Name: _____ **DOB:** _____

Pre-Qualification Questionnaire

Are you a Florida resident? Yes / No
Do you have a valid Florida ID? Yes / No
If Female, Are you pregnant? Yes / No
Have you been arrested or charged with a crime in the past two years? Yes / No
(If yes, please describe)

_____
_____

Are you currently on parole or probation? Yes / No**(If yes, please see clinic manager)**

Have you been evaluated for medical marijuana use by another physician in the past? Yes / No
(If yes, please give name of practice, doctor, date seen, and condition for evaluation)

_____
_____

Have you been denied a recommendation for medical marijuana use by another physician in the past? Yes / No
(If yes, please explain)

_____
_____

Are you currently attending, or have you attended any substance abuse or rehabilitation program? Yes / No
(If yes, please provide details)

_____
_____

Do you ever have thoughts of suicide or have you ever attempted suicide? Yes / No
(If yes, please provide details)

_____
_____

Did you bring any medical records with you today? Yes / No(If yes, what did you bring)

_____
_____

Do you currently use marijuana? Yes / No(If yes, how often)

_____
_____

Do you currently drink alcohol? Yes / No(If yes, how often)

_____
_____

Do you currently use cocaine, methamphetamine, opiates, heroin, or other street drugs? Yes / No
(If yes, please explain)

_____
_____

_____ _____
Signature of Patient/Parent or Minor/Legal Representative Date

Welcome to the West Coast Musculoskeletal Institute and Access Health Care. We would like to thank you for allowing us to care for your orthopedic condition. Please help us service your needs by answering the questions below regarding your situation.

Is your injury/pain related to your **Employment**?	☐ Yes	☐ No
Is your injury/pain related to an **Accident**?	☐ Yes	☐ No
Is your injury/pain related to a **Law Suit**?	☐ Yes	☐ No
Is there an **Attorney** related to this injury/pain?	☐ Yes	☐ No

If yes, please list the name, address and phone number:

_____

_____

_____

- If you have answered yes to any of the above questions, please see the receptionist (or call the scheduling department if forms were downloaded from the website) before completing the remaining paperwork.

We recognize that your time is valuable and we try very hard to stick to the schedule as to avoid any delay in patient care. Here are some office policies that will help you negotiate prescription refills and paperwork requests. Since these require the physician or PA to review your account, they will be performed at the end of the business day so that our patient in the office do not have to wait unnecessarily.

We require a 72-hour notice to refill prescriptions. Please don't wait until you take your last dose to call and request a refill. Additionally, the practice does not accept checks, but we do offer credit and debit transactions.

Paperwork requests are done in the order they are received. We require at least 72 hours to review the medical records and complete the paperwork. If you would like us to fax your paperwork directly from our office, please make sure you have signed a release of information form.

Again, let us welcome you to the practice and thank you for helping us stay on course. We welcome any suggestions you may have that will help us become more efficient.

_____

Signature of Patient/Parent of Minor/Legal Representative Date of Birth Date

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____

DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Marital Status: _____ Occupation: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Today's Date: _____ Date of Injury: _____ Are you: ☐ Right-handed ☐ Left-handed

Preferred Pharmacy (with cross streets): _____

How did you hear about WCMI? _____

INSURANCE INFORMATION:

Policy Holder's Name: _____ Date of Birth: _____

Insurance Company: _____ Phone Number: _____

Insurance Claims Address: _____

Group / Policy #: _____ Subscriber ID: _____

ONLY IF PATIENT IS A MINOR – RESPONSIBLE PARTY INFORMATION – *Please fill in ALL blanks.*

First Name: _____ MI: _____ Last Name: _____

Sex: ☐ M ☐ F DOB: _____ Phone: _____

Street Address: _____

Minor Pre-Authorization for Medical Care

I request and authorize West Coast Musculoskeletal Institute and its personnel to deliver medical care to my child listed above.

Guardian Name (Print): _____ Guardian's Signature: _____

Relationship to Patient (Print): _____ Date: _____

HISTORY OF PRESENT ILLNESS:

Height: _____ Weight: _____ lbs. Age: _____ Problem with: ☐ Right Extremity ☐ Left Extremity

Why are you here today? _____

SYMPTOMS:

Location: _____
(Where is the pain? Does it travel to other areas?)

Quality: _____
(Is the pain dull, throbbing, sharp? If a bump, is it warm, tender, red?)

Severity: _____
(How severe on a scale of 1 to 10, with 10 being the most severe?)

Duration: _____
(How long have you had this pain/problem? When did it start?)

Time: _____
(Does the pain/problem occur at a specific time? Is it rare, intermittent, constant?)

