Florida Joint Care Institute
2165 Little Road, Trinity, FL 34655
Phone (727)372-6637 Fax (727)375-5044
Dr. Jennifer Cook, Dr. Stephen Hanff, Dr. Aaron Mates, Dr. John Fuller, Dr. Rachel Dhani

Thank you for choosing Florida Joint Care Institute for your orthopedic needs. We have prepared a packet of information and forms to make your visit with us an efficient and pleasant experience. We ask that you complete the attached paperwork in its entirety and legibly.

When you come for your appointment please bring the following, without any of the following we will not be able to keep your scheduled appointment:

- ✓ Completed new patient paperwork
- ✓ Current Medical Insurance Cards (Medicare, primary provider, secondary provider, etc.)
- ✓ A complete list of ALL medications including strengths and dosage
- ✓ Photo ID: Driver's license or state issued ID
- ✓ X-Rays and MRI's. If you have any imaging pertaining to the body party our office will be treating, please be sure to bring those with you. You must also bring a paper copy of the report. We must have that in order to use the information from the image.

Please be prepared to pay via credit/debit card or cash for the following at the time of your visit:

- ✓ Co-payments. If your insurance requires co-payment you are responsible for this at the time of your appointment.
- ✓ Co-insurance and deductible. If your insurance requires a co-insurance or deductible, you are responsible for that at the time of your appointment.
- ✓ If you do not have insurance, payment will be collected at time of service.

Referrals/Authorizations: Most insurance requires referral/authorization from your primary care physician.

Please be sure to contact your primary care physician and let them know that they will need to fax the referral/authorization to (727)372-6637 at least 48 hours prior to your appointment. Without this referral/authorization 48-hours prior to your appointment, we will need to reschedule you. If you do not have a primary care physician and your insurance requires a primary care physician referral, you will need to establish with a primary care physician before we will be authorized to see you.

Please be sure to check-in 15 minutes prior to you scheduled appointment time to allow our staff to complete the administrative portion of your appointment.
No show fee of $25 is assessed if a patient does not call 24-hours in advance to cancel an appointment.

History and Intake Form

Last Name: _____ First Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (night): _____

Email Address: _____ Occupation / Workplace: _____

Emergency Contact (name): _____ Emergency Contact (number): _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Primary Care Provider: _____ ***Referring Physician:*** _____

Preferred Pharmacy

(Primary - *default*)

Name: _____

Phone Number: _____

City or Zip Code: _____

(Secondary – *if applicable*)

Name: _____

Phone Number: _____

City or Zip Code: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ None
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Cerebrovascular accident
- ☐ Chronic Anemia
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Deep Venous Thrombosis (Blood Clot)
- ☐ Depressive Disorders
- ☐ Diabetic on *Insulin*
- ☐ End Stage Renal Disease
- ☐ H/O: hypertension
- ☐
- ☐ Human immunodeficiency virus infection
- ☐ Hypothyriodism
- ☐ Inflammatory disease of the liver
- ☐ Leukemia
- ☐ Malignant Lymphoma
- ☐ Malignant tumor of the breast
- ☐ Malignant tumor of the colon
- ☐ Malignant tumor of the lung
- ☐ Malignant tumor of the prostate
- ☐ Obstructive sleep apnea syndrome
- ☐ Primary fibromyalgia syndrome
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- Type 2 diabetes mellitus
- ☐ Other

_____

_____

_____

_____

History and Intake Form

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ None
- ☐ Bypass of stomach
- ☐ Heart: Coronary artery bypass graft
- ☐ Excision of basal carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ History of appendectomy
- ☐ History of cholecystectomy
- ☐ History of colectomy
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissue graft heart valve replacement
- ☐ Hysterectomy
- ☐ Lumpectomy of breast
- ☐ Mastectomy or left breast
- ☐ Mastectomy or right breast
- ☐ Mechanical heart valve replacement
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Tonsillectomy
- ☐ Uterus: Total Hysterectomy
- ☐ NONE
- ☐ Other

_____

_____

_____

History and Intake Form

Orthopedic History

Have you had any of the following?

- ☐ Adhesive Capsulitis of shoulder
- ☐ Ankylosing Spondylitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Complex regional pain syndrome
- ☐ History of osteoporosis
- ☐ Left-handed
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Primary gout
- ☐ Psoriasis with arthropathy
- ☐ Right-handed
- ☐ Sarcoma of bone
- ☐ Sarcoma of soft tissue
- ☐ Sciatica
- ☐ Secondary malignant neoplasm of bone
- ☐ NONE
- ☐ Other

_____
_____
_____
_____

Orthopedic Surgical History

Have you had any of the following?

