Baker, Heard, Osteen, & Davenport, M.D., P.A.
Orthopedic Surgery

Patient Information

PLEASE ANSWER ALL QUESTIONS FULLY

PATIENT

NAME (Last, first, MI)	AGE	SOCIAL SECURITY	BIRTHDATE	SEX	MARITAL STATUS
MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE	
EMPLOYER	CITY	STATE	ZIP CODE	WORK PHONE	
DRIVER'S LICENSE NUMBER	STATE	NEAREST RELATIVE OR FRIEND	PHONE NUMBER	CELL NUMBER	

RESPONSIBLE PARTY

NAME (Last, First, MI)	SOCIAL SECURITY		AGE	BIRTHDATE	SEX	MARITAL STATUS
MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE		
EMPLOYER	CITY	STATE	ZIP	WORK PHONE		
DRIVER'S LICENSE	STATE	NEAREST RELATIVE OR FRIENDS NAME		PHONE NUMBER		

PRIMARY PHYSICIAN	REFERRING PHYSICIAN
NAME	NAME
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	YOUR EMAIL ADDRESS:

INJURY INFORMATION

NATURE OF INJURY OR COMPLAINT (SPECIFY LEFT OR RIGHT)	DATE OF COMPLAINT
IS INJURY WORK RELATED: ☐ YES ☐ NO	AUTO RELATED? ☐ YES ☐ NO

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	SUBSCRIBER'S NAME	RELATIONSHIP	POLICY #	GROUP #
SECONDARY INSURANCE COMPANY	SUBSCRIBER'S NAME	RELATIONSHIP	POLICY #	GROUP #

AUTHORIZATION? ☐ YES ☐ NO IF YES #_____ ☐ HMO ☐ PPO ☐ POS

HISTORY: (FOR OFFICE USE ONLY) **DATE:**

BAKER, HEARD, OSTEEN, & DAVENPORT, M.D., P.A.
ORTHOPEDIC HISTORY

Name: _____ SS#: _____ Date:_____

Height: _____ Weight: _____ Date of Birth:_____ Age:_____

Chief Complaint

Why are you seeing the doctor today?_____Dominant Hand (circle): L R Both

Past Medical History

Medical Problem(s):

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

Surgical History:

Date(s):	Procedure(s):
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

Allergy to Medication(s):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medication(s):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Review of Systems

Are you currently having or have you had problems with your:

	Circle		Describe All Yes Responses
Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Digestion	No	Yes	_____
Bowel movement	No	Yes	_____
Bladder Problem	No	Yes	_____
Diabetes	No	Yes	_____
Heart Disease	No	Yes	_____
High blood pressure	No	Yes	_____
Bleeding problems	No	Yes	_____
Balance problems	No	Yes	_____
Numbness/tingling	No	Yes	_____
Blackout/fainting	No	Yes	_____
Psychological problems	No	Yes	_____
AIDS	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Polio	No	Yes	_____
TB	No	Yes	_____
Epilepsy	No	Yes	_____

Have you had a DEXA Scan? Yes No If yes, when? _____

Social History

Occupation:_____

Tobacco: **(Packs/day)**

❑0 ❑ ½ ❑ 1 ❑ 2 ❑3

Alcohol:

❑ None ❑ Moderate ❑ Heavy

Social Drugs: ❑ Yes ❑ No

Physical Activity	Frequency
_____	
_____	
_____	

Marital Status: Married Divorced Widowed Single

Children: **Sex** **Age**

(e.g.) _F_ _7_ , ___ ___ , ___ ___, ___ ___

Family History (significant medical problems in blood relatives):

Relationship (e.g. Mother)	Problem
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature:_____ Date:_____

Reviewed By:_____, M.D. Date:_____

Meaningful Use Patient Form

PLEASE CIRCLE ONE:

Ethnicity:
Hispanic or Latino
Not Hispanic or Latino
Unknown

Race:
American Indian or Alaska Native
Asian Indian
Asian Other
Black or African American
Chinese
Filipino
Guamanian or Chamorro
Hawaiian Native
Japanese
Korean
Multiple
Other
Pacific Islander – Other
Samoan
Unknown
Vietnamese
White

Smoking Status:
Current every day smoker
Current some day smoker
Former smoker
Never smoker
Smoker, current status unknown
Unknown if ever smoker

Preferred Language: _____

Preferred Pharmacy List: _____

Pharmacy: Address: City: State: Zip: __

1. _____

2. _____

3. _____

Patient reminder Communication Preference (Circle one):

- HOME PHONE : _____
- MOBILE PHONE: _____
- EMAIL: Address: _____
- MAILED LETTER:

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Orthopedic Surgery
Phone: 407-843-9083 Fax: 407-420-2900
www.orthodoks.com

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Charles W. Heard, Jr., M.D.
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☐345 W. Michigan St. Suite 114
Orlando, FL 32806

☐9430 Turkey Lake Rd. Suite 116
Orlando, FL 32819

Medical Information Consent Agreement

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations
I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been allowed to review the **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will post a copy of any revised notice in the waiting room. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

☐ I request the following restrictions to the use or disclosure of my health information:

_____

_____

Optional

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed info
- ☐ Leave message with call back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed info.
- ☐ Leave message with call back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number _____

☐ Other _____
_____

_____ _____
Signature of Patient or Legal Representative Witness

_____ _____
Date Date

FOR OFFICE USE ONLY: ☐ Accepted ☐ Denied

_____ _____ _____
Signature Title Date

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FINANCIAL POLICY

In order for us to be able to continue to deliver high quality of care, it is necessary to describe our financial policies. PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