Context: _____
(What were you doing at the onset of the pain/problem?)

Associated signs/symptoms: _____
(Do you have numbness? Abnormal sounds like cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain?)

Modifying factors: _____
(What makes the problem worse or better? Example: Activities)

PAST HISTORY OF PRESENT ILLNESS:

Have you ever experienced any injury or symptoms regarding this body part? ☐ Yes ☐ No

If so, please provide details: _____

_____

Please list any hobbies/sports you enjoy:

_____

Which of the above activities are you unable to perform due to your pain?

_____

Have you seen any other physicians regarding THIS condition prior to coming to our office? ☐ Yes ☐ No

Doctor	When	Tests	Results	Treatment

PAST MEDICAL HISTORY:

☐ AIDS or HIV	☐ Cancer	☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Anemia	☐ Chicken Pox	☐ Hemorrhoids	☐ Mumps	☐ Tuberculosis
☐ Arthritis	☐ COPD	☐ Hepatitis	☐ Pneumonia	☐ Ulcer
☐ Asthma	☐ Dementia	☐ High Blood Pressure	☐ Polio	☐ Venereal Disease
☐ Back Trouble	☐ Diabetes	☐ Infectious Mono	☐ Rheumatic Fever	☐ Whooping Cough
☐ Bladder Infections	☐ Diphtheria	☐ Kidney Disease	☐ Scarlet Fever	☐ Other (Please List)
☐ Bleeding Tendency	☐ Epilepsy/Seizures	☐ Low Blood Pressure	☐ Sleep Apnea	☐ _____
☐ Blood Transfusions	☐ Fibromyalgia	☐ Measles	☐ Smallpox	☐ _____
☐ Bronchitis	☐ Glaucoma	☐ Migraine Headache	☐ Stroke	☐ _____

Please list **all medications** you are taking (Include non-prescription and herbal supplements):

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

Are you allergic to any medications?

Medication	Reaction	
		Tape Allergy: ☐ Yes ☐ No
		Latex Allergy: ☐ Yes ☐ No

Past Surgical/Hospitalization History:

Date	Surgery/Illness	Doctor	Hospital, City, State

Name: _____ DOB: _____

PATIENT SOCIAL HISTORY:

Marital Status	Use of Alcohol	Use of Tobacco	Living Situation
☐ Single	☐ Never	☐ Never	☐ With family
☐ Married	☐ Rarely	☐ Previously, but quit	☐ With friends
☐ Divorced	☐ Moderate	☐ Currently:	☐ Alone
☐ Widow	☐ Daily	_____ packs a day	☐ Other: _____

FAMILY MEDICAL HISTORY:

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

REVIEW OF SYSTEMS: Please indicate any personal history below:

Musculoskeletal

Joint pain	☐ No ☐ Yes
Joint stiffness or swelling	☐ No ☐ Yes
Weakness of muscles/joints	☐ No ☐ Yes
Muscle pain or cramps	☐ No ☐ Yes
Back pain	☐ No ☐ Yes
Cold extremities	☐ No ☐ Yes
Difficulty in walking	☐ No ☐ Yes

Constitutional Symptoms

Bad general health lately	☐ No ☐ Yes
Recent weight change	☐ No ☐ Yes
Fever	☐ No ☐ Yes
Fatigue	☐ No ☐ Yes
Headache	☐ No ☐ Yes

Ear/Nose/Mouth/Throat

Hearing loss or ringing	☐ No ☐ Yes
Earaches or drainage	☐ No ☐ Yes
Chronic sinus problems	☐ No ☐ Yes
Nose bleeds	☐ No ☐ Yes
Bleeding gums	☐ No ☐ Yes
Sore throat or voice change	☐ No ☐ Yes
Swollen glands in neck	☐ No ☐ Yes

Cardiovascular

Heart trouble	☐ No ☐ Yes
Chest pain or angina	☐ No ☐ Yes
Palpitations	☐ No ☐ Yes
Shortness of breath while walking	☐ No ☐ Yes
Swelling of feet, ankles or hands	☐ No ☐ Yes

Genitourinary

Frequent urination	☐ No ☐ Yes
Burning or painful urination	☐ No ☐ Yes
Blood in urine	☐ No ☐ Yes
Incontinence or dribbling	☐ No ☐ Yes
F-number of pregnancies	_____
F-number of deliveries	_____

Integumentary (skin, breast)

Rash or itching	☐ No ☐ Yes
Changes in skin color	☐ No ☐ Yes
Varicose veins	☐ No ☐ Yes
Breast pain	☐ No ☐ Yes
Breast lump	☐ No ☐ Yes

