Treasure Coast Orthopaedic Associates PA

1700 S.E. Hillmoor Drive, Suite 500
Port Saint Lucie, Florida 34952
Phone: 772.335.3200 Fax: 877.406.5592
William A. Stolzer, M.D. Paul J. Mondo, M.D.
Jeffrey Lazarus, M.D. Michele DiCarlo, PA

You have an appointment scheduled with our office.

The enclosed information is being supplied to every patient who accesses our services. We want to provide you with information both written and orally.

We attempt to call all patients prior to the day of your scheduled appointment. If we are unable to reach you, it is important for you to call us at 772-335-3200 to ensure your appointment time.

To expedite the check-in process, please fill out the attached paperwork in its entirety and bring with you to your scheduled appointment.

We also ask that you bring a photo identification card and one other proof of residency as we have to adhere to the "Red Flag Rules". You **MUST BRING YOUR INSURANCE CARD** for your first visit or we cannot see you. We will collect your copay and/or coinsurances and deductibles at the check-in window prior to your appointment.

If you have any prior x-rays, MRI scans, test results, or have seen another physician relating to the same issue and your appointment with us, we ask that you bring with you all notes and films .

If you are a current patient and are being asked to fill out these forms, please note that yearly updates/signatures are required by your insurance company. This is also for your protection and safety so that our physicians can provide you with optimum and efficient care.

We want to make your visit with us as comfortable and efficient as possible. If we can do anything to assist you at any time during your visit with us, please let us know.

Thank you for making Treasure Coast Orthopaedic Associates P.A. your provider of choice.

Doctors and Staff
Treasure Coast Orthopaedic Associates P.A.

If you have any questions or need to reschedule, cancel, or confirm an appointment, you may contact our office directly at **772-335-3200**.

You may visit our website at
www.treasurecoastorthopaedic.com

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REVIEWED BY DOCTOR:

APPT DATE:

PATIENT INFORMATION

Last Name: First: Middle: *Preferred Name | ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. | Date of Birth:

Race: ☐Decline to answer | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Sep ☐ Widow ☐ Significant Other | Hand Dominance: ☐ Right ☐ Left | Social Security #:

Preferred Language: | Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐Decline to answer | May we leave a message on your answering machine? ☐ Yes ☐ No

Mailing Address: | Home Phone # ☐Primary | Cell Phone #: ☐Primary

City: | State: | Zip Code: | Email Address:

Alternate Address: (Please provide dates)

Employer name: | Occupation: | Work Phone #:

Employer Address: | Employer city, state, zip | Retirement date:

Work Status: ☐ Working ☐ Not working ☐ Disabled ☐ Retired ☐ Student | Do you have a living will?

Primary Care Physician Name and location:

Pharmacy Name: | Pharmacy address or location: | Pharmacy Phone #:

Referred by (please check box): ☐ Dr. ____________________
☐ Insurance Plan ☐ Hospital ☐ Urgent Care Center ☐ Family ☐ Friend ☐ Yellow Pages ☐ Website ☐ Other

EMERGENCY CONTACT

Name and address: | Phone #: | Relationship to Patient:

INSURANCE

Primary Insurance: | Member/ID # | Co Pay $

Secondary Insurance: | Member/ID# | Co Pay $

Policy Holders Name: Address (if different than patient): | Date of Birth: | Home Phone #:

Is this person a patient here? ☐ Yes ☐ No | Social Security # of primary insurance holder: | Patient's relationship to primary insurance holder: ☐Self ☐Spouse ☐ Child ☐ Other

Is Medicare your PRIMARY Insurance? | Is Medicare your SECONDARY Insurance?

