FLORIDA ORTHOCARE

NEW PATIENT REGISTRATION

REASON FOR TODAYS VISIT / INJURED BODY PARTS	
IS THIS A NEW COMPLAINT? YES / NO IS THIS RELATED TO AUTO OR WORK COMP? (CIRCLE IF APPLIES)	HOW DID YOU HEAR ABOUT US?

PATIENT INFORMATION

Last Name:		Date of Birth:			
First Name:	Middle Initial:	Sex:	☐ MALE ☐ FEMALE		
Street Address:		Martial Status: ☐ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced ☐ Partner			
City:		Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___			
State:	Zip Code:	Employer:			
Home Phone: ( ) - Is it okay to leave message? ☐ YES ☐ NO	Cell Phone: ( ) - Is it okay to leave message? ☐ YES ☐ NO	Employment Status: ☐ Full Time ☐ Retired ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Other			
Work Phone: ( ) - Ext		Email Address (Required):_____ May we enable the patient portal and enroll you for monthly emails? (Required): Yes / No			
Preferred Language:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unreported/ Refused	Race: ☐ American Indian ☐ Hispanic ☐ Black or African American ☐ Asian ☐ White ☐ Pacific Islander			

REFERRED BY DOCTOR: PHONE NUMBER:	PRIMARY CARE PROVIDER: PHONE NUMBER:

PRIMARY INSURANCE COVERAGE / RESPONSIBLE PARTY

Insurance Company:				
Policy Holder/Responsible Party:	Policy Holder's Date of Birth:	Month	Day	Year
Policy Holders Relationship to Patient:	Policy Holders Social Security Number:			
Subscriber/ ID Number OR Claim Number	Group OR Policy Number:			

ATTORNEY INFORMATION

Attorney Name/ Law Firm:	Phone Number: Fax Number:
Case Manager/ Paralegal Phone:	Case Manager/ Paralegal E-Mail:

EMERGENCY CONTACT

Name/ Relation:	Phone Number:

