Florida Ortho Surgeons
Florida Sports Orthopaedic & Spine Medicine

Part of the OrthoCare Family OrthoCare The Largest Orthopaedic Group in Florida

Steven C. Mirabello M.D. • Mark D Torke M.D • Sang H. Choi M.D. • John H. Shim M.D. • Casey J. O'Donnell D.O.

THANK YOU FOR CHOOSING OUR PRACTICE FOR YOUR ORTHOPAEDIC AND SPINE CARE NEEDS

NEW PATIENT PAPERWORK PACKET
- PRINT OUT PACKET AND FILL IN ALL BLANKS, SIGN AND DATE

MEDICAL HISTORY FORM
- THIS CAN BE FILLED OUT ON YOUR COMPUTER OR TABLET AND PRINTED

Completing this paperwork ahead of time will help expedite your appointment and will also allow you to maximize your time with the physician.

PLEASE BRING THIS PAPERWORK ALONG WITH YOUR PHOTO ID AND ANY INSURANCE CARDS & CLAIM INFORMATION TO YOUR APPOINTMENT. ALSO, PLEASE BRING ALL IMAGING STUDIES (X-RAYS, MRI) WITH YOU.

WE RECOMMEND THAT YOU ARRIVE AT LEAST 10 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME IF YOU HAVE COMPLETED ALL OF THE ABOVE PAPERWORK AHEAD OF TIME.

IF YOU ARE UNABLE TO PRINT OUT THE NEW PATIENT PAPERWORK, PLEASE ARRIVE AT OUR OFFICE AT LEAST 20 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT.

WE MAKE EVERY EFFORT TO BE ON-TIME FOR YOUR SCHEDULED APPOINTMENT AND WHILE EMERGENCIES DO OCCUR, WE REQUEST THAT YOU NOTIFY OUR OFFICE AHEAD OF TIME IF YOU ARE GOING TO BE LATE. IN SOME CASES, WE MAY NEED TO RESCHEDULE YOUR APPOINTMENT.

Patient Name:____

CONSENT FOR TREATMENT / PAYMENT AGREEMENT

Thank you for choosing our practice. I, the undersigned, for myself or on behalf of the aforementioned patient, hereby authorize the physician, employees, and staff of Florida Sports Orthopaedic & Spine Medicine to administer such medical or surgical care as may be indicated for the diagnosis and treatment of the aforementioned patient.

Payment in Full is expected at the time of service. We accept **Cash, Credit Card, Debit Cards, and Checks.**

I understand and agree that I am responsible for any cost incurred for legal or collection fees necessary to satisfy my financial obligation to Florida Sports Orthopaedic & Spine Medicine including reasonable attorney fees, court costs, or collection expenses.

I understand and agree that photocopies of this form will be valid.

____

Signature of Patient or Responsible Party **Date**

MEDICARE PATIENTS ONLY

I understand that Dr. John Shim has opted out of Medicare and is not a participating provider. As such, I understand that Dr. Shim / FSOSM will not submit nor allow anyone else to submit a claim for services provided to a Medicare Beneficiary. I am aware that I have the right to seek treatment by a physician or practitioner who has not opted out of Medicare. By signing this agreement, I or my legal representative accept full responsibility for the physician's charges by entering into this private contract.

____

Signature of Patient or Responsible Party **Date**

____

Physician (or authorized agent)

Steven C. Mirabello M.D. • Mark D Torke M.D • Sang H. Choi M.D. • John H. Shim M.D. • Casey J. O'Donnell D.O.

PRESCRIPTION DRUG POLICY

The law requires responsible usage of drugs by doctors and patients. If you accept a prescription from one of our providers at any one of our locations, you are also accepting the responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe the medications in an appropriate dosage and amounts with clear instructions. We will answer any questions you have about the drug prescribed.

