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

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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FL 32536

Patient Questionnaire

Patient's Name:_____ Age: _____ Date: _____

JOB DESCRIPTION

Occupation: _____ Number of years at this job: _____
Are you currently working? ☐ YES ☐ NO
If so … ☐ Part-time ☐ Full-Time ☐ Regular Duty ☐ Modified Duty Working: _____ Hrs/Wk
What are your restrictions, if any? _____
Does your job require you to: (please check all that apply)
☐ Lift or carry greater than 15 lbs. ☐ Bend or twist repetitively.
☐ Work overhead. ☐ Repetitive motion of the arms or legs.

HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

Date of problem/symptoms started: _____
Location of symptoms/pain when the problem started: _____

HOW DID THE PROBLEM START?

☐ Home/Leisure ☐ At Work ☐ Motor Vehicle Accident ☐ Fall ☐ Other: _____
Please briefly describe: _____
Location of symptoms/pain now: _____
Frequency of symptoms/pain: (please check one)
☐ CONSTANT ☐ INTERMITTENT ☐ RARE
Since the onset of symptoms, has the problem: (please check one)
☐ IMPROVED ☐ WORSENED ☐ STAYED THE SAME
Does coughing or sneezing cause any pain? ☐ YES ☐ NO
If so, where? _____
Do any of the following activities make your symptoms worse? (please check all that apply)
☐ WALKING ☐ LYING ☐ BENDING/TWISTING ☐ WORKING OVERHEAD ☐ SITTING
☐ KNEELING ☐ LIFTING/CARRYING ☐ STANDING ☐ TYPING ☐ PUSHING/PULLING
☐ OTHER: _____
List anything (i.e. activities, positions, or treatments) that makes the pain better: _____
_____
Do you have any weakness, if so, which arm, leg, or muscle? _____
Have you had any new or recurrent problems with:
Control of urination? ☐ YES ☐ NO
Bowel movements? ☐ YES ☐ NO
Have you experienced recent weight loss or fevers? ☐ YES ☐ NO

Patient Signature: _____

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HISTORY OF TREATMENT OF THIS PROBLEM

DIAGNOSTIC HISTORY

TEST	RECEIVED	DATE OF TEST/LOCATIONS
X-Ray	☐ YES ☐ NO	_____
MRI Scan	☐ YES ☐ NO	_____
CT Scan	☐ YES ☐ NO	_____
Bone Scan	☐ YES ☐ NO	_____
EMG	☐ YES ☐ NO	_____
Other:	☐ YES ☐ NO	_____

MEDICATIONS	EXAMPLES	RECEIVED	DID THIS HELP?
Anti-Inflammatories	Naprosyn, Ibuprofen, Vioxx	☐ YES ☐ NO	☐ YES ☐ NO
Cox-2 Inhibitors	Voltaren, Celebrex, Bextra	☐ YES ☐ NO	☐ YES ☐ NO
Muscle Relaxers	Soma, Flexeril, Skelaxin, Zanaflex	☐ YES ☐ NO	☐ YES ☐ NO
Pain Medication	Tylenol w/ Codeine, Vicodin, Darvocet, Percocet	☐ YES ☐ NO	☐ YES ☐ NO
Oral Steroid	Prednisone, Medrol Dosepak	☐ YES ☐ NO	☐ YES ☐ NO
Neurontin, Zonegran, Paxil, Amitriptyline, Nortiptyline, Pamelor, Elavil, Prozac		☐ YES ☐ NO	☐ YES ☐ NO
Other	Please List:_____	☐ YES ☐ NO	☐ YES ☐ NO

TREATMENTS	RECEIVED	DID THIS HELP?
Physical Therapy/Exercise	☐ YES ☐ NO	☐ YES ☐ NO
Chiropractic Care	☐ YES ☐ NO	☐ YES ☐ NO
Injections in Muscles or other injections in office	☐ YES ☐ NO	☐ YES ☐ NO
Epidural Steroid Injections	☐ YES ☐ NO	☐ YES ☐ NO
Facet Blocks	☐ YES ☐ NO	☐ YES ☐ NO
Braces/Corsets	☐ YES ☐ NO	☐ YES ☐ NO

