Mid Florida Ortho Kissimmee-Melbourne, L.L.C.

†2571 W Eau Gallie Blvd Suite 1, Melbourne, FL 32935†

NOMBRE: _____ **FECHA:**_____

1. **Favor de marcar como comenzo su problema:**
   □ Repentinamente □ Gradualmente □ Doblandose □ Parado □ Caminando □ Levantando Algo
   □ Sentado □ Halando □Retorcido □Caida □ Accidente Automolistico □ Lesion En El Trabajo

2. **Favor de decribir detayadamente como sucedio la lesion/accidente o condicion cronica:**

   _____
   _____
   _____

3. **Sus sintomas permanesen mayormente en:** □ Espalda □ Pierna □ Cadera □ Rodilla □Tobillo □ Cuello □ Brazo □Hombro □ Codo □ La Muneca □ Otro

   Tiene dolor irradiando en su brazo or pierna? □ Si □ No

   A donde va: □ Brazo (L or R) □ Pierna (L or R) □ Manos (L or R) □ Piez (L or R)
   Tien entumecimiento o hormigueo en los brazos o piernas? □ Si □ No Donde? _____
   Tiene debilidad en los brazos o piernas? □ Si □ No Donde? _____
   El dolor no lo deja dormir? □ Si □ No

4. **Hace cuanto tiempo tiene estos sintomas?**
   □ < **2** meses □ **2-6** meses □ **6-12** meses □ > **1** ano
   El Dolor: □ Constante □ Viene y se va
   Que ayuda el dolor: □ Descano □ Hielo □ Calor □ Medicacion □ Cambio de Posicion
   □ Acostado □ Sentado □ Parado □ Otro: _____
   Que empeora e dolor? □ Sentado □ Parado □ Caminar □ Levantar algo
   □ girar la cabeza a la izquierda □ Girar la cabeza a la derecha □ Mirar para arriba/abajo
   □ Doblar hacia atras □ Doblar hacia adelante □ Durante Ejercicio □ Depues de ejericio
   □ Halando □ Empujando □ Acostado □ Agachandose Otro: _____

Previos Tratamientos y Examenes:

Vio otro doctor por este problema □ Si □ No **Quien**: _____
Que medicamento ha tomado para este problema?
□ Relajante muscular □ Medicamento para dolor
□ Anti-inflatorio (recetado o sin receta) □ Otro: _____
Que examines les han hecho? □ CT Scan □MRI □X-ray □EMG □ Other _____
Recibo terapia fisica / quiropractica? □ Si □No
El tratamiento mejoro sus sintomas? □ Si □ No
Le inyectaron para su problema?
□ Epidural Steroid Inj. □ Facet Inj. □ Trigger Point Inj. □Radiofrequency
□ Medial Branch Block □ Sacro-Iliac Inj.
Cirugias previas para su problem? □ Si □ No
Si, Favor de decriber: _____
_____
_____

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Historia Medica:

Previas cirugias con las fechas:

_____

_____

_____

_____

Favor de enumerar todos los medicamentos que esta tomando actualmente (incluendo sin recta, vitmains, y medicacion a base de plantas/hierbas)

NOMBRE DE MEDICINA	DOSIS	FRECUENCIA

Tiene alergias a medicinas? □ No conosco de alergias

Si tiene, favor de enumerar alergias a comida, medicaciones y el tipo de reaccion:

_____

_____

_____

Historia Social:

Fuma? □ No □ Si

Si: □ Diariamente □ Semanalmente □ Mensual y cuantos?_____Cigarillos/dia_____Cajetillas/dia

Bebe alcol? □ No □ Si

If so: □ Diariamente □ Semanalmente □ Mensual y cuanto _____

Trabaja? □ No □ Si

Cual es su ocupacion**:** _____

Su problema actual afecta su abilidad de trabajar? □ No □ Si

Si, como lo limita: _____

_____

_____

_____

_____

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Reviso de Sintomas:

Tiene actualmente o ha tenido en el pasado los siguientes problemas:
Si lo ha tiendo favor de describirlo.

