Foot/Ankle Evaluation **NAME:** _____

□ Right □ Left □ Bilateral
□ Ankle □ Foot

Chief Complaint: □ Pain □ Swelling □ Redness □ Weakness □ Wound Issues □ Other:_____

Onset: □ Acute □ Non- Traumatic □ Chronic Traumatic □ Chronic Non-traumatic

Date of Onset:_____

Injury:□ Yes □ No

Work related: □ Yes □ No **Motor Vehicle Accident:** □ Yes □ No **Sports Related:** □ Yes □ No

Please Explain: _____

Frequency: □ Intermittent □ Occasional □ Constant □ Rare □ Constant with intermittent worsening
Status: □ Improving □ Worsening □ Unchanged □ Stable □ Resolved □ Fluctuating □ Better
Severity of pain: □ Mild □ Mild-Moderate □ Moderate □ Moderate-Severe □ Incapacitating

Quality: □ Aching □ Burning □ Deep □ Discomforting □ Dull □ Piercing □ Sharp □ Stabbing □ Shooting □ Throbbing □ Superficial □ Electrical

When are the symptoms most severe: □ At night □ At rest □ In the morning □ With activity □ Continuous

Please rate your pain level at it's worse: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Please rate your level of pain at its best : □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Does the pain radiate? □ Yes □ No If so, where does the pain radiate? _____

Symptoms are aggravated by: □ Standing from seated position □ Movement □ Daily activities □ Driving □ Exercise □ Climbing stairs □ Kneeling □ Bending □ Walking □ Standing □ Running □ Sports □ Other:_____

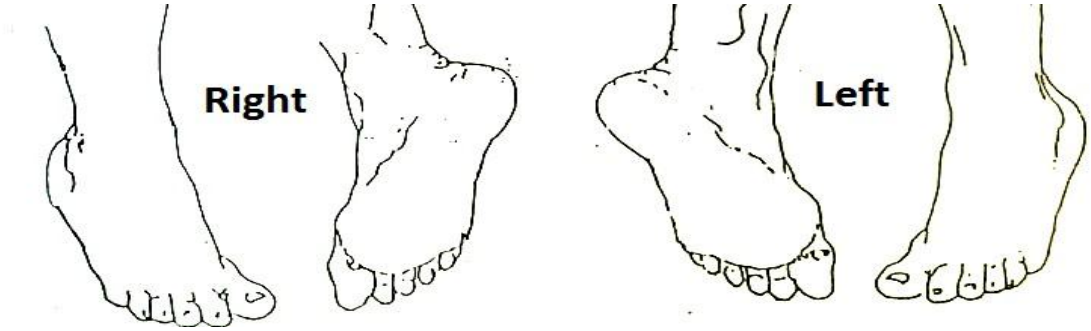
Symptoms are relieved by: □ Sling □ Elevation □ Heat □ Ice □ Massage □ NSAIDS □ Rest □ Pain medications □ OTC medications □ Stretching □ Nothing □ Other:_____

Associated Symptoms: □ Bruising □ Crepitus (crackling) □ Decreased mobility □ Difficulty going to sleep □ Instability □ Limping □ Locking □ Night pain □ Night-time awakening □ Numbness □ Popping □ Spasms □ Swelling □ Tingling in the legs □ Tenderness □ Weakness □ Catching □ Grinding □ Pain after inactivity □ Stiffness

Do you require use of gait aids? □ Yes □ No □ Cane □ Crutches □Walker □ Wheelchair

What treatment has been done so far?
□ X-rays and Date: _____
□ MRI and Date: _____
□ Medications: _____
□ Injections: _____
□ Previous Medical Treatment:_____
□ Previous Surgery and Date _____

Please mark the painful areas on the drawings below:



