Orthopedic Specialists OF SW FLORIDA

(p) 239.334.7000
(f) 239.334.7070
www.osswf.com
14601 Hope Center Loop, Fort Myers, Florida 33912

PATIENT REGISTRATION

PATIENT INFORMATION (PLEASE USE FULL LEGAL NAME)

LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH | SEX

STREET ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE # | CELL PHONE #

EMAIL ADDRESS

PRIMARY CARE PHYSICIAN (PCP) | REFERRING PHYSICIAN

EMERGENCY CONTACT NAME | RELATIONSHIP | PHONE #

GUARANTOR INFORMATION (PLEASE FILL OUT IF THE PATIENT IS UNDER 18)

LAST NAME | FIRST NAME | RELATIONSHIP TO PATIENT

DATE OF BIRTH | PHONE #

STREET ADDRESS | CITY | STATE | ZIP CODE

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ANNUAL CONSENTS

FINANCIAL POLICY

I understand that I am responsible for payment of all applicable deductibles, co-payments, co-insurance, and any services or supplies not covered by my insurance, including but not limited to braces, slings, and splints. Payment is due at the time of service. As a courtesy, Orthopedic Specialists of Southwest Florida will submit claims to my insurance company on my behalf. I understand that any balance not paid by my insurance is my responsibility, regardless of insurance coverage or benefit determination.
If my account balance remains unpaid and no payment arrangements have been made, my account may be referred to a collections agency. In the event of collection activity, I may be responsible for additional costs permitted by law, including collection fees, attorney fees, court costs, interest, and other related expenses.

Additional Fees
Requests for completion of forms or paperwork may incur a fee of up to $50. Returned checks are subject to a $35 fee.

No-Show Policy
We ask that you notify our office at least 24 hours in advance if you need to cancel or reschedule your appointment. Appointments cancelled or rescheduled with less than 24 hours' notice, or missed without notice, will be subject to a $50 no-show fee per occurrence. This fee is the patient's responsibility and is not billable to insurance.

By signing below, I acknowledge that I have read, understand, and agree with this financial policy.

_____
Patient Name

_____
Signature DATE

ASSIGNMENT OF BENEFITS AND PATIENT RESPONSIBILITY

I authorize Orthopedic Specialists of Southwest Florida ("OSSWF") to release information from my medical record as needed to process insurance claims. I assign and authorize direct payment of insurance benefits, including Medicare, PIP, or other health benefits, to OSSWF. I understand that I am financially responsible for all charges not covered by my insurance, including deductibles, co-pays, co-insurance, and non-covered services. Payment is due at the time of service, and I remain responsible for the full balance of my account regardless of my insurance coverage. I authorize OSSWF to share medical records with other physicians or facilities involved in my care when necessary.

_____
Patient Name

_____
Signature DATE

CONSENT FOR TREATMENT

I consent to medical care and treatment by the physicians of Orthopedic Specialists of Southwest Florida and their healthcare team. This may include examinations, x-rays, blood tests, or other diagnostic procedures that my physician determines are necessary. If unexpected conditions are found during treatment, I authorize my doctor to address them as needed.

I understand that all medical treatments have potential risks and benefits, and that no outcome can be guaranteed. My doctor will explain my condition, proposed treatments, alternatives, and risks, including the risks of not receiving treatment. I may ask questions at any time, and I understand that I may stop treatment if I need clarification.

I agree to provide accurate and complete medical history, including medications I have taken. I understand that my medical care may involve review of past and current records, test results, and prescription history as needed.

I also understand that Florida law allows physicians to practice without medical malpractice insurance if certain conditions are met. The physicians of Orthopedic Specialists of Southwest Florida have elected not to carry malpractice insurance, as permitted by law.

By signing below, I confirm that I understand and agree to this consent and that I have been offered assistance or an interpreter if needed.

_____

Patient Name

_____

Signature DATE

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HIPAA & NPP FORM

PATIENT INFORMATION

_____

PATIENT NAME DATE OF BIRTH

AUTHORIZATION OF RELEASE OF HEALTH INFORMATION

Our office will not communicate your PHI to any other entity not listed on this form. If you have adult children, extended family members, caretakers, or other persons whom you want us to be able to speak to on your behalf regarding treatment, clinical, and administrative functions in our office you will need to list the person(s) below.

☐ I hereby authorize orthopedic specialists of SW Florida and its employees' permission to discuss, send, and /or receive my personal health information to/with the following individual(s):

_____

NAME RELATIONSHIP PHONE NUMBER

_____

NAME RELATIONSHIP PHONE NUMBER

_____

NAME RELATIONSHIP PHONE NUMBER

☐ I do not wish any other entity or person other than myself to be able to discuss my care or treatment with this office.

_____

SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered access to Orthopedic Specialists of SW Florida's Notice of Privacy Practices (NPP), which describes how my health information may be used and disclosed. I understand that I may request a copy at any time.

_____

SIGNATURE DATE

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ACCIDENT / INJURY FORM

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____

REASON FOR TODAY'S VISIT _____

WAS THIS AN INJURY? ☐YES ☐NO DATE OF INJURY/ACCIDENT: _____

BODY PART: _____ WHICH SIDE? ☐LEFT ☐ RIGHT ☐ NA

HOW DID THIS OCCUR? _____

IF AUTO/MOTORCYCLE:

_____ _____

NAME OF AUTO/MED PAY INSURANCE CARRIER CLAIM NUMBER

Has a claim been made with your auto insurance carrier? ☐ YES ☐ NO

Were you the ☐DRIVER or ☐PASSENGER ? Do you own the vehicle? ☐YES ☐NO

If motorcycle related, do you have med pay that would cover medical expenses relating to this accident? ☐YES ☐NO

IF WORK:

_____

NAME OF EMPLOYER AT THE TIME OF INJURY

Are you self-employed? ☐YES ☐NO Which do you receive? ☐W-2 ☐1099

Have you filed a Workers' Compensation Claim? ☐YES ☐NO

Has the employer or the Workers' Compensation carrier accepted or denied liability? ☐ACCEPTED ☐DENIED

IF OTHER:

Please provide a description of how the accident occurred:

_____

_____

ATTORNEY INFORMATION ONLY FILL OUT IF YOU HAVE SOUGHT THE ASSISTANCE OF AN ATTORNEY FOR THIS ACCIDENT/INJURY

_____ _____

ATTORNEY'S NAME ATTORNEY'S PHONE NUMBER

ATTORNEY'S ADDRESS: _____

To the best of my knowledge, the above information is true, accurate and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, insurance carrier, or plan to make available to my health insurance company _____ all records necessary for processing claims filed by me or on my behalf. I authorize all insurance payments, including auto, PIP, and Med Pay to be made directly to Orthopedic Specialists of SW Florida. I authorize my auto insurance carrier _____ to release information regarding my PIP benefits and to provide a PIP log to OSSWF when requested.

PATIENT SIGNATURE DATE