Problema	NO	SI	FAVOR DE EXPLICAR DEBAJO
Piel			
Oidos/ Naris/ Garganta			
Cardiaco/ Presion Alta			
Pulmones (Asma, Infeccion)			
Estomago/ Digestion			
Vijia/ Intestino			
Hematologico / Trastorno Hemorragico			
Diabetes			
Cancer			
Musculo Esqueletico			
Neurologico			
Problema Psiquiatrico			
Problema Reproductivo/ Sexual			
Migrana / Dolor de Cabeza			
Ansiedad/ Depresion			
Fiebre/ Escalofrios			
Perdida de Peso			
Sudores Nocturnos			
SIDA			

Historia Familiar:

Tiene alguin de su familia historia de:

Problema	NO	SI
Ansiedad/ Depresion		
Artritis o Dolor Articular		
Diabetes		
Hipertension		
Problemas del Corazon		
Problemas de las Tiroides		
Problemas Psiquiatricos		
Trastornos Hemorragicos		
Cancer		
Epilepsia		
Reaccion adversa a Anestesia		

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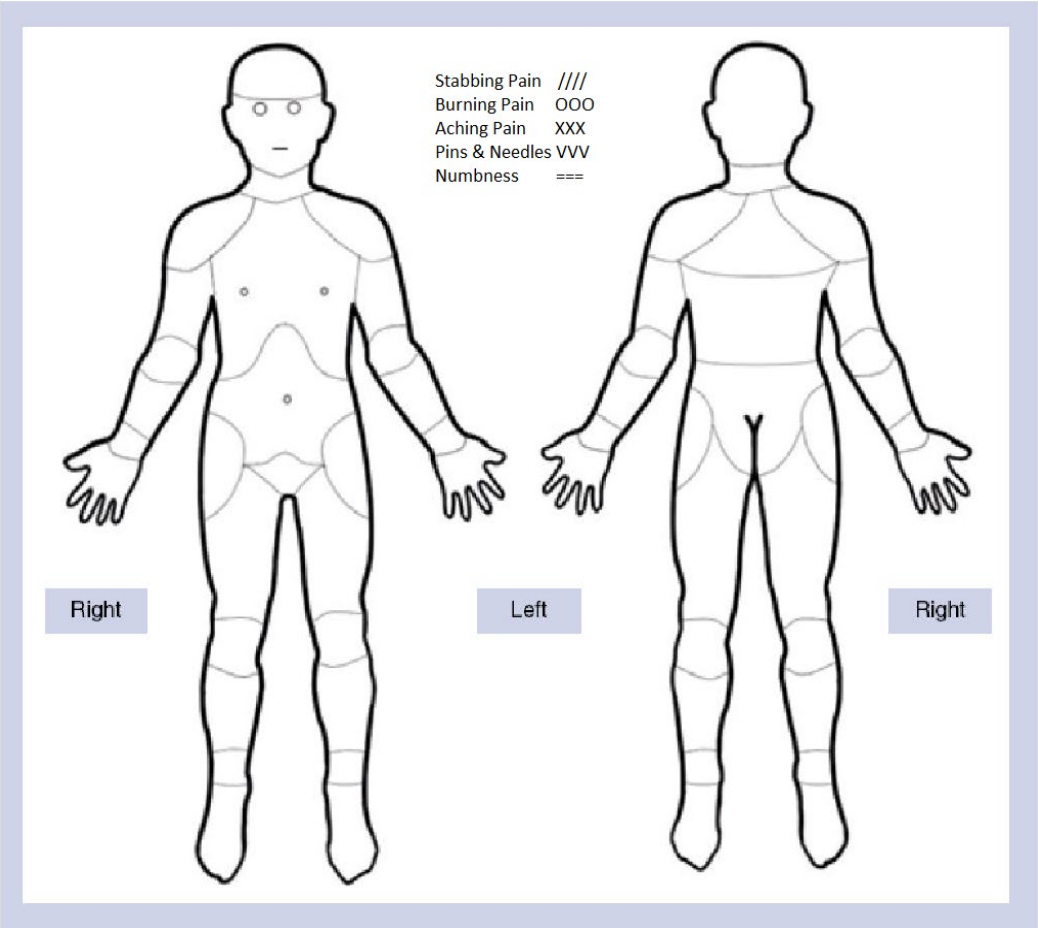
Donde es su dolor ahora?