FLORIDA ORTHOCARE

PATIENT CONSENTS AND RESPONSIBILITIES

1. **CONSENT FOR GENERAL MEDICAL OR SURGICAL TREATMENT** - I hereby authorize Royal Palm Beach Rehab, Corp DBA Florida OrthoCare and the physician(s), in charge of my care to administer any treatment, receive results of tests and services rendered, administer anesthetics and medications, perform surgical procedures, injections, laboratory tests (including blood tests for any disease or condition), and to dispose of any tissues, body parts or organs removed as deemed necessary or advisable in my diagnosis and treatment. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me and with any invasive procedure there is a risk of adverse reactions, including but not limited to allergic reactions, pain, scarring, reactive synovitis and infections.
2. **ACCESS TO CARE** – The practice hours for Florida OrthoCare are Monday through Friday from 9:00am-5:00pm. Should you have an urgent problem when our office is closed, please call 1-888-523-7981 and remain on the line to leave your message with our answering service. A returned phone call will be returned by the provider on call. In the event of a true emergency and/or life threatening medical condition, call 911.
3. **NARCOTIC MEDICATION –** I understand I may be prescribed narcotic and sedative medication for treatment of my condition(s). I am aware that the use of such medicine has certain risks associated with it, including but not limited to: dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, sleepiness or drowsiness, constipation, nausea, itching, vomiting, tolerance to analgesia, addiction and possibly that the medicine will not provide relief from pain. (1) I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly such as, using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for themselves. (2) Physical dependence is expected as a result of using these medicines for a long time. Physical dependence is not the same as addiction. Narcotic medication should not be stopped abruptly. A planned titrating regimen with your provider to come off the medication overtime will be necessary to prevent any abstinence syndrome to develop. (3) I will not abuse any narcotic medication by taking more than the prescribed dosage, combining the medication with illegal controlled substances, prescribed or non-prescribed or excessive amounts of sedatives, including alcohol, as this may result in profound sedation and death. (4) I consent to urine and blood screens. Because narcotic medication have potential for abuse or diversion, strict accountability is necessary. Urine or serum toxicology screens will be requested and your cooperation is required. Presence of unauthorized substances may prompt discontinuance of narcotic medication. (5) I may decline narcotic medication and associated toxicology screens. I may choose to use non-narcotic pain medication such as NSAIDS or Acetaminophen.
4. **FINANCIAL AGREEMENT** - I hereby guarantee payment of all charges incurred for services rendered at Royal Palm Beach Rehab, Corp. DBA Florida OrthoCare I understand the cost of my medical care is dependent upon the nature and complexity of my illness or injury, the determination of which can only be established by the physician or medical practitioner in charge of my care. I understand that any verbal information given to me by any center staff regarding fees and services is for informational purposes only and is in no way a contract between Royal Palm Beach Rehab, Corp DBA Florida OrthoCare and me. No verbal contracts will be made, or will be honored. **Payment is due in full upon date of service.**
5. **PRIVATE INSURANCE** - I understand that insurance is a contract between me and my insurance company and not a substitute for payment, and that I am responsible for payment of my bill regardless of any insurance company's arbitrary determination of usual and customary rates. If there is any question regarding coverage, benefits, or payment for services provided**, I understand that it is my responsibility to resolve this.**
6. **MEDICARE ASSIGNMENT –** Royal Palm Beach Rehab, Corp DBA Florida OrthoCare will accept payment in full for what MEDICARE pays. It is the patent's responsibility for the20% of the MEDICARE allowable for which MEDICARE does not pay. I agree to be responsible for this 20%. If I have secondary/ supplemental insurance it is to be provided to Royal Palm Beach Rehab, Corp. DBA Florida OrthoCare.
7. **RELEASE OF LIABILITY** - In consideration for the rendition of medical services, I hereby voluntarily release, waive, and discharge Royal Palm Beach Rehab, Corp DBA Florida OrthoCare, their staff, lessors, heirs, successors and/or assigns from any and all claims, demands, damages, costs, loss of services, expenses, compensation and causes of action of any nature whatsoever connected with the rendition of medical services which I, my spouse, my heirs, my assigns, my legal representatives or my successors may have against any of them arising out of or in any way growing out of personal injuries or death having already resulted or to result at any time in the future, whether or not they are in the contemplation of the parties at the present time. I understand that this waiver includes any claims based on negligence, action or inaction of Royal Palm Beach Rehab, Corp DBA Florida OrthoCare, their staff, lessors, heirs, successors and/or assigns. I have carefully read this release and fully understand its contents. I am aware that this is a release of liability and a contract between myself and Royal Palm Beach Rehab, Corp. DBA Florida OrthoCare, and said staff, and sign it of my own free will.
8. **ASSIGNMENT OF BENEFITS** – If Royal Palm Beach Rehab, Corp DBA Florida OrthoCare, participates with my insurance program(s), I understand that Florida OrthoCare, will, as a courtesy to me, submit the charges for my visit to my primary and secondary insurance carriers. I assign payment directly to Royal Palm Beach Rehab, Corp. DBA Florida OrthoCare. I understand that I am financially responsible for any covered or non-covered services which are not paid by my primary or secondary insurance. Any credit balance resulting from payment of insurance or other sources may be applied to other accounts owed to Florida OrthoCare, by the insured or family.
9. **PATIENT HIPAA FORM** - I have been given the opportunity to review Royal Palm Beach Rehab, Corps. DBA Florida OrthoCare, Health Insurance Portability and Accountability Act of 1996 and the full HIPAA notice is posted in our waiting room and a copy may be also provided by calling (561) 403-1616.
10. **NOTICE OF PRIVACY PRACTICES** – I have been given the opportunity to review Royal Palm Beach Rehab, Corps. DBA Florida OrthoCare. Notice of Privacy Practices. The full Notice of Privacy Practices is displayed in our waiting room and a copy may also be provided by calling (561) 403-1616.
11. **USES AND DISCLOSURES OF HEALTH INFORMATION** - I understand that Royal Palm Beach Rehab, Corp. DBA Florida OrthoCare, will use and disclose my personal health information to provide treatment, process payment claims, as necessary for healthcare operations (ex. Utilization Review, manufacturers of surgically placed implants) or as required by law. This includes release of information to insurance carriers, 3rd party payers or their agents, ancillary medical providers (IE; Physical therapy, Occupational therapy, Imaging facilities, etc), other medical providers and law enforcement agencies with any right to privacy waived including any treatment for mental illness, alcohol abuse, drug abuse or HIV as may be necessary. For details of uses and disclosures refer to Florida OrthoCare's, Notice of Privacy Practices.
12. **RIGHT TO ANCILLARY PROVIDERS/ FACILITIES –** When you are referred out for ancillary care, including but not limited to, diagnostic testing, physical therapy, chiropractic care, etc. It is within your patient rights to choose providers and/or facilities as you deem appropriate. Our recommendations are merely suggestions in efforts to provide convenient transition of care for our patients.

