

# BLUEWATER ORTHOPEDICS, P.A.

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## Patient Registration Information

PATIENT INFORMATION					
LAST NAME	FIRST	MI	SOCIAL SECURITY NO.	DATE OF BIRTH	
ADDRESS			<b>RESPONSIBLE PARTY STATEMENT</b>		
CITY	STATE	ZIP CODE	SEX	IN THE CASE OF MINOR CHILDREN MY SIGNATURE BELOW CONSTITUTES ACCEPTANCE OF FINANCIAL RESPONSIBILITIES FOR ABOVE NAMED MINOR.	
HOME PHONE ( ) ( ) ( )	CELL/PAGER ( ) ( ) ( )	WORK PHONE ( ) ( ) ( )	RESPONSIBLE PARTY SIGNATURE		TODAYS DATE
EMAIL ADDRESS			X		/ /
IF STUDENT, NAME OF SCHOOL			EMPLOYER		

WHY ARE YOU HERE?

HOW DID YOUR INJURY HAPPEN?

DATE OF INJURY OR PAIN:

HAVE YOU SEEN ANY DOCTOR IN THE PAST 30 DAYS?  
 YES  NO IF SO WHO?

PARENT / POLICY HOLDER / SPOUSE					
SPOUSE OR DEPENDENTS LAST NAME (IF DIFFERENT)		FIRST NAME	MI	EMPLOYEED BY	
DATE OF BIRTH	SEX	RELATIONSHIP	SOCIAL SECURITY NO.	ADDRESS	
ADDRESS		TELEPHONE ( ) ( ) ( )	CITY	STATE	ZIP CODE
CITY	STATE	ZIP CODE	WORK PHONE ( ) ( ) ( )		

IN CASE OF EMERGENCY NOTIFY (OUT-OF-HOUSEHOLD)				
LAST NAME	FIRST	MI	ADDRESS	TELEPHONE ( ) ( ) ( )

INSURANCE COMPANY INFORMATION						
PLEASE GIVE US YOUR INSURANCE CARD(S) TO BE COPIED						
MEDICARE ( )	MEDICAID ( )	BC/BS ( )	WORKERS COMP ( )	AUTO ( )	OTHER ( )	NONE ( )

MEDICAL RELEASE AUTHORIZATION	
Insured party must sign all claims. Dependent patient must also sign if not a minor. I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claims. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.	
INSURED PARTY SIGNATURE X	DATE / /
INSURED PARTY SIGNATURE X	DATE / /

PAYMENT OF BENEFITS	
I authorize payment of benefits, as determined by my insurance Company, to be made directly to: <div style="text-align: center;">BLUEWATER ORTHOPEDICS, P.A.</div>	
INSURED PARTY / GUARANTOR SIGNATURE X	DATE / /

**Thank You For Choosing Our Office!**  
 ALL RETURNED CHECKS SUBJECT TO FEES AS PER  
 FLORIDA STATE LAW.

## Financial Policy

It is the policy of Bluewater Orthopedics, P.A., that payment for all services are due and payable at the time of service. We will file your insurance as a courtesy, and as per our contractual arrangements with some insurance carriers.

### Contracted Insurance Carriers

Bluewater Orthopedics, P.A. has an ever-growing list of insurance carriers with whom we participate. Our offices will verify your benefits before your appointment. For those insurance companies that we have participation agreements with, we will accept assignment of benefits except for deductible, copay, and non-covered services, which are due and payable at the time of service. As contracts are being added and terminated during the course of the year, your provider guides may not accurately reflect our participation status, please contact your carrier to confirm our participation with your insurance.

### Medicare

Bluewater Orthopedics, P.A., will accept assignment of benefits as a participating provider with the Medicare program. The patient must present proof of Medicare coverage at the time of initial registration. The patient will be responsible for all co-insurance, deductible, and for services not covered by Medicare at the time of service.

### Medicaid

Bluewater Orthopedics, P.A., does participate in the Medicaid program. We will see adults by referral from hospital emergency rooms when we are on call and for all children with fractures.

### Workers Compensation

Bluewater Orthopedics, P.A., will accept assignment of benefits for workers treated at our facilities that are covered under verifiable workers compensation insurance, with which we have an active contract. Self-insured, or companies not wishing to file workers compensation, must pay for services at the time of service by company check or your employee will be expected to pay and you will be responsible for reimbursement. If this office is not able to verify and obtain authorization to treat, the patient will be considered personally responsible until we are able to verify and obtain such authorization.

