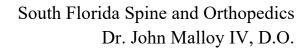


# Welcome to South Florida Spine and Orthopedics Non-Spine New Patient Packet

Patient Initial:	
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Patient Full Name:	Da	ate of Birth:
Age: Sex: Male/Female Height:	Weight:	Dominant Hand: L/R
Street:		Apt. #
City:	State:	Zip Code:
Phone Number:Em	ail:	
Race: OCaucasian OAfrican American OAsian	n OOther:	
Ethnicity: ONon-Hispanic OHispanic OUnkno	wn	
Preferred Language: English / Spanish / Chinese	/ Other:	
Pharmacy Name: Location:		Phone Number:
Primary Care Physician Name:	·	Phone Number:
Address:		Fax Number:
<b>Referring Physicians Name:</b>		Phone Number:
Is your problem related to an auto accident? OY	es Date of Acci	ident: ONo
Is your problem related to a work accident? OY	es Date of Acci	ident: ONo
<b>Emergency Contact Information:</b>		
Contact Full Name:		
Relationship to Patient:	Phone Number	r:
Spouse's Name (if applicable):		Phone Number:
Reason for visit: List Contributing events or known causes:		Left / Right / Bilateral
Please describe the onset of symptoms by choosing No Injury - gradual onset of symptoms Symptoms Symptoms Owork Injury on	toms began (# o	of) days / weeks / months
OMotor Vehicle Accident on		
Other injury onPlease Explain:	(date of	
Do your symptoms include pain? Yes / No On a scale 0-10 (10 is the worst) how severe is you  0 0 1 0 2 3 0 4 0 5 6 7 8 0  Frequency of Pain: Oconstant OIntermittent (cor Describe your Pain: OSharp ODull OStabbing (	9	Progressive ONot Progressive



# South Florida Spine and Orthopedics Dr. John Malloy IV, D.O.

Do symptoms Include:	
OSwelling OWeakness ONumbness ODecreased Range	of Motion OPins / Needles Sensation
Since the problem started, it is: OGetting Better OGettin	ng Worse OUnchanged
<b>Do you have difficulty:</b> Ocrossing your legs OPutting on	socks & shoes OGetting in/out of the car
Getting up or down stairs	_
How far can you walk before you notice pain?	
If applicable, is the joint: OPopping OLocking OClicking	ng OInstability/Giving Way OBending
I am NOT able to perform the following activities of dail	
ODoing yard work or shopping OPerforming household c	hores OGoing to work
OSocializing with friends OParticipating in recreational ad-	ctivities OExercising
Past Treatment of your current problem: (select all that	apply)
OIce Treatment OPhysical Therapy OHeat Therapy OP	
walker OInjections #ORest for How Long? _	
Motrin, Aleve	
<u>Past Medical Hi</u>	<u>istory</u>
<b>Current Medications:</b>	<del></del>
ONo Medications	
OCurrently Taking Medications	
Medication Name	Dosage
<u> </u>	
<del></del>	
All	
Allergies (not seasonal): No known allergies	
OPenicillin OAspirin OCodeine OTylenol OIodine OS	
OAdhesive Tape Other:	

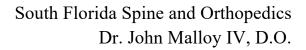
Patient Initial:	
New Patient Non-	Spine Packet Page 3 out of 11



# South Florida Spine and Orthopedics Dr. John Malloy IV, D.O.

<b>Diagnosed Condition</b>	<u>18:</u>	
Have you ever been	diagnosed with any of the fol	llowing? ONone
OAlcoholism	ODiabetes Type:	
OArthritis	○GERD	OLiver Disease
OAnemia	GI Disorders	ONeurological Disorders
OBlood Clots	OHeart Disease Specify:	Osteoporosis
OBlood Transfusion	OHepatitis Type:	_
OBronchitis	OHerna	ORenal Disease
OCancer	OHigh Blood Pressure	ORheumatoid Arthritis
○COPD	OHigh Cholesterol	OThyroid Disease
	OHIV AIDS OStroke	
Other:		
Are you pregnant? ( Past Surgical History	•	ou claustrophobic? OYes ONo
OAppendectomy	○D&C	ONeck Surgery
OArthroscopy	○Gallbladder Surger	y OPacemaker
OBack Surgery	Back Surgery OHeart Bypass OProstate Surgery	
OBreast Surgery	OHeart Valve Replacement	OSkin Cancer
OCataract Surgery	OHernia Repair	OTonsillectomy
OCarpal Tunnel	OHysterectomy	
OCesarean Section	OKidney Surgery	
OJoint Replacement	(specify joint):	
Other Surgeries:		

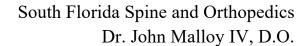
Patient Initial:	
New Patient Non-	Spine Packet Page 4 out of 11





