answer any questions related to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are NOT a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies. Our fees are considered USUAL, CUSTOMARY, AND REASONABLE by most insurance companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all serices are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize as medical providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask. We are here to help you.

MEDICARE PATIENTS

We accept assignment of Medicare benefits, however. WE ONLY FILE CERTAIN MEDIGAP INSURANCES. PLEASE CHECK WITH THE RECEPTIONIST IF YOU HAVE ANY QUESTIONS REGARDING YOUR PARTICULAR COVERAGE. Payment of 20% is due at the time of service if you do not have an approved Medigap insurer.

AUTHORIZATION FOR TREATMENT

I AUTHORIZE TREATMENT OF THE PERSON NAMED ON THE PREVIOUS PAGE AND AGREE TO PAY ALL FEES AND CHARGES FOR SUCH TREATMENT. I ALSO AUTHORIZE PETER CANDELORA, M.D., P.A. , AND/OR RICHARD OZUNA, M.D., P.A. TO RELEASE ANY INFORMATION (VIA FACSIMILE,MAIL, OR PHONE) ACQUIRED IN THE COURSE OF MY EXAMINATION FOR HEALTH REASONS OR IN ORDER TO PROCESS AN INSURANCE CLAIM.

I UNDERSTAND THAT IF I CONSENT TO THE RELEASE OF ANY OF MY MEDICAL RECORDS, THE RESULTS OF ANY HIV ANTIBODY TESTING, ALCOHOL AND DRUG ABUSE, AND PSYCHOLOGICAL INFORMATION ARE INCLUDED IN THE MEDICAL RECORDS.

I AGREE TO PAY ALL CHARGES FOR ME AND MEMBERS OF MY FAMILY SHOWN BY STATEMENTS, PROMPTLY UPON RECEIPT, UNLESS CREDIT ARRANGEMENTS ARE AGREED UPON IN WRITING. I HEREBY "ASSIGN ANY BENEFITS" FROM INSURANCE COVERAGE FOR MEDICAL SERVICES TO PETER CANDELORA, M.D., P.A. IN THE EVENT ACTION SHOULD BECOME NECESSARY TO COLLECT UNPAID BALANCE DUE FOR MEDICAL SERVICES RENDERED TO ME OR MY FAMILY, I/WE AGREE TO PAY COLLECTION FEES AND/OR REASONABLE ATTORNEY'S FEES OR OTHER SUCH COSTS AS THE COURT DETERMINES PROPER.

PLEASE INITIAL_____

Name _____

Email Address:_____

Ethnicity:

- ☐ Hispanic
- ☐ Non Hispanic
- ☐ Decline to answer
- ☐ Unknown

Race:

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiian
- ☐ White
- ☐ Other

Preferred Language:

- ☐ English
- ☐ Spanish

Cell Phone _____

Home Phone _____

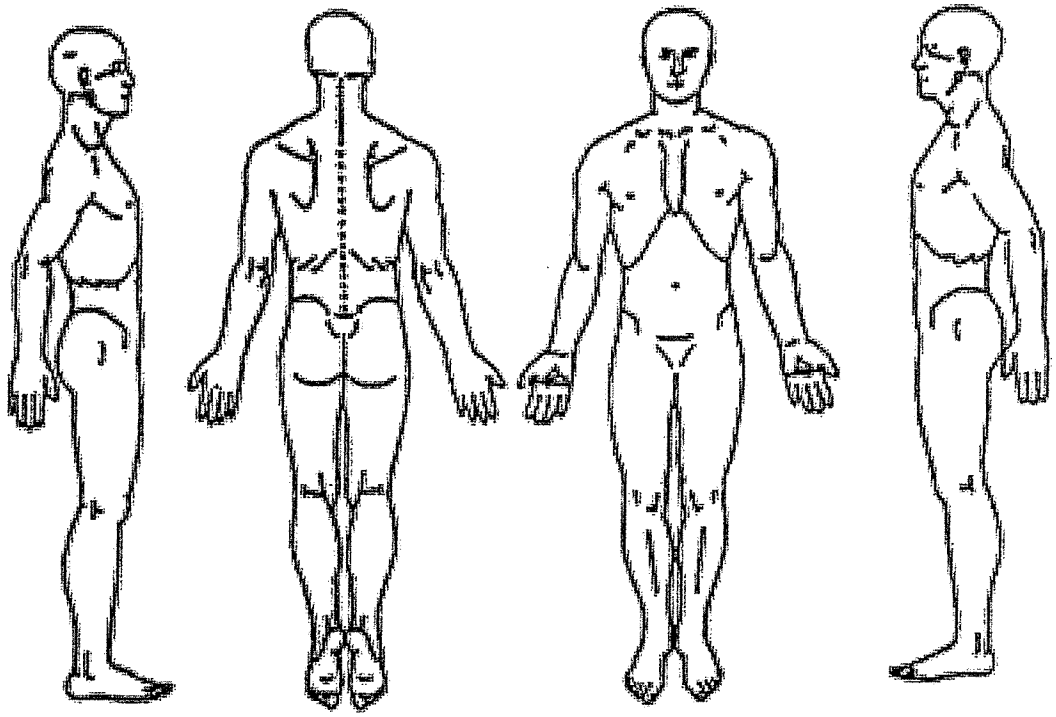
Work Phone _____

PAIN DIAGRAM

Patient Name: _____ **Date:** _____

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - -	0 0 0 0 0 0 0 0 0	v v v v v	x x x x x	* * * * * *
- - - - - - - -	0 0 0 0 0 0 0 0 0	v v v v v	x x x x x	* * * * * *



