New Patient Information Form

Date _____

Last Name _____ First Name _____ Middle _____

Local Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ ☐ Not Applicable

Pat. SS # _____ Date of Birth ____ / ____ / ____ F / M

Employer _____ Occupation _____ ☐ Retired

Address _____ City _____ State _____ Zip _____

Single Married Widowed Divorce E-mail Address: _____

Secondary Address (Do you live in Florida fulltime? yes no If no, dates you live in Florida _____

Street _____ City _____

State _____ Zip _____ Phone ( ) _____

Spouse's Name: First _____ Middle _____ Last _____

Address (if different from above) _____

Home Phone ( ) _____ Work Phone ( ) _____

Spouse's Employer _____ Occupation _____ ☐ Retired

Address _____ City _____ State _____ Zip _____

Spouse's SS # _____ Date of Birth _____ F / M

Nearest Relative not living with you _____ Relationship _____ Phone ( ) _____

Address _____

Nearest Friend not living with you _____ Phone ( ) _____

Address _____

Who may we contact in case of emergency? _____ Phone ( ) _____

Relationship _____ Who may we thank for referring you to us? _____

Name of Family Physician _____ Name of Pharmacy _____ Phone ( ) _____

Power of Attorney's Name _____ Phone ( ) _____

Insurance Company's Name _____

Policy # or ID # _____ Group # _____

Policy Holder _____ Policy Holder's Employer _____

Phone # (800) _____

Secondary Insurance _____

It is your responsibility to provide us with up to date and accurate information. Failure to do so will result in your being held responsible for all charges plus any additional fees associated with insurance filing.

Person responsible for payment _____ Payment Today ___ Cash ___ Charge ___ Check

Date _____ Signature of Patient/Responsible Party _____

FINANCIAL AGREEMENT AND AUTHORIZATION ON REVERSE SIDE.

For Office Use Only:

Information has been verified and changes have been made: Date _____ Initials _____

Date _____ Initials _____

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 SPECIAL circumstances 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 COASTAL ORTHOPAEDICS & SPORTS MEDICINE (A BILLING COMPANY) 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:

COASTAL ORTHOPAEDICS & SPORTS MEDICINE (A BILLING COMPANY)
5145 DEER PARK DR.
NEW PORT RICHEY, FL 34653

CANCELLATION POLICY: FAILURE TO CANCEL OR RESCHEDULE AN OFFICE VISIT 24 HOURS PRIOR TO THE SCHEDULED APPOINTMENT WILL RESULT IN A $75.00 CHARGE TO THE PATIENT.

COLLECTION FEE: A FEE TOTALING 50% OF THE BALANCE DUE WILL BE ADDED TO YOUR ACCOUNT IF WE HAVE TO SEND YOUR ACCOUNT TO A COLLECTION AGENCY. YOU GIVE US PERMISSION TO CHECK YOUR CREDIT AND EMPLOYMENT HISTORY AND TO ANSWER QUESTIONS ABOUT YOUR CREDIT EXPERIENCE WITH US. WE HAVE THE OPTION TO REPORT YOUR ACCOUNT TO ANY CREDIT REPORTING AGENCY SUCH AS A CREDIT BUREAU.

I have received a copy of the Doctors' privacy note as required by HIPAA.

_____ _____

Signature of Patient
or Responsible Party

Today's Date

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 _____

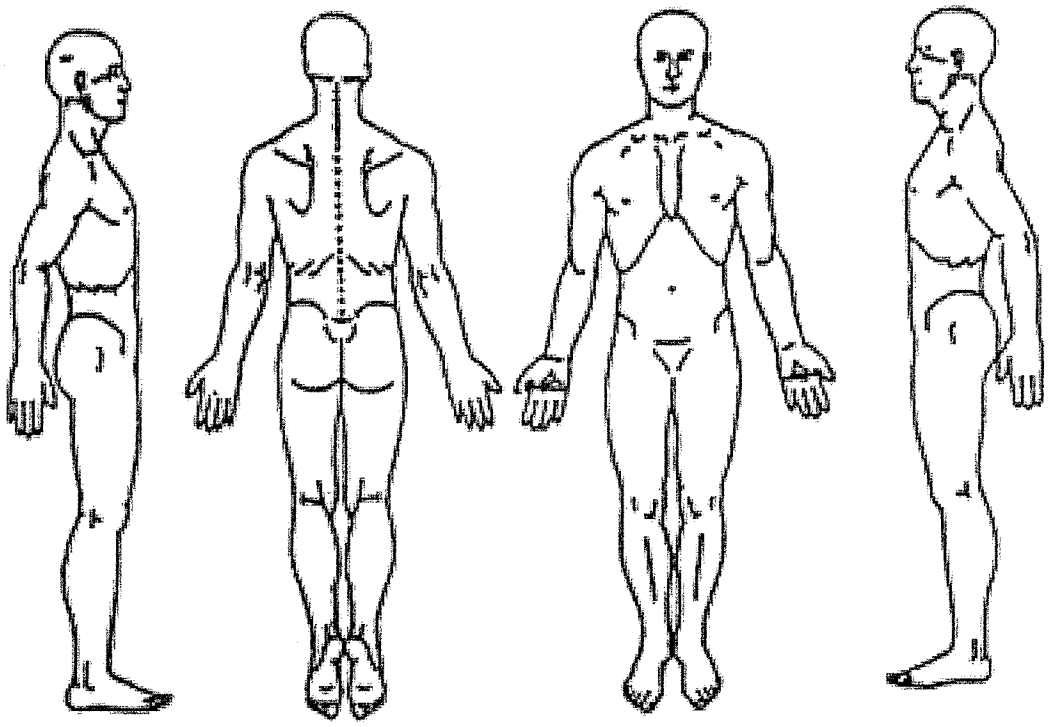
Work Phone _____

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

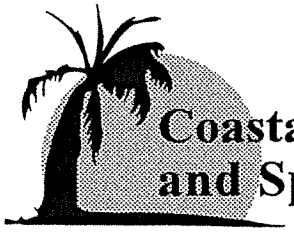
1. Where do you feel your health is: _____ 2. Where do you want your health to be? ____.

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)**

5145 Deer Park Drive • New Port Richey, FL 34653 • Phone (727) 848-1417 • Fax (727) 847-7526