SOUTH FLORIDA
SPINE AND ORTHOPEDICS

Welcome to South Florida Spine and Orthopedics
Non-Spine New Patient Legal/Work Compensation Packet

Patient Initial: _____

SOUTH FLORIDA
SPINE AND ORTHOPEDICS

Patient Full Name: _____ **Date of Birth:** _____
Age: _____ **Sex: Male/Female Height:** _____ **Weight:** _____ **Dominant Hand: L/R**
Street: _____ **Apt. #** _____
City: _____ **State:** _____ **Zip Code:**_____
Phone Number: _____**Email:**_____
Race: ◯Caucasian ◯African American ◯Asian ◯Other:
_____
Ethnicity: ◯Non-Hispanic ◯Hispanic ◯Unknown
Preferred Language: English / Spanish / Chinese / Other: _____
Pharmacy Name: _____ **Location:** _____ **Phone Number:**_____
Primary Care Physician Name: _____ **Phone Number:**_____
Address:_____ **Fax Number:**_____
Referring Physicians Name: _____ **Phone Number:** _____
Is your problem related to an auto accident? ◯Yes Date of Accident: _____ **◯No**
Is your problem related to a work accident? ◯Yes Date of Accident: _____ **◯No**
Emergency Contact Information:
Contact Full Name: _____
Relationship to Patient:_____ **Phone Number:**_____
Spouse's Name (if applicable): _____ **Phone Number:** _____

Reason for visit: _____ **Left / Right / Bilateral**
List Contributing events or known causes: _____
_____
_____
_____

Please describe the onset of symptoms by choosing ONE item below:
◯No Injury - gradual onset of symptoms Symptoms began (# of) _____ **days / weeks / months**
◯Work Injury on _____ **(date of injury)**
◯Motor Vehicle Accident on _____ **(date of accident)**
◯Other injury on _____ **(date of injury)**
Please Explain: _____
_____
_____
Do your symptoms include pain? Yes / No

On a scale 0-10 (10 is the worst) how severe is your pain?
◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10
Frequency of Pain: ◯Constant ◯Intermittent (comes & goes) ◯Progressive ◯Not Progressive
Describe your Pain: ◯Sharp ◯Dull ◯Stabbing ◯Burning
Do symptoms Include:
◯Swelling ◯Weakness ◯Numbness ◯Decreased Range of Motion ◯Pins / Needles Sensation
Since the problem started, it is: ◯Getting Better ◯Getting Worse ◯Unchanged
Do you have difficulty: ◯Crossing your legs ◯Putting on socks & shoes ◯Getting in/out of the car ◯Getting up or down stairs
How far can you walk before you notice pain? _____
If applicable, is the joint: ◯Popping ◯Locking ◯Clicking ◯Instability/Giving Way ◯Bending
I am NOT able to perform the following activities of daily living (select all that apply)
◯Doing yard work or shopping ◯Performing household chores ◯Going to work
◯Socializing with friends ◯Participating in recreational activities ◯Exercising
Past Treatment of your current problem: (select all that apply)
◯Ice Treatment ◯Physical Therapy ◯Heat Therapy ◯Prescription Medication ◯Use of cane or walker ◯Injections # _____ ◯Rest for How Long? _____ ◯Anti-Inflammatories: Advil, Motrin, Aleve

Past Medical History

Current Medications:
◯No Medications
◯Currently Taking Medications

Medication Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

Allergies (not seasonal): ◯No known allergies
◯Penicillin ◯Aspirin ◯Codeine ◯Tylenol ◯Iodine ◯Sulfur ◯Shellfish ◯Latex Allergy
◯Adhesive Tape ◯Other: _____

Diagnosed Conditions:

Have you ever been diagnosed with any of the following? ◯None

◯Alcoholism	◯Diabetes Type:_____	◯ Kidney Disease
◯Arthritis	◯GERD	◯Liver Disease
◯Anemia	◯GI Disorders	◯Neurological Disorders
◯Blood Clots	◯Heart Disease Specify: _____	◯Osteoporosis
◯Blood Transfusion	◯Hepatitis Type: _____	◯Pacemaker
◯Bronchitis	◯Herna	◯Renal Disease
◯Cancer	◯High Blood Pressure	◯Rheumatoid Arthritis
◯COPD	◯High Cholesterol	◯Thyroid Disease
	◯HIV AIDS	◯Stroke

◯Other: _____

Are you pregnant? ◯Yes ◯No **Are you claustrophobic?** ◯Yes ◯No

Past Surgical History:

◯Appendectomy	◯D&C	◯Neck Surgery
◯Arthroscopy	◯Gallbladder Surgery	◯Pacemaker
◯Back Surgery	◯Heart Bypass	◯Prostate Surgery
◯Breast Surgery	◯Heart Valve Replacement	◯Skin Cancer
◯Cataract Surgery	◯Hernia Repair	◯Tonsillectomy
◯Carpal Tunnel	◯Hysterectomy	
◯Cesarean Section	◯Kidney Surgery	

◯Joint Replacement (specify joint): _____

◯Other Surgeries: _____

Patient Initial: _____

Review of Systems

Have you had any of the following problems in the past 6 months?