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Back Surgery: ☐Cervical ☐Thoracic ☐Lumbar When: _____

Prior to the onset of your current problem, did you ever visit a healthcare provider for problems with your spine? ☐ YES ☐ NO If yes, please list …

PHYSICIAN NAME	**MONTH/YEAR OF TREATMENT**

LEGAL ADVICE

Do you have an attorney regarding this injury/problem? ☐ YES ☐ NO

If yes, please list your attorney's name:_____

Patient Signature:_____

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CONSENT FOR THE USE OF CONTROLLED SUBSTANCES OR CHRONIC OPIOID THERAPY

PATIENT:_____ DOB:_____ MRN#_____

As a patient at Orthopaedic Associates, you may or may not be prescribed a controlled substance for short or long term pain management, including opioid medication, which is sometimes referred to as narcotic analgesics. Any decision to provide you with a controlled substance is not done lightly and the decision to provide you with a controlled substance has been made because your condition is serious or other treatments have not relieved your pain.

1. **Narcotics are drugs that act like opioids, or are similar to morphine.** Such drugs can include, but are not limited to, Lortab, Percocet, Demerol, Darcon, Ultram, and Tylenol #3. I am aware that I have been prescribed: _____ which is considered a narcotic medication. I fully understand the importance of taking this medication as prescribed. The risks, benefits, possible problems, and treatment alternatives related to my use of this medication have been thoroughly explained to me. My doctor has explained and discussed the risks, benefits, and possible problems with use of this controlled substance(s) which may include, but are not limited to, the risk of abuse, death, bodily harm to myself and others, physical dependence, overdose, symptoms of withdrawal, sedation, over-sedation, constipation, urinary retention, itching, and sweating.

2. **Risk of Abuse, Death, Physical Harm, Overdose, and Synergistic Effect of Other Medications**. I am aware that this drug is extremely dangerous; capable of being abused, and that an overdose can be lethal. I am also aware that when this drug is taken in excess, not as prescribed, or taken in combination with other medications, alcohol or other illegal drugs, I may put myself at great risk of harm including, but not limited to, the risk of death and respiratory depression. In other words, I may become sleepy, fall asleep, will be difficult or unable to arouse, and finally, will stop breathing. Therefore, by signing below, I agree to take the above-referenced medication as prescribed by this practice and only as advised by my physician. I also fully agree to inform this practice and my physician of any and all of my medications prescribed by any other physicians.

3. **Risk Physical Dependence and Withdrawal.** I am fully aware that this drug(s) can cause physical dependence. This means when you stop taking the drug you will experience a withdrawal reaction. A withdrawal reaction can be characterized by severe nausea, vomiting, diarrhea, abdominal pain, muscle aches, low-grade fever, tremor, rapid heart rate, sweating, and chills. Physical dependence is not the same as addiction. Physical dependence means that if you suddenly stop using the drug, you will develop a withdrawal reaction (nausea, diarrhea, sweats, shaky and flu-like symptoms). I understand that physical dependence can be a normal and expected result of using controlled substances or opioid therapy for a long time.

4. **Risk of Developing a Tolerance to the Controlled Substance.** I am aware that tolerance to analgesics is not necessarily a significant risk for patients with chronic pain; however, it is still a risk and may occur. If I develop a tolerance, increasing doses may not always help and may cause unacceptable side effects. If I develop a tolerance or fail to respond well to the controlled substance(s) which have been prescribed to me, it may cause my physician to choose or recommend another form of treatment.

5. **Risk of Addiction.** I am aware that physical dependence is different from addiction. Although the risk of addiction is low, I am aware that the risk of addiction is associated with many controlled substances. Addiction is a psychological diagnosis characterized by cravings for the drug, uncontrollable use of the drug even when it causes harm to you and/or others. I understand that if I develop signs or symptoms of addiction, or if I am at high risk for developing an addiction based upon my history, I will be referred to an addiction specialist or psychiatrist. Should I not agree to such a referral, I understand that I may be discharged from the practice.