SOUTHEAST
ORTHOPEDIC SPECIALISTS

Phone: (904)-634-0640
Fax: (904)-634-0203
www.se-ortho.com

DATE: _____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ AGE: _____

CITY: _____ STATE: _____ ZIP: _____ SSN: _____

HOME PHONE: _____ ALT PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

MAY WE CONTACT YOU VIA EMAIL? ☐YES ☐NO E-MAIL ADDRESS: _____

ARE YOU A VETERAN? ☐YES ☐NO MARITAL STATUS: M W S D

SPOUSE NAME: _____ SPOUSE DOB: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY INSURANCE NAME: _____ ID# _____

PRIMARY CARD HOLDER NAME: _____ DOB: _____ RELATION: _____

SECONDARY INSURANCE NAME: _____ ID# _____

SECONDARY CARD HOLDER NAME: _____ DOB: _____ RELATION: _____

IS THIS ACCIDENT OR INJURY RELATED TO: ☐AUTO ☐JOB ☐OTHER DATE OF INJURY: _____

PRIMARY CARE PHYSICAN: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

PHYSICAL THERAPY FACILITY: _____ PROVIDER: _____

PAIN MANAGEMENT FACILITY: _____ PROVIDER: _____

TO BE IN COMPLIANCE WITH FEDERAL GUIDELINES, PLEASE INDICATE WHICH OF THE FOLLOWING BEST DESCRIBES YOU:

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black of African American
☐ More than one race ☐ Native Hawaiian or Pacific ☐ White
☐ Other ☐ Unknown/Not Reported

ETHNICITY: ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐Unknown/Not Reported

PRIMARY LANGUAGE: _____

HOW DID YOU HEAR ABOUT SOUTHEAST ORTHOPEDIC SPECIALISTS?

Referred By: _____ ☐Friend ☐Family ☐Physician ☐PT ☐PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NAME (Please Print):_____DOB:_____

I hereby acknowledge that I have been provided the **Notice of Privacy Policy** for Southeast Orthopedic Specialists. The notice explains in more detail how Southeast Orthopedic Specialists may use and/or share my health information in regards to treatment, payment, and health care operations. I was given the opportunity to ask questions regarding this policy.

I will allow Southeast Orthopedic Specialists to discuss my medical, payment, scheduling, and health care operations with the following individuals:

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

_____ _____

Signature **Date**

REVIEW OF SYSTEMS: **NAME:** **DOB:**

Constitutional

- □ Chills
- □ Fatigue
- □ Fever
- □ Malaise
- □ Night Sweats
- □ Weakness
- □ Weight Gain
- □ Weight Loss

Cardiovascular

- □ Chest pain
- □ Cyanosis
- □ Heart Murmur
- □ Irregular heartbeat
- □ Leg swelling
- □ Syncope (fainting)

Skin/Integumentary

- □ Contact allergy
- □ Itchy skin
- □ Rash
- □ Skin Infection
- □ Skin lesion

Metabolic/endocrine

- □ Cold intolerant
- □ Hair loss
- □ Heat intolerant

HEENT

- □ Blurred Vision
- □ Double Vision
- □ Dysphagia(problem swallowing)
- □ Ear drainage
- □ Facial pain
- □ Headache
- □ Hearing loss
- □ Hoarseness
- □ Nasal congestion
- □ Ringing in ears
- □ Vertigo
- □ Vision loss

Gastrointestinal

- □ Abdominal pain
- □ Constipation
- □ Black tarry stools
- □ Diarrhea
- □ Heartburn
- □ Jaundice
- □ Loss of appetite
- □ Nausea
- □ Vomiting

Neurological

- □ Difficulty walking
- □ Dizziness
- □ Poor coordination
- □ Memory loss
- □ Muscle weakness
- □ Paresthesia (numbness)
- □ Seizures
- □ Tremors

Psychiatric

- □ Anxiety
- □ Depression
- □ Insomnia

Respiratory

- □ Chest pain (respiratory)
- □ Cough
- □ Dyspnea (Shortness of Breath)
- □ Recent infections
- □ Known TB exposure
- □ Wheezing

Genitourinary

- □ Dysuria
- □ Frequent urination
- □ Hematuria
- □ Urge incontinence
- □ Urinary incontinence

Hematologic

- □ Bleeding
- □ Bruising

Immunological

- □ Asthma
- □ Bee sting Allergies
- □ Contact dermatitis
- □ Environmental Allergies
- □ Food Allergies
- □ Seasonal Allergies

HEIGHT: _____
WEIGHT: _____
(Office use only): B/P: ___/___

NAME: **DOB:**

MEDICATIONS AND ALLERGIES: Please attach medication list if available.