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: | Parent/Guardian Home Phone: | Parent/Guardian Cell #

Parent/Guardian Address: | Parent/Guardian City, State, Zip: | **Parent/Guardian Social Security #**

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FINANCIAL AGREEMENT / OFFICE POLICIES

CO-PAYMENTS AND BALANCES:

Co-payments, unpaid deductibles, co-insurance percentages, non-covered services and/or other outstanding balances are due at the time of check in, unless prior arrangements have been made with our Billing Department. This arrangement is part of your contract with your insurance company. Please note that our physicians are specialists and higher co-pays may apply. If you cannot pay your co-payment, unpaid deductibles, co-insurance percentages, non-covered services and/or other outstanding balances, you may have to reschedule your appointment.

FORM FEES:

If you require a particular form (ex: FMLA, Disability, AFLAC) to be completed by our physicians, there is a fee of $25 per form. This fee is to be paid prior to completion. Please allow adequate time, as every physician may not be in the office on a daily basis.

MEDICAL RECORD REQUESTS:

If copies of medical records are needed, the first patient request is no charge to the patient. All subsequent requests will be charged a fee of $1.00/page for the first 25 pages, and then it is $0.25/page from page 26 forward. If you need x- ray film copies for any reason, there is charge of $10/sheet. If you require they be mailed, there is an additional $5 postage fee. Please allow 48-72 hours for copies of records or films. Please be advised the original films must remain in our possession, as required by law, as they are a part of your permanent medical record.

PRESCRIPTION REFILL REQUESTS:

Prescription refill requests must be made Monday through Friday, 9:00 a.m. – 4:00 p.m. Please note that requests made after 4 p.m. will not be processed until the following business day. Please allow 48-72 hours to process your refill request, as every physician may not be in the office on a daily basis.

MEDICATION CONSENT:

I hereby authorize TCOA to access my medication list from Surescripts, which is a national database for prescription medications.

FOR SELF PAY PATIENTS:

A deposit of $350 is due at the time of check in, unless prior arrangements have been made with our Billing Department. Payment must be in the form of cash, Visa, MasterCard, Discover or money order. Personal checks are not accepted. All balances will be collected at time of check-in. If applicable, same-day refunds will be made if initial deposit is made with cash. All other refunds will be processed at the end of the month, with checks issued to Guarantor of Account.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize release of information necessary to file a claim with my insurance company, and I assign benefits, otherwise payable to me, to the doctor or group indicated on the claim. I understand that I am financially responsible for any balance not covered by insurance. A copy of my signature is as valid as the original. I understand and agree that health insurance policies are an arrangement between an INSURANCE CARRIER AND MYSELF (the insured).

GUARANTEE OF ACCOUNT:

This is to certify that I, the undersigned, promise to be responsible for the payment of all charges for services rendered to the named patient. I further understand that all applicable charges are due at the time services rendered excluding charges that my insurance company is contractually responsible for payment. When charges are filed with your insurance carrier and assignment of insurance benefits is accepted by our office, if the fees are not paid by insurance within 60 days, all fees become the patients' responsibility. If this account should require collection procedures, I, the undersigned, will be responsible for any charges associated with the collection process, including reasonable attorney's fees. I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. This assignment will remain in effect until revoked by me in writing.

Our office charges at fee of $25.00 for any returned check. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. A photocopy of this signature is valid as an original. I also authorize the physician to release all information necessary to secure payment.

Patient Signature	Date	Parent/Guardian Signature (if Minor)	Office Initials

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LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATIONS TO RELEASE INFORMATION

I. RELEASE OF INFORMATION – I, the below named, do hereby authorize any physician examining and/or treating me to release any third payer (such as insurance company or governmental agency -- Example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition, and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT – I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or any group and/or individual or surgical and /or medical benefits herein specified and otherwise payable to me for their services described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE -- Patient's certification/authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or it intermediaries or carriers any information needed for this or a related Medicare claim.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Patient Signature	Date	Parent/Guardian Signature (if Minor)	Office Initials

