Appointment Date:_____

Appointment Time:_____

2640 SW 32nd Place Ocala, FL 34471
Tel: (352) 369-1099 Fax: (352) 369-0299

PATIENT INFORMATION

DOB:_____/_____/_____Pharmacy:_____Pharmacy Location: _____

Name:_____Gender: M F Social Sec# _____

Mailing Address:_____City:_____State:_____Zip: _____

Phone: (Home)_____(Work)_____(Cell) _____

Email:_____Preferred method of contact: _____

Employer:_____Occupation: _____

Marital Status:_____Married_____Single_____Widowed Living Will / Advanced Directive? Yes No

Spouse's Name_____DOB:_____/_____/_____

Emergency Contact:_____Relationship:_____Phone #: _____

IF PATIENT IS UNDER 18

Responsible Party:_____Relationship_____

Phone #:_____DOB:_____Social Sec#: _____

Insurance Name:_____Subscriber's Name: _____

Subscriber's DOB:_____/_____/_____Subscriber's Social Sec#: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amounts, co-insurance, or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed 60 days. If the amount is assigned to an attorney for collections and/or suit the prevailing party shall be entitled to a reasonable attorney's fees and costs of collections. There will be a 25.00 fee for all returned checks.

Date:_____Patient Signature: _____

Subscriber Signature (if different from the patient): _____

*****My signature of this document acknowledges that I have received a copy of the Twin Palm Orthopedics' HIPPA Notice of Privacy Practices and Financial Policy/Lifetime Authorization for Insurance Assignments.

Twin Palm
ORTHOPEDICS

OFFICE PATIENT HEALTH HISTORY FORM

Date:_____/_____/_____

Patient Name:_____Primary Doctor: _____

Male____Female____Age____Right or Left handed (circle) Height:_____Weight:_____

*BRIEFLY DESCRIBE THE INJURY/CONDITION THAT YOU ARE BEING SEEN FOR:

_____

_____

Do you have any of the following medical conditions?

Heart Disease	Y/N	Chronic Cough	Y/N
Hypertension	Y/N	Night Sweats	Y/N
Respiratory Disease	Y/N	Eye Problem/Vision Difficulties	Y/N
Hepatitis/Jaundice	Y/N	Emotional Distress/Anxiety	Y/N
Diabetes	Y/N	Problems with Anesthesia	Y/N
Cancer	Y/N	Any Infectious Disease	Y/N
Bleeding/Clotting Disorder	Y/N	Stroke	Y/N
Blood Transfusions	Y/N	Chemo Therapy/Radiation	Y/N
Convulsions/Blackouts	Y/N	Rashes or Skin Difficulty	Y/N
Seizures/Epilepsy	Y/N	Dental Difficulty	Y/N
Frequent/Severe Headaches	Y/N	Missing Teeth	Y/N
Back Problem	Y/N	Nickel/Metal Allergy	Y/N

Flu Vaccine ____/____/____ Pneumonia Vaccine ____/____/___

Other medical conditions NOT listed: _____

List any MEDICAL ALLERGIES: _____

List any MEDICATION/DOSAGE you are currently taking: _____

_____

List SURGICAL HISTORY with dates: _____

_____

Do you smoke? Y/N If yes, how much do you smoke each day?___ Packs/Cigarettes per day (circle)

Are you former smoker? Y/N If yes, how long did you smoke before you quit?_____years/months

How much alcohol (in drinks) do you consume? day/week (circle)

Any history of recreational drug use? Y/N If yes, which drug(s) and how often _____

SUPER CONFIDENTIAL INFORMATION

PAST MEDICAL HISTORY Please check any disease diagnosed at any time - items left blank indicate a negative response.