- Please present your insurance card(s) at each visit. It is your responsibility to provide us with the correct information so that we may submit to your insurance.
- If you have a change of address, telephone number, or employer, please notify the receptionist.
- **METHODS OF PAYMENT**: We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa, Master card, American Express, and Discover.
- **INSURANCE FILING**: If we do not participate with your insurance, we may file your claims as a courtesy. You will be expected to follow-up to make sure payment is made to us in a timely manner. If we do not receive payment from them within 45 days, you will be billed for any unpaid balance.
- **COLLECTIONS:** If your insurance denies our charges, or does not pay us in a timely manner, you will be billed for the entire balance. You will be expected to pay your balance in full within 30 days or call our Billing Department to make payment arrangements. If you do not pay in a timely manner, your account may be referred to a collection agency and reported to the credit bureau.
- **MEDICARE PATIENTS**: We are a participating provider with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, at our discretion we may submit your claim for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
- **HMO/PPO PATIENTS**: If we participate with your plan, we will bill your insurance for you. Your co-payment/co-insurance will be collected at the time of service--NO EXCEPTIONS. If your plan requires you to have an authorization to see a specialist, you will need to obtain that from your PCP's office prior to seeing the specialist. It is not our responsibility to obtain retroactive referrals, therefore we will need to reschedule your visit. If we do not participate with your plan, we will verify your out-of-network benefits, file your charges, and will expect payment of your portion of the charges at the time of service.
- **DURABLE MEDICAL EQUIPMENT (DME)**: Some insurance plans require their subscribers to purchase these supplies from particular contracted DME suppliers and therefore will not reimburse our office for these services. As a courtesy to you, you can purchase at your expense these DME supplies from our office. Please initial the bottom of this financial policy if you wish to take advantage of this courtesy.
- **SELF-PAY PATIENTS**: Patients with no insurance will be expected to **PRE PAY the visit in the amount of $300.00 BEFORE seeing the doctor.** If Surgery is required you will be expected to pre-pay the full amount, if your not able to pay in full, you will be required to contact our Credit Manager prior to the surgery to make payment arrangements. Only Cash, Money Order, and Credit Card will be accepted.
- **X-RAY COPIES**: You do not own these films, they are legal documents that belong to the doctor. When you pay for having x-rays taken, you are paying for the technologist to take them, the film, and the developing cost. You may purchase copies at the rate of $8.00 per sheet. X-ray copies are only done during NON-Patient hours (12:00 to 2:00PM) in which you must be present and please plan on a wait for these x-ray copies.

Remember that whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our Billing Department at 843-9083.

I have read and agree to abide by the above financial policy of Baker, Heard, Osteen, Davenport, M.D. P.A.

_____ _____

Patient or Guardian Date

Baker, Heard, Osteen, & Davenport, M.D., P.A.

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ASSIGNMENT OF BENEFITS AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint BAKER, HEARD, OSTEEN, &DAVENPORT, M.D., P.A., and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said BAKER, HEARD, OSTEEN, DAVENPORT, M.D., P.A., which checks, drafts or money orders are made payable for services which have been made by BAKER, HEARD, OSTEEN, & DAVENPORT, M.D., P.A., at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft of money order.

Furthermore, the undersigned allows BAKER, HEARD, OSTEEN, & DAVENPORT, M.D., P.A. or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said BAKER, HEARD, OSTEEN,& DAVENPORT M.D., P.A. as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to BAKER, HEARD, OSTEEN,& DAVENPORT M.D., P.A. or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize_____
(Name of Insured / Patient) (Name of Insurance Carrier)

to make medical benefits payments otherwise payable to me for services rendered by BAKER, HEARD, OSTEEN, & DAVENPORT, M.D., P.A., but not to exceed the charges of those services, payable to and mailed directly to:

BAKER, HEARD, OSTEEN, & DAVENPORT, M.D., P.A.
345 W MICHIGAN ST., STE 114
ORLANDO, FLORIDA 32806

I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of unpaid benefits claimed by BAKER, HEARD, OSTEEN,& DAVENPORT, M.D., P.A. is to be set aside and not disbursed until the dispute is resolved.
Furthermore, I hereby IRREVOCABLY ASSIGN to BAKER, HEARD, OSTEEN, & DAVENPORT, M.D., P.A. the rights and benefits and any and all causes of action resulting from non payment under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by BAKER, HEARD, OSTEEN, &DAVENPORT M.D., P.A.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, _____

_____ _____
PATIENT'S SIGNATURE PATIENT'S NAME (PLEASE PRINT)

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Self Insurance Notice

Dear Patient:

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Dr.'s Baker, Heard, Osteen, & Davenport, have decided not to carry medical malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

_____ _____
Patient/Responsible Party Date

_____ _____
Print Name Date of Birth

Notificacion De la Cancelacion del Seguro de la Negligencia Medica

Queirdo Paciente:

Bajo las leyes de la Florida, los proveedores requieren tener seguro medico de negligencia, o demostrar la responsabilidad financiera para cubrir los reclamos echos por negligencia. Baker, Heard, Osteen, y Davenport han decidido no tener este seguro de negligencia. Bajo las leyes de la Florida es permitido no tener este seguro subjeto a ciertas condiciones. La ley de la Florida impune penalidades a los proveedores sin este seguro, hacia proveedores que fallen satisfacer los reclamos de juicios adversos a causa de la negligecia. Este anuncio esta provido por la ley de la Florida.

_____ _____
Firma del Paciente/Persona Respondable Fecha

_____ _____
Firma en molde Feche de namimiento