WAYPOINT
ORTHOPAEDIC ASSOCIATES

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: _____

Emergency Contact: _____ Phone #: _____

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

Who is your chiropractor? ______________________________

Are you able to work? ☐ 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 -

Do you have health insurance? ☐ Yes ☐ No

Health Insurance Company: ______________________________

Name of Insured: ______________________________

Policy #: ______________________________

Group #: ______________________________

Name of Primary Care Doctor: ______________________________

Preferred Pharmacy: ______________________________

____

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

Check all that Apply:

☐ Constant ☐ Intermittent ☐ Worsening ☐ Improving ☐ Unchanged

☐ Pain ☐ Stiffness ☐ Swelling ☐ Instability ☐ Weakness ☐ Numbness/Tingling

What makes is worse?

What makes it better? _____

What previous formal treatment have you had for this problem? (Medications, Therapy, Surgery, Injections)

_____

PAST SURGICAL HISTORY

Previous Type of Operation	Year
1.	
2.	
3.	
4.	
5.	

Any previous fractures? ☐ Yes ☐ No Where? _____

DO YOU HAVE ANY DRUG ALLERIES? ☐ Yes ☐ No

If yes, name the drug and the reaction, please be specific (Example: rash, nausea, etc)

_____

_____

Current Meds: (List any medications you are currently taking, include items such as aspirin, vitamins, etc)			
Name Of Drugs	REASON FOR USE	DOSING INSTRUCTIONS (Strength & Frequency)	Start Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10			

(CONTINUE TO MEDICAL HISTORY)

MEDICAL HISTORY/REVIEW OF SYSTEMS					
	YES	NO		YES	NO
GENERAL			**CARDIOVASCULAR**		
Are you currently pregnant?			Chest Pain / Angina		
Diabetes - ☐ Type 1 ☐ Type 2			Heart Attack / Myocardial Infarction		
Stroke			Palpitations		
Kidney Disease			High Blood Pressure / Hypertension		
Ulcers			Shortness of Breath		
Asthma or Lung Disease			Swelling of Lower Extremities		
Canter: Type?			**HEMATOLOGIC**		
Fatigue			Anemia		
Weakness			Blood Clots		
Fevers			Bleeding Tendency		
Skin problems: Type:			Easily Bruised		
Rheumatic Fever			Circulatory Problems		
Tuberculosis			Currently on Blood Thinners		
Recent Weight Gain/Loss? How Much?			If Yes, what type?		
BLOODBORNE PATHOGENS			Phlebitis		
HIV / AIDS			**MUSCULOSKELETAL**		
Hepatitis			Joint Pain		
Other			Joint Swelling		
SITE OF INFECTION			Muscle Tenderness		
Urinary			Morning Stiffness		
Dental			Arthritis / Osteoarthritis		
Other			Rheumatoid Arthritis		
NEUROLOGICAL			Bone / Joint Infection		
Headaches			Gout		
Dizziness			**PSYCHOLOGICAL**		
Fainting			Depression		
Memory Loss			Anxiety Disorder		
Loss of Consciousness			Stress		
Muscle Spasm					
Numbness or Tingling Hands/Feet					
Blindness or Trouble Seeing					
Deafness or Trouble Hearing					
Seizures					

FAMILY HISTORY

Please check if any of your family (parents, siblings, grandparents) have a history of ay of the following:					
	YES	NO		YES	NO
Diabetes			Abnormal Bleeding Tendencies		
Heart Disease			Rheumatoid Arthritis		
Anesthetic Complications			Osteoarthritis		
Cancer: Type?			Gout		

SOCIAL HISTORY

Occupation: _____ Job Duties:

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed # of Children

Do you smoke? ☐ Yes ☐ No

If Yes, How may packers per day? _____ Year Started _____

Have you been counseled to quit or cut down? ☐ Yes ☐ No

If No, Former smoker? ☐ Yes ☐ No Year Started? _____ Year Quit? _____

Do you consume alcohol? ☐ Yes ☐ No If so, how many drinks per week? _____

PATIENT SIGNATURE: I, as the patient, state the information is correct and accurate to the best of my knowledge.