6. **Other Side Effects and Risks.** There are numerous side effects which can occur as a consequence of the use of a controlled substance. These side effects include, but are not limited to:

   A. Sedation. If I experience this side effect, even slightly, I understand that I am not to be involved in any activity that may be dangerous to myself or someone else. Such activities include, the use of heavy equipment, operating a motor vehicle, working at unprotected heights or being responsible for another individual who is a minor or is unable to care for themselves. If confusion, mental changes, or excessive sleepiness occur, report this to your physician or present to the nearest hospital's emergency department immediately.

   B. Constipation. If this occurs you will not adapt to this effect. You should drink eight (8) eight-ounce glasses of water per day, take daily doses of Senokot S or Dulcolax, use milk of Magnesia no more than every third day for no bowel movement, and notify your physician that you are experiencing this complication. People over the age of 60 are especially at risk for this complication.

   C. Urinary retention. This means it is difficult to start your stream. Males over the age of 60 are especially at risk for this complication.

   D. Itching. These drugs can cause itching in some patients.

   E. Sweating. Profuse sweating can occur at any time with the use of these medications.

   F. Nausea and vomiting. If this occurs, notify your physician.

   G. Decreased sex drive. (See below for further details).

   H. Mild suppression of the immune response.

7. **MALES ONLY:** I am aware that the use of controlled substances has been associated with low testosterone levels in males. I am aware that this may affect my mood, stamina, and sexual desire, as well as physical and sexual performance. I understand that my physician may make a referral to a specialist for further evaluation should I develop any of these symptoms.

8. **FEMALES ONLY:** If I plan to become pregnant or believe that I have become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call this practice and my obstetrician/gynecologist. I am aware that, should I carry a baby to delivery while taking this medicine, the baby may be physically dependent on opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects, as birth defects can occur whether or not the mother is taking any opioids or medications, However, the risk of birth defects is always a possibility when I am taking an opioid or any other number of medications.

9. **Substance Abuse Agreement.** I understand that along with this consent, I am required to read and abide by the terms of the Substance Abuse Agreement and Protocol that is in place at this practice if I am to be maintained on any controlled substance for a significant length of time or as a treatment for chronic pain. Should I fail to adhere to the Substance Abuse Agreement, I understand that I will be discharged from this practice.

By signing below, I consent to receive the controlled substance(s) or chronic opioid therapy referenced above. I certify that I have read this consent or have had it read to me in a language that I understand; that I have had an opportunity to ask questions; that all my questions have been answered to my satisfaction; and that I knowingly and willingly give my consent to receive this medication and wish to proceed with the use thereof. I understand the risks, benefits, cautions, potential problems, and alternatives, and I give my full consent to receive this medication and understand that I must take the above-referenced medication as prescribed by my doctor.

_____ _____

Patient Print Name Date

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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SUBSTANCE ABUSE PROTOCOL AND AGREEMENT

PATIENT:_____ DOB:_____ MRN#_____

As a patient at Orthopaedic Associates, you may or may not be prescribed a controlled substance, including opioid medicine, sometimes called narcotic analgesics, for pain management. Any decision to provide you with a controlled substance is not done lightly and the decision to provide you with a controlled substance has been made because your condition is serious or other treatments have not relieved your pain. If you are prescribed a controlled substance, we ask that you agree to our controlled substance abuse protocol. If you will not accept our protocol, or fail to follow the terms of this substance abuse agreement, we cannot treat you and you will need to work with another physician.
Any violations of this protocol will result in immediate dismissal from our practice, as necessary.

