

**Marianna Orthopedic and Sports Medicine Clinic**  
 3051 6th Street  
 Marianna, FL 32446  
 (850) 526-3236 • Fax (850) 526-4060



**Tallahassee Orthopedic Clinic  
 Tallahassee Sports Medicine**  
 3334 Capital Medical Blvd., Suite 400  
 P.O. Box 13100 • Tallahassee, FL 32317-3100  
 (850) 877-8174 • Fax (850) 877-5636



**Southern Orthopedic Specialists**  
 603 S. Wheat Ave., Suite 800  
 Bainbridge, GA 39819  
 (229) 246-3608 • Fax (229) 246-1635

Acct. #: \_\_\_\_\_ Doctor #: \_\_\_\_\_ Date: \_\_\_\_\_

**I. PAYMENT METHOD:**  Cash  Credit Card:  MasterCard  Visa  American Express  Discover  Personal Check

**II. PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_

Current Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Permanent Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Widowed

Describe your medical problem for today's visit: \_\_\_\_\_

How were you injured? \_\_\_\_\_

Right  Discomfort

**IMPORTANT**

Left  Injury Date of onset or accident: \_\_\_\_\_

If Injury:  Work Related  Auto-Accident  Athletic-Name of School: \_\_\_\_\_ Sport: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Doctor that referred you: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

**X-RAY/MRI:** Have you had X-Rays? . . . . .  Yes  No

Have you had a MRI? . . . . .  Yes  No

Do you have these CD/Films with you today? . . . . .  Yes  No

**III. INSURANCE**

**PRIMARY INSURANCE CARRIER:**

Name of Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Holder's SS #: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Policy Holder's Employer Address: \_\_\_\_\_

Policy Holder's Employer Phone #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**SECONDARY INSURANCE CARRIER:**

Name of Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Holder's SS #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

#### IV. DISCLOSURE

TOC, pursuant to applicable Federal and Florida law, makes the following disclosures: Patient is not required to obtain items of service from any of the following departments of TOC or other entities which patient may be referred. Patient may obtain items or services from a provider or supplier of patient's choice. Alternative sources are described below:

**Tallahassee Outpatient Surgery Center:** The following Tallahassee Orthopedic Clinic III, P.L. members own an investment interest in Tallahassee Outpatient Surgery Center: Tom C. Haney, M.D.; W.D. Henderson, Jr., M.D.; Robert L. Thornberry, M.D.; Charles H. Wingo, M.D.; Donald M. Dewey, M.D.; Steve E. Jordan, M.D.; Mark E. Fahey, M.D.; D. Christian Berg, M.D.; Garrison A. Rolle, M.D.; William H. Thompson, M.D.; Floyd R. Jaggars, M.D.; Andrew M. Wong, M.D.; Andrew H. Borom, M.D.; David A. Bellamy, M.D.; and Thomas M Park, M.D. Patient may obtain alternative services from a provider of their choice or any of the following providers:

(a) Capital Regional Medical Center, 2626 Capital Medical Blvd., Tallahassee, FL; or (b) Tallahassee Memorial Hospital, 1300 Miccosukee Road, Tallahassee, FL.

**Tallahassee Orthopedic Clinic, MRI Department:** TOC MRI is wholly owned and operated by TOC. Patient may obtain alternative services from another provider or any of the following: (a) Open MRI of Tallahassee, LLC, 2910 Kerry Forest Parkway, Tallahassee, FL; (b) Centre Pointe Diagnostic Imaging, 2457 Care Drive, Tallahassee, FL; (c) Tallahassee Diagnostic Imaging, 1623 Medical Drive, Tallahassee, FL; (d) Tallahassee MRI, 2332 Capital Circle NE, Tallahassee, FL; (e) Tallahassee Health Imaging, 1925 Capital Circle, NE, Tallahassee, FL; (f) Tallahassee Neurological Clinic Open MRI Center, 2824 Mahan Drive, Tallahassee, FL; (g) Capital Regional Medical Center, 2626 Capital Medical Blvd., Tallahassee, FL; (h) Tallahassee Memorial Hospital, 1300 Miccosukee Road, Tallahassee, FL.

**Tallahassee Orthopedic Clinic, Division of Orthotics and Prosthetics:** TOC Division of Orthotics and Prosthetics is wholly owned and operated by TOC. Patient may obtain alternative services from another provider or any of the following: (a) Williams Orthotic-Prosthetic, 2360 Centerville Road, Tallahassee, FL; (b) Hanger Prosthetics & Orthotics, 1718 Mahan Drive, Tallahassee, FL; (c) Ambulatory Ankle & Foot Care Center P.A., 1608 W. Plaza Drive, Tallahassee, FL; (d) Freedom Fabrication, 815 N. Main Street, Havana, FL.

