ORTHOPAEDIC ASSOCIATES
The Strength of Experience

Fort Walton Beach
1034 Mar Walt Drive
Fort Walton Beach, FL 32547

Destin
36474C Emerald Coast Parkway, Suite 3101
Destin, FL 32541

Niceville
554-D Twin Cities Boulevard
Niceville, FL 32578

Panama City
1827 Harrison Avenue
Panama City, FL 32405

Crestview
5300 South Ferdon Boulevard
Crestview, FL 32536

PATIENT INFORMATION: **E-MAIL:**_____

LAST NAME:_____ **FIRST:**_____ **M:**_____

LOCAL ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

MAILING ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

SOCIAL SECURITY NO:_____ **DATE OF BIRTH:**_____ **AGE:**_____

HOME PHONE:_____ **CELL PHONE:**_____ **SEX:** □ **M** □ **F** **MARITAL STATUS:** □ **S** □ **M** □ **D** □ **W**

PREFERED LANGUAGE:	**ETHNICITY:**	**RACE:**
__Arabic __Chinese	__Hispanic or Latino	__American Indian or Alaskan Native
__English __French	__Not Hispanic or Latino	__Asian
__German __Greek	__Decline	__Black or African American
__Italian __Japanese		__Native Hawaiian or Other Pacific Islander
__Other __ Sign Language		__White
__Spanish __Vietnamese		__Decline

EMERGENCY CONTACT PERSON:_____ **RELATION:**_____

EMERGENCY NUMBER:_____

EMPLOYMENT INFORMATION: PATIENT OR PARENT

EMPLOYER:_____ **OCCUPATION:**_____ **EMPLOYEE NAME:**_____

ADDRESS:_____ **CITY:**_____ **STATE:**_____

ZIP CODE:_____ **WORK PHONE:**_____ **EXT:**_____

RESPONSIBLE PARTY (If different from above or if patient is a minor):

NAME:_____ **SOCIAL SECURITY:**_____

MAILING ADDRESS:_____

PHONE:_____ **DATE OF BIRTH:**_____ **MARITAL STATUS:**_____

RELATION TO PATIENT: □ **SPOUSE** □ **PARENT** □ **STEP-PARENT** □ **OTHER**

HOW DID YOU HEAR ABOUT US: _____

PRIMARY CARE PHYSICIAN: _____ **REFERRING PHYSICIAN:**_____

PREFERRED PHARMACY: _____

PRIMARY INSURANCE: (Please provide copy of insurance card)

Name of Insurance _____ **Policy#** _____ **Group#** _____

Name of Policy Holder _____ **Relationship to Patient**_____

PATIENT SIGNATURE: _____ **DATE:**_____

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Orthopaedic Associates
Authorization/Consent Acknowledgment

RELEASE OF INFORMATION:
I acknowledge that records concerning the patient are the property of Orthopaedic Associates and are maintained for the use and benefit of Orthopaedic Associates and its staff in providing care and treatment to the patient. I hereby authorize Orthopaedic Associates to disclose all or any part of my patient record to my referring physician, primary care physician, admitting physician, consulting physician and /or hospital based physician. I further authorize Orthopaedic Associates and providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to Orthopaedic Associates, myself or a family member of mine, for all or part of Orthopaedic Associates charges, including but not limited to, hospital or medical service companies, insurance companies, Workers' Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations.

ASSIGNMENT OF BENEFITS:
I hereby request that my insurance company pay any/all benefits due and payable under the terms of my contract to Orthopaedic Associates. I hereby authorize Orthopaedic Associates to release such information as may be necessary for the completion of any insurance claim. Any parent or guardian who brings in a minor for treatment is and hereby agrees to be financially responsible for paying the minor's account in full. In the event that an account is referred to an outside collection agency and/or small claims suit, the responsible party will be subject to paying any/all fees associated with the collection processes. I hereby authorize Orthopaedic Associates to obtain a credit history for such collection purposes. In the event that our office must commence legal action against the patient for payment of the patient's balance, the patient agrees to be liable for attorney fees and costs incurred by the office as part of such action and any attorney fees and costs incurred by this office in order to recover on the resulting judgment.

