

South Florida Institute of Sports Medicine®

Sports Medicine Associates of South Florida P.A.

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|---|--|
| <input type="checkbox"/> Alfred A. DeSimone, M.D., Orthopaedic Surgeon | <input type="checkbox"/> 1600 Town Center Blvd., Weston, FL 33326(954) 389-5900 |
| <input type="checkbox"/> Fernando A. Moya, M.D., Ph.D., Orthopaedic Surgeon | <input type="checkbox"/> 17842 N.W. Second St., P. Pines, FL(954) 430-9901 |
| <input type="checkbox"/> Alexander J. Bertot, M.D., Orthopaedic Surgeon | <input type="checkbox"/> 7447 N. University Dr., Tamarac, FL 33321(954) 720-1530 |
| <input type="checkbox"/> Mark Fishman, D.O., Physiatrist | |
| <input type="checkbox"/> David Shenassa, M.D., Hand Surgeon | |

The Doctors and their staff would like to welcome you to this office.
Please assist us in answering the following questions to help us become better acquainted with you.

PATIENT INFORMATION

PLEASE PRINT Date _____

Name (First) _____ (MI) _____ (Last) _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Driver's License # _____ Driver's License State _____

D.O.B. _____ Age _____ Sex _____ SS No. _____ Occup. _____

Employer/School _____ Business Phone _____

Address _____ City _____ State _____ Zip _____

Permanent Resident Yes No If no, Please list 2nd address.

Address _____ City _____ State _____ Zip _____

If patient is a minor - please complete:

Father's Name _____ Mother's Name _____

Employer _____ Employer _____

Position _____ Phone _____ Position _____ Phone _____

Please list the name of a person to contact in case of emergency other than a spouse or parent:

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Phone _____

PRIMARY INSURANCE

Name of Company _____ Phone _____

Address _____ City _____ State _____ Zip _____

ID# _____ Group No. _____

Insured's Full Name _____ Is this an employer's plan? Yes No

Insured's Soc. Sec. No. _____ Insured's D.O.B. _____

Relationship to Insured (self, spouse, child, other) _____

SECONDARY INSURANCE

Name of Company _____ Phone _____

Address _____ City _____ State _____ Zip _____

ID# _____ Group No. _____

Insured's Full Name _____ Is this an employer's plan? Yes No

Insured's Soc. Sec. No. _____ Insured's D.O.B. _____

Relationship to Insured (self, spouse, child, other) _____

AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION/FINANCIAL AGREEMENT. I, the undersigned, knowing the patient, (minor) and/or self, is suffering from a condition requiring health care, diagnosis and/or medical treatment hereby voluntarily agree to such diagnostic procedure and health care and assignees. I authorize the release of medical information to my referring doctor, health agency, government agency, insurance company or worker's compensation. I request that payment to insurance benefits made on my behalf be paid directly to the doctor. I assume full financial responsibility for all debts incurred in any treatment and follow-up care received. I understand that any unpaid patient balances will be assessed at an interest rate of 1.5% per month. Any patient assigned to collections will be assessed a 25% surcharge on the balance.

I understand that no guarantee or assurance has been made as to the results of the procedure or treatment and that it may not cure the condition. It is the patient's responsibility to obtain authorization from their Primary Care Physician or Insurance company (if required by your insurance company) prior to services being rendered.

Patient's Legal Guardian's Signature _____ Date _____

Medical History

Primary Care Doctor _____ Phone No. _____ Date of Last Exam _____

Describe the condition that brought you to this office _____

If auto accident, date of accident _____

Have you had previous care for this condition? YES NO Dr. _____ Date _____

Whom may we thank for referring you to us? _____

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> Expressions | <input type="checkbox"/> City Limits | <input type="checkbox"/> Our City Weston | <input type="checkbox"/> Salud al Dia | <input type="checkbox"/> Parklander |
| <input type="checkbox"/> Weston Lifestyle | <input type="checkbox"/> Estate Lifestyle | <input type="checkbox"/> Weston Express | <input type="checkbox"/> Hospital | <input type="checkbox"/> Insurance Company |
| <input type="checkbox"/> Sport and Activities | <input type="checkbox"/> Pines/Miramar Advisor | <input type="checkbox"/> Davie and the Ranches | <input type="checkbox"/> Parkland Lifestyle | <input type="checkbox"/> Bellsouth |
| <input type="checkbox"/> Doctor's Name _____ | <input type="checkbox"/> Patient Name _____ | <input type="checkbox"/> Other _____ | | |

Medical: (Please check any of the following if it pertains to you)

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizures | <input type="checkbox"/> Scar Former | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Stroke/TIA's | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Circulation Disorder | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Human Immunodeficiency Virus (HIV) | <input type="checkbox"/> Other: _____ | | | |

Allergies:

- Penicillin Aspirin Codeine Novocaine Iodine Tape

Other: _____

Medications: (Please include Aspirin, Tylenol, Vitamins and Birth Control Pills)

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Previous Surgeries & Hospitalizations:

1. _____ 2. _____ 3. _____ 4. _____

Family History: Diabetes High Blood Pressure Bleeding Tendencies Other

Social History: Smoking Alcohol Recreational Drugs

Do you Currently (or in the past) suffer from any of the following?:

Podiatric History:

- Flat Feet
- Pain or fatigue in feet & legs with activity
- Heel or arch pain (child or adult)
- Numbness and tingling in feet & toes
- Pain in feet getting out of bed
- Bunions (prominent foot bones)
- Crooked toes (hammertoes)
- Ankle swelling & stiffness
- Ankle instability (easy twisting injuries)
- Leg pain (shin splints)
- Growing pains
- Difficulty running
- Poor coordination with sports
- In toe or out toe gait
- Abnormal foot posture (clubfoot, metadductus)
- Achilles tendon pain