I certify that I am the patient or the patient's legal representative, that I have read the foregoing, fully understand the consents and releases contained in this record, and voluntarily execute it. I understand that the consents regarding my personal health information are subject to revocation at any time except to the extent that action has been taken in reliance thereon and that said consents shall remain in effect until I choose to revoke them in writing.

_____ _____

Signature of Patient and/or Legal Representative **Date**

Patient Name: _____ **Height:** _____ **Weight:** _____

Family Physician: _____ **Account #:** _____ **Date:** _____

FLORIDA ORTHOCARE

Allergies:

- ☐ No change since last visit
- ☐ New info

Please list any medication allergies:

_____

_____

_____

Medications:

- ☐ No change since last visit
- ☐ New info

Please list all medications you are taking:

_____

_____

_____

_____

_____

_____

_____

Is it possible you may be pregnant?

- ☐ Yes
- ☐ No
- ☐ N /A

Are you

- ☐ Right Handed?
- ☐ Left Handed?

Social History

- ☐ No change since last visit
- ☐ New info

Do you smoke?

- ☐ Yes,

If yes how many per day?

_____

- ☐ No

Do you drink?

- ☐ Yes,

If yes how many per week?

_____

- ☐ No

Medical History:

- ☐ No change since last visit
- ☐ New info

Have you had any of the following

Depression	☐ Y	☐ N
Diabetes	☐ Y	☐ N
Thyroid Disease	☐ Y	☐ N
High Cholesterol	☐ Y	☐ N
High Blood Pressure	☐ Y	☐ N
Lung Disease	☐ Y	☐ N
Heart Attack	☐ Y	☐ N
Rheumatic Fever	☐ Y	☐ N
Stroke	☐ Y	☐ N
Seizures/Epilepsy	☐ Y	☐ N
Asthma	☐ Y	☐ N
Emphysema	☐ Y	☐ N
Bronchitis	☐ Y	☐ N
Tuberculosis	☐ Y	☐ N
Liver Disease	☐ Y	☐ N
Pancreatitis	☐ Y	☐ N
Gout	☐ Y	☐ N
Osteoporosis	☐ Y	☐ N
Joint Replacement	☐ Y	☐ N
HIV Infection/ AIDS	☐ Y	☐ N
Hepatitis	☐ Y	☐ N
Thrombosis	☐ Y	☐ N
Kidney Disease	☐ Y	☐ N
Glaucoma	☐ Y	☐ N
Pace Maker	☐ Y	☐ N
Cortisone Treatment	☐ Y	☐ N

Others (list):

_____

_____

_____

Review of Systems:

- ☐ No change since last visit
- ☐ New info

General

Weight Change	☐ Y	☐ N
Fever	☐ Y	☐ N
Night Sweats	☐ Y	☐ N
Fatigue	☐ Y	☐ N

Immune/Allergy

Hives	☐ Y	☐ N
Rashes	☐ Y	☐ N
Frequent Infections	☐ Y	☐ N
Swollen Glands	☐ Y	☐ N

Eyes

Blurry Vision	☐ Y	☐ N
Loss of Vision	☐ Y	☐ N
Itching	☐ Y	☐ N

Skin

Rashes	☐ Y	☐ N
Discoloration	☐ Y	☐ N

Ear/Nose/Throat

Loss of hearing	☐ Y	☐ N
Nose Bleeds	☐ Y	☐ N
Ringing in the ears	☐ Y	☐ N
Trouble swallowing	☐ Y	☐ N

Digestive

Abdominal Pain	☐ Y	☐ N
Nausea	☐ Y	☐ N
Vomiting	☐ Y	☐ N
Bloody Stools	☐ Y	☐ N

Respiratory

Wheezing	☐ Y	☐ N
Cough	☐ Y	☐ N
Shortness of Breath	☐ Y	☐ N

Surgical History:

☐ No change since last visit ☐ New info

Please List Any Surgeries you have had:

Procedure:	**Year:**

Cardiovascular

Chest Pain	☐ Y	☐ N
Blood Clot	☐ Y	☐ N
Swelling Feet/Leg	☐ Y	☐ N
Irregular Heartbeat	☐ Y	☐ N

