Mid Florida Ortho Kissimmee-Melbourne, LLC

2571 West Eau Gallie Blvd, Suite 1, Melbourne, FL
32935 Phone: (321) 221-5660 Fax: (321) 221-5661

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Date of Accident:** _____

Please check how your current problem began: □ Suddenly □ Gradually □ Bending □ Standing □ Walking □ Lifting □ Sitting □ Pulling □ Twisting □ Fall □ Motor Vehicle Accident □ Work Comp Injury □ Other _____

In detail, please describe how the injury / accident or chronic condition occurred:

_____

_____

_____

Are your symptoms mostly in the: □ Back □ Leg □ Hip □ Knee □Ankle □ Neck □ Arm □ Shoulder □ Elbow □ Wrist □ Other _____

Do you have any radiating pain in your arm or leg? □ Yes □ No

Where does it go: □ arm (L or R) □ leg (L or R) □ hands (L or R) □ feet (L or R)

Any numbness or tingling in arm or leg? □ Yes □ No Where? _____

Any weakness in arm or leg? □ Yes □ No Where? _____

Does the pain keep you up at night? □ Yes □ No

How long have you had these symptoms? □ < 2 months □ 2-6 months □ 6-12 months □ > 1 year

The pain is: □ Constant □ Comes and goes □ Other: _____

What makes the pain better: □ Rest □ Ice □ Heat □ Medication □ Changing Positions □ Lying Down □ Sitting □ Standing □ Other _____

What makes the pain worse? □ Sitting □ Standing □ Walking □ Lifting □ Turning your head to the left □ Turning your head to the right □ Looking up/down □ Bending Backward □ Bending Forward □ During Exercise □ After Exercise □ Pulling □ Pushing □ Lying Down □ Squatting Other

Previous Treatment & Tests

Did you see another physician for this problem? □ Yes □ No If yes who (list all): _____

_____

What medications have you taken for this problem? □ muscle relaxant □ pain medication □ anti-inflammatory (prescription or over the counter) □ Other:

What tests have you had? □ CT scan □MRI □X-ray □EMG □ Other

Did you receive physical therapy / chiropractic treatment? □ Yes □ No

Did the treatments improve your symptoms? □ Yes □ No

Did you have any injections for this problem? □ Epidural Steroid Inj. □ Facet Inj. □ Trigger Point Inj. □ Radiofrequency □ Medial Branch Block □ Sacro-Iliac Inj. □ Other: _____

Did you have previous surgery for this problem? □ Yes □ No If yes, please describe: _____

_____

_____

Past Surgical History:

List any PREVIOUS SURGERIES you have had and the dates:

_____

_____

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Past Medical History:

List all **pre-existing medical conditions** you are aware of, including but not limited to any prior injuries to the area(s) of your body for which you are seeking treatment here:

Check off if you have ever had any of the following:

□ Alzheimer's Disease	□ Anxiety	□ Asthma	□ Atrial Fibrillation	□ Bleeding Disorders
□ Blood Clots	□ Bronchitis	□ Cancer	□ Congestive Heart Failure	□ COPD
□ Defibrillator	□ Depression	□ Diabetes	□ Coronary Artery Disease	□ Emphysema
□ Gastro Reflux	□ Gout	□ Heart Attack	□ Heart Disease	□ Heart Murmur
□ Hepatitis	□ HIV/AIDS	□ Seizures	□ High Blood Pressure	□ High Cholesterol
□ Liver Disease	□ Osteoporosis	□ Pacemaker	□ Kidney Disease	□ Peripheral Artery Disease
□ Rheumatic Fever	□ Sleep Disorders	□ Stroke or TIA	□ Thyroid Disease	
HAVE YOU EVER BEEN TREATED IN THE PAST FOR ANY OF THE FOLLOWING PROBLEMS:				
□ Ankle Pain	□ Elbow Pain	□ Hip Pain	□ Knee Pain	□ Low Back Pain
□ Mid-Back pain	□ Neck Pain	□ Wrist Pain	□ Shoulder Pain	

Please list **ANY and ALL MEDICATIONS** you are currently taking (including over the counter, vitamins, and herbal medication)