Neurological

Light headed or dizziness	☐ No ☐ Yes
Numbness/tingling sensations	☐ No ☐ Yes
Tremors	☐ No ☐ Yes
Paralysis	☐ No ☐ Yes

Hematologic/Lymphatic

Bleeding/bruising tendency	☐ No ☐ Yes
Anemia	☐ No ☐ Yes
Enlarged glands	☐ No ☐ Yes
Slow to heal after cuts	☐ No ☐ Yes

Endocrine

Excessive thirst or urination	☐ No ☐ Yes
Heat or cold intolerance	☐ No ☐ Yes
Dry Skin	☐ No ☐ Yes

Psychiatric

Memory loss or confusion	☐ No ☐ Yes
Nervousness/Anxiety	☐ No ☐ Yes
Depression	☐ No ☐ Yes
Insomnia	☐ No ☐ Yes

Gastrointestinal

Loss of appetite	☐ No ☐ Yes
Nausea or vomiting	☐ No ☐ Yes
Frequent diarrhea	☐ No ☐ Yes
Constipation	☐ No ☐ Yes
Rectal bleeding/blood in stool	☐ No ☐ Yes
Abdominal pain	☐ No ☐ Yes

Respiratory

Chronic or frequent coughs	☐ No ☐ Yes
Spitting up blood	☐ No ☐ Yes
Shortness of breath	☐ No ☐ Yes
Wheezing	☐ No ☐ Yes

Eyes

Eye disease or injury	☐ No ☐ Yes
Wear glasses/contacts	☐ No ☐ Yes
Blurred or double vision	☐ No ☐ Yes

Allergic/Immunologic

List food/environmental allergies:

_____

_____

_____

_____

Patients 65 or older: **Spiritual/Cultural Preference?** _____

Healthcare Proxy? ☐ **Yes** ☐ **No** **Name:** _____

Power of Attorney for Healthcare? ☐ **Yes** ☐ **No** **Name:** _____

Copy of POA? ☐ **Yes** ☐ **No** **Do Not Resuscitate?** ☐ **Yes** ☐ **No**

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____

Patient Printed Name DOB

_____ _____

Signature of Patient/Parent of Minor/Legal Representative Date

Financial Policy

Welcome to our Office

At West Coast Musculoskeletal Institute and Access Health Care Physicians, we are committed to providing you with the highest level of service and quality care, and we regard your understanding of our financial policies and those of your insurance as an essential element of your care and treatment. If you have any question regarding your account, charges, insurance, or payments, please ask to speak with one of our billing representatives.

Payment Policy

Payment in full is expected at the time service is rendered. For your convenience, we accept cash, credit or debit cards at your appointment. We do not accept checks.

Insurance Plans

If you are insured, we will bill those insurance plans with which we have an agreement. **It is ultimately your responsibility to be aware of the details of your insurance plan.** If you are not familiar with the allowable benefits of your insurance, we recommend that you contact your insurance company prior to your visit so you understand what services are or are not covered. **Please note that if your insurance requires a co-pay, co-insurance, or deductible, it will be collected at the time of your visit.** In the event that your insurance determines that a service is "non-covered," we will bill you and payment will be due upon receipt of that statement.

Self-Pay Accounts

If you do not have a valid insurance plan to cover the cost of services, you will be required to make full payment at the time services are rendered, unless other arrangements have been made in advance with our office.

Outstanding Balances

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify the billing department immediately and we will gladly work out a payment plan with you. Please note that in the event of non-payment, the account may be turned over to an outside collection agency and the expenses will be added to your account balance. Any payment made by check for an outstanding balance that is returned for insufficient funds or due to a "stop payment" will result in a $25.00 fee.

Referrals

If your insurance plan requires a referral, we prefer that the referral is provided before making an appointment with our office. We do our best to obtain referrals from your primary care doctor, but in the event that we do not receive it, your appointment, if one is made, will need to be rescheduled until the necessary paperwork is obtained.

I understand that WCMI agrees to bill my insurance as a courtesy, and that I must submit information as needed to ensure payment for services. I further understand that I am ultimately responsible for all payment of services.

AUTHORIZATION AND ASSIGNMENT

I hereby authorize West Coast Musculoskeletal Institute and Access Health Care Physicians to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to West Coast Musculoskeletal Institute (or named physicians or affiliates) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to crossover Medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

Name of Patient (Please Print)	Date of Birth
Signature of Patient or Responsible Party	Date

PATIENT PRIVACY QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Name: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship: _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name: _____ Phone #: _____

Name: _____ Phone #: _____

☐ I understand that all correspondence from our office will be sent in a sealed envelope marked ***"CONFIDENTIAL"***.