Controlled substance medications (i.e. opioids, narcotic analgesics, tranquilizers, and barbiturates) are very useful; however, they have high potential for misuse and are therefore closely controlled by our office as well as local, state, and federal governments. They are intended to relieve pain, to improve function, and/or ability to work, not simply to feel good. By signing below, I acknowledge and agree to the following:

1. I will be prescribed a thirty (30) day supply of my medication(s) which will not be filled earlier than one (1) month.
2. I am responsible for my controlled substance medications. If my medication is lost, misplaced, stolen, or used sooner than prescribed, I understand that it will not be replaced.
3. I agree to provide copies of all my medical records from previous and concurrent physicians as requested.
4. I agree to provide a full and current medical history to my physician at Orthopaedic Associates, including any personal history and/or family history of substance abuse.
5. I agree to provide a full and current list of medications to my physician at Orthopaedic Associates and to any other physician who provides me with medical care or treatment.
6. I will not request or accept controlled substance medication from any other physician or individual while I am receiving medication from the physicians affiliated with Orthopaedic Associates.
7. I understand that my physician may have access to a record of the controlled substances prescribed to me through participation in E-FORCSE or through communication made directly to my physician by various pharmacies. If it is determined that I have received prescriptions from other physician(s) in violation of this agreement, or have attempted to obtain medications from multiple pharmacies improperly, I understand that I will be immediately discharged from this practice
8. My medication will be kept in a locked location in the original containers from the pharmacy for each medication.

9. If requested, I will bring the original containers of all medication prescribed to me, even if there is no medication remaining.
10. Refills of controlled substance medication will be made only during regular office hours, Monday through Friday, 8 am to 4 pm. Refills will not be made at night, on holidays, or weekends. I will call at least seventy-two (72) hours ahead if I need assistance with a controlled substance medication prescription. Refill calls made on Friday will be filled and addressed the following week.
11. Refills of controlled substance medications will not be made if I "run out early." I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
12. I understand that refills of my controlled substance medications will not be made as an "emergency," and that a follow-up visit to the office will likely be required for a refill. (i.e. on Friday afternoon because I suddenly realize I will "run out tomorrow").
13. I understand that no trustworthy physician-patient relationship can be present when a patient abuses illegal drugs. The use of "street drugs" such as marijuana, cocaine, amphetamines, etc. are dangerous and illegal in this state. I understand that mixing any of my medication prescribed for pain management with "street drugs," may be lethal. Therefore, use of any "street drugs" during the course of the physician-patient relationship will not be tolerated at this practice. I understand that discovery of my use of illegal "street drugs" will result in immediate dismissal from the practice.
14. I understand that I will be submitted to random drug screens during the course of my use of controlled substance medications. If my urine drug screen test is positive for any medication not prescribed as part of my pain management therapy by this practice, I will be discharged as a patient at the discretion of my physician.
15. Also, upon request from my physician, if narcotic abuse is suspected, I may be asked to submit to a urine drug screen. If I decline, it will be the sole discretion of Orthopaedic Associates to discontinue my narcotic pain medication or discharge me from the practice.
16. Under Florida law, I understand that I am obligated, at minimum, to follow-up with my physician at three (3) month intervals to assess my condition and treatment plan. I will attend these visits and understand that my failure to attend a follow-up appointment may result in my discharge from the practice, depending on the circumstances surrounding the scheduled visit.
17. I understand that I may be referred to an addiction specialist or psychiatrist, if indicated, during the course of my use of controlled substances. If I refuse such a referral or fail to follow through with a referral to an addiction specialist or psychiatrist, I will be discharged from the practice.
18. I understand that my physician may recommend alternative therapies and treatment modalities to treat my chronic pain in an effort to reduce or limit my long-term reliance on and/or tolerance to controlled substances. As a patient of this practice, I will remain open to these alternative treatment recommendations.

19. I also acknowledge that my physician may require diagnostic imaging studies during the course of my care, and I agree to obtain such studies as recommended by my physician. If I fail to follow any physician orders for such recommendations I understand that I may be discharged from the practice.
20. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following my doctor's instructions regarding my healthcare.

I have read this agreement. I understand that if I do not follow the rules of this agreement, I will no longer be able to obtain medications from Orthopaedic Associates. I understand that if I violate any of the rules or terms of this agreement, I will be discharged from the practice.

_____ _____

Patient Print Name Date

_____ _____

Patient Signature Date

_____ _____

Employee Witness Date

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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:	Relationship to the patient:
_____	_____
_____	_____
_____	_____
_____	_____

_____
Patient signature

_____
Date

_____
Witness signature

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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

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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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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

Rev. 03/09/2020

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.