MEDICARE: (for Medicare patients only)
I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize all medical records to be released to the Social Security Administration or its intermediaries or carriers and request that payment of authorized benefits be made on my behalf and I assign the benefits payable for physician service to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

AUTHORIZATION FOR MEDICAL CARE AND TREATMENT:

1. I recognize that a medical condition may exist requiring medical care and I voluntarily consent to such medical care, treatment and diagnostic procedures by Orthopaedic Associates and its medical and professional staffs, associates and agents as deemed necessary.
2. I hereby authorize my physician, as provided by law to furnish medical treatment, diagnostic procedures, x-ray/MRI diagnosis or therapy as he/she considers necessary and proper in the treatment process.
3. I am aware that the practice of medicine and surgery, and the administration of medical care, are not exact sciences and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, treatments, examinations or care undertaken with Orthopaedic Associates.

ACKNOWLEDGMENT OF HEALTH INFORMATION PRACTICES
Orthopaedic Associates Notice of Privacy Practices provides information about how health information about patients may be used and disclosed. I have been offered an opportunity to review the Notice of Privacy Practices before signing this consent. I understand the terms of the Notice may change and that a copy of the revised Notice will be posted in all Orthopaedic Associates facilities. By signing this form, I acknowledge that I have been offered and or received Orthopaedic Associates' Notice of Privacy Practices.

The contents of the form have been fully explained to me and I have been given the opportunity to ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of this form in its entirety.

Termination of care may result from failure to cooperate and/or comply with Orthopaedic Associates Policy and Procedures as well as failure to cooperate and/or comply with medical care and/or treatment deemed necessary by Orthopaedic Associates' physicians and medical staff.

_____ _____

Signature of Patient or Authorize Representative/Date Witness/Date

Orthopaedic Associates, P.A. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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ARBITRATION AGREEMENT BETWEEN DOCTOR AND PATIENT

(Please read carefully)

This agreement is made between Orthopaedic Associates and Theodore I. Macey, M.D., Mark J. Tenholder, M.D., Jason W. Thackeray, M.D., Michael Shawbitz, M.D., James F. Watt, D.O., Donald Chipman, M.D., Dale Landry, M.D., Thomas Fusco, D.P.M., Jacob Seales, M.D., Brandon Cook, M.D., Jack E. McKay, M.D. David J. Dean, M.D., Robert J. White, D.P.M. and their physician extenders, agents, employees, or any of the foregoing referred to hereinafter as "doctors" and _____ hereinafter referred to as "patient".
(Patient name)

It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians, or any other persons deriving their claims through, and on behalf of, the patient.

It is understood by the patient that he or she has voluntarily selected, and he or she is neither required to use Orthopaedic Associates nor any of the doctors involved in their treatment and that there are other competent Orthopaedic physicians in Florida who may act as the patient's treating physician.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other 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 Statues.

Disputes and Consideration; In the unfortunate event of any claim for medical malpractice or otherwise, and in consideration for this agreement, the parties would like to (a) keep things as simple as possible; (b) enhance early resolution of their differences; (c) avoid lengthy drawn-out litigation through the courts; (d) avoid the stress associated with traditional litigation and jury trials; and (e) minimize all costs, expenses, and attorney's fees.

This arbitration shall be binding and shall be in lieu of, and instead of, any trial by judge or jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery available for under the Florida Rules of Civil Procedure. The panel of three (3) arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction.

Duty to Defend and Indemnify: For each individual or entity with a claim that is not bound by this agreement ("non-party"), it is the parties' intent that they shall adopt and comply with this agreement 100% so that the parties can avoid piecemeal litigation and ensure consistency, closure, and finality in one forum. For each non-party claim against the patient's physician brought outside this agreement, you shall (a) defend and (b) indemnify the patient's physician against said claim(s).

