ADVANCED ORTHOPEDICS INSTITUTE

Alfred J. Cook, Jr., M.D.
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Megan Benoit, FNP-C, APRN
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Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Secondary Address: _____

_____

Date of Birth: _____ SSN: _____ Sex: _____ Marital Status: _____

Are you: Retired? ☐ Student? ☐ Work Full time? ☐ Work Part time? ☐ Unemployed? ☐

Employer: _____ Employer's Phone: _____

Spouse Name: _____ Spouse DOB: _____

Spouse's Employer: _____ Employer's Phone: _____

Parent Name (if minor): _____ Parent SSN: _____ Parent DOB: _____

Parent's Employer: _____ Employer's Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Primary Insurance: _____ Subscriber Name: _____

Insurance Address: _____

Policy #: _____ Group#: _____

Secondary Insurance: _____ Subscriber Name: _____

Insurance Address: _____

Policy #: _____ Group#: _____

Who is your Primary Care Physician? _____

Who referred you to us? _____

Which pharmacy and location do you prefer? _____

Do you have allergies? ☐ Yes ☐ No

If yes, please list them: _____

IT IS OUR POLICY THAT ALL OFFICE VISITS AND OFFICE SERVICES ARE TO BE PAID FOR AT THE TIME THESE SERVICES ARE RENDERED.

HOW WILL YOU BE PAYING? ☐ Check ☐ Cash ☐ Charge

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, WHETHER OR NOT THEY ARE PAID FOR OR SUPPLEMENTED BY INSURANCE COMPANY.

New Beneficiary Signature Regulations in effect since April 1, 1992, allow physicians {or other suppliers in most cases) to obtain from the beneficiary and retain in their files, a lifetime signature authorization for the physician or supplier to submit assigned or unassigned claims on the beneficiary's behalf.
The beneficiary must sign a brief statement substantially as follows: "I request that payment for authorized Medicare benefits and any other insurance benefits be made either to me or on my behalf to Advanced Orthopedics Institute for any services furnished me by Advanced Orthopedics Institute. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services."

_____ _____

Signature of Patient or Responsible Party Date

ADVANCED ORTHOPEDICS INSTITUTE

Please fill out this form in its entirety.

PATIENT INFORMATION

Patient: _____ Date: _____

Date of Birth:_____ Height: _____ Weight: _____

Current Problem: _____

What are you being seen for today? _____

Date of injury or start of pain: _____

Is this work related? ☐ Yes ☐ No

Is this the result of a motor vehicle accident: ☐ Yes ☐ No

Pain Description

Severity of your pain? ☐ Mild ☐ Moderate ☐ Severe

Type of pain? ☐ Sharp ☐ Dull ☐ Other: _____

Social History

Do you smoke cigarettes? ☐ Current ☐ Former ☐ Never

How long have you smoked? ☐ >1 year ☐ 1-10 years ☐ 10+ years

How many packs per day? ☐ <1 pack ☐ 1-2 packs ☐ 3+ packs

Do you drink alcohol? ☐ Yes ☐ No

How many drinks? ☐ 1-2 per day ☐ 1-2 per week ☐ 1-2 per month

Do you have any history of: ☐ Anxiety ☐ Depression ☐ Drug/alcohol abuse

Family History

Mother:	☐ Cancer	☐ Heart Disease	☐ Stroke	☐ Arthritis	☐ Diabetes	☐ Osteoporosis
Father:	☐ Cancer	☐ Heart Disease	☐ Stroke	☐ Arthritis	☐ Diabetes	☐ Osteoporosis
Grandparents:	☐ Cancer	☐ Heart Disease	☐ Stroke	☐ Arthritis	☐ Diabetes	☐ Osteoporosis

Allergies (Please list all allergies and your reaction)

_____ _____

_____ _____

_____ _____

Medications (Please list name of medications and dosage) or ☐ See attached List (If you have a premade list)

_____ _____

_____ _____

_____ _____

Surgeries (Please list surgery type and year)

_____ _____

_____ _____

_____ _____

_____ _____

Patient Signature Date

ADVANCED ORTHOPEDICS INSTITUTE

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name: _____ Birth Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize Advanced Orthopedics Institute of 1400 North US Highway 441, Suite 552, The Villages, FL 32159 to disclose my protected health information to the following people: (Family, Friends, etc.)

_____ _____

_____ _____

_____ _____

Name Relation to patient

Information to be released:

_____ All
_____ X-ray Reports/MRI
_____ Laboratory Reports
_____ Allergy Records
_____ Medicare History, Examination Reports
_____ Surgical Reports
_____ Hospital Records including Reports
_____ Prescriptions
_____ Drug Abuse
_____ Other: (Please specify) _____

*A listing of the statutory exceptions to release of HIV test results without consent is available.