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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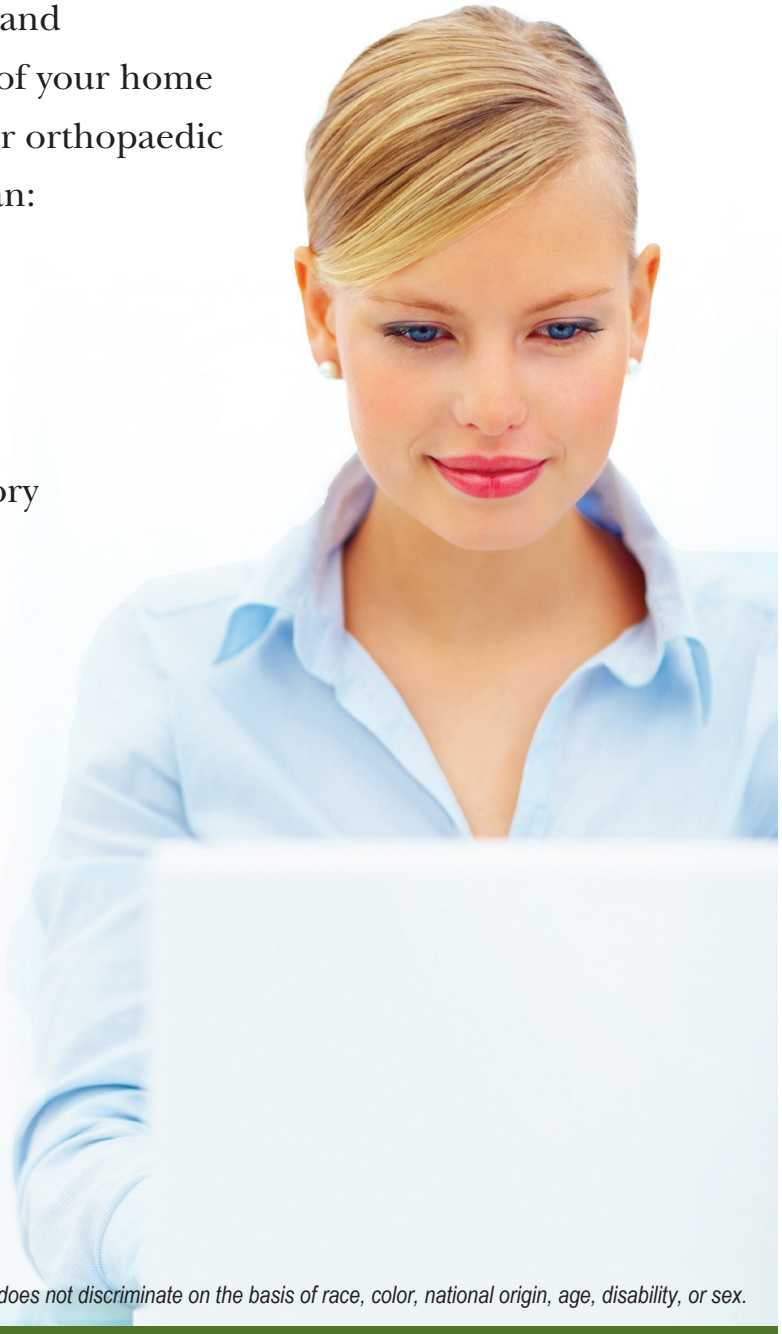
Our online Patient Portal is easy and convenient!

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!

ORTHOPAEDIC ASSOCIATES
The Strength of Experience

www.orthoassociates.net

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GENERAL INFORMATION

ORTHOPAEDIC ASSOCIATES
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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 850-315-9244.

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 850-315-9244.

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

Fort Walton Beach
1034 Mar Walt Drive
Fort Walton Beach,
FL 32547
850-863-2153

Destin
36474C Emerald
Coast Parkway, Suite 3101
Destin, FL 32541
850-837-3926

Niceville
554-D Twin
Cities Boulevard
Niceville, FL 32578
850-678-2249

Crestview
5300 South Ferdon Boulevard
Crestview, FL 32536
850-863-2153

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