# Children's Orthopaedic History Form

**Patient Name:** _____ **Age:** _____ **Date of Birth:** _____

1. **Why are you here today? When did this problem start?**

2. **Is there a family history of this problem?** ☐ **Yes** ☐ **No**

3. **If your visit is for an injury or fracture, how and what date did this happen?**

4. **List any general medical problems or previous injuries:**

5. **List any previous surgical operations with dates:**

6. **List any current medications with doses:**

7. **List allergies to medications with reaction:**

8. **Were there any complications of the mother's pregnancy, labor, or delivery? Please list complications:**

9. **List child's birth weight:** ☐ **C-section** ☐ **Natural:**

10. **Did the child sit, crawl, walk, or talk at a normal age? If not, explain:**

11. **Does patient participate in physical or occupational therapy? Where?**

12. **Does child use a wheelchair or wear braces? If yes, please list what kind and for how long:**

13. **If patient is a female, has menstruation begun? If so please list date of first period:**

14. **Is there a family history or any other congenital or development musculoskeletal problem?** ☐ **No** ☐ **Yes (please list)**

15. **Does the child see any specialist?** ☐ **Yes** ☐ **No** **Who?**_____

16. **Are immunizations up to date?** ☐ **Yes** ☐ **No**

17. **Who does the child live with?** ☐ **Father** ☐ **Mother** ☐ **Both** ☐ **Other** _____

**Signature:** _____ **Relationship:** _____ **Date:** _____

**Office Use Only: Height:**_____**in. Weight:**_____**lbs. BP:** _____/_____ **Pulse:**_____

# Children's Orthopaedic and Scoliosis Surgery Associates, LLP

## Patient Registration Form

| Patient Information | | | |
|---|---|---|---|
| Last Name | First Name | Middle Name | Preferred or Nickname |
| Address | City | State | Zip Code |
| Social Security Number | Date of Birth | Age | Sex F ☐ M ☐ | Who Does Patient Live With? |
| Referring Physician | | | Referring Physician Telephone |
| Address | City | State | Zip Code |
| Primary Care Physician (PCP) | | | Primary Physician Telephone |
| Address | City | State | Zip Code |

**Insurance Information- Please list all insurance plans the patient is covered by. Florida law determines which commercial plan is billed first as well as requiring commercial plans to be billed primary to Medicaid plans.**

| | | |
|---|---|---|
| Primary Insurance | | Policy Number:<br>Group/ID Number: |
| Policy Holder Last Name/ First Name | | Relationship to Pt |
| Date of Birth | Social Security Number | Insurance Phone Number: |

| | |
|---|---|
| Secondary Insurance | Policy Number:<br>Group/ID Number: |
| Policy Holder Last Name/First Name | Date of Birth/Social Security Number |

| Mother/ Legal Guardian Information ☐Parent ☐Legal Guardian ☐Other | | |
|---|---|---|
| Last Name | First Name | Email Address |
| Home Address | City, State, Zip | May we email you educational materials? Yes ☐ No ☐ |
| Home/Cell Number | Mother's Social Security | Date of Birth |
| Employer | Occupation | Work Number |

| Father/ Legal Guardian Information ☐Parent ☐Legal Guardian ☐Other | | |
|---|---|---|
| Last Name | First Name | Email Address |
| Home Address | City, State, Zip | |
| Home/Cell Number | Father's Social Security | Date of Birth |
| Employer | Occupation | Work Number |

**SIGNATURE**_____ **DATE:** _____

| **Injury/Accident Information** | | | |
|---|---|---|---|
| Is visit due to an Injury? ☐YES ☐NO | How and when did the injury occur?: | | |
| Location of Injury: ☐ Home ☐ School ☐ Work ☐Other | | | |
| Address | City | State | Zip Code |
| Phone Number | Was a claim filed? ☐YES ☐NO | | |
| Adjuster's Name: | Phone Number: | | |

| **Motor Vehicle Accident Information** | | | |
|---|---|---|---|
| Motor Vehicle Injury ☐YES ☐NO | If yes, date of accident: | | |
| Motor Vehicle Insurance Carrier | Claim Number | | |
| Address | City | State | Zip Code |
| Phone Number | Policy Holder | Adjuster Name | |

| **Attorney Information** | | | |
|---|---|---|---|
| Attorney's Name | Phone Number: | | |
| Address | City | State | Zip Code |

| **Emergency Contact (**Different from your home information) | |
|---|---|
| Name | Relationship |
| Home Telephone | Work Telephone |

| **How did you find out about Children's Orthopaedic and Scoliosis Surgery Associates, LLP?** | |
|---|---|
| ☐Family / Friend / Relative | ☐All Children's Hospital |
| ☐COSSA Employee | ☐Other Emergency Center |
| ☐Primary Care/ MD / DO | ☐ Insurance Referred |
| ☐ After Hours/Urgent Care Center | ☐Website |
| ☐Other (Please Specify) | |

I hereby request and give my permission for the physicians of Children's Orthopaedic and Scoliosis Surgery Associates to provide such medical examination and treatment as they deem best for the child's physical or mental welfare.

