

WELCOME TO OUR OFFICE

Please review a few of our office policies. If you would like a copy of this, please notify the receptionist:

Prescription Refills

Refill request made after 12:00 p.m. will not be filled until the next business day.

Due to prescription fraud, it is our office policy that written prescriptions are only released to authorized individuals listed on the patient information sheet. If any other person (not listed) picks up a written prescription we must have a signed consent from the patient notifying us of this. Copy of a picture ID is necessary in order to release the prescription. **WE WILL NOT RELEASE THE PRESCRIPTION WITHOUT WRITTEN CONSENT!!**

The on-call physician will not call in prescriptions on weekends, please call in advance for all refill requests. Do not wait until you are completely out of medication.

Payment Policy

Payment is expected at time of service unless prior arrangements have been made in advance. Patients are responsible for paying their annual deductible, co-insurance payments and any non-covered service charges at the time of the visit. The office accepts MasterCard, Visa, Discover and American Express.

HMO/Medicare Replacement Plans

If you are enrolled in a HMO or Medicare Replacement Plan it is your responsibility to notify the office staff before treatment. It is the responsibility of the patient to assure that the office staff has a referral/authorization on file for your visit. Your signature below indicates you understand and will assume financial responsibility for any claims rejected by the insurance carrier for reasons such as non-provider, no authorization, etc.

Copy Request

Your records are the property of Coastal Orthopaedic & Sports Medicine Center. This includes X-rays or MRI's performed within our practice. We will be happy to provide you with a copy of your records after receiving a written request. The cost associated with copying is \$1.00 per page for medical records (.50 cents if your injury is being covered by workers compensation) and \$7.50 per sheet for x-rays or \$7.50 per CD for MRI's. (charges associated for copying MRI's or X-rays will be covered by the workers compensation carrier if your injury is work related). **The office requires a 24-hour advance notice if you need copies of medical records, x-rays or MRI's.**

Forms

Forms can be submitted to the office for completion. This is an additional service that is provided for our patients. Therefore, there is an additional charge of \$10 up to \$25 depending on the form. Payment must be made in full before the form can be completed. Please allow adequate time for completion.

Patient Signature

Date

NORMAN PALMERI, M.D.
 JOHN HRUSKA, M.D.

EDWARD ROSSARIO, M.D.
 GERALD SHUTE M.D.

(Please Print)

DATE: _____		REFERRING DOCTOR: _____	
PATIENT INFORMATION			
PATIENT'S LAST NAME	FIRST	MI: _____	<input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS <input type="checkbox"/> MS.
_____		_____	
Marital status:		Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name? _____	DOB: _____	Age: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address: _____		Social Security no.: _____	Home phone no.: () _____
City _____	State _____	ZIP Code: _____	Alternative Phone # (cell) _____
Employer: _____	Employer Address: _____	Employer phone no.: () _____	
How were you referred: (Please check one ox):		<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Phonebook <input type="checkbox"/> Insurance plan <input type="checkbox"/> Family
<input type="checkbox"/> Friend: Name: _____	Hospital: SLMC OR LPMC	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other _____
Please list any person/s that we may speak with about your healthcare. You may at any time with written authorization change or revoke this authorization. By completing this section, you authorize the following person/s to discuss all your health care needs, billing issues and or questions.			
1. _____		2. _____ 3. _____	

INSURANCE INFORMATION	
(Please present your drivers license and your insurance card/s to the receptionist.)	
PRIMARY INSURANCE: _____ POLICY # _____ GROUP# _____	
NAME OF INSURED: _____ DOB _____ SSN# _____	
SECONDARY INSURANCE: _____ POLICY # _____ GROUP# _____	
NAME OF INSURED: _____ DOB _____ SSN# _____	
Is the <u>Primary</u> insurance listed above provided by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please list employers name. Name of Employer: _____	
Is the <u>Secondary</u> insurance listed above provided by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please list employers name. Name of Employer: _____	

RESPONSIBLE PARTY INFORMATION (If Minor)	
Last Name: _____	First Name: _____ MI _____ DOB _____
Address: _____ Home # _____ Work # _____	
Relationship to Patient _____	

IN CASE OF EMERGENCY	
Name of local friend of relative (not living at the same address)	
Home # _____	Work # _____
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Coastal Orthopaedic & Sports Medicine Center or insurance company to release any information required to process my claims.	

Patient Signature (<i>parent if minor</i>) _____	Date _____
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SOCIAL HISTORY

Right Handed Left Handed Do you live Alone? Yes No

Do you Smoke? Yes No Never Quit Date _____

Do you use Alcohol? Yes No How often? Socially Moderate to Heavy

History of Drug Abuse? Yes No How Often? Presently Past

Do you exercise? Yes No List your Interest or Hobbies: _____

PREVIOUS SURGERIES

Tonsils Gallbladder Appendix Prostate Hysterectomy Cancer

Back Cervical Lumbar Fracture

Other List: _____

FAMILY HISTORY

Has a member of your family had a history of any of the following conditions?