MEDICATION NAME	DOSAGE	FREQUENCY

Do you have any ALLERGIES to medication? ☐ NO KNOWN DRUG ALLERGIES

If yes, list any ALLERGIES you have to food, medications, and type of reaction:

_____

_____

_____

Social History:

Do you Smoke? □ No □ Yes
If so, □ daily □ weekly □ monthly and how many? _____Cigarettes/day _____Packs/day
Do you drink alcohol? □ No □ Yes
If so: □ daily □ weekly □ monthly and how much _____
Are you working? □ No □ Yes
If so, what is your occupation, _____
Does your current complaint affect your ability to work? □ No □ Yes
If so, how does it limit you: _____

_____

_____

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Review of Current Complaints: Do you currently have any of the following symptoms:

PROBLEM	NO	YES	PLEASE EXPLAIN BELOW
GENERAL: Fever, Weight Loss, Difficulty Sleeping			
SKIN: Rashes, Abrasions, Bruising, Bumps/Lumps			
EYES: Changes in Vision – Blurred or Double Vision			
ENT: Ears Ringing, Difficulty w/ Balance			
NEURO: Migraines/Headaches, Seizures, Dizziness, New Onset of Anxiety/Depression, Memory Loss			
HEART: Chest Pain, Ankle Swelling, Palpitations			
RESP: Cough, Shortness of Breath, Wheezing			
GI: Nausea, Vomiting, Changes in Appetite, Ulcers			
GU: Difficulty in urinating, Incontinence, Bowel Changes			
Neck or Back Pain, Radiating pain, Numbness			
Pain in Shoulder, Knee, Arm, Leg, Elbow, Hip, Ankle			
Weakness in any Extremity			
Reproductive or Sexual Problems			

Family History:

Do any of your family members have a history of any of the following:

PROBLEM	NO	YES
Anxiety/Depression		
Arthritis or Joint Pain		
Diabetes		
Hypertension		
Heart Problems		
Thyroid Problems		
Psychiatric Problems		
Bleeding Disorders		
Cancer		
Epilepsy		
Adverse Reaction to Anesthesia		

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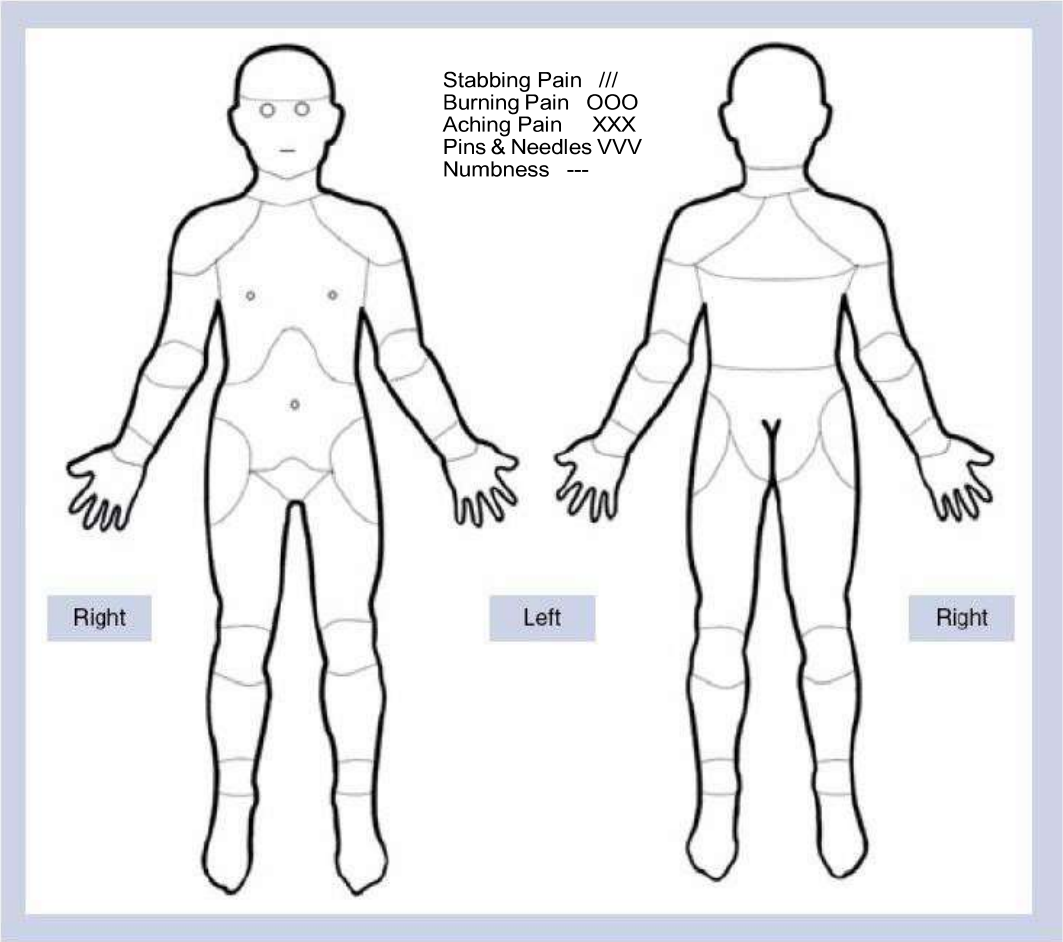
Where is your pain now?

