WAYPOINT
POWERED BY BAY AREA Orthopaedic Specialists

1-888-8-THE-WAY main 727-789-5400 fax
www.WaypointOrtho.com

* CONFIDENTIAL PATIENT CASE HISTORY *
This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time to answer each question as completely as possible and please sign each page.

TODAY'S DATE: _____

Is the patient a minor child? ☐ Yes ☐ No

Patient Information -

Full Name: _____

Gender: _____ Race: _____

DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell # _____ Home # _____ Work #: _____

Email Address: _____

Parent/Guardian Information -

First Name: _____

DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell # _____ Home # _____ Work #: _____

Email Address: _____

Accident Information -

Date of Accident _____

☐ Motor Vehicle Accident ☐ Motorcycle Accident ☐ Slip & Fall

Were you? ☐ Driver ☐ Front Seat Passenger ☐ Back Seat Passenger

Were you wearing a seat belt? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No

If "Yes", which hospital? _____

Did you go by ambulance? ☐ Yes ☐ No

Were you admitted? ☐ Yes ☐ No

Discharge Date? _____

Have you received prior therapy? ☐ Yes ☐ No

Did you see a physician within 14 days of the accident? ☐ Yes ☐ No

Where are you currently treating and what is your doctor's name? _____

Are you able to work? ☐ Yes ☐ No

Pain Levels- -

Please indicate your pain levels below using a scale of 1 = Very little 10 = Excruciating
Leave blank if No Pain

Head		Tailbone	
Neck		Right Hip	
Mid-Back		Left Hip	
Low-Back		Right Leg	
Right Shoulder		Left Leg	
Left Shoulder		Right Knee	
Right Arm/Elbow		Left Knee	
Left Arm/Elbow		Right Foot/Ankle	
Right Hand/Wrist		Left Foot/Ankle	
Left Hand/Wrist		Other (Please List)	
Other			

Is the pain affecting your ability to sleep? ☐ Yes ☐ No

Medications -

Any allergies to medications? ☐ Yes ☐ No

_____

_____

_____

Auto Insurance Information -- - - - - - - - - - -

Auto Insurance Company: ______________________________

Name of Insured: ______________________________

Policy #: ______________________________

Claim #: ______________________________

Attorney Information -

Attorney/Firm Name: ______________________________

Phone #: ______________________________

Case Manager's Name: ______________________________

Health Insurance Information - - - - - - - - - - - -

* It is important to note that Waypoint Orthopaedic Associates is not enrolled in any health insurance networks, Medicare or Medicaid but we collect this information in the event an outside referral is required.

Do you have health insurance? ☐ Yes ☐ No

Health Insurance Company: ______________________________

Name of Insured: ______________________________

Policy #: ______________________________

Group #: ______________________________

Name of Primary Care Doctor: ______________________________

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AUTHORIZATIONS AND AGREEMENTS

PATIENT NAME: _____

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-rays and physical findings diagnosis and prognosis. You are authorized to provide this information in accordance with the automobile personal injury protection law (Chapter 71-252 F.S.) .
I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. You are authorized to provide this information in accordance with the automobile personal injury protection law. (Chapter 71-252 F.S)

_____**(Initials)**

Consent for Treatment

I understand that services rendered are necessary for the patient by the above company and its physicians. I hereby consent to and authorize the administration of the medical treatment that may be considered advisable or necessary in the judgment of the physician. I hereby authorize the above company to release any information in the course of my treatment to my insurance company or any physician needing this information for treatment.

_____**(Initials)**

Acknowledgement of Receipt of Noticed of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, (found at detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____**(Initials)**

Payment Agreement

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Waypoint Orthopaedic Associates, will prepare any necessary reports and forms to assist me in making collection for the insurance company and that any amount authorized to be paid directly BAY AREA ORTHOPAEDIC SPECIALISTS , LLC dba WAYPOINT ORTHOPAEDIC ASSOCIATES will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

_____**(Initials)**

Assignment of Benefits

I hereby assign form any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title and interest to BAY AREA ORTHOPAEDIC SPECIALISTS, LLC dba WAYPOINT ORTHOPAEDIC ASSOCIATES ("Assignee") for payment for services rendered unto me both by of accident or illness. In the event my insurance company fails to pay Assignee the full amount owing to Assignee after proper statutory notice, I hereby also by this instrument , all rights and causes of action in tort, in contract and the laws of Florida, against the personal injury protection carrier for the above named insured patient for it's failure to
pay for services rendered unto me by Assignee in relation to my accident or illness. This assignment may only be rescinded / reassigned by the mutual consent of the patient / insured / assignor and the health care provider / assignee.

_____(Initials)

Reservation of Benefits

Please be advised that I am hereby placing you on notice pursuant to Florida case law that should you deny, reduce or fail to pay either a part or an entire bill, which was submitted on my behalf from this healthcare provider. I am requesting you reserve, or hold aside, that same amount until the dispute is resolved. Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, or if my benefits should become exhausted, please notify me and this health care provider of this fact immediately.