Stroke Heart Disease Arthritis Gout Seizures Cancer

Mental Illness Kidney Disease or Stones Bleeding Disorders Alcoholism Addiction

HIV/Aids Leukemia Hypertension Other: _____

Explain all Yes Answers: _____

LIST OF CURRENT MEDICATIONS, DOSAGES AND FREQUENCY

Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATION

NAME OF DRUG	REACTION YOU HAD

PATIENT SIGNATURE: _____ DATE: _____

COASTAL ORTHOPAEDIC & SPORTS MEDICINE CENTER

TAX ID: 56-1746429

- Norman Palmeri, M.D. Edward Rossario, M.D.
 John Hruska, M.D. Gerald Shute, M.D.

INJURY/ACCIDENT INFORMATION FORM

Dear Patient:

At times, insurance companies require accident details in order to properly process claims. If your injury was a result of an accident of **ANY KIND** (fracture, fall, sports injury, auto, work injury) please fill out the requested information. If your injury was not related to any type of accident, please make NA (not applicable) on this entire form and sign at the bottom.

Patients Name:

Insurance Company:

Please answer the following questions in order to provide your insurance company information to process claims for benefits for all types of accidents. If this form is not completely filled out you may be responsible for any accrued balances.

When and where did the accident occur? Please be specific as to exact date and time and place if possible.

In detail, describe how the injury/accident occurred.

Are there any additional benefits payable by other responsible persons as a result of the accident? (Example: Homeowners Ins or Personal Liability)

- Yes No

If yes, please notify the front desk before treatment is provided. We will need the name, address and ID# of responsible party.

IF INVOLVED IN A MOTOR VEHICLE ACCIDENT, ANSWER THE BELOW QUESTIONS. IF YOU WERE NOT INJURED IN AN AUTO ACCIDENT, MARK N/A:

Were you the: Driver Passenger

Were there any other passengers in the vehicle with you that may have been injured?
Yes No

Was a police report filed? If so, please provide the name and address of police department taking the report.

Thank You

Patient's Signature (parents if minor)

Date

Office Use Only: Receptionist

Initials: _____

COASTAL ORTHOPAEDIC & SPORTS MEDICINE CENTER

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Coastal Orthopaedic and Sports Medicine (herein after referred to as the “practice”) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations. I understand diagnosis or treatment of me by my treating physician: may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment for healthcare operations of the practice. The practice agrees to a restriction that I request, the restriction is binding on Coastal Orthopaedic & Sports Medicine Center and My Treating Physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that My Treating Physician and Coastal Orthopaedic & Sports Medicine Center has taken action in reliance on this consent.

My “protected health information” means health information including demographic information, collected from me and created or received by physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or if there is a reasonable basis to believe that information may identify me.

I understand I have a right to review the practices Notice of Privacy Practices prior to signing this document. By signing this document, I acknowledge that the practices Notice of Privacy Practices has been provided to me and that I have had the opportunity to read, ask questions, get answers and get a copy to take with me if I so desire. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the practice. The Notice of Privacy Practices also describes my right and the practice duties with respect to my protected health information.

I understand that the Physical Therapy performed at Coastal Orthopaedic & Sports Medicine Center is generally performed in an open room. If I find the openness uncomfortable, the practice is happy to accommodate my request to be treated in a curtained area.

The practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a copy to be sent by mail or given at my next appointment.

Signature of Patient or Parent (if Minor)

Print Name

Date

**COASTAL ORTHOPAEDIC & SPORTS MEDICINE CENTER
ASSIGNMENT OF BENEFITS**

I authorize Coastal Orthopaedic and Sports Medicine Center, Inc. to endorse checks and/or to sign any piece of paper which will enhance or expedite payment to providers for services rendered, including but not limited to a release of medical records and assignment of benefits/authorization to pay.

**I, _____ Hereby authorize _____
(Name of Insured/Patient) (Name of Auto/Ins. Carrier)**

to make medical benefits payments otherwise payable to me for services rendered by Coastal Orthopaedic and Sports Medicine Center, Inc. but not to exceed the charges of those services, payable to and mailed directly to:

**COASTAL ORTHOPAEDIC & SPORTS MEDICINE CENTER
7710 S. US HIGHWAY ONE
PORT ST. LUCIE, FL 34952**

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I understand that payment of charges incurred is due at the time of service unless financial agreements have been made prior to treatment. I also authorize Coastal Orthopaedic and Sports Medicine Center, Inc. to charge my account \$25.00 if co-payments, deductibles, etc. are not paid on the same day services are rendered. I agree to pay for all reasonable attorney fees and collection cost in the event of default payment for services rendered. I further authorize and request that insurance payments be made directly to Coastal Orthopaedic and Sports Medicine. I understand that the office files to my insurance carrier/s for insurance reimbursement as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay any balance due to Coastal Orthopaedic and Sports Medicine Center.

I have read and fully understand the above financial responsibility and insurance authorization. I have read all the information on this sheet. I certify that all the information in this packet is true and correct to the best of my knowledge. I will notify you of any changes in my status or information given.

Patient Name (Print)

Patient Signature

Parent/Guardian (if Minor)