Please indicate in the table below the percentage of pain that you have on average in the appropriate body part and mark the corresponding pain on the body: **Total percentage=100%**

Neck	% L R	Shoulder	% L R
Back	% L R	Hip	% L R
Leg	% L R	Arm	% L R
Knee	% L R	Elbow	% L R
Ankle	% L R	Wrist	% L R



Please mark an "X" on the face that most accurately describes your overall degree of pain.

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Patient Information

First Name:	Middle Initial:	Last Name:	Gender: □Male □Female
Street Address: Apt #:		City:	State, Zip:
Date of Birth: / /	SSN: - -	Marital Status: □Married □Single □Divorced □Partnered □Widowed	
Home Phone:	Cell Phone:	May we web enable the patient portal? (Required)	
E-mail Address (Required):			
What is your preferred method of contact? □ Home Phone □Cell Phone □E-mail □Mail			
Occupation: □ Full time □Part time □Self Employed □Not Employed □ Retired			
Emergency Contact:	Contact Phone:	Relationship to Patient: □Spouse □Child □Sibling □Parent □Friend	
Do you have an Advanced Directive or Living Will? □Yes (Please provide a copy for office records.) □No			
Race □White □ Black or African American □Hispanic Asian □ Pacific Island □ American Indian □Other race:_____ □Unreported/ Refuse to Report			
Preferred Language:	Ethnicity: □Hispanic □ Non-Hispanic □Unreported/ Refused to Report		
Please provide your pharmacy name as required by law:		**Phone:** **Zip:**	

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PATIENT NAME:_____ **DATE:** _____

We wish to maintain current and comprehensive information applicable to your treatment at our facility; therefore, please indicate below if you have health insurance coverage. Thank you.

- ❑ Yes, I have health insurance.

Primary Insurance

Name of Carrier _____

Policy Number _____

Secondary Insurance

If yes, Name of Carrier _____

Policy Number _____

- ❑ No, I do not have health insurance.

Important

Please present insurance cards to the
Front Office Staff. Thank you.

Signature_____ Date _____

Print Name: _____

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Consent for Treatment and Assignment of Benefits

_____(Initials) I, the referenced or undersigned patient, agree that the healthcare provider entity with which I am hereby contracting, does not owe me a non-delegable duty to provide me with non-negligent healthcare. Therefore, I agree that as to any claim that I may have or acquire concerning or involving my healthcare that includes, in whole or part, a claim of liability for negligent or deficient conduct (whether by act or omission), I hereby release the aforesaid healthcare provider entity from any and all liability, and will look solely to the individual doctor or physician who treats me, or operates on me, for any and all claims of liability or damages.

_____(Initials) I hereby voluntarily consent to the rendering of care, including treatment, administration of anesthesia and performance of diagnostic and /or surgical procedures. I understand that I am under the care and supervision of physicians/providers who are independent contractors for Mid Fl Ortho Kissimee-Melbourne, LLC, and it is my responsibility to carry out instructions of my physicians/providers.

Consent for treatment of a minor

_____(Initials) I understand that the patient named above may be suffering from a condition that requires diagnosis and medical treatment which may require further testing and clinical evaluation. With full understanding of all the forgoing, I do hereby consent to and authorize the performance upon the patient of clinical evaluation and diagnostic procedure as ordered by Mid Fl Ortho Kissimee-Melbourne, LLC.

Name of Minor: _____

Parent or Guardian Signature: _____

Financial Agreement

_____(Initials) I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as original.

_____(Initials) Insurance authorization must be obtained before a patient is seen, if I do not inform the physicians seen in this clinic of my current insurance and the insurance is denied because of no authorization, I will be responsible for payment. If authorization is not obtained from the insurance company before my scheduled appointment and I still choose to see the doctor, I will be responsible for the bill at the time of service.

