2640 SW 32nd Place Ocala, FL 34471
Tel: (352) 369-1099 Fax: (352) 369-0299

PATIENT INFORMATION

DOB: _____/_____/_____ Pharmacy: _____ Pharmacy Location: _____

Name: _____ Gender: M F Social Sec# _____

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

Phone: (Home) _____ (Work) _____ (Cell) _____

Email: _____ Preferred method of contact: _____

Employer: _____ Occupation: _____

Marital Status:_____Married_____Single_____Widowed Living Will/ Advanced Directive? ○Yes ○No

Spouse's Name_____ DOB: _____/_____/_____

Emergency Contact: _____ Relationship:_____ Phone #: _____

IF PATIENT IS UNDER 18
Responsible Party: _____ Relationship_____
Phone #: _____ DOB: _____ Social Sec#: _____
Insurance Name: _____ Subscriber's Name: _____
Subscriber's DOB: _____/_____/_____ Subscriber's Social Sec#: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amounts, co-insurance, or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed 60 days. If the amount is assigned to an attorney for collections and/or suit the prevailing party shall be entitled to a reasonable attorney's fees and costs of collections. There will be a 25.00 fee for all returned checks.

Date: _____ Patient Signature: _____

Subscriber Signature (if different from the patient): _____

*****My signature of this document acknowledges that I have received a copy of the Twin Palm Orthopedics' HIPPA Notice of Privacy Practices and Financial Policy/Lifetime Authorization for Insurance Assignments.

SUPERCONFIDENTIAL INFORMATION

PAST MEDICAL HISTORY Please check any disease diagnosed at any time - items left blank indicate a negative response.

☐alcoholism ☐depression / anxiety ☐other _____

☐hepatitis ☐controlled substance (Rx drugs) abuse Females Only -

☐HIV / AIDS ☐illegal drug use Are you Pregnant? ☐Yes ☐No ☐Uncertain

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CONSENT TO EXAMINATION / TREATMENT
INSURANCE ASSIGNMENT, RECORDS AUTHORIZATION AND INFORMATION ACKNOWLEDGEMENT

I HEREBY CONSENT TO EXAMINATION AND TREATMENT AS DEEMED NECESSARY BY TWIN PALM ORTHOPEDICS AND ITS PHYSICIANS. I HEREBY AUTHORIZE TWIN PALM ORTHOPEDICS AND ITS PHYSICIANS TO FURNISH PATIENT HEALTH INFORMATION CONCERNING MY RELEVANT MEDICAL HISTORY (INCLUDING BUT NOT LIMITED TO THE SUPERCONFIDENTIAL INFORMATION LISTED ABOVE) TO ANY OF THE FOLLOWING: OTHER HEALTHCARE PROVIDERS INVOLVED IN MY CARE, INSURANCE CARRIERS, ATTORNEYS AND ADJUSTORS. I HEREBY CONSENT TO THE USE OF A PATIENT PORTAL, SURVEYS, AND AUTOMATED TELEPHONIC AND EMAIL APPOINTMENT REMINDERS. I HEREBY ASSIGN TO TWIN PALM ORTHOPEDICS AND ITS PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE. I ACKNOWLEDGE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION IN THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE _____ DATE___/___/___

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____

AUTHORIZATION FOR MEDICARE BILLING PURPOSES
LIFETIME FILE (MEDICARE PATIENTS ONLY)

I hereby certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I hereby authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby request that payment of authorized benefits be made on my behalf and hereby assign the benefits payable for physician services to the physician if he/she chooses to accept assignment.

SIGNATURE _____ DATE___/___/___

PARENTAL RELEASE (IF PATIENT IS A MINOR)

I,_____(legal guardian's name), hereby authorize TWIN PALM ORTHOPEDICS and its physicians to release any or all patient health information including superconfidential information regarding my child to the person(s) listed below (Example: A relative or someone other than a legal guardian may accompany your child on a future appointment).

SIGNATURE _____ DATE___/___/___

Name_____Relationship to patient_____Ph( )_____

Name_____Relationship to patient_____Ph( )_____

Name_____Relationship to patient_____Ph( )_____

PATIENT RELEASE

I,_____(patient's name), hereby authorize TWIN PALM ORTHOPEDICS and its physicians to release any or all of my patient health information including superconfidential information to the person(s) listed below. (Example: A spouse or relative may be involved in billing and insurance inquiries or medication refills.)

SIGNATURE _____ DATE___/___/___

Name_____Relationship to patient_____Ph( )_____

Name_____Relationship to patient_____Ph( )_____

Name_____Relationship to patient_____Ph( )_____

Patient Name_____

PRESCRIPTION HISTORY CONSENT

I agree that TWIN PALM ORTHOPEDICS may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

SIGNATURE _____ DATE___/___/___

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____

PRIVACY NOTICE

In accordance with the Health Insurance Portability and Accountability Act, patients of TWIN PALM ORTHOPEDICS are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. A patient's Protected Health Information ("PHI") may only be released as authorized by this law. TWIN PALM ORTHOPEDICS will strive to ensure that patient information is used only for purposes authorized by the patient, including but not limited to patient treatment and payment operations, lawful subpoenas, and as otherwise required by law. Upon request we can provide you with a complete copy of our Privacy Policies.

Additionally, upon providing reasonable advance notice, patients have a right to review their medical records and furnish comments to their records during normal business hours. In addition, patients have the right to obtain information regarding entities to which Protected Health Information has been provided.

Moreover, patients have the right

- to be informed of any breach of their unprotected PHI;
- to have marketing communications made to them only if authorized by the patient; and
- to decline to have PHI delivered to health insurers if the patient pays for services in full without submitting a claim.

If you have any concerns or wish to file a complaint, please contact Ann Episcopo, Twin Palm Orthopedics at (352) 369-1099.

SIGNATURE _____ DATE___/___/___

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____