Please use the space below to describe your condition/injury further:

_____

_____

_____

Have you ever experienced the same condition/injury in the past? [ ] NO [ ] YES

If yes, use the space below to explain:

_____

_____

_____

Patient Signature: _____ **ACCT NO:** _____

Patient name:_____ Account Number:_____ Date:_____

Medication List

Prescription	Diagnosis (why taking medication?)

Over the Counter Medications

Supplements (NutraMetrix, vitamins etc.)

Acct No: _____

Identifying Your Wellness Care Plan

INTERNAL USE: PCID: _____Health Goal: ____

Name: _____ **Date:** _____ **Age:** _____
Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Email Address: _____ **Phone:** _____ **Date of Birth:** ___/____/___

DIETARY INTAKE SUMMARY:

How many servings of fruit do you consume per day? _____
How many servings of vegetables do you consume per day? _____
How many servings of protein do you consume per day? _____
How many servings of bread/crackers/pasta do you consume daily? _____
Do you consume artificial sweeteners? __Yes __ No If yes, what brands? _____
Do you consume fast food? __ Yes __ If yes, what do you typically eat? _____
Do you eat breakfast? __ Yes __ No If no, what time is your first meal of the day? _____
Do you consume alcoholic beverages? __ Yes __ No If yes, how many per week? _____
Do you consume coffee? __ No __ Yes If yes, how many cups per day? _____
Do you consume dietary supplements? __ No __ Yes If yes, please list all of them below. Additionally, please bring them in so we can check for ingredients that are not healthful or may have contraindications with medications.

_____

Please indicate the areas of health that you want to improve:

_____ Lose weight ___ More energy ___ Sleep better ___ Improve digestion
_____ Improve blood work ___ Prevent problems ___ Anti-aging support ___ Improve general health

If you could improve ONE thing about your health, what is your priority?

_____

IDENTIFYING YOUR HEALTH GOAL:

To help our office understand your wellness goals and give you the type of care that you want, please answer:

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
						I have achieved or want to achieve...				
I feel seriously concerned for my health	I feel very negative about my health condition	I am unhappy with my current health	I have some complaints that affect me on a daily basis	I have some minor complaints	I have neutral health, no solid complaints	A solid foundation of core health & nutrition	An optimized foundation of good health & nutrition	A custom solution to help me target my health needs	An advanced, fitness oriented, custom solution for wellness	An advanced custom solution with fitness and anti-aging support

1. Where do you feel your health is: _____ 2. Where do you want your health to be? ____.

NOTE: In our commitment to your health, our office provides our patients with an online resource for education, science and wellness support. We will create your login ID and provide access information..

Please Indicate which free wellness classes you wish to be informed of:
__ Health Reality Check __ Genetics & Your Health __ Why Diets Don't Work __ Other: _____

For your health care, do you prefer __ Prescription Drugs __ Natural Health Alternatives or __ A combination of both as needed

Coastal Orthopaedics and Sports Medicine

Peter Candelora, MD
Specializing in General Orthopaedics and Joint Replacement

OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve this objective.

Please read carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1.) On arrival, please check in at the front desk and present your **current** insurance card at every visit. You will be asked to sign and date the accuracy of the face sheet that is pre-printed. If **any** information is incorrect, please provide the correct information. This is your verification of the accurate insurance and consent to bill them on your behalf.
2.) IF THE INSURANCE INFORMATION YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
3.) According to your benefit plan, you are responsible for any and all co-payments, deductibles and coinsurances. **ALL** co-payments will be collected at check-in.
4.) It is your responsibility to understand your benefit plan. It is important for you to know if a written referral or authorization is required by your plan to see a specialist, if preauthorization is required prior to a procedure/surgery and what services are covered.
5.) All applicable insurance deductibles and coinsurance amounts will be collected at the last visit, **PRIOR** to surgery.
6.) Patient balances are billed immediately upon receipt of your insurance's plan explanation of benefits (EOB).
7.) If previous arrangements have **NOT** been made with our billing office, any account with an outstanding balance greater than 45 days will be charged a $10.00 re-bill fee.
8.) A $35.00 fee will be charged for any checks returned for insufficient funds.
9.) We charge a $1.00 per page to copy or electronically transfer medical records.

Please note that not ALL plans cover ALL services. In the event your insurance determines a service is NOT covered, you will be responsible for that charge.

I have read and understand the financial policy for, Coastal Orhtopaedics and Sports Medicine and agree to comply and accept the responsibility for any payment that becomes due as outline.

_____ _____

Patient Name **(PRINTED)** Date

_____ _____

Patient Signature Acct No: **(Office Use Only)**

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