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%**



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

Revised 08/29/2026

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First Name:	Middle Initial:	Last Name:	Gender: □ Male □ Female
Street Address:			City, State, Zip:
Date of Birth:	SSN:	Marital Status: □ Married □ Single □ Divorced□ Partnered □ Widowed	
Home Phone:	Cell Phone:	Email:	
May we enable the patient portal? (Required) □ Yes □ No			
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 Number:	Relationship to Patient: □ Spouse □ Child □ Sibling □ Parent □ Friend	
Do you have an Advanced Directive or Living Will? □ No □ Yes (Please provide a copy for office records)			
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/Refuse to Report		
Please provide your pharmacy name as required by law: Pharmacy Name: Phone Number: Address:			

I, the patient named above, do hereby make Mid Florida Ortho Kissimmee-Melbourne, LLC, my agent and representative under the HITECH ACT for all purposes permissible under that Act, and under any other federal or state law concerning the obtaining or producing of medical information or records. In any event, should my aforesaid agent make any request of any other person or healthcare provider for medical information or records referencing, relating to, or involving me, all such information and records must be fully sand timely produced to my aforesaid agent as required by law, and any penalties, fines, damages, or other recompense available under law for delayed or refused production thereof (such as but not limited to statutory damages, attorneys' fees, and costs) may be pursued by my aforesaid agent in its or his own name and for its or his own account.

Patient Signature _____

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We wish to maintain current and comprehensive information applicable to your treatment at our facility; therefore, please indicate below if you have either Auto Insurance coverage or Health Insurance coverage.

□ **Auto Insurance**

Policy Holder: _____
Policy Number: _____
Phone number on back of card: _____

□ **Yes, I have Health Insurance**

Primary Insurance
Name of Carrier: _____
Policy Number: _____

Secondary Insurance
Name of Carrier: _____
Policy Number: _____

□ **No, I do not have Health Insurance**

IMPORTANT
Please present your insurance card to the Front Office Staff.
Thank-You!

We may choose not to bill your health insurance, even if you ask us to or want us to, because this practice is not in network with any health insurance carrier and by obtaining medical care from this practice you are agreeing that you will pay the full bills issued to you out of your own funds.

_____ _____
Signature **Date**

_____
Print Name

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Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Person Requesting records and relationship: _____

Home Phone: _____ Daytime Phone: _____

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 a 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 and discussed with the following:

√ Primary Care Physician √ Referring Physician √ Attorney Representing Me

√ My auto insurance carrier / Health Insurance √ Entity to who I have been referred in regard to treatment

and, if I am represented by an attorney, please send all of my records, documents, Good Faith Estimates, and billing statements to my attorney, as my agent.

