CITRUS PARK SPORTS MEDICINE & ORTHOPAEDICS
6918 Gunn Hwy.
Tampa, Fl 33625
T: 813-855-8450 x. 5 F: 813-855-7540

Patient Information

Today's Date _____Home Phone _____

Name _____ SS# _____

Address _____Cell Phone _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Married ☐ Widow ☐ Single ☐ Divorced/Separated ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Phone _____

Emergency Contact _____ Phone _____

Family/Referring Dr _____Phone _____Fax _____

Primary Insurance please give receptionist your photo ID and insurance cards

Insured Name _____ DOB _____

Address if different then above _____ Phone _____

City _____ State _____ Zip _____ SS# _____

Insured Employer _____ Wk Phone _____

Insurance Company _____

Subscriber ID # _____ Group # _____

Insurance Address _____ Phone _____

City _____ State _____ Zip _____ Fax# _____

Do you have secondary Insurance? ☐ Yes ☐ No Insurance Company _____

Workers Compensation

Claim Number _____ Date of Injury _____

WC Company Name _____ Phone _____

Address for Claims _____

Adjuster Name _____Phone _____Fax _____

Nurse Case Manager _____Phone _____Fax _____

Attorney Name _____Phone_____Fax _____

_____/_____/ _____

Patient/Guardian Signature Relation to Patient If Minor Date

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Patient:_____Age: _____DOB: _____

Date:_____ Height:_____ Weight:_____ Work Comp Only DOI: _____

What is the main reason you are here for: _____

_____

CURRENT MEDICATIONS (List all medications-use back of this sheet if you need more room)

MEDICATION	DOSAGE	# Per Day /Frequency	Reason for Taking (if known)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES NO If so what?_____

Past Medical History (Patient)

Check all that apply

_Diabetes
_Asthma
_Hypo/Hyper Thyroid
_High Cholesterol
_High Blood Pressure
_Bronchitis or Emphysema
_Rheumatoid Arthritis
_Other:_____
_Heart Disease
_Pneumonia
_History of Cancer
type: _____
_Heart Attack
_Ulcers
_Blood Clots

Other Medical History not listed above:_____

_____

Past Surgical History (Patient)

_Appendix (Appendectomy)
_Gall Bladder (Cholecystectomy)
_Heart Bypass
_Prostate
_Breast Surgery
_Back Surgery
_Total Joint Replacement
_Tonsillectomy
_Hysterectomy
_Arthroscopy

Other Surgery not listed above:_____

Family Medical History

Has anyone in your immediate family died of heart disease: Yes No
Has anyone in your family had an adverse reaction to anesthesia: Yes No
Has anyone in your family had an adverse reaction to Latex: Yes No
List any medical illnesses that run in your family: _____

Social History

Who do you live with now: SPOUSE BY YOURSELF OTHER FAMILY FRIENDS OTHER _____
Do you smoke tobacco? YES NO How much? _____ packs per day How long? _____ years
Do you drink alcohol? YES NO How much? _____drinks per day How long? _____years

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PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking for the control of your pain. This is also to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that if I break this agreement which is essential to the trust and confidence necessary in a doctor / patient relationship which my doctor undertakes to treat me based on this agreement the doctor has the right to discharge me as a patient of the practice.

I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program maybe recommended.

I have communicated, and will continue to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use illegal controlled substances, including marijuana, cocaine etc. at any time.

I will inform Dr. Kevin Scott of all the medications I am presently taking, including all remaining refills. I will not attempt to obtain any controlled medicines which include opium pain medicines and refills, controlled stimulants, or anti-anxiety medicines from **ANY OTHER DOCTOR**.

I WILL NOT SHARE, SELL, OR TRADE MY MEDICATION WITH ANYONE.

I WILL SAFEGUARD MY PAIN MEDICINE/S FROM LOSS OR THEFT. LOST OR STOLEN MEDICINES **WILL NOT** BE REPLACED.

I UNDERSTAND THAT DR. KEVIN SCOTT RESERVES THE RIGHT TO TERMINATE MY CARE AND TREATMENT IF SUCH IS THE CASE ANY ANYTIME.

Please don't wait until you run out of medicine to call for a refill. In fact, call at least two days ahead. In order to protect you, your doctor must review your medical file before renewing a prescription. Therefore please do not call for medications after hours or on weekends when records are unavailable. It could take up to 48 hours after you call before your doctor can review your file and call in any prescription. The files are reviewed and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. By law, doctors cannot order refills for certain narcotics over the phone. A written prescription is required in those cases.

_____

Patient Name (Print) Patient Signature Date

CITRUS PARK SPORTS MEDICINE & ORTHOPAEDICS

PATIENT / PHYSICIAN AGREEMENT

FAILURE TO FOLLOW PHYSICIAN ORDERS

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but is not limited to missing or postponing appointments or refusal of additional tests to rule out, confirm, or discover illness. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

PRESCRIPTION REFILLS

Please don't wait until you run out of medicine to call for a refill. In fact, call at least two days ahead. In order to protect you, your doctor must review your medical file before renewing a prescription. Therefore please do not call for medications after hours or on weekends when records are unavailable. **It could take up to 48 hours after you call before your doctor can review your file and call in any prescription.** The files are reviewed and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. By law, doctors cannot order refills for certain narcotics over the phone. A written prescription is required in those cases. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

STATEMENT OF FINANCIAL RESPONSIBILITY

I the undersigned realize that all medical and surgical charges incurred by me or my dependents are my financial responsibility. I understand that I am responsible for any deductibles or coinsurance. I understand that if my insurance does not pay I may still be responsible for the charges incurred by me or my dependents.

Patient/Guardian Signature:_____ Date:_____

CONSENT FOR TREATMENT

I give Citrus Park Sports Medicine & Orthopaedics consent to treat myself or my dependents.

Patient/Guardian Signature:_____ Date:_____

INDIVIDUAL PATIENT AUTHORIZATION

Name the people and/or organization and their relationship to you that are authorizing to use and/or disclose your personal health information.

_____

CORDINATION OF BENEFITS

I hereby do authorize any and all parties, including any insurance company to pay directly to Citrus Park Sports Medicine & Orthopedics/Scott Sports Med, sums as may be due and owing for medical services rendered to me .

I hereby further give my authorization to Citrus Park Sports Medicine & Orthopaedics/Scott Sports Med to record a Uniform Commercial Code Form (UCC-1) to protect this medical lien and to send any unpaid sum to Collections. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES

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.

At Citrus Park Sports Medicine & Orthopaedics**,** we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act that requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice at any time upon request.

If we change any details of this notice we will notify you in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer: Barbara Knapp at (727) 446-5681. This notice went into effect on October 01, 2007.

Acknowledgement: I have read, understand, and agree with the above Notice of Privacy Practice.

Patient/Guardian (Please Print Name) Patient/Guardian (Signature) Date