Medication or Vitamin Name:	Dosage	Reason for taking
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

ALLERGIES:	REACTION:
1.	
2.	
3.	
4.	
5.	

NAME: _____ **DOB:** _____

PAST MEDICAL HISTORY: Please select if condition applies to your medical history:

□ AIDS/HIV
□ Anemia
□ Angina (Chest Pain)
□ Arthritis
□ Asthma
□ Cancer
□ Congestive Heart failure
□ COPD
□ Coronary artery disease
□ Crohn's disease
□ Deep venous thrombosis
□ Degenerative joint disease
□ Depression
□ Diabetes
□ Drug Abuse
□ Fibromyalgia
□ Fracture
□ Gout
□ Headache, migraine
□ Hepatitis/liver disease
□ Hypertension
□ inflammatory bowel disease
□ Lyme disease
□ Myocardial infarction
□ Obesity
□ Osteoporosis
□ Parkinson disease
□ Peptic ulcer disease
□ Psoriasis
□ Scoliosis
□ Seizure disorder
□Sleep apnea
□ Spinal stenosis
□ Spondyloarthopathy
□ Stroke
□ Systemic lupus erythematosus
□ Thyroid disease
□ Valvular disease
□ Other: _____

PAST SURGICAL HISTORY: Please list all previous surgeries that required anesthesia.

_____ _____

_____ _____

_____ _____

_____

FAMILY HISTORY

	Father	Mother	Siblings	Grandparent	Other:_____
Arthritis	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High BP	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐

SOCIAL HISTORY:

Tobacco Use: □Yes □No □Former Type: _____ Packs per day: _____ Years smoked: _____ Year Quit: _____

Alcohol Use: □Yes □No □Former Type: _____ Frequency:_____Amount per day: _____ Last Drink:_____

Caffeine Use: □Yes □No Type: _____Frequency:_____ Amount per day: _____

Activity: □Moderate □Sedentary □Vigorous Type(s) of exercise:_____Frequency:_____

Work Status: □ F/T □ P/T □ Disabled □Retired
HAND DOMINANCE: □ RIGHT □LEFT □AMBIDEXTROUS

Privacy Policy

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Southeast Orthopedic Specialists, we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule and is effective November 26, 2013. It applies to all PHI as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Southeast Orthopedic Specialists; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your PHI.

Understanding what is in your record and how your PHI is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your PHI, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Southeast Orthopedic Specialists, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. Southeast Orthopedic Specialists maintains an electronic medical record ("EMR").
- You have the right to access your health record in a machine readable electronic format. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity. Southeast Orthopedic Specialists may charge you a reasonable, cost-based fee for the labor and supplies associated with copying or transmitting the electronic PHI.
- Amend your health record which you believe is not correct or complete. Southeast Orthopedic Specialists is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for Southeast Orthopedic Specialists; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by Southeast Orthopedic Specialists, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.
- Obtain an accounting of disclosures of your PHI. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and health care operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. The first list you request within a 12-month period is free of charge, but Southeast Orthopedic Specialists may charge you for additional lists within the same 12-month period. Southeast Orthopedic Specialists will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- Communications of your PHI by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).
- Place a restriction to certain uses and disclosures of your information. In most cases Southeast Orthopedic Specialists is not required to agree to these additional restrictions, but if Southeast Orthopedic Specialists does, Southeast Orthopedic Specialists will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law).

Southeast Orthopedic Specialists must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.

- Revoke your authorization to use or disclose PHI except to the extent that action has already been taken.