Drugs have the potential for abuse and are regulated closely by the state and federal agencies. More closely controlled drugs (narcotic, pain medications, and tranquilizers) require even more responsibility on your part. Pain medications are in the same family of narcotics as stronger more harmful drugs such as morphine or heroin. Actually pain pills can block your perception of pain but when they wear off, you feel the pain more because your own body has not made endorphins **(natural pain pills)** and the body thinks that the body does not needs its own natural remedy. When the pills wear off, you may experience worse pain before. Therefore, we must be careful in the prescribing of these medications to ensure they are medically necessary. We will accept **NO** excuses for medication loss or theft and will not order replacements. We will **NOT** prescribe narcotics if you are using the other than exactly prescribed or receiving them from another source. Any change of pharmacy id your choice and therefor, your responsibility to notify our office.

Many drugs are appropriate for short term use only. Our office policy is to prescribe pain medication only if necessary and in your best interest post surgically for the 90 days following your procedure. If you are not a surgical patient we will prescribe a narcotic pain medication for no more than **(30) thirty days** from the last visit. Any request past **(30) thirty days** will require you to come into the office for an appointment to be reassessed as to need. We may also require the consultation of other specialist to help decide on the course of action when we disagree about your continued use of a substance. We may decide not to refill any medication even within the **(30) day period** if it is deem not medically necessary. Otherwise, we hold to a **NO NARCOTIC POLICY.**

Our office requires a **(48) hour call in policy** for refills of any prescription. Please call for refills before 12:00pm on Fridays and before 4:00pm on other weekdays. Medications will not be filled after normal business hours or over the weekend. Failure to follow these policies will force our practice to terminate our professional relationship and may require us to file a report with the **Department of Professional Regulation** or the local police.

If you are in agreement with all information stated above, please sign and date on the line below.

____________________________________ ________________________

Signature of Patient or Patient Guardian **Date**

____

Printed Name of Patient/Guardian

ARBITRATION AGREEMENT – DOCTOR / PATIENT

This agreement is made between Florida Sports, Orthopaedic & Spine Medicine to include; Sang H. Choi M.D., Steven C. Mirabello M.D., John H. Shim M.D., Mark D. Torke M.D. and Casey O'Donnell D.O., their agents: Physician Assistants, employees, servants or any of the foregoing, referred to hereinafter as "Physician" and…

Referred to hereinafter as the "Patient". It is the intention of the parties of this agreement to bind not only themselves, but also their heirs, personal representatives, guardians or any persons deriving their claims through or on behalf of the Patient.

It is understood by the Patient that he or she is not required to use the aforesaid Physician or any of the physicians named for orthopaedic care, treatment and surgery and the numerous other physicians in the state of Florida and West Central Florida are qualified to perform orthopaedic care, treatment and surgery.

It is further understood that in the event of any controversy or dispute which might arise between the physicians and patient, regardless of whether the dispute concerns the medical care rendered, payment of surgical fees or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statutes. This arbitration shall be binding and shall be in lieu of and instead of any trial by judge or jury. Each party shall be entitled to the discovery provided for Rules 1.280-1.390, Florida Rules of Civil Procedure. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court or competent jurisdiction in and for Pinellas County, Florida.

This agreement shall remain in effect for all treatment and surgery provided the patient presently and at any future date.

In witness whereof, I (we) have set our hand this date ___________________________

____ ____

Physician (or authorized agent) **Patient Signature**

Steven C. Mirabello M.D. • Mark D Torke M.D • Sang H. Choi M.D. • John H. Shim M.D. • Casey J. O'Donnell D.O.

NOTICE OF PRIVACY POLICY ACKNOWLEDGEMENT

The Notice of Privacy Practice tells you how we may use and share your health records. It also describes your rights with regards to your health records.
I acknowledge that the Florida Sports, Orthopaedic & Spine Medicine Notice of Privacy Policy has been made available to me. A paper copy of this Notice will be provided at my request. This Notice is also available for review at the office front desk.

______________________________ ______________________________
Signature **Date**

HIPAA DISCLOSURE AUTHORIZATION

______________________________ ______________________________
PATIENT NAME **PATIENT MEDICAL RECORD #**

______________________________ ______________________________
DATE OF BIRTH **PHONE NUMBER**

In order to abide by Federal and State HIPAA requirements, Florida Sports Orthopaedic & Spine Medicine CANNOT and WILL NOT disclose ANY protected health information to anyone (**including family members and spouses**) without your written consent. This includes post-surgery questions, appointment verifications, and billing inquiries.