If any provision of this Agreement shall be held invalid under any applicable laws, such invalidity shall not affect any other provision of this Agreement that can be given effect without the invalid provision. Further, all terms and conditions of this Agreement shall be deemed enforceable to the fullest extent permissible under applicable law, and, when necessary, the court is requested to reform any and all terms or conditions to give them such effect.

Patient initials _____ **I understand that by signing this agreement I am waving my right to a jury trial, and instead, have agreed to participate in arbitration.**

This agreement shall remain in effect for all treatment and surgery provided to the patient, presently and at any future date.
By signing below, I am indicating that I have read and agree to the foregoing terms.

In witness whereof, we have set our hands this date: _____

PATIENT:

By: _____
(Patient Signature as Authorized as Agent)

_____
Patient's Spouse, if available

WITNESS:

By:_____
(Employee of Orthopaedic Associates)

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Correspondence Authorization

I wish to be contacted in the following manner (check all that apply)

☐ **Home Phone** _____
☐ Leave message with detailed information
☐ Leave message with call back number only

☐ **Cell Phone** _____
☐ Leave message with detailed information
☐ Leave message with call back number only

☐ **Work Phone** _____
☐ Leave message with detailed information
☐ Leave message with call back number only

☐ **Written Communications**
☐ Can mail to home address
☐ Can mail to work address
☐ Can fax to this number _____
☐ Can email to the email address _____

☐ **Appointment Reminders**
☐ Home phone
☐ Cell phone
☐ Text
☐ Email

_____ _____
Patient or Legal Guardian if a minor Date

The patient's condition prohibits the individual from signing at this time. This information will be obtained as reasonably practical after the patient's condition improves.

_____ _____
Orthopaedic Associates Representative Date

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Patient Pain Medication Consultation Form

Pain Medication

- To help control pain, you may be prescribed an opioid. Florida Law limits the prescription to 7 days following a postsurgical procedure or 3 days for an acute painful condition. You and the physician will discuss tapering prescribed medications. You may also be placed on an adjunctive medications like Tylenol or anti-inflammatories.
- Controlled substance medications (i.e., opioids, narcotic analgesics, tranquilizers, and barbiturates) have a high potential for misuse and user dependence, and therefore are closely controlled and monitored by our office as well as local and federal governments under House Bill 451 (Nonopioid Alternatives). The bill requires that before providing anesthesia or prescribing, ordering, dispensing, or administering an opioid listed as a Schedule II controlled substance to treat pain, the patient must be informed about available nonopioid alternatives. They are intended to relief pain, to improve function and/or the ability to work, not simply feel good.
- HB831 Section 456.42(3), (electronic prescribing) Florida Statutes, requires prescribing health care practitioners to electronically transmit prescriptions for medicinal drugs. Please allow up to 24 hours for completion. Check the status of your prescription by calling your pharmacy directly.

After Surgery

- For all patients who continue to have pain following surgery or have a condition that requires ongoing pain medication, the office has a consulting service to help with chronic pain. Chronic pain management patients will be referred to this service.

Refills

- You are expected to take your medication exactly as it is prescribed. In the event that you run out of this medication early, the office will not be able to write or refill a prescription unless your doctor or physician assistants examines you and/or your medical record.
- The office will not re-write prescriptions for pain medication that are lost, stolen, destroyed, or misplaced.
- To get a prescription refill, call our office at (850)315-9241 and leave the information on the prescription line. Please allow 48 to 72 business hours, excluding holidays and weekends to process the request. Once the refill request is processed, the patient will receive a call. Please check with your pharmacy before calling the office to check the status of a refill request.

I understand that my physician has access to a record of controlled substances prescribed to me through participation of E-Forcse or through communication made directly to my physician by various pharmacies. If it is determined that I have received prescriptions from other physicians in violation of the agreement, or have attempted to obtain medications from multiple pharmacies improperly, I understand that I will be immediately discharged from this practice.