Neurological

Dizziness	☐ Y	☐ N
Numbness	☐ Y	☐ N
Stroke	☐ Y	☐ N
Seizures	☐ Y	☐ N
Headaches	☐ Y	☐ N

Hematologic

Anemia	☐ Y	☐ N
Blood Clot	☐ Y	☐ N
Bleed or Bruise Easily	☐ Y	☐ N

Endocrine

Excessive Thirst	☐ Y	☐ N
Weight Gain	☐ Y	☐ N
Excessive Hunger	☐ Y	☐ N

Musculoskeletal

Joint Pain	☐ Y	☐ N
Back or Neck Pain	☐ Y	☐ N
Muscle Weakness	☐ Y	☐ N
Muscle Pain	☐ Y	☐ N

Urinary

Incontinence	☐ Y	☐ N
Painful Urination	☐ Y	☐ N
Blood in Urine	☐ Y	☐ N
Burning	☐ Y	☐ N

Family History:

☐ No change since last visit

☐ New info

Has anyone in your family ever had:

Heart Disease	☐ Y	☐ N

If yes who? _____

Lung Disease	☐ Y	☐ N

If yes who? _____

Kidney Disease	☐ Y	☐ N

If yes who? _____

Diabetes	☐ Y	☐ N

If yes who? _____

Cancer	☐ Y	☐ N

If yes who? _____

Patient / Guarantor Signature: _____ **Date:** _____

PHARMACY INFORMATION REQUIRED:

Store Name: _____ Phone: _____

Address: _____ Fax: _____

FLORIDA ORTHOCARE

WRITTEN DISCLOSURE FORM (F.S. 456.052)

Dr. John Papa, DC has a financial interest in the following entities:

ROYAL PALM BEACH REHAB, CORP. DBA ACTION PHYSICAL THERAPY
Offices in Miami, Broward, Palm Beach, Martin (www.actionphysical.com)
ROYAL PALM BEACH REHAB, CORP. DBA FLORIDA ORTHOCARE
Offices in Miami, Broward, Palm Beach, Martin (www.florthocare.com)
CERTIFIED SPINE AND PAIN CARE, LLC
Offices in Miami, Broward, Palm Beach (www.certifiedspineandpain.com)
ORTHOPEDIC URGENT CARE CENTERS OF FLORIDA (www.orthopedicurgentcarecenters.com)
Offices in Palm Beach County

AS THE PATIENT YOU HAVE A RIGHT TO OBTAIN THE SAME ITEMS/SERVICES AT ONE OF THE ABOVE-LISTED LOCATIONS OR AT A DIFFERENT LOCATION OF YOUR CHOICE. YOU MAY OBTAIN THESE SAME ITEMS/SERVICES AT THE FOLLOWING LOCATIONS WHERE DR. JOHN PAPA, DC, DOES NOT HAVE A FINANCIAL INTEREST:

MIAMI-DADE COUNTY
- Pain Medicine, Baptist Health, 13101 S. Dixie Highway, Suite 400, Miami, FL 33156
- Advanced Institute for Pain Management, University of Miami, 1120 NW 14 Street, 9th Floor, Suite 101, Miami, FL

BROWARD COUNTY
- American Pain Experts, 1164 E. Oakland Park Blvd., Suite 201, Oakland Park FL, 33334
- Broward Health Pain Management, 2100 E Sample Road, Suite 203, Lighthouse Point, FL 33064

PALM BEACH COUNTY
- National Pain Institute, 5365 West Atlantic Avenue, Suite 504, Delray Beach, FL 33484
- Resolute Pain Solutions, 4510 Donald Ross Road, Palm Beach Gardens, FL 33418

MARTIN COUNTY
- Pain Management, Martin Health, 509 Riverside Dr., Suite 203, Stuart, FL 34994
- Resolute Pain Solutions, 2100 SE Ocean Boulevard, Suite 100, Stuart, FL 34996

_____ _____
Patient Signature Date

The 2018 Florida Statutes

Title XXXII
REGULATION OF PROFESSIONS AND OCCUPATIONS

Chapter 456
HEALTH PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS

View Entire Chapter

456.052 Disclosure of financial interest by production.—

(1) A health care provider shall not refer a patient to an entity in which such provider is an investor unless, prior to the referral, the provider furnishes the patient with a written disclosure form, informing the patient of:

(a) The existence of the investment interest.