**Tallahassee Orthopedic Clinic, Pharmacy Department:** All physicians of the Tallahassee Orthopedic Clinic, III, P.L. own an investment interest in the pharmacy. Patients may obtain pharmaceutical services from any other pharmacy of their choice.

#### V. AUTHORIZATION

The undersigned patient, legal guardian of patient or authorized individual acting on behalf of the patient, understands and agrees as follows:

I. **Consent: Tallahassee Orthopedic Clinic III, P.L. (TOC) reserves the right to designate any of its physicians, physician extenders, medical staff and/or other lawfully authorized designee to perform and administer all care and treatment to the patient.**

II. **Release and Medical Information:**

- A. **Workers' Compensation Patient:** TOC is hereby granted by patient authority to release to patient's insurance carrier, health maintenance organization, employers, attorney, their representatives or referring physician, all medical information regarding workplace injury in connection with any treatment rendered to patient by TOC.
- B. **Insurance Carrier/Health Maintenance Organization:** TOC is hereby authorized to release to patient's insurance carrier/HMO or other similar plan, all medical information necessary to process payment claims for services rendered by TOC.
- C. **Governmental Benefits:** TOC is hereby authorized to release all medical information necessary to process governmental claims, including, but not limited to Medicare, Medicaid, Tricare, Vocational Rehabilitation, for services rendered by TOC.
- D. I acknowledge that Tallahassee Orthopedic Clinic generates and maintains electronic medical records and agrees to such. I acknowledge and agree that all such electronic records and any electronic signatures shall have the same force and effect as original written records and signatures. I further acknowledge that I am entitled to a copy of my records in paper form upon request and reasonable payment for such copies.

III. **Financial Responsibility:**

**Unless otherwise stated herein, the undersigned shall pay to TOC such sums as are now or may become due for services rendered to or on behalf of patient by TOC.** In the event that Patient/undersigned is financially responsible for medical services rendered to patient by TOC and the patient or undersigned fails to pay account balance within 30 days from the due date, TOC may refer the account to an attorney or collection agency for recovery of sums due to TOC. In that event, TOC shall be entitled to recover attorney's fees and/or collection costs (28%). TOC does offer payment plans through Care Credit for outstanding balances which on the request of the financially responsible party may be discussed with a TOC Account Specialist.

**Preauthorizations:** In the event that patient at time of appointment with TOC fails to obtain the required preauthorization number, patient's appointment may be rescheduled or canceled. Patient shall be financially responsible for services rendered by TOC if patient's HMO/insurance carrier fails to pay the claim for services rendered. Likewise, if patient provides to TOC a preauthorization number that has expired or otherwise is not a valid preauthorization number and patient's insurance carrier/HMO fails to pay the claim, the patient shall be fully financially responsible for services rendered by TOC.

**THE UNDERSIGNED ACKNOWLEDGES THAT THEY HAVE READ AND FULLY UNDERSTAND THE FOREGOING DISCLOSURE AND AGREE TO BE BOUND BY THE OBLIGATIONS HEREUNDER AND CONSENT TO THE AUTHORIZATIONS DESCRIBED ABOVE.**

I acknowledge, understand and agree that Sections IV and V of this Form shall remain in full force and effect from this date forward, through the current and all future courses of treatment, unless and until revoked or modified by me in writing provided to TOC. I also acknowledge, understand and agree that I must provide TOC with updated information regarding my personal and insurance information and that I will complete and sign such documentation as required by TOC.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT OR PARENT/LEGAL GUARDIAN

#### VI. ASSIGNMENT OF BENEFITS

I, the undersigned insured or beneficiary of an insurance policy, assign to Tallahassee Orthopedic Clinic III, P.L. (TOC) any and all rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest and/or damages pursuant to Section 624.155 of the Florida Statutes. This AOB supersedes any request by the insured to reserve benefits for lost wages. I request that payment of authorized State, Federal or private insurance carrier benefits be made to TOC for any covered services furnished to me by TOC. I acknowledge that TOC objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by TOC shall be done under protest, at the risk of the Insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. If my insurance carrier pays me directly, I agree to forward all funds to TOC within 10 working days. I agree that I am responsible for paying all non-covered or unpaid amounts unless otherwise provided by law, regulations or TOC's contractual relationships. I agree to be responsible for the full amount of the charges from the date services are rendered which my third party payer does not pay for within 60 days. I acknowledge, understand and agree that this Assignment of Benefits and Direction to Pay Benefits Owed shall remain in full force and effect from this date forward, through the current and all future courses of treatment. I also acknowledge, understand and agree that I will complete and sign such documentation as required by TOC in order to complete or perfect its rights to any and all benefits payable to me for medical services provided to me by TOC. A photocopy of this Assignment shall be considered as effective and valid as the original.