_____	_____	_____
Print Name	Signature	Date

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MEDICATION RECORD

Today's Date: _____

Patient Name (Last): _____

Patient Name (First): _____ Middle Initial: _____

Height: _____ Weight: _____ Date of Birth: _____

Patient's Family Doctor: _____

Preferred Pharmacy: _____ Location: _____

Medication (including over the counter & supplements)	Frequency

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Authorization for Release of Medical Information

I, _____, give Orthopaedic Associates permission to release and/or discuss my medical records or conditions with the following individual(s):

Name:

_____

_____

_____

_____

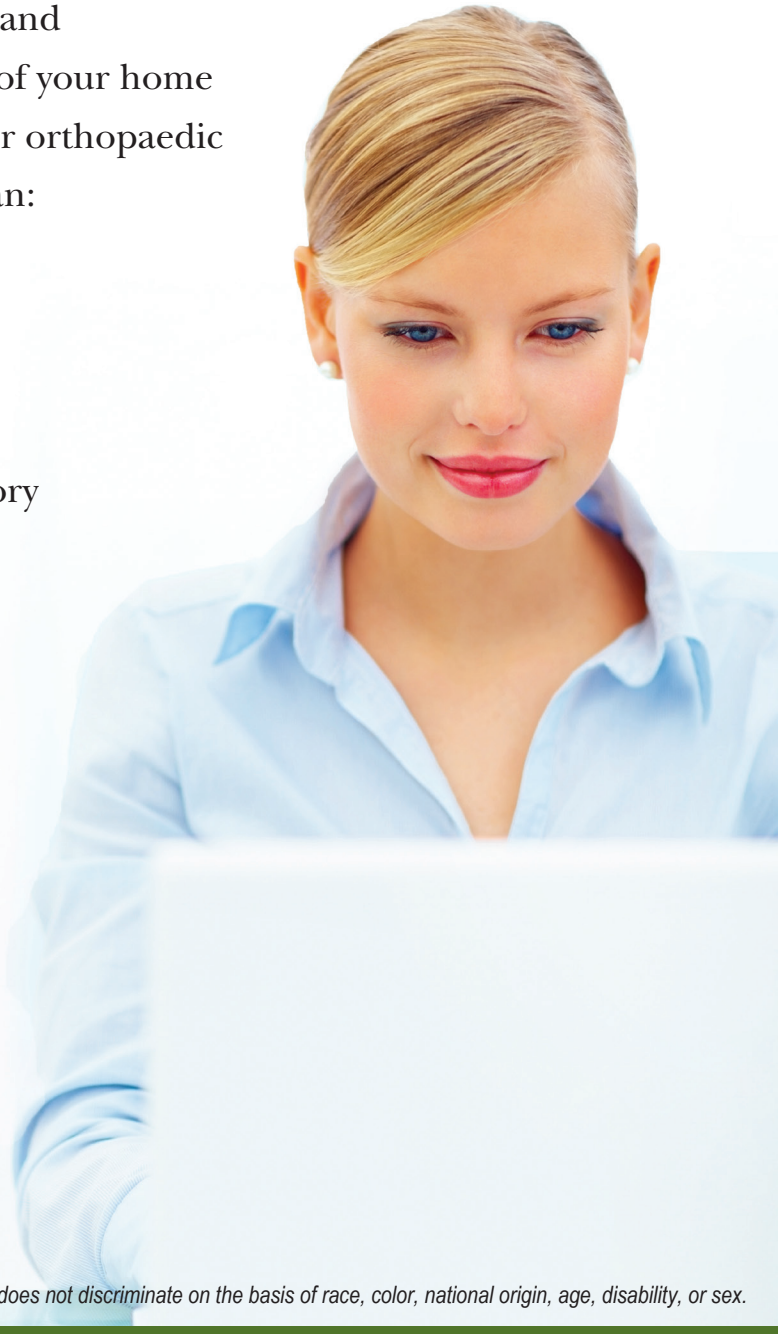
_____
Patient signature

_____
Witness signature

Our online Patient Portal is easy and convenient!