(b) The name and address of each applicable entity in which the referring health care provider is an investor.

(c) The patient's right to obtain the items or services for which the patient has been referred at the location or from the provider or supplier of the patient's choice, including the entity in which the referring provider is an investor.

(d) The names and addresses of at least two alternative sources of such items or services available to the patient.

(2) The physician or health care provider shall post a copy of the disclosure forms in a conspicuous public place in his or her office.

(3) A violation of this section shall constitute a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. In addition to any other penalties or remedies provided, a violation of this section shall be grounds for disciplinary action by the respective board. **History.**—s. 1, ch. 86-31; s. 84, ch. 91-224; s. 13, ch. 92-178; s. 92, ch. 97-261; s. 76, ch. 2000-160.

Note.—Former s. 455.25; s. 455.701.

FLORIDA ORTHOCARE

Authorization to Release Medical Records

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Requesting Patient Information:
Patient Name: _____ Date of Birth: _____
Address: _____Last 4 of SS#: _____
City: _____ State: _____ Zip: _____ Phone: _____

_____I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization I must do so in writing and present my written request to the Medical Records Department.

_____I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign and the facility of Royal Palm Beach Rehab dba Florida Orthocare will not base treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect a copy of the information to be disclosed, as provided in 45 CFR 164.524 (with reasonable charge).

_____I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of the information and no longer protected by federal confidentiality laws or Ideal. I Authorize (print name of party releasing the records): _____ to release my health information to Royal Palm Beach Rehab dba Florida Orthocare for the purpose of my healthcare and treatment.

Information to be Disclosed (please check all that apply):

_____All Records _____ Imaging _____ Lab _____ EKG _____ Other: _____
Purpose for Disclosure: _____ Continuation of Care _____ Other: _____

Unless otherwise revoked, this authorization will expire 36 months from the date of the signature listed below.

Patient/Patient's Representative Signature: _____Date: _____

FLORIDA ORTHOCARE

RELEASE OF INFORMATION

(WHO CAN WE SPEAK TO ON YOUR BEHALF?)

PATIENT NAME:	
DOB:	

RELEASE OF INOFMRATION : I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE FOLLOWING PRIVATE INDIVIDUALS WHICH WE MAY DISCUSS YOUR PROTECTED HEALTH INFORMATION.

_____ I GRANT AUTHORIZATION TO LEAVE A VOICEMAIL TO ANYONE LISTED BELOW:

PLEASE NOTE IF THE PERSON(S) IS NOT LISTED BELOW WE WILL NOT SHARE ANY OF YOUR PROCTECTED HEALTH INFORMATION

#1 NAME:	
CONTACT NUMBER:	
RELATIONSHIP:	

#2 NAME:	
CONTACT NUMBER:	
RELATIONSHIP:	

#3 NAME:	
CONTACT NUMBER:	
RELATIONSHIP:	

X _____ X _____

Signature of Patient and/or Legal Representative

Date

FLORIDA ORTHOCARE

Patient X-Ray Consent Form:

Name: _____ Date: _____
We would like to make you aware that x-rays were ordered by the doctor in order to administer treatment. In order to perform x-rays on any patient our office requires the patient's consent for such tests to be performed. Please Choose One: (Then sign at the bottom at the page)

_____ I understand that my condition requires my doctor to take x-rays to further diagnose my condition and render treatment for my symptoms. I give permission of **ALL** needed diagnostic X-ray examination and treatment.

_____I understand that my condition requires my doctor to take x-rays to further diagnose my condition and render treatment for my symptoms. I choose **NOT** to have any X- rays at this time and release my doctor of all liabilities.

Please note: Copies of your x-rays are available on disc for an extra charge of $10.

Females Only:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exam. With those factors in mind, I am advising my doctor that:

I am pregnant: YES / NO / DON'T KNOW
I could be pregnant: YES / NO / DON'T KNOW
My menstrual period is late: YES / NO / DON'T KNOW
I have an IUD: YES / NO

With the full understanding of the above, and believing that I am not currently at risk, I wish to have an X-ray examination performed today requested by my doctor.

Signature: _____ Date: _____

If the patient is a minor:

I, _____ am the parent / legal representative of _____ who is a minor. I authorize the performance of diagnostic X-ray of this minor.

Signature: _____ Date: _____