Shoulder Evaluation NAME: _____

□ Right □ Left □ Bilateral

Chief Complaint: □ Pain □ Swelling □ Redness □ Weakness □ Wound Issues □ Other:
Onset: □ Acute Traumatic □ Non- Traumatic □ Chronic Traumatic □ Chronic Non-traumatic

Date of Onset: _____

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

What happened? How did it happen? 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

Location of pain: □ Anterior (front) □ Posterior (back) □ Medial (inner side) □Lateral (outer side) □ Clavicle □ Base of neck

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

Radiation: □ Yes □ No Where does the pain radiate? _____

Symptoms are aggravated by: □ Lifting □ Movement □ Daily activities □ Driving □ Exercise □ Pushing □ Reaching □ Work Activities □ Sports □ Repetitive activities □ Work activities □ Everything □ Pulling □ Gripping □ Typing □ Grasping □ Writing □ Other _____

Symptoms are relieved by: □ Sling □ Elevation □ Heat □ Ice □ Massage □ NSAIDS □ Rest □ Pain medications □ OTC medications □ Stretching □ 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/arms □ Tenderness □ Weakness □ Catching □ Grinding □ Pain after inactivity □ Stiffness □ Other _____

Hand Dominance: □ Right □ Left □ Ambidextrous

What treatment has been done so far?

□ X-rays and Date: _____
□ MRI and Date: _____
□Medications: _____
□ Injections: _____
□ Physical Therapy: _____
□ Brace (Describe): _____
□ Previous Surgery and Date _____

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: ___ / ___

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.	

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

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 about you responsibly. This Notice of Health Information Practices 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 protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Yours 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, often referred to as your health or medical record, serves as a:

*Basis for planning your care and treatment,
*Means of communication among the many health professionals who contribute to your care.
*Legal document describing the care you received.
*Means by which you or a third-party payer can verify that services billed were actually provided.
*A tool in educating health professionals.
*A source of data for medical research.
*A source of information for public health officials charged with improving the health of this state and the nation, *A source of data for our planning and marketing, *A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing discloser 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:
***Obtain a paper copy of this notice of information practices upon request,**
***Inspect and copy your health record as provided for in 45 CFR 164.524,**
***Amend your health record as provided in 45 CFR 164.528, *Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,**
***Request communications of your health information by alternative means or at alternative locations,**
***Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and**
***Revoke your authorization to use or disclose health information except to the extent that action has already been taken.**

Our Responsibilities: Southeast Orthopedic Specialists is required to:
*Maintain the privacy of your health information.
*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 this notice.
*Notify you if we are unable to agree to a requested restriction, and Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information about your authorization, except as described in this notice. We will also discontinue to use or disclose your heath Information after we have received a written revocation of the authorization according to the procedures included in the authorization.

We will use your health information for treatment.

F*or example:* Information obtained by a nurse, physician, or other member of your health care team will be recorded and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: 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, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations:

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team 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 healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts and business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

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 designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care. We may mail to your home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. We may email to your home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements**. Communication with family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

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.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Funeral directors*:* We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation or organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund- raising effort.

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.

Workers compensation*:* We may disclose health information to the extent authorization by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

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

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights: U.S Department of Health and Human Services 200 Independence Avenue, S.W: Room 509 F, HHH Building Washington, D.C 20201

Examples of Disclosures for Treatment, Payment and Health Operations:

2627 Riverside Ave Ste.300 Jacksonville, FL 32204 : 10475 Centurion Parkway,Ste.220 Jacksonville, FL 32256: 1658 St.Vincent's way Ste. 100 Middleburg, FL 32068 2300 Park Ave .Ste 203 Orange Park, FL 32063: 232 Ponte Vedra Park Dr. Ponte Vedra Bch, FL 32082

SOUTHEAST ORTHOPEDIC SPECIALISTS

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