Access your Orthopaedic Associates medical and appointment information from the comfort of your home or office. You can easily manage many of your orthopaedic needs. With our online Patient Portal, you can:

- View your patient summary
- View your visit summary
- Complete and update your medical history
- Make an appointment



Try the Orthopaedic Associates Patient Portal by adding your email to your account at the front desk today!

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www.orthoassociates.net

GENERAL INFORMATION

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Orthopaedic Care

Orthopaedic care deals with issues related to the musculoskeletal system, including bones, joints, muscles, tendons, and ligaments that are affected by injury or aging.

All our physicians are board-certified or board-eligible, and most are active surgeons. You will have a primary surgeon within our group. Due to areas of specialization, you may, over time, work with more than one of our physicians. One of our physicians is "on call" every night to respond to emergencies.

Several of our physicians have a physician assistant (PA) that helps provide exceptional patient care during clinic and surgery. Each PA is a licensed healthcare professional with prescriptive medication authority, certified by the National Commission on Certification of Physician Assistants. All our PAs have specialty training in orthopaedics, and they report directly to the supervising physician. Typically, you will see both in the same visit but not always.

Appointments

Appointments may be scheduled:

- **Phone** – Between 8:00 a.m. and 5:00 p.m., Monday through Friday
- **Online** – An appointment request may be submitted 24/7 at www.orthoassociates.net on the header of each page: "Online Appointment Request"
- **Email** – An appointment request may be submitted 24/7 via sportsmed@orthoassociates.net

When making an appointment, please specify which physician and which clinic location you are requesting. On your first visit, please remember to bring with you any X-rays and MRIs specific to your visit. You must bring the actual images, not just the report. The images will not be mailed by the referring facility. You must hand-carry them.

If you are unable to attend your scheduled appointment, please contact us within 24 hours of your appointment at 850-863-2153.

Urgent Needs

At Night – Should you have an urgent nonemergency need for help during the night, please call our general number, 850-863-2153. The answering service will contact the physician on call. Please inform the service if you have had a surgery or another procedure within 4 weeks.

During Business Hours – Please call our general number, 850-863-2153, and we will do everything we can to address your concerns.

Billing

It is expected that you will pay your portion of the clinic visit the day of your visit. We accept cash, check, Visa, Mastercard, American Express, and Discover. Our receptionists have our clinic visit fee information and will provide that information to you, upon request, prior to your examination. For specific billing questions, please call our billing specialists at 850-863-2153.

Insurance

We are contracted with most major commercial insurance plans as well as Medicare, military, and VA plans. For specific insurance questions, please call our billing specialists at 850-863-2153.

Prescriptions

Refills – When you are under continuing care, certain medications will be refilled with a phone request. This request may take 3 business days to complete.

Your Medical Record

We use an electronic medical record system that holds the entire history of your medical care that has been provided by our physicians and PAs. All of this information is confidential and will not be given to anyone without your specific instructions to do so. You are always welcome to request a copy of your medical record by completing a medical release request; HIPAA requires a signed release from the patient to release records to other physicians and even the patient. This request may take 5 – 10 business days to complete. You may also request a patient summary after each clinical visit when you check out. There may be a fee for this service.

Your X-Rays/MRIs

Your medical record also includes the X-rays and MRIs that are part of the care we have provided to you. Should you need a copy of your X-rays/MRIs, we will provide them to you on a CD for a fee of $5.00. To request X-rays and/or MRIs, please call 850-863-2153. This request may take up to 7 business days to complete. There may be a fee for this service.

Patient Advocate

Should you have any questions or concerns that you feel have not been handled appropriately, please contact our patient advocate at 850-315-9201.

Contact Information

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