Our Responsibilities

Southeast Orthopedic Specialists is required to:

- Maintain the privacy of your PHI.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect.
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your PHI without your written authorization, except as described in this Notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact:

Compliance Officer
Southeast Orthopedic Specialists
6500 Bowden Rd. Ste 103
Jacksonville, FL 32216
www.se-ortho.com

If you believe your privacy rights have been violated, you can file a written complaint with Southeast Orthopedic Specialists' Compliance Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Compliance Office will provide you with the address. There will be no retaliation for filing a complaint with either the Compliance Officer or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, Southeast Orthopedic Specialists operates an EMR. This is an electronic system that keeps PHI about you.

Southeast Orthopedic Specialists may also provide a subsequent healthcare provider with PHI about you (e.g., copies of various reports) that should assist him or her in treating you in the future. Southeast Orthopedic Specialists may also disclose PHI about you to, and obtain your PHI from, electronic PHI networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

Southeast Orthopedic Specialists may use a prescription hub which provides electronic access to your medication history. This will assist Southeast Orthopedic Specialists health care providers in understanding what other medications may have been prescribed for you by other providers.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to perform functions or activities on behalf of, or certain services for, Southeast Orthopedic Specialists that involve the use or disclosure of PHI and disclose your PHI to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail, in person, or by text, in reference to any items that assist Southeast Orthopedic Specialists in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist Southeast Orthopedic Specialists in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam room, it is considered implied consent that a disclosure of your PHI is acceptable.

Open treatment areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

To Avert a Serious Threat to Health or Safety: We may use your PHI or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. Southeast Orthopedic Specialists may use a single compound authorization to combine conditioned and unconditioned authorizations for research (e.g. participation in research studies, creation or maintenance of a research database or repository), provided the authorization: (i) clearly differentiates between the conditioned (provision of research related treatment is conditioned on the provision of a written authorization) and unconditioned research components; and (ii) provides the individual with an opportunity to opt in to the unconditioned research activities.

Coroners, Medical Examiners and Funeral Director: In the unfortunate event of your death, we may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

Organ Procurement Organizations: Consistent with applicable law, we may disclose PHI to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Fund Raising: We may contact you as part of a fund-raising effort. We may also disclose certain elements of your PHI, such as your name, address, phone number and dates you received treatment or services at Southeast Orthopedic Specialists, to a business associate or a foundation related to Southeast Orthopedic Specialists so that they may contact you to raise money for Southeast Orthopedic Specialists. If you do not wish to receive further fundraising communications, you should follow the instructions written on each communication that informs you how to be removed from any fundraising lists. You will not receive any fundraising communications from us after we receive your request to opt out, unless we have already prepared a communication prior to receiving notice of your election to opt out.

Sale of your PHI: Southeast Orthopedic Specialists may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.

Health Oversight Activities: We may release your PHI to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Workers Compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement: We may disclose PHI for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your PHI if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

As Required by Law: We may use or disclose your PHI if we are required by law to do so.

SOUTHEAST
ORTHOPEDIC SPECIALISTS

Statement of Policies

We are committed to providing excellent care to our patients regardless of insurance coverage or financial limitations.

Your understanding of our policies is extremely important to our business. Our goal is to simplify the process for our patients. The following policies are established for mutual convenience and benefit. Please read them carefully and sign at the bottom to indicate your agreement of the statement of policies.

1 .Southeast Orthopedic Specialists provides orthopedic services only. Patients are expected to have or arrange for a Primary Care Physician.

2. Insured Patients: Our relationship is with our patients and families, not insurance companies. However, the insurance carriers have considerable influence on this relationship. In order for our office to file a claim with your insurance company you must provide us with the necessary information prior to being treated. We must have copy of a valid I.D. and insurance card on file. **Deductibles and Co-Pays** are payable at the time of service. We cannot bill for these. Any previous balance is expected to be paid at time of service. If your health plan is a HMO, you must obtain authorization/referral from your primary care physician. **All charges incurred are your responsibility if your insurance company does not pay for any reason.** It is important that you read your policy handbook provided and to understand which services are covered and which may be considered "not medically necessary". The physician may perform services that fall within this category. This does not relieve you of the financial obligation.