1. GI	◯Heartburn, Ulcers	◯Nausea, Vomiting	◯Blood in stool		◯None
2. ENDO	◯Thyroid Disease	◯Heart or Cold Intolerance			◯None
3. CON	◯Weight Loss	◯Loss of Appetite	◯Fatigue		◯None
4. EYE	◯Blurred Vision	◯Double Vision	◯Vision Loss		◯None
5. ENT	◯Hearing Loss	◯Hoarseness	◯Trouble Swallowing		◯None
6. CV	◯Chest Pain	◯Palpitations			◯None
7. RS	◯Chronic Cough	◯Pneumonia	◯Shortness of Breath		◯None
8. GU	◯Painful Urination	◯Blood in Urine	◯Kidney Problems		◯None
9. SK	◯Frequent Rashes	◯Skin Ulcers	◯Lumps	◯Psoriasis	◯None
10. NEU	◯Headaches	◯Dizziness	◯Seizures	◯Numbness	◯None
11. PSY	◯Depression/Anxiety	◯Drug/Alcohol Addiction	◯Sleep Disorder		◯None
12. HEM	◯Easy Bleeding	◯Easy Bruising	◯Anemia		◯None

Comments: _____

_____

_____

Family History

Have any direct relative had any of the following disorders?

Father: ◯Diabetes ◯Anesthesia Problems ◯High Blood Pressure ◯Bleeding Problems ◯Rheumatoid Arthritis ◯None

Mother: ◯Diabetes ◯Anesthesia Problems ◯High Blood Pressure ◯Bleeding Problems ◯Rheumatoid Arthritis ◯None

Sibling: ◯Diabetes ◯Anesthesia Problems ◯High Blood Pressure ◯Bleeding Problems ◯Rheumatoid Arthritis ◯None

Social History

Smoking Status:

◯Current everyday smoker #____ packs ◯Occasional smoker #____packs

◯Previous Smoker ◯Never Smoked

Alcohol Use: ◯Social ◯Frequent ◯None

Marital History: ◯Married ◯Single ◯Divorced ◯Widowed

Are you currently working? ◯Yes ◯Part-Time ◯Full-Time ◯No ◯Retired ◯Disabled

Occupation: _____ Employer: _____ ◯Student

Patient Initial: _____

Scheduling Policies For All Appointments and Procedures

In an effort to make the schedule accessible to all of our patients, we appreciate a 24 hour notice for cancellations and rescheduling of all appointments and procedures. Please be advised the failure to comply with this scheduling policy may result in a $25.00 fee. Please be advised that this policy includes not showing up.

Additional Information

- I understand that co-payments, co-insurance and deductibles are my responsibility and are due at each visit.
- I understand that regardless of my insurance coverage, any charges that are not covered during my treatment are my responsibility and are due upon receipt of statements.
- I authorize South Florida Spine and Orthopedics, LLC to release information regarding my condition to my insurance company, referring physician or attorney.
- I authorize all diagnostic facilities and other treating physician's offices to release my records to South Florida Spine and Orthopedics, LLC.

Only Complete the Section Below if the Patient is a Minor

Insurance Company: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____ Social Security Number _____

Patient Initial: _____

SOUTH FLORIDA
SPINE AND ORTHOPEDICS

Letter of Protection (page 1)

Patient Full Name: _____ **Date of Birth:** _____

I hereby authorize and direct my attorney to pay directly to South Florida Spine and Orthopedics, all sums due and owing for any and all services by, or through, South Florida Spine and Orthopedics and/or for any monies owed, including, but not limited to: monies owed for medical services, reports, records requests, billing requests, depositions, or time spent as an expert witness in any matter related to the patient, etc. Specifically, I instruct and authorize my attorney to withhold all such sums from any insurance settlement, judgment, verdict, or any other source as may be necessary, to adequately and fully protect South Florida Spine and Orthopedics on any and all amounts that may be owed in connection with any services provided South Florida Spine and Orthopedics or their employees/agents.