_____(Initials) I have received or been given the opportunity to receive your Notice of Privacy Practices.

Patient Signature: _____

Or ***Responsible Party Signature:*** _____

PATIENT NAME: _____ **DATE:** _____

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ASSIGNMENT OF BENEFITS

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to **Mid Fl Ortho Kissimee-Melbourne, LLC** ("Assignee") such sums as may be due and owing Assignee for services rendered by reason of accident, illness, and for any other bills due Assignee, and to withhold such sums from any disability benefits, medical payments, No-Fault benefits, or any other insurance benefits in which I may have a right or interest in any respect, including as reimbursement from any settlement, judgment, or verdict on my behalf, as may be necessary to adequately protect and satisfy the charges of said Assignee. Whether I do or do not have insurance coverage, I understand I remain personally responsible for payment of services rendered. I further give an irrevocable priority lien to said assignee against any and all insurance benefits referenced herein and any and all proceeds of any settlement, judgment, or verdict which may be due or paid to me as a result of the injuries or illness for which I have been treated by the Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided, but not a delegation of any duties. In the event any insurance company that may be obligated to make payment to me upon charges made by the Assignee for its services, delays or refuses to make such payment upon such cause of action that I might have or that might exist in my favor against such company, I authorize Assignee to prosecute said cause of action either in my name or Assignee's, and I further authorize Assignee to compromise, settle, or otherwise resolve said claim or cause of action as Assignee sees fit.

Direction of Payment

I hereby authorize and instruct any insurance company or attorney to pay directly to Assignee the amount of this and/or future bills for services rendered. Without limitation of any other terms of this assignment or any other agreement with the Assignee, I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. This assignment also allows Assignee to endorse any check or draft provided to Assignee in my name for purposes of payment for services rendered to me by Assignee or its employees, contractors, or agents.

PIP Log & Declaration Sheet Request

I hereby authorize Assignee to release requested information, which is pertinent to my case or condition(s), to my insurance company or the attorney Involved in this case, pursuant to 627.4137 Florida Statutes. I hereby request that a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, be provided to this Assignee. I hereby authorize this Assignee to request and receive a copy of my pip log periodically as Assignee deems necessary. If any term or provision of this Assignment, Lien, and Authorization or the application thereof to any person or circumstance shall, to any extent, be determined to be invalid or unenforceable, the remainder of this Assignment, Lien, and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien, and Authorization shall be valid and enforced to the fullest extent of the law.

Reservation of Benefits

Be further advised, I am hereby placing you on notice pursuant to Florida case law that should you (the insurance company/carrier) deny, reduce, delay, or fail to pay any part of or the entire bill which was submitted on my behalf from this health care provider, I (the assignor) as well as the assignee (health care provider) are requesting, in advance, that you reserve, or "set-aside," the amount reduced or denied or delayed until the dispute is resolved. Should you submit a check to this health care provider which is less than the correct contractual amount, and it contains any language referring to or purporting to declare payments as "Full and Final Payment," or the like, then I have instructed this health care provider to return the check to you (the insurer) and consider the bill still due and owing (i.e. a late payment as defined in F.S. 627.736). Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount you reduced, delayed, or failed to pay, please notify me (the assignor) and this health care provider (the assignee) immediately.

Patient Name and Date:

Print Name: _____

Signature: _____

Date: _____

Health Care Provider
Mid Florida Ortho Kissimmee-Melbourne, L.L.C
2571 W Eau Gallie Blvd Suite 1
Melbourne, FL 32935

Mid Florida Ortho Kissimmee-Melbourne, L.L.C.

Medical Records Release Form

Patient Name: _____

Date of Birth: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

I give permission for my medical information / medical notes to be disclosed to the following:

√ Primary Care Physician √ Referring Physician √ Attorney Representing Me

√ Auto Insurance/ Health Insurance √Entity to whom I have been referred to for treatment

I give permission to release my protected health information to the following entity:

Name: Mid Florida Ortho Kissimmee-Melbourne, L.L.C.

Patient/Guardian Signature:_____Date: _____

Return Fax Number: (321) 425-2548

☐ STAT REQUEST

Mid Florida Ortho Kissimmee-Melbourne, L.L.C.