- ☐ Arthroplasty of the carpometacarpal joint of the thumb
- ☐ Decompression of the lumbar spine
- ☐ History of arthroplasty of left knee
- ☐ History of arthroplasty right knee
- ☐ History of arthroscopy of knee joint
- ☐ History of repair of musculotendinous cuff of shoulder
- ☐ Lumbar spinal fusion
- ☐ Prosthetic arthroplasty of left hip
- ☐ Prosthetic arthroplasty of right hip
- ☐ Reconstruction of anterior cruciate ligament of the knee joint
- ☐ Release of trigger finger
- ☐ Repair of tendo achilles
- ☐ Total shoulder replacement
- ☐ Meniscus Repair
- ☐ Reverse Total Shoulder Replace
- ☐ NONE
- ☐ Other

_____
_____

History and Intake Form

Orthopedic Family History

Is there a history of any of the following? (*Immediate family

- ☐ Charcot Marie Tooth Disease
- ☐ Diabetes
- ☐ Hypertension
- ☐ Multiple Hereditary Exostosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ NONE
- ☐ Other _____

Medications

Please list ALL current medications *(or check the box if it applies)*

☐ *Currently not taking any medication(s)*

Medication	Dosage	Frequency

History and Intake Form

Allergies

Please list ALL known allergies *(or check the box if it applies)*

☐ *No Known Allergies (NKA)*

Using the following options, describe your reaction(s) with severity provided below

Reaction Types			Severity Scale
Anaphylaxis	Angioedema	Diarrhea	Mild
Dizziness	Fatigue	GI upset	Mild to Moderate
Hives	Liver toxicity	Nausea	Moderate
Rash	Shortness of breath	Swelling	Moderate to Severe
Weal	Other: (specify)		Severe
			Fatal

Allergy	Reaction(s)	Severity
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____
4.) _____	_____	_____
5.) _____	_____	_____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Exercise Frequency (please choose one):

- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

History and Intake Form

Review of Systems

Alerts

Please check yes for the following if it applies:

Symptom	Yes
Fever or Chills	
Rash	
Visual Changes	
Neck or Back Pain	
Nausea or Vomiting	
Constipation	
Painful Urination	
Frequent Urination	
Numbness or Tingling	
Anxiety	
Depression	
Weight loss	
Abnormal Bleeding	

Alert	Yes
Pacemaker	
Blood thinners	
Defibrillator	
Premedication prior to procedures	
Rheumatoid Arthritis	
RSD	
Allergy to shellfish/iodine	
Allergy to latex	
Allergy to adhesive	
Under pain management	

Florida Joint Care Institute Patient Name_____

Authorization and Assignment

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in above information.

I request that the payment of authorized Medicare/insurance benefits be made to me or on my behalf for any services furnished by Florida Joint Care Institute. I authorize any holder of medical information about me to release to CMS (Medicare)/insurance carriers and its agents any information needed to determine these benefits for services rendered.

I hereby authorize Florida Joint Care Institute to furnish information to CMS (Medicare)/insurance carriers concerning my medical condition, illness, and treatment to determine the benefits for services rendered. I hereby authorize (assign) my insurance carrier(s)/CMS (Medicare) to make payment directly to Florida Joint Care Institute for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of the professional services rendered. I understand that CMS (Medicare) and/or other insurance carriers do not cover all office services/procedures, and I agree to take full responsibility for any unpaid balances, and that such payment will be made to this physician's office for services rendered.

Signature _____ Date _____

Permission for Treatment

I, the undersigned, hereby voluntarily consent to medical/diagnostic treatment and or minor surgical treatment (for example: Cortisone injections) by Florida Joint Care Institute that is deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and therefore acknowledge that no guarantees have been made to me as a result of treatment or examination in the office of Florida Joint Care Institute.

Signature _____ Date _____

Doctor-Patient Arbitration Agreement

This agreement is made between Florida Joint Care Institute, including Jennifer L. Cook, M.D., Stephen A. Hanff M.D., Aaron K. Mates M.D., John B. Fuller M.D., Rachel S. Dhani M.D., their agents, employees, servants, or any of the foregoing,referred to hereafter as "Physician," and _____ (patient's name), referred to hereinafter as the "Patient." It is the intention of the parties of the agreement to bind themselves, their heirs, personal representatives, guardians, or any person deriving their claims through or on behalf of the patient.

It is understood by the patient that he or she is not required to use any of the Physicians named for orthopedic care, treatment, and surgery, and that numerous other physicians in the state of Florida and West Central Florida are qualified to perform orthopedic care, treatment, and surgery.

It is further understood that in the event of any controversy, dispute, or claim which might arise between the Physician and Patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682 of the Florida Statutes. The arbitration shall be binding and shall be in lieu of and instead of any trial by judge or jury. Each party shall be entitled to the discovery provided for in rule 1.280 of the Florida Rules of Civil Procedure. The panel or arbitrator shall hear and decide the controversy, dispute, or claim, and the decision shall be binding on all parties.

The agreement shall remain in effect for all treatment and surgery provided for the patient presently and at any further date.