_____ Date: _____

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 to PATRICK J. MIXA M.D. P.A. 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, all fees for professional services rendered to me will be immediately due and payable.

_____**(Initials)**

Assignment of Benefits

I hereby assign from any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title and interest to PATRICK J. MIXA M.D. P.A. dba WAYPOINT ORTHOPAEDIC ASSOCIATES ("Assignee") for payment for services rendered unto me due to of accident or illness. In the event my insurance company fails to pay Assignee the full amount owing to Assignee after proper statutory notice, In the event my insurance company fails to pay Assignee the full amount owing to Assignee after proper statutory notice, I hereby also assign by this instrument all rights and causes of action in tort, in contract, and under 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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ORTHOPAEDIC ASSOCIATES

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 PATRICK J. MIXA M.D. P.A. 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.

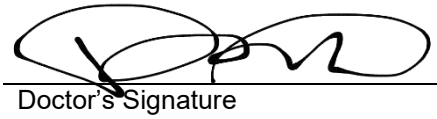
5. That you have the right to have such items or services provided by other physicians or practitioners for whom payment would be made from health insurance.

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 PATRICK J. MIXA M.D. P.A. dba WAYPOINT ORTHOPAEDIC ASSOCIATES. Also note that Dr. Patrick J. Mixa, MD 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 PATRICK J. MIXA M.D. P.A. 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 stands alone and is not subject to any other contingency or occurrences.
2. All treatment administered by the Provider is deemed medically necessary care and treatment and will be billed 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:

WAYPOINT
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PRESCRIPTION DRUG POLICY

Patient Name: _____ **DOB:** _____ **Date:** _____

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from Dr. Mixa, you are also accepting the responsibly to use the drug for yourself and only in the prescribed manner. Our responsibility is to prescribe medications in an appropriate dosage and amounts with clear instructions. We will also inform you of the reasons we are prescribing the drug, the expected benefits from its use, and the major precautions and side effects. We will answer any questions you may have about the prescription drug you are being given.

Prescription drugs have potential for abuse and are regulated closely by the state and federal agencies. Certain more closely controlled drugs (narcotic pain medications and tranquilizers) require even more responsibility on your part. We accept NO excuse for their loss or theft and will not order replacements. We will not prescribe them if you are using them other than exactly as prescribed or receiving them from another source. We expect you to notify our office if you change drug stores, so that the order at the first correct course of action.

Many prescription drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue on a medication, we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the course of action.

Our office also requires a 24-48 hour call-in policy for the refill of your prescription. When your medications are getting low and you feel you need a refill, please call our office with the name of your pharmacy and the pharmacy phone number. 24-48 hours prior so that we will have sufficient time to confirm your medication and then to call your prescription into your pharmacy.

Failure to follow these policies will force our office to terminate our professional relationship and may require us to file a report with the Department of Professional Regulations (DPR) or call the local police.

If you are in agreement with all the information that has been provided above, please sign your acceptance to abide by these policies.

I agree to the following guidelines:

1) I will take any medications only as prescribed and I will not change the amount or the frequency without authorization from my physician.
2) I understand that due to the high potential for abuse and these medications, the following rules apply: I will NOT be allowed to obtain early refills or receive replacement of lost or stolen medication. Refills will be provided during regular office hours.
3) If another provider prescribes additional medications, I will notify my primary care physicians as soon as possible.
4) I will submit to random urine or blood tests if requested by my physician to assess my compliance.
5) If I do not follow these guidelines, I understand my treatment may be terminated.

Patient Signature: _____ **Date:** _____

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Health Care Power of Attorney
Living Will Declaration

Patient Name: _____

Date of Birth: _____

I have completed a **Health Care Power or Attorney:** **Yes** _____ **NO** _____

I have completed a **Living Will Declation:** **Yes** _____ **NO** _____

Signature: _____ **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:

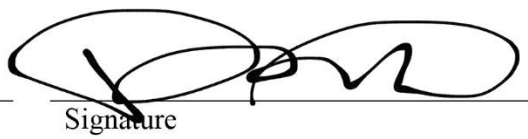
A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

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(14) and (15), 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**)*:

Patrick J. Mixa, 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.