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

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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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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: _____

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ORTHO MIAMI

NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby affirms:

1. The injured patient below, has in the opinion of this medical provider, suffered an **Emergency Medical Condition**, as a result of the patient's injuries sustained in an automobile accident that occurred on _____.
   Insert date of Accident

2. The basis for the finding of an **Emergency Medical Condition** is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to patient health; b) serious impairment to bodily functions; or c) serious dysfunction of a bodily organ or part.

I hereby attest that I am a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464, and that the above facts are true and correct.

_____ _____ _____
Physicians Name Signature Date

The undersigned injured person or legal guardian of such person affirms:

1. The symptoms I reported to the medical provider are true and accurate.

2. I understand the medical provider has determined I sustained an **Emergency Medical Condition** as a result of the injuries I suffered in the car accident.

3. The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient:

_____ _____ _____
Name of Injured Person or Guardian Signature of Insured Person or Guardian Date

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FLORIDA OFFICE OF INSURANCE REGULATION

Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.

C. The accompanying statement or bill is properly **completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded,** unbundled, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (Signature by his/ her **own han**d):

_____	_____	_____
Name (*PRINT or TYPE*)	Signature	Date

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered**. This means that those services have **already been provided**.
EMERGENCY MEDICAL CONDITION (EMC)

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

If you need any further assistance you can contact Ortho Miami at (305)596-2828 ext: 121.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name of insured person or Guardian	Signature of insured person or Guardian	Date

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