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AGREEMENT THAT MEDICARE SHALL NOT BE BILLED

I, the undersigned Patient, whose date of birth is _____, hereby acknowledge and agree that neither Mid Florida Ortho Kissimmee-Melbourne, LLC nor any physician contracting with it to provide any services to me (whether or not a Medicare participating provider), shall bill or receive payment from Medicare for any services and treatment provided to me. Rather, in accord with: (a) the Medicare Secondary Payer Rules (See *42 USC §1395y, et. seq.);* (b) the Medicare Secondary Payer Manual, Chapter 2 (which expressly instructs that a physician, whether or not participating in Medicare, may pursue his lien agreement with the patient for his full charges in liability matters, and may collect his full charges from the primary payer (liability insurance or the tortfeasor), but cannot attempt to collect from the patient until the liability proceeds are available to him/her); and (c) the Florida Supreme Court's holdings in *Joerg v. State Farm*, 176 So.3d 1247 (Fla. 2015) (including that Court's determination that Medicare makes the tortfeasor the primary payer), payment for the full charges shall be sought from the tortfeasor who caused my injuries necessitating the services and treatment I receive from Mid Florida Ortho Kissimmee-Melbourne, LLC and its contracted physicians (and the tortfeasor's liability insurance carrier, and any other insurance carrier that may have any legal responsibility for paying medical bills I incur). This means that any settlement or other recovery I may obtain from the tortfeasor or his liability carrier, other insurance carrier, or all thereof, shall be subject to my lien agreement with this provider, and therefore, I understand that Mid Florida Ortho Kissimmee-Melbourne, LLC shall fully enforce its lien rights pursuant to its express Lien Agreement with me, in accord with Florida law and the above-stated legal authorities, which I acknowledge and agree do not require healthcare providers to opt out of Medicare before being able to charge and collect their full charges for services rendered pursuant to the Medicare Secondary Payer Manual, Chapter 2, Alternative Billing (see, for example, pages 16-19 thereof).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I acknowledge that I was provided a copy of the Notice of Privacy and that I have read (or had the opportunity to read it if I so chose) and understood the Notice.

Patient Signature:

_____

Print Patient Name:

_____

Mid Florida Orthopedics:

/s/ _____

Jeffrey Kugler, MD

Dated: _____

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Financial Responsibility Agreement

I, the below-named patient, hereby knowingly and voluntarily acknowledge that regardless of whether the healthcare provider identified herein has entered into a lien and/or letter of protection (collectively "LOP") with me, I am responsible for paying the full amount(s) billed to me or on my account for the healthcare services provided to me or for my benefit, including but not limited to care, treatment, other services, medicine, and supplies, and that no act or omission by the healthcare provider shall constitute a waiver of the right of to charge and collect from me the entire amount(s) billed to me or on my account, and in further consideration of the care, treatment, services, medicine, and/or supplies provided to me or on my behalf by the healthcare provider, I do hereby waive any and all statutes of limitation on any claim or cause of action that the healthcare provider may have or hereafter acquire against me, regarding the care, treatment, services, medicine, and supplies provided to me or for my benefit, including the charges therefor, whether any such claim be in law or equity, and do further waive any and all head of family or other protection(s) from collection by a creditor under Florida and/or Federal law. If you provide more than one-half of the support for a child or other dependent, all or part of your income is exempt from garnishment under Florida law. You can waive this protection only by signing this document. By signing below, you agree to waive the protection from garnishment.

Patient Signature: Mid Florida Orthopedics:

_____ /s/ _____
Jeffrey Kugler, MD

Print Patient Name:

_____ Dated: _____

If the patient is a minor, the parent must sign below on the parent's and the minor's behalf:

Patient Name: Parent Signature:

_____ _____

Dated: _____

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LIEN AGREEMENT AND DIRECTION TO PAY

PATIENT: _____

DATE OF BIRTH: _____

DATE OF INJURY: _____

IMPORTANT: THIS IS A CONTRACT. IF YOU DON'T UNDERSTAND THIS, THEN CONSULT WITH AN ATTORNEY BEFORE SIGNING.

Patient authorizes and irrevocably directs his/her present and any future attorneys related to the above- referenced date of injury ("Attorneys") to honor this agreement. This irrevocable agreement is made in favor of the above-referenced Medical Provider and shall be termed a "Lien Agreement." This Lien Agreement shall place a continuing lien in favor of the Medical Provider on any proceeds I recover in any legal action related to the above-referenced date of injury, and any other fund to which I may become entitled, such as, for example only, an employment bonus, lottery winnings, or an inheritance. The Direction to Pay contained in this agreement applies to and binds the Patient's current and future Attorneys, and the Medical provider is agreed to be an intended third-party beneficiary of that direction to pay from the Patient to the Patient's Attorneys. Therefore, the rights of the Medical Provider with regard to the Patient and the Patient's Attorneys are hereby agreed to be an interest coupled with a grant, and cannot be terminated or cancelled.