Other People with whom you allow us to discuss your healthcare with:

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

I give permission to release my protected health information to the following entity:
Mid Florida Ortho Kissimee-Melbourne, L.L.C

Return to Fax Number:
□ 321-325-6026

Patient / Guardian Signature: _____Date: _____

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Consent for Treatment and Assignment of Benefits

_____(Initials) I, the referenced or undersigned patient, agree that the above-named healthcare company/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 company/entity and its employees, officers, members, and managers 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 Florida Ortho Kissimmee-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 and therapeutic procedure(s) as ordered by Mid Florida Ortho Kissimmee-Melbourne, LLC.

Name of Minor: _____
Parent or Guardian Signature: _____

Financial Agreement

_____(Initials) In addition to all other agreements I have or come to have with this healthcare provider, I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting physicians and healthcare providers for services rendered. I understand that I am financially responsible for paying the full amount all charges whether or not they are covered by insurance. In the event I do not pay the full amount of all charges, 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 agree that a photocopy of this agreement shall be valid as an original.

_____(Initials) If health insurance is going to be used as a pay source, then Insurance authorization must be obtained before a patient is seen. If I do not inform the healthcare providers here who see or treat me, of my current insurance or the insurance is denied because of no authorization, I agree that I will remain responsible for payment in full of all billed charges. If authorization is not obtained from the insurance company before my scheduled appointment and I still choose to see a healthcare provider here, I will be responsible for the entire bill at the time of service. Notwithstanding anything hereinabove, I authorize the healthcare providers here not to bill my health insurance for any services provided to me, at the election of the healthcare providers.

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

Patient Signature: _____

Or ***Responsible party Signature:*** _____

ASSIGNMENT OF BENEFITS

I hereby authorize and direct you, all insurance companies that may provide any benefits to me, jointly and severally, to pay directly to Mid Florida Ortho Kissimmee-Melbourne, LLC d/b/a Mid Florida Ortho Kissimmee-Melbourne, LLC (referred to herein as "MFO" or "Assignee") such sums as may be due and owing Assignee for services rendered by reason of accident or illness, and for any other bills issued by Assignee, and to withhold such sums from any insurance benefits in which I may have or acquire a right or interest in any respect, as may be necessary to fully satisfy the charges of said Assignee. With regard to submitting for no-fault ("PIP") benefits or reimbursement for services personally rendered by a Physician or other healthcare provider who may be an employee or contractor of MFO, I hereby assign to such individual physician(s) or other healthcare provider(s) who render any services to me all rights and benefits I may have, or come to have, under any Personal Injury Protection / No-Fault Insurance ("PIP"), including the right to submit to any such PIP carrier directly for reimbursement bills for services rendered to me. Said assignment by me is not a delegation of any duties that I may have under any such PIP insurance. Further, should any or all such physicians or healthcare providers authorize MFO, in any manner, to bill, receive, or process any PIP payments I have hereby assigned for the benefit of any or all such physicians or other healthcare providers, then in that event MFO shall be considered merely a billing agent of or clearinghouse for such physicians or other healthcare providers, regardless of whether any such billings for PIP reimbursements or benefits may appear to be in the name of MFO (and as such, MFO shall be acting merely as an agent of/for said physicians and other healthcare providers, rather than billing or submitting for PIP reimbursements or benefits in its own name or right). To supplement this process I specifically give and grant to MFO a power of attorney rendering MFO my attorney-in-fact to act as my agent to facilitate any/all such physicians' and other healthcare providers' individual rights and efforts to process all applications for payment and receipt of payment of PIP benefits or reimbursements in the name and under the EIN of any such physician or other healthcare provider or his/her practice entity, or in the name and under the EIN of MFO as the billing agent or clearinghouse for any/all such physicians or other healthcare providers, at MFO's election, with all PIP payments received to be posted to the given Physician's or other healthcare provider's account as revenue of said physician or other healthcare provider. This power of attorney granted to MFO by me herein is a grant coupled with an interest, is irrevocable, and shall survive the end of services rendered to me for a period of sixty (60) months. Whether I do or do not have insurance coverage or may have or come to have any rights under any insurance policy, I understand that I am and shall remain personally responsible for payment in full of all bills for services rendered by the Assignee and healthcare providers who may be employees or contractors of 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 I may have under or regarding any benefits I have, come to have, or hereby assign. In the event that any insurance company that may be obligated to make payment to me upon or concerning charges made by the Assignee or healthcare providers who may be employees or contractors of Assignee for services rendered to me, either delays or refuses to make such payment upon any claim that I might have or that might exist in my favor against anyone, I authorize Assignee and healthcare providers who may be employees or contractors of Assignee to prosecute said claim either in my name or Assignee's, and I further authorize Assignee to compromise, settle, or otherwise resolve said claim as Assignee sees fit.

