Williams Institute of Orthopedics, PA

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PATIENT INFORMATION E-mail Address:_____

Last Name: _____ First Name: _____ M:_____

Local Address: _____City:_____ State: _____ Zip:_____

Mailing Address (if different):_____

Secondary Address: _____

Date of Birth:_____ Age:_____ SSN:_____ Sex: M ☐ F ☐

Home Phone: _____Cell Phone:_____ Marital Status:_____

Emergency Contact: _____ Relation: _____ Phone: _____

Are you: *Retired* ☐ *Student* ☐ *Work Full Time* ☐ *Work Part Time* ☐ *Unemployed* ☐

Employment Information: Employer: _____ Employer's Phone: _____

Responsible Party (If different from patient)

Name: _____ SS#:_____ Date of Birth:_____

Mailing Address: _____ City:_____ State: _____ Zip:_____

Phone: _____ Relation to patient: Spouse Parent Other

Spouse: _____ Spouse DOB:_____

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

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

Preferred Imaging Center:_____ How did you hear about us:_____

Preferred Pharmacy Name:_____Phone: _____

Pharmacy's Address:_____

Allergies? YES NO If yes, please List_____

Name of *Primary* Insurance_____ Policy #_____ Group#:_____

Address of Insurance Company_____

Name of Policy Holder_____Relationship to Patient_____

Name of *Secondary* Insurance_____ Policy #_____ Group#:_____

Address of Insurance Company_____

Name of Policy Holder_____Relationship to Patient_____

_____ _____

Signature of Patient or Responsible Party **Date**

07/02/24

Williams Institute of Orthopedics, PA

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 MY 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

Patient Information

Patient Name: _____ Date: _____
Birth Date: _____ 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 use other forms of tobacco?	_____ Yes	_____ No	
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 medication and dosage ___ See attached list (if you have a premade list)

_____ _____

_____ _____

_____ _____

_____ _____

Surgeries: Please list surgery type and year

_____ _____

_____ _____

_____ _____

Patient Signature _____ Date _____

Appointment Cancellation Policy Agreement

Williams Institute of Orthopedics, 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 352-775-1221 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 in on a Monday, the cut off time to provide notice is 2:00 p.m. 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/cancelled appointment, which must be honored prior to rescheduling. In the event that you do not show for the physician's visit on three (3) occasions, you may be dismissed from the practice. This agreement is intended for appointments made in the year of 2024.

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

Please sign below to consent to these terms.

Patient Signature: _____ Date: _____

Print Name: _____

Prescription Policy

This agreement between the Patient: _____and Prescribing Provider, Williams Institute of Orthopedics, PA, 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 form 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.

Acknowledgement 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 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 the terms of this agreement may result in the withdrawal of the prescribed medication.

Patient Signature _____Date _____

Financial Policy

Thank you for choosing us as your health care provider. We are committed to quality care and treatment for 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 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 except 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 to 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 services 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 time of service. An estimate will be provided to you by the Receptionist. Balance must be paid in full after services are rendered.

SURGERY PATIENTS- It is the patient's responsibility to check with our Financial Counselor PRIOR to surgery to make financial arrangements. An estimate will be provided and payment is due in full at your preoperative appointment.

AUTO/WORKER'S COMP/THIRD PARTY- WE DO NOT ACCEPT ANY OF THESE INSURANCES.

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 through Care Credit.

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 (print) _____ Date_____

Patient or Responsible Party's Signature _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve of.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of you health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by contacting the office at 352-775-1221 and asking to speak to the Office Manager who serves as the Privacy Office.

Patient's Name (print) _____ Date _____

Patient or Responsible Party's Signature _____

Acknowledgement 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 Williams Institute of Orthopedics, PA., Notice of Privacy Practices. This notice describes how Williams Institute of Orthopedics, PA., may use and disclose my protected health information, utilize certain restrictions on the use and disclosure of my healthcare information, and uphold rights I may have regarding my protected health information.

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

- o Home Telephone: _____
  - o Okay to leave message with detailed information
  - o Leave message with call-back number only
- o Cell Phone: _____
  - o Okay to leave message with detailed information
  - o Leave message with call-back number only
- o Written Communication
  - o Okay to mail to my home address
  - o Okay to mail to my work/office address

Patient Name (print) _____ Birth Date _____

Patient Signature _____ Date _____

Acknowledgements and Representations Related to Auto/Workers' Compensation/Third Party Insurances

I, _____ Birth Date _____
(Print patient name)

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

Initial _____ I acknowledge and understand that Williams Institute of Orthopedics, PA 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, workers' compensation of 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 Williams Institute of Orthopedics, PA 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 Responsible Party's Signature _____

Date _____

Authorization for Disclosure of Health Information

Name _____ Birth Date _____

Address _____

I hereby authorize Williams Institute of Orthopedics, PA 13696 N. US Hwy 441, Lady Lake, Fl 32159 to disclose my protected health information to the following people: (Family, Friends, etc)

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

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: _____

Purpose for Need of Disclosure:

_____ At 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 organization(s) listed above have already made reference in this authorization.

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

Patient or Responsible Party's Signature _____

Relation to patient _____ Date _____