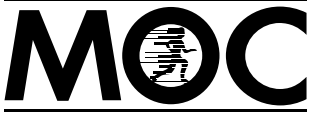
\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT OR PARENT/LEGAL GUARDIAN

I acknowledge and understand the TOC Notice of Privacy Practices and have received, read and understand the TOC Financial Policies brochure.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT OR PARENT/LEGAL GUARDIAN



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## PATIENT MEDICAL HISTORY FORM

Acct. #: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender:  Male  Female

Reason for visit: \_\_\_\_\_

Any recent diagnostic tests for this problem? \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_ Who referred you to this office? \_\_\_\_\_

**ALLERGIES:**

Are you allergic to latex?  No  Yes

Are you allergic to any medicines (including any tape, iodine or latex)?  No  Yes (If "Yes", please complete the allergy information below):

Allergies to Medications	Type of Reaction You Experience

**PAST SURGICAL HISTORY:**

Type of Operation	Date or Age at Time of Operation

**CURRENT MEDICATIONS:**

Medication	Dose	Frequency	Medication	Dose	Frequency

Are you required to take antibiotics before procedures?  Yes  No

Are you on Oxygen or CPAP?  Yes  No

Is there a chance you may be pregnant?  Yes  No

**SOCIAL HISTORY:**

Do you smoke? . . . . .  Yes  No If "Yes", how much per day and how many years? \_\_\_\_\_  
 Have you ever smoked? . . . . .  Yes  No If "Yes", start date/quit date: \_\_\_\_\_  
 Do you drink alcohol? . . . . .  Yes  No If "Yes", how much, how often? \_\_\_\_\_  
 Are you exposed to second-hand smoke? . . .  Yes  No  
 What is your occupation? \_\_\_\_\_ Who currently lives in your home? \_\_\_\_\_  
 (relationship to you) \_\_\_\_\_ (relationship to you) \_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

Cancer . . . . .  Yes  No \_\_\_\_\_ Bleeding Problem . . .  Yes  No \_\_\_\_\_  
 High Blood Pressure . . . . .  Yes  No \_\_\_\_\_ Diabetes . . . . .  Yes  No \_\_\_\_\_  
 Heart Problems . . . . .  Yes  No \_\_\_\_\_ Seizures/Epilepsy . . .  Yes  No \_\_\_\_\_  
 Hepatitis . . . . .  Yes  No \_\_\_\_\_ Asthma . . . . .  Yes  No \_\_\_\_\_

Unusual reaction to anesthesia? \_\_\_\_\_

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Today's Date

Acct. #: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Have you been diagnosed with or are you currently having problems with any of the following:

- Cardiac (heart/circulation)**      Yes No
- Chest Pain . . . . .
  - Congestive Heart Failure. . . . .
  - High Blood Pressure . . . . .
  - Heart Valve Problems . . . . .
  - Heart Murmur . . . . .
  - Heart Attack. . . . .
  - Pacemaker . . . . .
  - Palpitations . . . . .
  - Rheumatic Fever . . . . .
  - Irregular Heart Beat . . . . .

- Pulmonary (lung)**
- Shortness of Breath . . . . .
  - Wheezing . . . . .
  - Emphysema/COPD . . . . .
  - P.E./Pulmonary Embolism . . . . .
  - Asthma . . . . .
  - Chest Tightness. . . . .
  - Lung Cancer . . . . .
  - Recurrent Bronchitis . . . . .
  - Recurrent Cough . . . . .
  - Bloody Cough . . . . .
  - Productive Cough . . . . .

- Digestive (stomach/intestines)**
- Heart Burn . . . . .
  - Ulcers . . . . .
  - Abdominal Pain. . . . .
  - Acid Reflux Disease . . . . .
  - Pancreatitis . . . . .
  - Diverticulitis. . . . .
  - Cirrhosis . . . . .
  - Crohn's/Colitis . . . . .
  - Irritable Bowel Syndrome . . . . .
  - Constipation. . . . .

- Kidneys**      Yes No
- Kidney Failure. . . . .
  - Recurrent Kidney Infection . . . . .
  - Urinary Retention . . . . .

- Endocrine (hormone)**
- Thyroid Problems. . . . .
  - Chronic Fatigue. . . . .
  - High Blood Sugar . . . . .
  - Excessive Thirst . . . . .
  - Diabetes . . . . .

- Hematologic (blood)**
- Anemia . . . . .
  - Immune Deficiency . . . . .
  - Leukemia . . . . .
  - Clotting Problem/DVT (deep vein thrombosis) . . . . .

- Infectious Disease**
- Hepatitis (A, B, or C). . . . .
  - Chronic Fatigue Syndrome. . . . .
  - AIDS/HIV. . . . .
  - Chronic Epstein-Barr . . . . .
  - Tuberculosis . . . . .