Direction of Payment

I hereby authorize and instruct any insurance company and all other agents or representatives of mine to pay in full directly to Assignee the amount of all bills for services rendered to me. Without limitation of any other terms of this agreement or any other agreement with the Assignee, I also agree to pay directly to Assignee in a current manner any difference between the total charges and the amount paid by any insurance company. This agreement and the foregoing power of attorney 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. Assignee is an express beneficiary and a third-party beneficiary of the instructions I have given in this Assignment and can enforce any or all of said instructions in its own name and right just as if I were the Assignee seeking to enforce said instructions.

PIP Log & Declaration Sheet Request

I hereby authorize Assignee to release requested information that is pertinent to me in any way, to any insurance company, or any other person(s) Involved in any matter pertinent to me, my health, or my medical condition, pursuant to Section 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 or any other accident in which I may be involved, be provided to this Assignee upon each and every request of said Assignee. I hereby authorize this Assignee to request and receive a copy of my pip log and all medical records related to me in any way, periodically as Assignee deems necessary. If any term or provision of this Assignment 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 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 and Authorization shall be valid and enforced to the fullest extent of the law (for example only, as by any physician or other healthcare provider who rendered any service to me, instead of by MFO).

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(s) which was/were submitted on my behalf from this healthcare provider, I (the assignor) as well as the assignee (for itself any and all physicians and other healthcare providers who may be employees or contractors for MFO) 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 MFO or any physician or other healthcare provider who may be an employee or contractor of MFO which is less than the correct amount, and it contains any language referring to or purporting to declare payment(s) as "Full and Final Payment," or the like, then I have instructed assignee 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 the assignee in writing immediately

Patient Signature: _____

Print Name: _____

Date: _____

Assignee/Health Care Provider:

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

/S/ Assignee/Healthcare Provider.
Jeffrey Kugler, Administrator

Revised 08/29/2026

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FIRST COAST SERVICE OPTIONS, INC.
WHEN EXPERIENCE COUNTS & QUALITY MATTERS

A CMS-Contracted Medicare Administrative Contractor

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE

Section 4507 of the 1997 Balanced Budget Act allows a physician or practitioner to enter into a private contract with a Medicare beneficiary. Enter the provider's name and the beneficiary's name in the appropriate boxes. Signatures from the provider, a witness and the patient/beneficiary or their legal representative are required below. The supplier must submit an affidavit to Medicare expressing his/her decision to opt-out.

I _____ (provider's name) have not been excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act
_____ (provider's NPI)

I (the Medicare beneficiary) or my legal representative accept full responsibility for payment of charges for all services furnished by _____ (provider's name).

I (the Medicare beneficiary) or my legal representative understand that Medicare limits do not apply to what _____ (provider's name) may charge for items or services furnished.

I (the Medicare beneficiary) or my legal representative agree not to submit a claim to Medicare or to ask _____ (provider's name) to submit a claim to Medicare.

I (the Medicare beneficiary) or my legal representative understand that Medicare payment will not be made for any items or services furnished by _____ (provider's name) that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I (the Medicare beneficiary) or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The expected or known effective date and expected or known expiration date of the opt-out period is _____ (effective date) and _____ (expiration date).

I (the Medicare beneficiary) or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

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This contact cannot be entered into by me, (the Medicare beneficiary), or by my legal representative during a time when I, (the Medicare beneficiary), require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual)

I (the Medicare beneficiary) or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract before items or services are furnished to me under the terms of this contract.

I _____ (provider's name) will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.

I _____ (provider's name) will supply CMS with a copy of this contract upon request.

I _____ (provider's name) understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

Provider's NPI: _____ Provider's Specialty: _____

Provider's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patients Legal Representative Signature: _____ Date: _____

Witness: _____ Date: _____

Contact Name: _____ Phone #: _____

Contact Email: _____