_____(Initials)

Direction of Payment / Release of Information

I hereby authorize any auto insurance company or attorney to pay direct to Assignee the amount of this and / or any future bills for services rendered unto me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to the Assignee. I hereby authorize Assignee to release any information requested that is pertinent to my case to any insurance company or attorney involved in this case. Pursuant to FS 627.4137, **I hereby request a copy of the PIP payment log and any available policy of insurance or declaration sheet, which reflects the applicable policy limits available at the time of this accident, to be provided by the insurance company to the Assignee.** I hereby authorize Assignee the permission to request and receive a current
copy of my PIP payment log periodically as they deem necessary. A photocopy of this assignment shall be considered as valid and effective as the original.

_____(Initials)

Signature Agreement

I, _____, hereby consent and agree to all terms of this Agreements and Authorization section and have freely provided my initials for the terms therein.

_____ _____

Patient's Signature or Parent / Guardian Date

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Waiver of Health Insurance Agreement

Patient: _____

If you are a patient seeking treatment for an injury arising from an automotive accident or a tort action, you will be considered an automotive or legal patient throughout the course of your treatment. You have requested and chosen for us NOT to bill any insurance or other payment entity, and agree to be responsible for reasonable charges. By seeking treatment from BAY AREA ORTHOPAEDIC SPECIALISTS, LLC dba WAYPOINT ORTHOPAEDIC ASSOCIATES, you agree as follows:

1. To forego submission of claims to your health insurance for covered items or services.

2. To be responsible for payment of such items or services and understand that no reimbursement will be provided by your health insurance.

3. That no limitations on charges from health insurance fee schedules are applicable to amounts that may be charged for items and services provided.

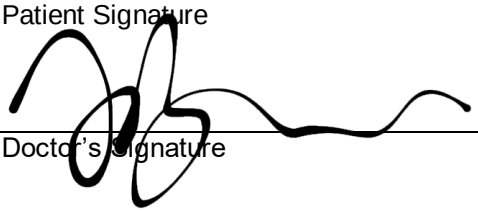
4. That Medigap plans and other supplemental insurance plans may elect not to make payments for such items and services because payment is not made from your primary health insurance.

5. That you have the right to have such items or services provided by other physicians or practitioners for whom payment would be made from health insurance.

Should surgery or extensive treatment be required, as a courtesy to you and for your convenience, we will obtain the necessary authorization through your health insurance should you request it. However, that does not constitute a waiver of this Agreement by PRIMACARE HEALTH, LLC. Also note that John L. Wheeler, ARNP-CS is not excluded from participation in the Medicare program under U.S.C. §1320a-7 of Title 42.

By signing this, you agree that you fully read and understand the contents of this Agreement.

Patient Signature _____ Date _____



Doctor's Signature

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Irrevocable Medical Lien Agreement

Patient Name: _____
Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Social Security Number: _____

I, _____ (the "Patient"), hereby acknowledge and agree that I am financially responsible for all medical services provided to me by BAY AREA ORTHPAEDIC SPECIALISTS, LLC dba WAYPOINT ORTHOPAEDIC ASSOCIATES ("Provider").

In consideration of the medical services rendered by the Provider, I agree as follows:

1. I understand and agree that I am personally responsible for any and all medical charges billed by the Practice for my treatment and that if at any time, I default on this obligation, I am subject to collection actions and/or civil litigation instituted by the Practice to recover the above medical debt. My obligation under this Agreement stand alone and are not subject to any other contingency or occurrences.
2. All treatment administered by the Provider is medically necessary medical care and treatment and billed me at their usual and customary rate.
3. I understand that the Provider may impose interest on any unpaid balance at the rate of 5% per annum, or the maximum rate allowed by Florida law, whichever is less.
4. I understand the Provider agrees to defer the collection any billing for medical care and treatment provided to me for 24 months without interest.
5. I agree that in the event I fail to make timely payments, the Provider may take necessary legal action to collect the outstanding balance, and I will be responsible for all costs and expenses incurred by the Provider, including reasonable attorney's fees and court costs.
6. I have received a copy of this signed agreement and had an opportunity to have this Agreement reviewed by my attorney

Effective Date and Cancellation: This Irrevocable Medical Lien Agreement shall come into full effect 72 hours after it has been signed by the Patient. The Patient may cancel this agreement within the 72-hour period by providing written notice to Waypoint Orthopaedic Associates. Such written notice must be received by the Provider before the 72-hour

period has elapsed at which time any unpaid portion for medical services shall become immediately due. If no written notice of cancellation is received within the 72-hour period, this agreement shall remain in full force and effect.

This Medical Lien Agreement is irrevocable and shall remain in effect until the Provider has received full payment for all medical services provided.

_____

Patient's Signature (or Legal Guardian if patient is a minor):

_____

Date:

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 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.**

_____

_____

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.

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

Name *(PRINT or TYPE)*	Signature	Date

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 hand**)*:

Dr. David T. Braun, MD		
Name *(PRINT or TYPE)*	Signature	Date

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.