Purpose for Need of Disclosure:

_____✓_____ At the request of the individual

_____

_____

I understand that the health information disclosed, as a result of this authorization, may no longer be protected by the federal privacy standards and my health information might be disclosed without obtaining my authorization.

I understand that I have the right to:

Receive a copy of this authorization.

Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.

Revoke this authorization except to the extent that the person(s) and or organizations(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s):

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative (authority to act on patient's behalf): Relation to patient _____

ADVANCED ORTHOPEDICS INSTITUTE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I, _____ acknowledge that I have read a copy of Advanced Orthopedics Institute Notice of Privacy Practices. This notice describes how Advanced Orthopedics Institute may use and disclose my protected health information, utilize certain restrictions on the use and disclosure of my healthcare information, and upholds rights I may have regarding my protected health information.

I wish to be contacted in the following manner: (check all that apply)

_____ Home Phone:_____

_____ O.K. to leave message with detailed information

_____ Leave message with call-back number only

_____ Work Phone:_____

_____ O.K. to leave message with detailed information

_____ Leave message with call-back number only

_____ Written Communication

_____ O.K. to mail to my home address

_____ O.K. to mail to my work/office address

_____ O.K. to fax to this number

_____ Other: _____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birth Date

.....

For office use only

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to whom Address or fax number	1	Description of disclosure/ Purpose of disclosure	By whom disclosed	2	3

1. Check this box if the disclosure is authorized.
2. Type key: T=Treatment records; P=Payment information; O=Healthcare operations
3. Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the quality care and treatment of all of our patients. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

REGARDING INSURANCE

MEDICARE - We accept Medicare assignment. We also accept SOME Medicare Replacement plans. Please check with the Receptionist before seeing the doctor to make sure your Replacement plan is one that we accept. This means that we have agreed in contract to accept the fees and bill according to Medicare allowed amount. The patient is responsible for the annual deductible and 20% of the approved amount at the time of service except when there is a supplemental policy to pay these amounts.

MEDICAID - We do not accept Medicaid as a form of payment. If you have Medicaid as your healthcare coverage you will be responsible for the charges at the time services are rendered.

SHARE OF COST - It is our policy that the patient will be responsible for any charges incurred at the time of service. Upon payment, a receipt will be given with detailed charges that can be turned into the case worker for reimbursement.

PRIVATE INSURANCE - It is the patient's responsibility to verify with the receptionist that their insurance is one that we accept prior to seeing the doctor. Failure to do so will make the patient responsible for 100% of the charges incurred. All co-pays and deductibles are due at the time of service. In the event that there is a remaining balance on our account after insurance has paid, payment is due within 30 days of the insurance payment. If payments are not made within 30 days of the insurance payment, then the account will be submitted for collections. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between yourself and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the service provided may be non-covered services and not considered reasonable and necessary under your insurance policy contract.

REFERRAL/ AUTHORIZATIONS - Certain health insurances {HMO, POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider {PCP) before visiting a specialist. If your insurance company requires a referral and/ or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

SELF PAY - If you do not fall within any of the categories above we require FULL PAYMENT AT THE TIME OF SERVICE. You will be considered a Self-Pay patient and upon the first visit, a $400 CASH OR CREDIT CARD advance is required. We DO NOT ACCEPT checks for this. After the first visit you may pay by cash, check, Visa, Master Card, Discover, American Express, or CareCredit. Your cash advance will be held until you check out. At that time, you will be asked to pay the remaining balance, if applicable. Please be advised that the $400 cash advance is only an estimate and charges may either be less or more than $400 depending on the services received.

SURGERY PATIENTS - It is the patient's responsibility to check with our Financial Counselor PRIOR to surgery to make financial arrangements.

AUTO/WORKER'S COMP/THIRD PARTY - WE DO NOT ACCEPT ANY OF THESE INSURANCES. If you fall under any of these three categories, then you are considered a Self-Pay patient and are responsible for all charges at the time of service.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

For your convenience we accept CASH, CHECK, CREDIT, OR DEBIT CARDS. If necessary, and if you qualify, WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient's Name (please print) _____ Date _____

Patient or Responsible Party's Signature _____

ADVANCED
ORTHOPEDICS
INSTITUTE

Alfred J. Cook, Jr., M.D
Board Certified Orthopedic Surgeon
Specializing in Sports Medicine, Shoulder Surgery, and Cartilage Regeneration

John T. Williams, Jr., M.D.
Board Certified Orthopedic Surgeon
Specializing in Total Joint Replacement

Megan Benoit, FNP-C, APRN, RNFA

Heather Fleming, FNP-C, APRN, RNFA

PRESCRIPTION POLICY

This agreement between the Patient: _____ and Prescribing Advanced Orthopedics Institute Provider is for the purposes of establishing agreement on clear conditions for prescription and use of pain control medications prescribed by the Provider for this Patient. Provider and Patient agree that this document is essential in maintaining the trust and confidence necessary in a Provider-Patient relationship.

The patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Provider to the Patient.

I understand that the reduction in the intensity of my pain and the improvement in my quality of life are the goals for this medication.

I realize that all the medications have potential side effects and I will have any recommended laboratory studies required to keep the regimen as safe as possible.

I will not use any illegal controlled substances and I will not share, sell or trade any medication for money, goods or services. I will safeguard my medications from loss or theft and agree that the consequences of failure to do so is that I will be without my prescribed medication for some time.

I will not fill the prescription for pain medications from any other healthcare provider without telling them I am taking pain medication by the Provider. If another provider prescribes the pain medications for me, I will inform the Provider, in order to avoid duplication.

I agree that I will use my medication at a rate no greater than the prescribed rate, and that use of my medication at a greater rate will result in my being without medication for a period of time.

I agree to call and request a refill within 2 days of my medication running out.

Acknowledgment of Driving Impairment: I acknowledge that while I am under the care of my Provider, I may be prescribed medication that could impair my ability to operate a motor vehicle, machinery, or other equipment. I realize that it is my responsibility to keep myself and others safe from harm, including the safety of my driving. If there is a question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform such activity until my ability to perform said activity has been formally evaluated, or I have not used any medication for at least four days. As such, I will refrain from operating a motor vehicle under the influence of prescribed medication that impairs judgment. I will arrange for proper transportation and use the proper precautions when taking prescribed medications.

Provider and patient agree that this agreement is essential to the provider's ability to treat the patient's pain effectively and failure of the patient to abide by the terms of this agreement may result in the withdrawal of the prescribed medication.

Patient's Signature:_____ Date:_____ Witness: _____

ADVANCED
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APPOINTMENT CANCELLATION POLICY AGREEMENT:

Advanced Orthopedics Institute, PA is committed to providing exceptional care. Unfortunately, when one patient cancels or misses appointments without giving enough notice, they prevent another patient from being seen. Please call us at 352- 751-2862 by 2:00 p.m. on the business day prior to your scheduled appointment to notify us of any changes or cancellations. If your appointment is on Monday, the cut off time to provide notice is 2 pm on Friday. This gives the staff enough time to offer the appointment to another patient.

If timely prior notification is not given by you, you will be charged $50.00 for the missed/canceled appointment, which must be honored prior to rescheduling. In the event that you no show for the physician's visit on three (3) occasions, you may be dismissed from the practice.

By signing and dating below, you acknowledge and agree that you are consenting to these terms and to your personal financial liability for missed/canceled appointments.

Please sign below to consent to these terms.

Patient's Signature:_____

Print Name:_____ Date: _____

ADVANCED ORTHOPEDICS INSTITUTE

ACKNOWLEDGMENTS AND REPRESENTATIONS RELATED TO AUTO/ WORKERS' COMPENSATION/ THIRD PARTY INSURANCES

I, _____ ,
(PRINT Patient name)

Initial _____ I acknowledge and understand that Advanced Orthopedics Institute does **NOT** accept Auto, Workers' Compensation, or Third-Party Insurances.

Initial _____ I acknowledge and understand that Advanced Orthopedics Institute does **NOT** get involved with the treatment of problems where litigation is being or will be pursued.

Initial _____ I acknowledge that my current problem(s) for which treatment is sought is **NOT** covered by auto, worker's compensation, or third-party liability insurance(s).

Initial _____ I acknowledge my current problem(s) for which treatment is sought is **NOT** for any work-related injuries.

Initial _____ I have **NOT** been directed to Advanced Orthopedics Institute by my employer or its workers' compensation insurance carrier to treat the current problem(s)

Initial _____ My current problem(s) for which treatment is sought is **NOT** for auto-related injuries.

Initial _____ My current problem(s) for which treatment is sought is **NOT** the subject of any pending litigation.

Initial _____ An attorney has **NOT** been retained in anticipation of litigating the current problem(s) for which treatment is sought.

_____ _____
Patient or Person Authorized to Sign for Patient Date

_____ _____
Witness Date