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We, at Treasure Coast Orthopaedic Associates PA, understand that medical information about you and your health is personal. As the custodians of your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures. Please understand that this is not our Notice of Privacy Practices, nor is it a substitute. The actual notice is available to you, as required by law. If you wish to keep a copy of our Privacy Practices, the receptionist will be happy to provide you with it. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient Signature	Date	Parent/Guardian Signature (if Minor)	Office Initials

RELEASE OF INFORMATION

I authorize Treasure Coast Orthopaedic Associates PA to disclose my protected health information **(medical records, prescriptions, appointment information, etc.)** to the following: *(For example: Primary Care Physician, Spouse, Family Member, etc.)*

Name (PRINT)	Relationship
Name (PRINT)	Relationship
Name (PRINT)	Relationship

❑ **Check the box ONLY if you decline to release your protected information to anyone.**

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HEALTH HISTORY QUESTIONNAIRE

DATE: ______________________________ REVIEWED BY DOCTOR: ____________________

Patient Name:		Age:	Sex: ☐ M ☐ F
Number of children: _______	Height: ______ Weight: _______	Blood Pressure: _____________(staff only)	

Reason for your visit today present problem: ____

How long have you had this problem? ________ Days ________ Weeks ________ Months ________ Years

If Accident, Date of Accident _______________ Occupation: ______________________________

If Injury, briefly describe how injured: ____

Is your injury work or auto related? ☐ Yes ☐ No If yes, date of injury: _________________

If work related, have you ever had any problems or injuries with this body part before? ☐ Yes ☐ No

Is your injury military related? Yes ☐ No ☐

If auto related, were you the driver? Yes ☐ No ☐

Was there a police report filed? Yes ☐ No ☐

What prior treatment have you had for this injury? Physical therapy ☐ Cortisone injection ☐ X-rays or MRI ☐

Circle a number from 0 to 10 that best describes your pain level:

No Pain **Distressing pain** **Unbearable pain**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What increases your pain? ____

What relieves your pain? ____

FAMILY MEDICAL HISTORY: Have any direct relatives had any of the following? If yes, indicate relationship		
☐ High Blood Pressure _______________	☐Arthritis ________________________	☐ Cancer____________________
☐ Stroke ________________________	☐Diabetes ________________________	
☐ Heart Attack____________________	☐ Blood Disorders ___________________	
Is your mother ☐ Living or ☐ Deceased Current Age: ________	Is your father ☐ Living or ☐ Deceased Current Age: ________	

CURRENT MEDICATIONS (Include OTC supplements and vitamins!)			
Name of Drug	Dosage (mg, mcg)	Frequency	Date Started

☐ I am not on any current medications, supplements, or vitamins

ALLERGIES/ADVERSE REACTIONS TO MEDICATION	
Name of Medication	Reaction

☐ I have no known allergies or adverse reactions to any medication.

SOCIAL HISTORY

Alcohol Use: ☐ None ☐ Socially ☐ Frequently ☐ Daily Drinks per ☐ day or ☐ week._____ Type:________________

Do you use any tobacco products?