Background. Medical Provider expects and is hereby agreed to be entitled to be paid from any fund in which the Patient has or later obtains an interest, including but not limited to proceeds related to the above- referenced date of injury, and any future injury, in exchange for providing medical care/treatment at this or any later time. Medical Provider also agrees not to place patient in collections until the resolution of Patient's claims related to the above-referenced date of injury. Patient expects to receive medical care that is reasonable, related to the above-referenced accident, and medically necessarily or reasonably obtained, from the Patient's perspective. Patient has sustained damages as a result of injuries related to the above-referenced date of injury and currently does not have the funds to pay for the medical care which he/she needs and/or desires. Patient is signing this Lien Agreement in order to receive medical care.

Insurance Benefits. In the event that there are disability benefits, medical payment benefits, No-Fault benefits, accidental benefits, worker's compensation benefits, or any other insurance benefits available to the patient besides Bodily Injury and/or Un-insured Motorist (aka Underinsured Motorist) coverage thenthis Lien Agreement can be used to cover any co-payments and/or deductibles if we choose to bill it. However, it is agreed that the Medical Provider does not have to bill any such insurance unless required by law.

Protection of Medical Bills. If Patient recovers any money related to the above-referenced date of injury, or otherwise obtains an interest in any fund whatsoever, including but not limited to those referenced hereinabove, then the Patient and Patient's Attorney shall withhold from said fund(s) sufficient money to pay in full the outstanding balance of any and all bill(s) owed to Medical Provider. It is understood that Attorney's fees/costs are not first-in-line and that this Lien Agreement does not interfere with Attorney's retainer agreement with Patient. Patient authorizes Medical Provider to provide Attorney with a copy of Patient's medical records, bills, etc., about the above-referenced date of injury, and Patient's or Patient's representative's signature below shall operate as a HIPAA-compliant authorization for the release of such medical records from the Medical provider to Patient's Attorneys.

Patient's Responsibility for Bills. Patient understands that he/she is directly responsible to Medical Provider for services rendered and that payment is not contingent on anything, including but not limited to a settlement, judgment, or verdict related to the above-referenced date of injury. Regardless of any settlement, judgment, or verdict, Patient is still responsible for paying Medical Provider's outstanding bills incurred for medical advice, care, or treatment rendered by medical provider to the Patient.

Patient's Responsibility Regarding His/Her Attorney (Present and Future). Patient is responsible for informing every attorney retained or used by him/her of the existence of this agreement. However, this agreement shall bind all such attorneys whether the Patient provides him/her with notice thereof. Additionally, Medical Provider has the right to notify Patient's Attorney(s) about the existence of this Lien Agreement. Upon request, Patient and Patient's Attorney shall provide status updates about any claims related to the above-referenced date of injury, any other fund(s) to which the Patient has obtained an interest, as well as the contact information for any new Attorneys. It is also the Patient's responsibility to advise the Medical Provider at least 10 days prior to collecting any funds from any source (other than Patient's customary wages from his/her employer) and to request a bill for any and all outstanding charges. Patient understands that if funds related to the above-referenced date of injury are insufficient to cover the medical bill(s) then Medical Provider has the right to collect the remaining balance.

Disputes. If the Patient fails to pay the medical provider's full outstanding balance and medical provider is the prevailing party in an action to enforce this Lien Agreement then the medical provider shall have the right to recover all attorneys' fees and costs including post-judgment proceedings. Binding arbitration is an option if both parties agree in writing.

Direction to Pay. ATTENTION ATTORNEY: THIS IS AN IRRECOVABLE DIRECTION TO PAY MY MEDICAL PROVIDER. Patient irrevocably directs his/her attorneys to pay any outstanding medical bills about the above-referenced date of injury. Patient hereby directs his/her Attorneys to provide a status update in writing within 15 days of receiving a request from Medical Provider. Patient further directs his/her Attorneys not to disburse any proceeds from any fund to which I may become entitled, including but not limited to any settlement or recovery relating to the above-referenced date of injury, without first or simultaneously paying the Medical Provider all sums owed to him/her for medical care, advice, or treatment rendered to me.

Effective Date. This agreement becomes effective when the Patient signs the agreement below, whether or not also signed by the Patient's Attorney(s).

_____ _____

Patient Signature Date

_____ _____

Attorney Signature Date