#### Review of Systems

<u>-</u>	any of the following p	-		
1. GI	OHeartburn, Ulcers			ONone ONone
2. ENDO	OThyroid Disease	OHeart or Cold Into	lerance	○None
3. CON	OWeight Loss	OLoss of Appetite	OFatigue -	○None
4. EYE	OBlurred Vision	ODouble Vision	OVision Loss	○None
5. ENT	OHearing Loss	OHoarseness	OTrouble Swallowing	○None
6. CV	OChest Pain	○ Palpitations		ONone
7. RS	OChronic Cough	OPneumonia	○Shortness of Breath	ONone
8. GU	OPainful Urination	OBlood in Urine	OKidney Problems	ONone
9. SK	OFrequent Rashes	OSkin Ulcers	OLumps OPsoriasis	ONone
10. NEU	OHeadaches	ODizziness	OSeizures ONumbness	ONone
11. PSY	ODepression/Anxiet	ty\ODrug/Alcohol Add	diction OSleep Disorder	ONone
12. HEM	OEasy Bleeding	OEasy Bruising	○Anemia	ONone
Comments: _				
		Family Hist	orv	
Have any dire	ct relative had any of t			
-	<del>_</del>	_	OBleeding Problems ORheumato	id Arthritis ONone
		•	Bleeding Problems ORheumato	
Sibling: ODia	betes () Anesthesia Proble	ms ()High Blood Pressure	OBleeding Problems ORheumato	oid Arthritis ()None
		Coolal High	0.444	
Smolzing State	na.	<u>Social Histo</u>	<u>ory</u>	
Smoking State	rent everyday smoker	# neeles OOo	casional smoker # packs	
_	vious Smoker	" packs Occ		
Alcohol Use:	Social	OFrequent ONor		
	_		vorced OWidowed	
Marital Histor	,			inad
_	ntly working?○Yes(	Part-11me Orun-11	me ()No ()Ret	ired
Opis		F1.		OC+- 1
Occupation: _		Emplo	yer:	Student
			Dations Initial	
			Patient Initial:	
			New Patient Non-Spine Packet	et rage 5 out of 11





Insurance Company:

### 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**

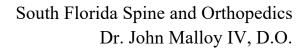
- I understand that co-payments, co-insurance and deductibles are my responsibility and are due at each visit.
- I understand that regardless of my insurance coverage, any charges that are not covered during my treatment are my responsibility and are due upon receipt of statements.
- I authorize South 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

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

Patient Initial: \_\_\_\_

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# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name:	Date:
SIGNATURE	
Ι,	have had full opportunity to read and consider the contents of Privacy Practices. I understand that, by signing this Consent form, I
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 treatment, payment activities and heal	disclosure of my protected health information to carry out
	Date:
GEOGRAPH A D. C. A. D. C. D. C. A. D. C. D.	
SECTION B: To the Patient - Please r	read the following statements carefully
	orm, you will consent to our use and disclosure of your protected ent, payment activities and healthcare operations.
whether to sign this Consent. Our Not healthcare operations, of the uses and of other important matters about your	the right to read our Notice of Privacy Practices before you decide ice provides a description of our treatment, payment activities and disclosures we may make of your protected health information, and protected health information. A copy of our Notice accompanies ad it carefully and completely before signing this Consent.
change our privacy practices, we will	vacy practices as described in our Notice of Privacy Practices. If we issue a revised Notice of Privacy Practices, which will contain the any of our protected health information that we maintain.
your revocation submitted to the Cont Consent will not affect any action we	ght to revoke this Consent at any time by giving us written notice of act Person listed above. Please understand that revocation of this took in reliance on this Consent before we received your revocation, or to continue treating you if you revoke this Consent.
Consent To Release to:	
Name:	Relationship:
Name:	Relationship:
	Patient Initial:



#### **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 inperson 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;
- o Engage in review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results via asynchronous communication;
- o Two-way interactive audio in combination with store-and-forward communications between you and your Provider;
- o Two-way interactive audio-video interaction between you and your Provider;
- o 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:**

- o 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:	
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#### **Service Limitations:**

- o 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.
- o 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.

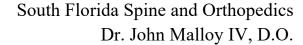
#### **Security Measures:**

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:**

- o Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- o 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.
- o 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.
- o In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.
- o 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:	
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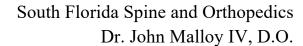


#### **Patient Acknowledgements:**

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:	
New Patient Non-S <sub>1</sub>	oine Packet Page 10 out of 11





- 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:

Box should not be pre-checked.] Patient's Name:	
Patient's Signature:	Date:
If signing on behalf of a minor:	
If signing on behalf of a minor: Parent/Legal Guardian's Name:	