### Non Contracted Payors/Indemnity Coverage

As a courtesy to our patients that hold insurance for companies with whom we are not contracted, we will bill the plan with a valid assignment of benefits. You will be responsible for copays; co insurance, deductibles and non-covered services. We will expect payment at the time of service.

### Non Insured/Self Pay

Payment will be expected for all services at the time of service. At the time of initial appointment, we will give you an estimate of charges. You will be expected to be prepared to pay this amount at the time of initial visit. **Prior** arrangements can be established with the approval from the business office. Payment plans will be as follows; initial office visit charges are due and payable at the time of service. Additional or extensive services can be set up on a \$50 per month installment plan, with the expectation that the balance be paid within 90 days of the completion of treatment.

### Surgery

Non insured surgical patients would be expected to fully pay for the surgical procedure. Payment in full is due at the time the surgery is scheduled.

All insured patients will be expected to pay before surgery, their patient responsibility, surgical copays, co insurance percentages, and unsatisfied deductibles.

The charges that you will be expected to pay are for the surgeon's fee only and will not include anesthesia, or facility fees or other services rendered in conjunction with your surgery.

Some insurance companies pay fixed allowances for procedures, others pay based on percentage of the actual charge. It is your responsibility to pay for any unsatisfied deductible, co insurance, copays, or balances owed for services not covered by your insurance. As this insurance is your policy, you are responsible to know your benefits. We will assist you in any way we can.

I have read and understand the above written financial policy. My signature below signifies my understanding and agreement with the policies that are applicable to my situation.

I directly assign all medical/surgical benefits to Bluewater Orthopedics, P.A. and understand that I am financially responsible for all charges, whether or not they are paid by my insurance. I hereby authorize Bluewater Orthopedics, P.A. to release all information necessary to secure payment of these benefits.

**Insured/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

# BLUEWATER *BD* ORTHOPEDICS

## PATIENT HISTORY FORM

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Age: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: Single \_\_ Married \_\_ Divorced \_\_ Widow \_\_  
 Occupation: \_\_\_\_\_ Referring Physician \_\_\_\_\_  
 Chief Complaint (*Reason for today's visit*): \_\_\_\_\_  
 HPI (*Please leave blank*): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAST MEDICAL HISTORY:** Do you or have you ever had (*circle yes or no*)

Heart Problems.....Yes No	Kidney Disease.....Yes No	Epilepsy.....Yes No
Diabetes.....Yes No	Arthritis.....Yes No	Cataracts.....Yes No
High Blood Pressure.....Yes No	Stroke.....Yes No	Jaundice.....Yes No
Pneumonia.....Yes No	Thyroid Disease.....Yes No	Gout.....Yes No
Cancer.....Yes No	Nervous Breakdown.....Yes No	Other Illness (please list) _____
Stomach/Duodenal Ulcer...Yes No	Asthma or Emphysema.....Yes No	_____

**PAST SURGICAL HISTORY:** (*List all previous operations*)

1)	<u>Type</u>	<u>Year</u>	<u>Surgeon</u>
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____

Any previous fractures: Yes\_\_ No\_\_ Describe: \_\_\_\_\_  
 \_\_\_\_\_

Any other serious injuries: Yes\_\_ No\_\_ Describe: \_\_\_\_\_  
 \_\_\_\_\_

**CURRENT MEDICATIONS:** (*Please list all current medicines*)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DRUG ALLERGIES:** (*Please list all medicines you are allergic to*)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY:** Do you know of any blood relative who has had (*Check and give relationship*)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cancer_____                  | <input type="checkbox"/> Tuberculosis_____      | <input type="checkbox"/> High Blood Pressure_____ |
| <input type="checkbox"/> Anesthesia Complication_____ | <input type="checkbox"/> Heart Disease_____     | <input type="checkbox"/> Mental Illness_____      |
| <input type="checkbox"/> Diabetes_____                | <input type="checkbox"/> Bleeding Disorder_____ | _____   |
| <input type="checkbox"/> Epilepsy_____                | <input type="checkbox"/> Stroke_____            | _____   |

