

BLUEWATER ORTHOPEDICS, P.A.

THOMAS M. FOX, D.O. • WILLIAM J. MARKOWSKI, M.D. • STEVEN S. DONCHEY, M.D.
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Patient Registration Information

PATIENT INFORMATION						
LAST NAME		FIRST	MI	SOCIAL SECURITY NO.		DATE OF BIRTH
ADDRESS				RESPONSIBLE PARTY STATEMENT		
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 X		TODAYS DATE / /
EMAIL ADDRESS				EMPLOYER		
IF STUDENT, NAME OF SCHOOL						

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: <p style="text-align: center;">BLUEWATER ORTHOPEDICS, P.A.</p>	
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 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*)

Type	Year	Surgeon
1) _____	_____	_____
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 _____ | _____ |

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 4-14-03

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a physician, hospital or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnosis, treatment, a plan for future care or treatment, and billing related information. Your record represents Protected Health Information.

We are committed to treating and using Protected Health Information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice applies to all Protected Health Information, as defined by federal regulations that is generated by our office.

THE FOLLOWING CATEGORIES DESCRIBE EXAMPLES OF THE WAY WE USE AND DISCLOSE HEALTH INFORMATION.

For Treatment: We may use your health information to provide you with medical treatment or services. We may disclose medical information about you to other health professionals who contribute to your care (such as doctors, nurses, technicians, or other personnel who are involved in taking care of you).

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. For example, we may need to give your insurance company information about your treatment so they will pay us for the treatment. We may also tell you health plan about treatment you are going to receive to determine whether your plan will cover it.

For Healthcare Operations (Business Associates): There are some services provided in our office through contracts with business associates. Examples include transcription of your dictated health information, a copy service making copies of your health records, and off-site storage of medical records. When services such as these are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

For Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Communication with Family or Friend: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

We may also use and disclose medical information to /for the following:

- To remind you that you have an appointment
- To assess your satisfaction with our services
- Food and Drug Administration
- Organ and Tissue Donation Organizations
- Health Oversight Agencies
- Funeral Directors, Coroners, Medical Directors
- Public Health Authorities
- Workers Compensation Agents
- Legal Authorities
- Military Command Authorities
- National Security & Intelligence Agencies
- Proactive Services for the President
- for law enforcement purposes as required by law or in response to subpoena
- to notify or assist in notifying a disaster relief entity that your family can be notified about your health status

Although your health record is the physical property of this office, you have the right to:

Inspect and Copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We are allowed to charge you for these copies.

Amend: If you feel that medical information is incorrect or incomplete, you may ask us to amend (not change) the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment, or healthcare operations.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food and Drug Administration, work-related injury, and OSHA compliance.

A Paper Copy of this Notice: You may ask us to give you a copy of this Notice.

If you have any questions about this Notice, please contact our Privacy Officer at 850-897-8081.

We reserve the right to change this notice and make the new provisions effective for all Protected Health Information in our office at 1950 Bluewater Blvd, Suite 100, Niceville, FL 32578. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may revoke your permission to use or disclose medical information about you, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of Notice of Privacy Practices, Office of Bluewater Orthopedics PA, Niceville, FL.

By signing this document, I acknowledge that I have read a copy of this office's Notice of Privacy Practices.

PRINT NAME

SIGNATURE

DATE

OFFICE USE ONLY:

Date Acknowledgement received _____ by _____

OR reason Acknowledgment was not obtained. _____

Bluewater Orthopedics, P.A.

DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act of 1996 you have the right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating below.

Thomas M. Fox, D.O.
Orthopedic Surgeon
Sports Medicine
Board Certified

DESIGNATION SECTION

William J. Markowski, M.D.
Orthopedic Surgeon
Sports Medicine
Board Certified

I, _____ (Print Name) hereby nominate the following person(s) to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

Steven S. Donchey, M.D., F.A.C.P.
Musculoskeletal Medicine
Sports Medicine
Board Certified

_____	_____
Name	DOB
_____	_____
Name	DOB

Rustin G. Sorensen, P.A.-C
Certified, National Commission on
Certification of Physician Assistants

The authority of this person(s) when acting as my personal representative is restricted to the following functions (describe in detail):

Erin N. Robinson, P.A.-C
Certified, National Commission on
Certification of Physician Assistants

I understand that not completing the description of privileges, will allow my personal representative to have the same privileges that would be afforded to me.

I understand that I may revoke this designation at anytime by signing the revocation section below. I understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

Signature Date

REVOCACTION SECTION

I hereby revoke this designation of a personal representative effective this _____ day of _____

Signature Date

BLUEWATER ORTHOPEDICS, P.A.

CONTROLLED SUBSTANCES

The purpose of the acknowledgment is to protect your access to controlled substances and to protect our ability to prescribe for you.

Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If you medication has been stolen, please file a police report regarding theft and notify the office.

Prescriptions need to be called into the office at least **48 hours prior** to refill requests. This will allow ample time for the response of your request to be handled in a timely manner with nurses and physicians. If you call in the prescriptions after hours or on the weekends, the request will be handled the next business day and given up to 48 hours for refills.

For continuation of prescribed medication you must be seen within a three (3) month period. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit, or as recommended by your physician.

All controlled substances should be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they proved long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with prior addition.

These drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. Multiple sources can lead to untoward drug interactions or poor coordination of treatment. All controlled substances must come from the physician, or during his or her absence, by the covering physician, unless specific authorization is obtained for an exception.

You may not share, sell or otherwise permit others to have access to these medications. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left in reach of children or any person who is not tolerant to their effects.

If the policy is not adhered to or violated, this could be grounds for dismissal.

PATIENT SIGNATURE

PRINT NAME

DATE