Signature _____ Date _____

Medical Assignment of Benefits, Authorization for Treatment and Payment Responsibility

1) The undersigned hereby authorizes Florida Joint Care Institute ("Provider") to render treatment to Patient. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of services.
2) The undersigned hereby certifies that all information provided by the undersigned or Patient, including any information in connection with applying for payment under title XVIII of the Social Security Act, is true and accurate in all respects.
3) The undersigned hereby authorizes Provider to disclose any information furnished to Provider or obtained by Provider in connection with the Patient's treatment (including information concerning a related Medicare Claim) to insurance company or health care facility requesting such information.
4) The undersigned hereby assigns to Provider all Medicare benefits to which Patient may be entitled for any services rendered by Provider. In addition, the undersigned approves contact with appropriate family members for medical claims management purposes.
5) The undersigned hereby assigns to Provider all private medical insurance benefits (primary and secondary, including medigap Providers) or other benefits to which Patient may be entitled for any services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file all such benefits on behalf of Patient.
6) The undersigned hereby agrees that the undersigned shall be ultimately financially responsible for any portion of Provider's claim that is not paid. The undersigned understands that Medicare or any Health Maintenance Organization (HMO) may deny some charges that the Physician deems necessary. Medicare and other HMO's have been denying payment for some soft goods and services (braces, cast shoes, finger splints, arm slings, elastic bandages, ace wraps, injections, x-rays, fracture treatment, office visits, casting materials and certain blood tests conducted on an outpatient basis). The undersigned agrees to be responsible for payment of these charges should they be denied for payment. Payment of your account is your responsibility regardless of your insurance coverage.
7) The undersigned and Patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned and Patient warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms, or court orders appointing the undersigned as legal guardian of Patient.
8) The undersigned agrees that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; however, the above-mentioned paragraphs 2, 4, 5, and 6 shall survive any such termination.
9) The undersigned grants permission for the Provider to treat the undersigned and/or minor child and/or dependent. If Patient is a minor, the parent/guardian must be present at the time of the visit.
10) The undersigned agrees that treatment by the Provider will not be construed as willingness on the part of the Provider to be a witness in a personal injury ligation case.
11) The undersigned understands that confabulation or fabrication either by commission or omission will be sufficient reason for unilateral discontinuation of treatment and cancellation of any contract either expressed or implied.
12) The undersigned agrees that x-rays and laboratory tests are the property of the Provider and the fees charged for these services are for processing and interpretation. These records or their copies will be released at the discretion of the Provider. A nominal fee may be charged to cover additional expense for their release.
13) The undersigned acknowledges that he/she has received a copy of the Florida Joint Care Institute Privacy Notice (HIPPA Privacy Notice).

Signature _____ Date _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your Rights	**Your Choices**
You have the right to: • Get a copy of your paper or electronic medical record • Correct your paper or electronic medical record • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Get a copy of this privacy notice • Choose someone to act for you • File a complaint if your privacy rights have been violated	You have some choices in the way that we use and share information as we: • Tell family and friends about your condition • Provide disaster relief • Include you in a hospital directory • Provide mental health care • Market our services and sell your information • Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record

• You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.

• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Choose someone to act for you

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care

• Share information in a disaster relief situation

If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

• Marketing purposes

• Most sharing of psychotherapy notes

• Sale of your information

In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use/share health information in the following ways.

• We can use your health information and share it with other professionals who are treating you.

• We can use and share your health information to run our practice, improve your care, and contact you when necessary.

• We can use and share your health information to bill and get payment from health plans or other entities.

• Electronic Exchange: Your information may be shared with other providers, labs and radiology groups through our EHR system as listed:

None

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. **For more information go to: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**
We can use or share health information about you:
- To help with public health and safety issues, such as:
  Preventing disease
  Preventing or reducing a serious threat to anyone's health or safety
  Helping with product recalls
  Reporting suspected abuse, neglect, or domestic violence
  Reporting adverse reactions to medications
- To do research.
- To comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- To respond to organ and tissue donation requests.
- To work with a medical examiner or funeral director.
- To respond to lawsuits and legal actions

To address governmental agency requests we can use or share health information about you:
For workers' compensation claims
For law enforcement purposes or with a law enforcement official
With health oversight agencies for activities authorized by law
For special government functions as military, national security, and presidential protective services

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information go to: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you.
The new notice will be available upon request, in our office, and on our website.

You Have A Right To File A Complaint If You Feel Your Privacy Has Been Violated

If you feel your Privacy Rights have been violated,
- Please ask our staff for a Privacy Complaint Form. Our Compliance Officer will review the form and promptly notify you of the actions our office will take.
- Or you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

We will not retaliate against you for filing a complaint.

Florida Joint Care Institute

HIPAA Compliance Officer: Kerri OBrien
Phone: 727-372-6637 ext. 405

This Notice of Privacy Practices is effective September 13, 2018

Get a copy of this privacy notice from our office. You can ask for a paper copy of this notice at any time.