I hereby authorize use or disclosure of protected health information about me to the following individuals:

______________________________ ______________________________
NAME **RELATIONSHIP**

______________________________ ______________________________
NAME **RELATIONSHIP**

______________________________ ______________________________
NAME **RELATIONSHIP**

☐ **I choose NOT to have any protected health information released to anyone.**

May we leave a message and/or appointment reminder? ☐ **Yes** ☐ **No**

Phone number for messages & appointment reminders: ______________________________

I understand I may add individuals or revoke this authorization at any time.

______________________________ ______________________________
Signature **Date**

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NAME:_______________________________________ **DATE:** ______________

Height:_________ Weight______

PHARMACY NAME & LOCATION:

____

____

CURRENT MEDICATIONS: ☐ None

Drug / Strength / Frequency Taken

____

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ALLERGIES: ☐ None

____

____

MEDICAL HISTORY OF THE PATIENT:

(Check all that apply in the past & present)

☐Anemia
☐Artificial Joints
☐Asthma
☐Back Pain
☐Blood Clots/DVT
☐Bowel Disorders
☐COPD
☐Cancer:__________________
☐Chronic Sinus/Rhinitis
☐Claustrophobic
☐Coronary Artery Disease
☐Depression
☐Diabetes
☐Diverticulitis
☐Emphysema
☐Fibromyalgia
☐GERD/Reflux/Ulcers
☐Gallbladder Disease
☐Gout
☐Had reaction to anesthesia?
☐Head Trauma/Injury
☐Heart Problems / Heart attack
☐Hepatitis / HIV / AIDS
☐Hernia
☐High Cholesterol
☐High Blood Pressure
☐Kidney Disease / Stones
☐Liver Disease
☐Lung Disease
☐Neurologic Disorder
☐Neuropathy
☐Osteoporosis
☐Pacemaker
☐Peripheral Vascular Disease
☐Polio
☐Rheumatoid Arthritis
☐Seizures/Epilepsy
☐Sleep Apnea
☐Spinal Stenosis
☐Stroke/ TIA
☐Thyroid Problems
☐Tuberculosis
☐Urinary Tract Infection(s)
☐Other:______________________________

Are you Pregnant? ☐No ☐Yes

Date of Last Bone Density Test: ___________

SURGICAL HISTORY: ☐ None

Procedure: ____________________ Date: ___

____

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____

____

____

SOCIAL HISTORY:

Occupation:_________________________

Marital Status:

☐Married ☐Separated
☐Single ☐Widowed
☐Divorced ☐Domestic Partner

Alcohol Use: ☐Yes ☐No

If Yes, how often?

☐Occasional ☐ < 3 times/wk ☐> 3 times/wk

Tobacco Use: ☐Yes ☐No ☐ Quit

☐Cigarettes____ pks/day
☐Cigars________ /day
☐Chew________ cans/day

Recreational Drug Use: ☐Yes ☐No ☐ Past

FAMILY HISTORY:

Mother ☐Cancer ☐Diabetes ☐Osteoporosis
Father ☐Cancer ☐Diabetes ☐Osteoporosis

REVIEW OF SYSTEMS:

☐Weight Gain___lbs
☐Weight Loss___lbs
☐Fatigue
☐Fever

☐Glasses or Contacts
☐Blurred Vision

☐Ringing in Ears
☐Hearing Aids
☐Nosebleeds
☐Bleeding Gums

☐Chest Pain
☐Palpitations / Tachycardia
☐Pacemaker

☐Headaches
☐Dizziness
☐Seizures
☐Loss of Sensation
☐Vertigo

☐Heartburn
☐Rectal Bleeding
☐Abdominal Pain

☐Joint Pain
☐Arthritis
☐Muscular Weakness
☐Stiffness
☐Muscular Pain

☐Blood Clots
☐Easy Bruising
☐Bleeding Tendency

☐Shortness of Breath
☐Cough
☐Wheezing

☐Nervousness
☐Depression
☐Anxiety

☐Blood in Urine
☐Burning with Urination
☐Feeling of Urgency

(Please write on back of this form if you need additional space to answer any of the above)