□alcoholism □depression / anxiety □other _____

□hepatitis □controlled substance (Rx drugs) abuse Females Only -

□HIV / AIDS □illegal drug use Are you Pregnant? □Yes □No □Uncertain

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CONSENT TO EXAMINATION / TREATMENT

INSURANCE ASSIGNMENT, RECORDS AUTHORIZATION AND INFORMATION ACKNOWLEDGEMENT I HEREBY CONSENT TO EXAMINATION AND TREATMENT AS DEEMED NECESSARY BY TWIN PALM ORTHOPEDICS AND ITS PHYSICIANS. I HEREBY AUTHORIZE TWIN PALM ORTHOPEDICS AND ITS PHYSICIANS TO FURNISH PATIENT HEALTH INFORMATION CONCERNING MY RELEVANT MEDICAL HISTORY (INCLUDING BUT NOT LIMITED TO THE SUPERCONFIDENTIAL INFORMATION LISTED ABOVE) TO ANY OF THE FOLLOWING: OTHER HEALTHCARE PROVIDERS INVOLVED IN MY CARE, INSURANCE CARRIERS, ATTORNEYS AND ADJUSTORS. I HEREBY CONSENT TO THE USE OF A PATIENT PORTAL, SURVEYS, AND AUTOMATED TELEPHONIC AND EMAIL APPOINTMENT REMINDERS. I HEREBY ASSIGN TO TWIN PALM ORTHOPEDICS AND ITS PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE. I ACKNOWLEDGE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION IN THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE_____ DATE____/___/____

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____

AUTHORIZATION FOR MEDICARE BILLINGPURPOSES LIFETIME FILE
(MEDICARE PATIENTS ONLY)

I hereby certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I hereby authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby request that payment of authorized benefits be made on my behalf and hereby assign the benefits payable for physician services to the physician if he/she chooses to accept assignment.

SIGNATURE_____DATE / /____

PATIENT RELEASE

I,_____(patient's name), hereby authorize TWIN PALM ORTHOPEDICS and its physicians to release any or all of my patient health information including super confidential information to the person(s) listed below. (Example: A spouse or relative may be involved in billing and insurance inquiries or medication refills.)

SIGNATURE_____DATE / /____

Name_____Relationship to patient_____Ph( )_____

Name_____Relationship to patient_____Ph( )_____

Name_____Relationship to patient_____Ph( )_____

PARENTAL RELEASE (IF PATIENT IS A MINOR)

I,_____(legal guardian's name), hereby authorize TWIN PALM ORTHOPEDICS and its physicians to release any or all patient health information including super confidential information regarding my child to the person(s) listed below (Example: A relative or someone other than a legal guardian may accompany your child on a future appointment).

SIGNATURE_____ DATE____/____/____

Name_____Relationship to patient_____Ph( )_____

Name_____Relationship to patient_____Ph( )_____

Name_____Relationship to patient_____Ph( )_____

PRESCRIPTION HISTORY CONSENT

I agree that TWIN PALM ORTHOPEDICS may request and use my prescription medication history from other healthcare provider's or third party pharmacy benefit payor for treatment purposes.

SIGNATURE_____ DATE____/___/____

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____

_____

ACKNOWLEGEMENT OF "ABUSE FREE ZONE"

At Twin Palm Orthopedics we appreciate and respect our staff. It is our belief our staff should have a work environment free from verbal and physical abuse. We expect each of you to treat each of our staff members, as you would like to be treated. Outburst against our staff, physicians or physicians assistants will not be tolerated and will result in your immediate discharge from the practice. _____ (initials)

SIGNATURE_____ DATE_____/_____/____

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____

PRIVACY NOTICE

In accordance with the Health Insurance Portability and Accountability Act, patients of Twin Palm Orthopedics are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. A patient's Protected Health Information ("PHI") may only be released as authorized by this law. Twin Palm Orthopedics will strive to ensure that patient information is used only for purposes authorized by the patient, including but not limited to patient treatment and payment operations, lawful subpoenas, and as otherwise required by law. Upon request we can provide you with a complete copy of our Privacy Policies.

Additionally, upon providing reasonable advance notice, patients have a right to review their medical records and furnish comments to their records during normal business hours. In addition, patients have the right to obtain information regarding entities to which Protected Health Information has been provided.

Moreover, patients have the right

- to be informed of any breach of their unprotected PHI;
- to have marketing communications made to them only if authorized by the patient; and
- to decline to have PHI delivered to health insurers if the patient pays for services in full without submitting a claim.

If you have any concerns or wish to file a complaint, please contact Ann Episcopo, Twin Palm Orthopedics at (352) 369-1099.

SIGNATURE_____ DATE____/___/____

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____