I fully understand that I am personally and fully responsible to South Florida Spine and Orthopedics for all services rendered. I further understand that this agreement is made solely for the additional protection of South Florida Spine and Orthopedics and in consideration of South Florida Spine and Orthopedics awaiting payment. I understand that nothing herein releases me of the primary responsibility and obligation of paying South Florida Spine and Orthopedics in full for services rendered and/or provided. In addition, I understand and agree that, at the sole discretion of South Florida Spine and Orthopedics, that South Florida Spine and Orthopedics, the patient, or the patients attorney will not bill, or bill on the behalf of, South Florida Spine and Orthopedics my medical insurance, including HMO or any other health/medical plan without explicit written permission provided by South Florida Spine and Orthopedics. I further understand that my obligation of payment to South Florida Spine and Orthopedics is not contingent on any settlement, judgment or verdict related to any matter, or any other pending insurance payment(s).

Both my attorney and I agree to keep South Florida Spine and Orthopedics apprised of the names and addresses of all attorneys who represent me. Notification of any changes must be made to South Florida Spine and Orthopedics within ten (10) days of any change of representation or personal contact information. I also understand that if my attorney does not wish to cooperate in protecting South Florida Spine and Orthopedics South Florida Spine and Orthopedics will not await payment but, may require me to immediately pay for any and all services rendered.
In addition, I further agree that any and all charges for medical reports, review of records, independent medical evaluations, depositions, conferences, expert testimony, and photocopying are not charges payable on a contingent basis and that my attorney(s) and I are fully responsible for these charges.

Patient Initial: _____

Continued Letter of Protection (page 2)

In the event any dispute arises between South Florida Spine and Orthopedics any myself as to the charge or billing of any services provided by or through South Florida Spine and Orthopedics, I hereby authorize, instruct and direct by attorney to withhold the full amount owed to South Florida Spine and Orthopedics until the matter is settled by compromise, settlement, or judgment. If a dispute arises, payout will be made only upon agreement of all parties or court order. In the event of a dispute, I also agree that I shall be responsible for all attorney's fees and costs of collection to East Coast Orthopedics. As a material condition of services rendered by South Florida Spine and Orthopedics to the patient, I hereby agree and instruct my attorney(s) to maintain all monies/funds in the attorney's trust account to protect South Florida Spine and Orthopedics for any and all services rendered.

The undersigned agree to notify South Florida Spine and Orthopedics in writing within ten (10) days, if the above-named patient changes the attorney record. Lastly, the undersigned agree that any action brought on account of, or related to, any matter set forth above must be brought in the Circuit Court in and for Broward County, Florida.
South Florida Spine and Orthopedics will not transfer, sell or outsource this account to a 3rd party collection agency as long as this signed Letter of Protection remains in force by all parties.

I have read and understand the terms of this agreement and have been notified of the fees and/or costs associated with the services provided by, or through, South Florida Spine and Orthopedics.

Patient Full Name: _____
Patient Signature: _____ Date: _____

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all the terms above and agree to withhold such sums from any payment, settlement, judgment or verdict as maybe necessary to adequately and fully protect South Florida Spine and Orthopedics. I, the undersigned, also hereby agree and acknowledge that I shall observe and protect all the terms outlined herein.

Attorney Name: _____
Attorney Signature:_____ Date: _____

Patient Initial: _____

SOUTH FLORIDA
SPINE AND ORTHOPEDICS

Auto Accident Form

Date of Birth:_____ Social Security Number: _____
Patient Full Name: _____ Patient Phone Number: _____

Attorney Name: _____
Attorney Address: _____
Attorney Phone: _____ Attorney Fax: _____

Date of Accident: _____
Auto. Insurance Company: _____
PIP Exhausted: ◯Yes ◯No Deductible: _____
Policy Number: _____ Claim Number: _____
Were you wearing a seatbelt at the time of the accident? ◯Yes ◯No
Did the airbags go off in the vehicle you were in? ◯Yes ◯No
Were you evaluated by Emergency Medical Services? ◯Yes ◯No
Were you taken to the hospital by Emergency Medical Services? ◯Yes ◯No
If so, which hospital: _____

Adjuster Name: _____ Adjuster Number: _____
Claim Address: _____ Fax Number: _____

Health Insurance Company: _____
I.D. Number: _____ Benefits: _____
Address: _____

This document shall serve as formal notice to the insurer that the first examination of treatment of the claimant has occurred. While Florida Stature 627.736 requires medical providers to submit bills to insurance companies within 35 days of treatment, subsection (5)(c) allows medical providers to submit bills within 75 days of treatment if this notice is provided within 21 days of the first examination of treatment. Any deficiencies to this notice are deemed waived if they are not specifically objected to in writing before the 21-day window expires.