Orthopaedic History:

- Neck pain (cervical discogenic pain)
- Lower back pain
- Shoulder pain (bursitis) (rotator cuff tendonitis) (impingement)
- Shoulder (rotator cuff) tear
- Shoulder instability (labral tear) (dislocation)
- Tennis Elbow/Golfer's Elbow
- Chronic wrist pain
- Carpal Tunnel Syndrome (numbness and tingling)
- Trigger finger (catching or locking fingers)
- Hip or knee arthritis
- Knee pain and swelling (cartilage or meniscal tear)
- Knee instability or looseness (ACL ligament tear)
- Bursitis (shoulder, elbow, hip or knee)
- Thigh (hip) pain (that refers down the leg)
- Knee cap (patella) instability (subluxation)

Please complete for Worker's Compensations Injury

Describe Injury:	Type of Job:
How did accident happen?	Date of Accident?

FOR WORKER'S COMPENSATION INJURIES ONLY. You must report your injury to your employer and he must then report it to his insurance carrier. If we do not receive worker's compensation forms to fill out within 60 days, you will be billed and held responsible for payment.

Sports Medicine Associates of South Florida, P.A.

PATIENT PAYMENT AGREEMENT

I understand that I am responsible for the cost of the professional medical services provided to me by Sports Medicine Associates of South Florida, P.A. ("Sports Medicine") regardless of the availability of certain other sources of payment, including insurance benefits and pending claims I may have against third parties who may be responsible for my medical condition. I elect to pay for the professional services provided by Sports Medicine as follows:

Check one of these if this is a legal case:	Check one of these if this is NOT a legal case:
<ul style="list-style-type: none"><li data-bbox="245 541 784 961">○ I have a Third Party Claim (defined below) and intend to seek compensation from a third party. I have engaged an attorney and will sign, with my attorney, a Letter of Protection in favor of Sports Medicine. If PIP insurance is available, a claim may be submitted to the applicable PIP insurance company. I will not use any health insurance or Medicare benefits. I understand my charges may exceed the benefits available from my PIP insurance, and I am responsible for payment of all charges to the fullest extent.<li data-bbox="245 1003 784 1058">○ Self-pay. I will be personally responsible for all charges by Sports Medicine.	<ul style="list-style-type: none"><li data-bbox="849 541 1430 659">○ I intend to use available health insurance benefits, as applicable, subject to coordination of benefits rules applicable to these policies and benefit programs.<li data-bbox="849 701 1430 785">○ I intend to use any available PIP benefits. Once exhausted, I will personally be responsible for all remaining balances.<li data-bbox="849 827 1430 869">○ Self-pay. I will be personally responsible for all charges by Sports Medicine.

Accordingly, in consideration for the medical services rendered by Sports Medicine and its physicians, I agree to the following terms and conditions:

1. Guarantee of Payment. I guarantee prompt payment of all such services not otherwise paid by insurance or any third party. Payment for any services provided to me is not contingent upon the receipt of any award of damages or payment upon any claim I may make against a third party.
2. Health or PIP Insurance. If I am entitled to and intend to utilize health insurance, Medicare, or PIP insurance coverage for the services rendered to me by Sports Medicine, I understand that coinsurance and deductible amounts are due and payable at the time that professional services are rendered. Upon the exhaustion of the above benefits, I understand that I am responsible for all charges in excess of such exhausted benefits, to the extent permitted by law, which charges, together with charges for services which are not covered shall be payable at the time that professional services are rendered. I acknowledge that Sports Medicine's charges may exceed the benefits available from my PIP and health insurance policies and that I am responsible for the payment of such charges, to the fullest extent permitted by law.
3. Authorization. I hereby authorize any and all assigned insurance companies to pay the amount due in any pending claims directly to Sports Medicine. I understand that, unless otherwise required by law, any amounts not covered or not paid by my insurance policy or any third party payor, including charges for services which are not covered benefits under my insurance policy, are my personal responsibility. If any action at law or in equity is brought to enforce this agreement, Sports Medicine and/or treating physicians shall be entitled to recover attorney's fees, court costs, and any other costs of collection incurred. Sports Medicine will not balance bill when prohibited by law.

4. Third Party Claims. If I seek, or intend to seek, the recovery of monetary damages in connection with an accident or other tort claim from a third party ("Third Party Claim"), I must provide a Letter of Protection, subject to the approval of Sports Medicine, that is duly signed by me and my legal counsel ("LOP"). According to the LOP, Sports Medicine will accept payment of professional fees upon settlement or final judgment in my case. I understand that, if there is no settlement or if I otherwise receive no payment in consideration of my Third Party Claim, I am fully responsible for the professional fees charged by Sports Medicine, which fees shall be due and payable immediately upon the earlier to occur of the following: (i) final judgment against me or dismissal of my Third Party Claim, or (ii) the abandonment of my Third Party Claim by me or my legal counsel.

5. No Insurance Benefits. If I have no insurance and there is no third party payor available to pay for Sports Medicine's professional services, I understand that payment is due at the time professional services are rendered.

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS DOCUMENT HAS BEEN READ BY OR EXPLAINED TO ME AND THAT I UNDERSTAND THIS INFORMATION. I WILL RECEIVE A COPY OF THIS DOCUMENT UPON REQUEST. I ACKNOWLEDGE THAT A COPY OF THIS DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

Patient Signature: _____ Date: _____

Print Patient Name _____

Signature of Patient's Authorized Representative: _____

Relationship to Patient: _____