☐ Never ☐ Former ☐ Current some days ☐ Current every day

Type of tobacco: ________________ Amount used: _________________________

Age Started: __________________ Age Stopped: _________________________

Highest Level of Completed Education

☐ Some High School ☐ High School Graduate

☐ Some College ☐ College Degree

☐ Master's Degree ☐ Doctoral Degree

List any hobbies that may be affected by your current injury or problem: ____

Rate your current health: ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

SURGERIES	
WHEN	TYPE OF SURGERY

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY

PLEASE CHECK IF APPLICABLE

ALLERGIC/IMMUNOLOGIIC	ENDOCRINE	GENERAL	MUSCULOSKELETAL	SKIN
☐ Animal Allergies	☐ Diabetes	☐ Breast Cancer	☐ Back pain	☐ Abrasion
☐ Food Allergies	☐ Dry Skin	☐ Chills	☐ Bursitis	☐ Discoloration
☐ Seasonal Allergies	☐ Excessive Hunger	☐ Depression	☐ Carpal Tunnel	☐ Eczema
☐ None	☐ Excessive Thirst	☐ Endometriosis	☐ Fibromyalgia	☐ Itching/Burning
	☐ Excessive Cold	☐ Fatigue	☐ Gout	☐ Psoriasis
CARDIOVASCULAR	☐ Hashimoto's Dis	☐ Fever	☐ Herniated Disc	☐ Rash
☐ Atrial Fibrillation	☐ Hypothyroidism	☐ Hair Loss	☐ Joint Stiffness	☐ Skin Cancer
☐ Chest Pain	☐ Parathyroid	☐ Night Sweats	☐ Joint Pain	☐ Skin Ulcers
☐ Heart Disease	☐ Prostate Cancer	☐ Sleep Apnea	☐ Joint Swelling	☐ Thin Skin
☐ Heart Stent	☐ Thyroid	☐ Swollen Glands	☐ Knee Pain	☐ Normal
☐ High Blood Pressure	☐ Weight Gain	☐ Weakness	☐ Leg Pain	
☐ Irregular Heat Beat	☐ Weight Loss	☐ Weight Change	☐ Muscle Cramps	URINARY
☐ Mitral Valve Prolapse	☐ Normal	☐ Normal	☐ Muscle Pain	☐ Bladder Dysfunction
☐ Murmur	EYES	HEMATOLOGIC	☐ Muscle Weakness	☐ Blood in Urine
☐ Prolapsed Valve	☐ Blurry Vision	☐ Anemia	☐ Neck Pain	☐ Burning
☐ Tachycardia	☐ Cataract	☐ Bleed/Bruise Easy	☐ Osteoarthritis	☐ Catheter
☐ Normal	☐ Double Vision	☐ Blood Clots	☐ Osteoporosis	☐ Difficult Urinating
DIGESTIVE	☐ Lens Implant	☐ Dialysis	☐ Rheumatoid Arthritis	☐ Kidney Infections
☐ Abdominal Pain	☐ Legally Blind	☐ Hemochromatosis	☐ RVE	NEUROLOGIC
☐ Acid Reflux	☐ Other:	☐ Low Platelets	☐ Sciatica	☐ Headaches
☐ Bloody Stools	IMMUNE ALLERGY	☐ Lyme Disease	☐ MRSA	☐ Lightheaded/Dizzy
☐ Bowel Disease	☐ HIV/AIDS	☐ Normal	☐ Normal	☐ Memory Loss
☐ Crohn's Disease	☐ Lupus	RESPIRATORY	EARS/NOSE/THROAT/MOUTH	☐ Stroke
☐ GERD	☐ Rashes	☐ COPD	☐ Hearing Aid	☐ Seizures
☐ Hepatitis A,B,C	☐ CVID	☐ Tuberculosis	☐ Ringing in Ears	☐ TIA
☐ Ulcerative Colitis	☐ Frequent Infection	☐ Pulmonary Fibrosis	☐ Tubes in Ears	☐ Numbness
☐ Diarrhea	☐ Swollen Glands	☐ Asthma	☐ Sinusitis	☐ Vertigo
☐ Heartburn	☐ Itching	☐ Sleep Apnea	☐ Loss of Hearing	☐ Tremors
☐ Bloating/Gas	☐ Hay Fever	☐ Oxygen	☐ Nose Bleeds	

PATIENT SIGNATURE (or representative): ______________________________

Thank you for taking the time to fill out this questionnaire. The information you present is vital to providing you with optimum and efficient care. Please ask if you need assistance in filling out this form.

WORKERS' COMPENSATION (To be completed by physician's staff)			
W/C Insurance Co Name			Date of Injury
Claims address	City	State	Zip
Employer at time of injury	Phone #		
Adjuster's Name	Phone #		
Name of person authorizing treatment	Phone #		
Claim #	Fax #		
Treatment authorized?	**X-Rays Authorized?**	**P/T Authorized?**	