Patient Initial: _____

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SPINE AND ORTHOPEDICS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____ Date: _____

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.
Signature: _____ Date: _____

SECTION B: To the Patient - Please read the following statements carefully

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

Right to Revoke. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.
Consent To Release to:
Name: _____ Relationship:_____
Name: _____ Relationship:_____

Patient Initial: _____

SOUTH FLORIDA
SPINE AND ORTHOPEDICS

Telemedicine Informed Consent

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing, and/or referring the patient to in-person care, as determined clinically appropriate.
This **"Telehealth Informed Consent"** informed the patient **"you,"** or **"your"**) concerning the treatment methods, risk, and limitations of using a telehealth platform.

Services Provided:
Telehealth services offered by South Florida Spine and Orthopedic or John P. Malloy, IV DO (**"Practice"**), and the Practice's engaged providers (our "Providers" or your Provider") may include a patient consultation, diagnosis, treatment recommendation, prescription and/or a referral to in-person care, as determined clinically appropriate (the **"Services"**). Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law.

Electronic Transmissions:
The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling;
- Completion of medical intake forms;
- Engage in review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results via asynchronous communication;
- Two-way interactive audio in combination with store-and-forward communications between you and your Provider;
- Two-way interactive audio-video interaction between you and your Provider;
- Review and treatment recommendations by your Provider based upon output data from medical devices and sound and audio files;
- Delivery of a consultation report; and/or
- Other electronic transmissions for the purpose of rendering clinical care to you.

Expected Benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available 3-5 hours a day, 5 days a week.
- Easy access for follow-up care. If you need to receive non-emergent follow care related to your treatment, please contact your Provider by phone.
- More efficient care evaluation and management Messages will be returned within the next 24-48 business hours.

Patient Initial: _____

Service Limitations:

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **OUR MEDICAL PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. DO NOT ATTEMPT TO CONTACT South Florida Spine and Orthopedic or John P. Malloy, IV DO, OR YOUR PROVIDER AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE DOCTOR.**
- If it is determined during the initial screening of the telehealth visit that you should be seen in person either in your Provider's office or in a recommended facility, you will not be charged for the telehealth visit. Appropriate emergency questions will be asked at the beginning of the telehealth visit that will determine what will be the best place for you to receive care.

Security Measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data in to ensure its integrity against intentional or unintentional corruption. All the services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Practice at 954-500-4554.
- The quality of transmitted data may affect the quality of services provided by your Provider. Changes in the environment and test conditions could be impossible to make during delivery of telehealth services.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other clinical judgment errors.

Patient Initial: _____

Patient Acknowledgements:
By checking the box associated with "Telehealth Informed Consent," you acknowledge that you understand and agree to the contents above and further agree with the following:

1. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that our Providers are not able to connect me directly to any local emergency services.
2. I acknowledge that I have been given an opportunity to select a provider; Or, I have elected to consult with the next available provider. I acknowledge that prior to the consultation, I have been given the provider's credentials.
3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of the Practice. I agree to hold harmless the Practice for delays in evaluation or for information loss due to such technical failures.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at this time for any reason or for no reason.
5. I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in telehealth consultation, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted by individuals at my location, or at a testing facility, and the direction of our Providers.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care but that no results can be guaranteed or assured.
7. I understand that it is necessary to provide a complete and accurate medical history and will update my medical health records periodically but no less than once a year.
8. I understand persons may be present during the consultation other than my Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.
9. I understand I have the right to object to the videotaping of telehealth consultation.
10. I understand that there is no guarantee that I will be treated by our Providers. Our Providers reserve the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of our Providers, the provision of the Service is not medically or ethically appropriate.
11. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.

Patient Initial: _____

12. I understand that federal and state law requires healthcare providers to protect the privacy and the security of health information. I understand that Practice will take steps to make sure my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners engaged by Practice who may be located in other areas, including out of state.
13. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records and/or consultation report, which will be provided to me at reasonable cost of preparation, shipping and delivery.
14. I understand that I may be asked if I have a primary care doctor and, if so, whether I consent to sending a copy of my medical records and/or consultation report to my primary care doctor. Upon my consent, Practice will send a copy of medical records and/or consultation report to my primary care doctor, which will be billed to me at reasonable cost of preparation, shipping and delivery.
15. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
16. I understand that I may not be covered under my current health insurance plan for telehealth services.

Patient Informed Consent

I have carefully read this form and fully understood its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with "**TELEHEALTH INFORMED CONSENT**", I acknowledge that I understand and agree with the above and hereby consent to receive Practice's telehealth services:

☐ ACCEPT. By check the Box for this "TELEHEALTH INFORMED CONSENT" I hereby stat that I have read, understood, and agree to the terms of this document. [Note-Box should not be pre-checked.]

Patient's Name: _____

Patient's Signature: _____ **Date:** _____

If signing on behalf of a minor:

Parent/Legal Guardian's Name: _____

Parent/Legal Guardian's Signature: _____ **Date:** _____

Patient Initial: _____