Confidential messages (i.e., appointment reminders) ☐ May / ☐ May **not be left on answering machine or voicemail.

Please print the phone number where you want to receive calls about your appointments:

_____

☐ I am fully aware that a cell phone is not a secure and private line.

CONSENT TO TREAT
and
RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, the undersigned, voluntarily give consent to my West Coast Musculoskeletal Institute and Access Health Care Physicians medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. Also, I have received/reviewed a copy of the West Coast Musculoskeletal Institute/Access Health Care Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ _____

Signature of Patient/Legal Representative Date

_____ _____

Please *print* Patient Name Date of Birth

_____ _____

Legal Representative Relationship to Patient

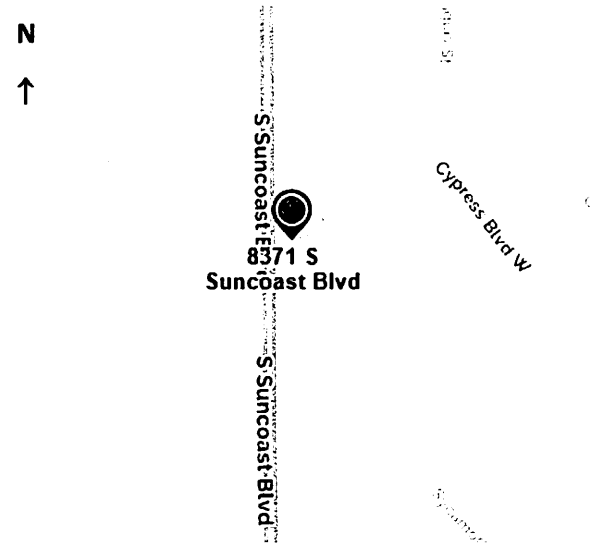
OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement for the Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

Office Locations

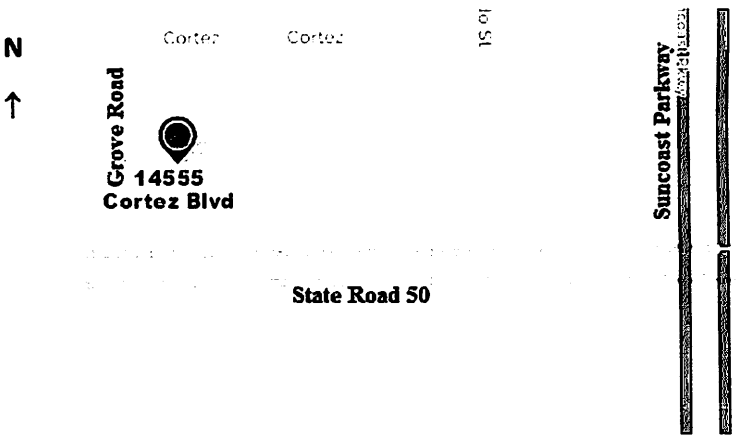
Citrus County



8371 South Suncoast Blvd.
Homosassa, FL. 34446

South of Cypress Blvd at Sugar Mill Woods Entrance.

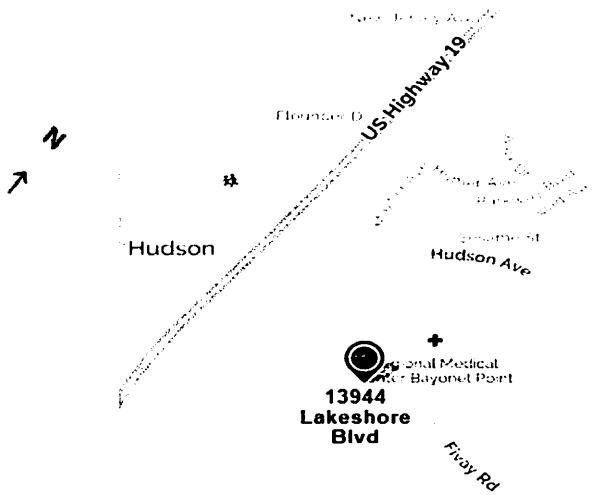
Hernando County



14555 Cortez Blvd.
Brooksville, FL. 34613

On the corner of Cortez Blvd and Grove Rd.

Pasco County



13944 Lakeshore Blvd.
Suite C,
Hudson, FL. 34667

Take Hudson Avenue to Fivay Road. Across the street from Bayonet Point Hospital.

ENTER THROUGH SUITE A

WCMIORTHO
Orthopedics at its best

HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES
Effective Date: March 24, 2017

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.