- Musculoskeletal**
- Chronic Back Problems . . . . .
  - TMJ Syndrome. . . . .
  - Chronic Neck Problems . . . . .
  - Arthritis MS or MD. . . . .
  - Fibromyalgia. . . . .

- Skin**      Yes No
- Psoriasis . . . . .
  - Eczema . . . . .
  - Jaundice . . . . .
  - Slow Healing . . . . .
  - Scarring/Keloids . . . . .

- Neurologic**
- Seizure . . . . .
  - Multiple Sclerosis . . . . .
  - Loss of Strength . . . . .
  - Stroke/TIA . . . . .
  - Parkinson's . . . . .
  - Migraine Headaches . . . . .
  - Numbness . . . . .

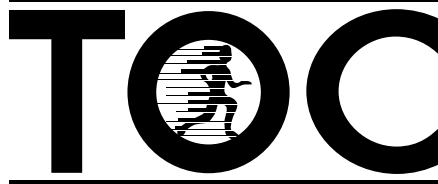
- Psychological**
- Depression . . . . .
  - Bipolar Disorder . . . . .
  - Anxiety/Nervousness . . . . .
  - Schizophrenia . . . . .
  - Paranoia . . . . .

- Immune System**
- Lupus . . . . .
  - Autoimmune Disease . . . . .
  - Immune Deficiency . . . . .

**Cancer:**  
 Type: \_\_\_\_\_ First Diagnosed: \_\_\_\_\_  
 Treatment: \_\_\_\_\_

**Other:**  
 Do you have any reactions with anesthesia? \_\_\_\_\_  
 Do you have any other health conditions that are not listed? \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_



**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Many insurance companies write requesting account detail after we send in the claim. Please indicate if those charges are the result of an accident / injury. Please answer the following questions and return to the receptionist. To process this claim, we need complete accident / injury details.

Name of Insurance: \_\_\_\_\_

Body Part: \_\_\_\_\_  Right  Left  Discomfort  Injury

If injury:  Work Related  Athletic

Auto Accident

Name of School: \_\_\_\_\_

Sport: \_\_\_\_\_

Other: \_\_\_\_\_

Was there a specific accident / injury:  No  Yes (*please give details*):

Describe how the accident / injury occurred:

Date of accident / injury: \_\_\_\_\_ Time: \_\_\_\_\_ am / pm

Place of accident / injury: \_\_\_\_\_

Owner of property where accident / injury occurred (*name*):

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\* Completion of this form expedites payment of your medical bills \*\***

3334 CAPITAL MEDICAL BOULEVARD, SUITE 400  
P.O. BOX 13100 • TALLAHASSEE, FL 32317-3100  
(850) 877-8174 • FAX (850) 877-5636

[www.tlhoc.com](http://www.tlhoc.com)

# TALLAHASSEE ORTHOPEDIC CLINIC

## DISCLAIMER OF LIABILITY FOR MULTIPLE RADIOLOGIC STUDIES

In the event you or your physician provide a disk or other media that contains multiple radiology images or studies, Tallahassee Orthopedic Clinic (“TOC”) physicians will only review those images or radiologist reports related to the problem for which you are being treated by a TOC physician. In some cases, your TOC physician will only review the radiologist report for the radiological study performed related to the problem for which you are being treated by the TOC physician and will not review any other images contained on the disk or other media.

I (*print patient name*), \_\_\_\_\_, acknowledge that TOC physicians will not review all radiological images, studies and reports on the computer disk or other media I or my physician provided to TOC, and will only view to the extent deemed medically necessary and appropriate the report issued by the radiologist and those specific images relevant to the treatment to be provided by TOC; and I hereby acknowledge and agree that I, my successors, and my assigns forever release from liability TOC, its Board of Directors, shareholders, agents, employees, independent contractors, and designees (“Released Parties”) from any and all claims or demands for personal injury, sickness or death, of any nature whatsoever which may be incurred by the undersigned and/or the minor or incompetent patient that may result in the event a Released Party does not read any or all radiological images, studies or reports on the computer disk or other media I or my physician provided to TOC. To the extent that the radiology report indicates that follow up should be initiated for any condition, injury, or illness that is not associated with the basis for the treatment provided by TOC, it shall be the responsibility of the patient and his or her primary physician to arrange for any needed follow up or treatment.

I certify that I am at least 18 years of age (or if under 18 years of age, that I am joined herein by my parent or legal guardian) and that this release is signed voluntarily, under no duress, and with the full understanding of the terms of this Agreement.

This Agreement contains the full terms of release intended by the parties and may not be changed except in writing signed by both parties to this Agreement.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian  
(*If Patient is under the age of 18 or incompetent*)

\_\_\_\_\_  
Date