3.Uninsured Patients: If you are uninsured, payment for office related services are due at the time services are rendered. In the event an elective surgical procedure is decided upon, full payment must be made prior to surgery.

4.Workman's Compensation: We will require the following information prior to scheduling an appointment. Adjustor's name, phone, ext, fax, email, carrier, date of injury, specific body part to be treated under this claim and claim number if applicable. Without this information we will not be able to treat you under workman's compensation insurance. First appt. must be made by adjustor.

5. Auto Claims: We will file your auto insurance. If benefits under your auto exhaust prior to completion of treatment, we will then file to your health insurance. For this reason, an active private health insurance must be on file. At that time all future claims will transfer to your health insurance and the normal deductibles, copays and coinsurance with be due at time of service.

6. Monthly Statement: You will receive a monthly statement if you have a balance after your insurance pays for charges billed. All patient due balances are due within thirty (30)days. If you are unable to pay in full, we require you to contact our business office to make payment arrangements. Any default to fulfill your payment obligations will result in a third party collection agency. You will incur a 30% collection fee and you will be discharged from the practice until the obligation has been met.

7. Returned Checks: Any returned checks will be subject to a $35.00 service fee. This must be resolved before any future treatment is rendered.

8. Paperwork: There is a $25.00 pre-paid fee for all disability, FMLA, and other forms/ paperwork that you need to have filled out by the physician. Paper work may dropped off at any location. The forms will be forwarded to your provider for completion. Please allow 7-10 business days to complete. We will be glad to contact you for pick up or we will fax or mail as directed for you.

9. Minor Children: All minor children under the age of 18 years old must be accompanied by a parent, guardian or authorized adult. We require a notarize letter giving consent to supervise treatment for anyone other than parent or legal guardian.

10. Prescription Policies:
A. If you are in need of a refill, please have your pharmacy fax a request to 904-634-0203. Please allow 48 to 72 hours.
B. Refills will be called in only between 9am-5pm Monday through Friday. No refills after 5pm on weekdays. No refills on weekends.
C: You will not be prescribed pain medication unless and until such time that you need surgery. Once surgery is performed, you may receive pain medication only up to 90 days after surgery.
D:. If you continue to need pain medication past 90 days after surgery, or for the treatment of pre operative pain or chronic pain, you will require an office visit to discuss this with your provider.

I acknowledge that I have carefully read and understand the Statement of Policies, and agree to abide by them.

Name (please print)_____DOB_____

Signature_____ DATE_____

SOUTHEAST
ORTHOPEDIC SPECIALISTS

Name:_____ **DOB:** _____

Authorization and Assignment of Benefits:

For the services rendered and those about to be rendered, I hereby assign to Southeast Orthopedic Specialists, all medical benefits otherwise payable to me under the described policy not to exceed the charges made to such service. I further authorize the above mentioned insurance company to pay said benefits directly to Southeast Orthopedic Specialists and further direct that they make no payment to me. In the event that I receive payment from the insurance company, I agree to endorse such payment to Southeast Orthopedic Specialists. I understand that I am directly and primarily responsible to Southeast Orthopedic Specialists for the usual and customary fee for the services rendered to me. I realize that if my insurance company fails to pay or there is a delay (more than 90 days) in their paying, it is my sole responsibility to promptly pay my bill directly. I also realize that any services not covered under my insurance company will be my responsibility to pay in full. I further understand and agree if I fail to make prompt and timely payments, I will be directly responsible for any and all cost of collection including the filing fees as well as reasonable attorney fees. I hereby authorize Southeast Orthopedic Specialists to release to my insurance company, any information acquired including the diagnosis and the records in the course of my treatment.

_____ _____

Signature Date

Medicare Certification for Payment: (Lifetime Authorization)

I certify that the information given by me in applying for payment under the title XVII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be payable to Southeast Orthopedic Specialists for my behalf. I also assign the benefits payable for physician service to the physician furnishing the services and authorize such physician to submit a claim to Medicare in my behalf.

_____ _____

Signature Date