As parent or legal guardian I give my full consent to Dr. Neustadt, Beck, Hahn, Dr. Warnick, and/or Dr. Benfanti for office medical examination and treatment for my child. I will notify the physicians' office of any change in the above information or permission.

The undersigned agrees to accept full responsibility for all charges due upon receipt of statement. I direct my insurer and third parties to pay directly to the physicians' office any insurance benefits due for services on behalf of the patient. I hereby assign to the physician's office all my rights to receive payments from my insurer and third parties for services rendered by physicians' office. I understand I am responsible for any costs incurred in the collection of the patient's account in case of default, including reasonable attorney fees and/or court costs. I understand that my credit history, as part of public record, may be requested by Children's Orthopaedics.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to the natural mother, natural father, stepmother/father, referring Physician, other physicians involved in the care of my child, and my insurance company (ies).

_____ _____

**SIGNATURE** **DATE**

*All the information provided above is complete and accurate to the best of my knowledge.

**NOTICE OF PRIVACY PRACTICES**
**Children's Orthopaedic & Scoliosis Surgery Associates, LLP**

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.**

Allowed Uses and Disclosures of Your Medical Information:

- Treatment – such as ordering diagnostic tests, other health care providers (ex: PCP), Pharmacy, etc.
- Payment – such as submitting billing information to your insurance company, disclosures to consumer reporting agencies (limited to specified identifying information about the individual, his or her payment history, and identifying information about the covered entity).
- Health Care Operations – such as quality assurance review, coordination of care, eligibility verification.
- Public Health Activities – such as child abuse or neglect.

In addition to the above, your medical information may be used or disclosed for emergency treatment; when we are required by law to treat you, we attempt to obtain consent, and are unable to do so; we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under the circumstances; or we created or received the information in treating an inmate.

You have a right to:

- Request restriction on certain uses and disclosures, however, we are not required to agree to any restriction.
- Receive confidential communications from us, upon written request.
- Inspect and request copies of your medical information.
- Request to amend incorrect or incomplete medical information.
- Receive an accounting of any disclosures made, upon written request.
- Receive a paper copy of the notice upon request or review our entire policy.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice and obtaining written acknowledgement.
- Abiding by the terms of this notice.
- Providing written notice of any change to this notice.

Complaints:

You may complain to us or to the Health & Human Services secretary if you believe that your privacy has been violated. If you wish to file a complaint with us, please provide the office manager with written notice of how you believe we violated your privacy. All notices received will be investigated and reviewed by a physician. We will respond to all notices within two (2) weeks of receipt, and we will not retaliate for any allegations you make. We have a form you can request to fill out.

Authorizations:

Upon your authorization, we may disclose your medical information to a requesting entity, such as an attorney, another insurance company (applying for life insurance), or a relative. You may revoke any authorization you make at any time, except to the extent that it was already relied on.

Patient contact:

We need to contact you to provide test results, appointment reminders, treatment information, or for patient satisfaction surveys. Our appointment reminders are done by telephone from a computer system. If you want to request alternative or confidential communication, please ask to speak with the privacy officer.

To obtain information, contact: Administrator at (727) 898-2663 0r Tampa Office Manager (813) 879-2663.

# Consent for Purposes of Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Children's Orthopaedic and Scoliosis Surgery Associates, LLP for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Children's Orthopaedic and Scoliosis Surgery Associates, LLP. I understand that diagnosis or treatment of me by **Dr. Neustadt, Beck, Hahn, Warnick, and/or Dr. Benfanti** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Children's Orthopaedic and Scoliosis Surgery Associates, LLP is not required to agree to the restrictions that I may request. However, if **Dr. Neustadt, Beck, Hahn, Warnick, and/or Dr. Benfanti** agrees to a restriction that I request, the restriction is binding on Children's Orthopaedic and Scoliosis Surgery Associates, LLP and Dr. Neustadt, Beck, Hahn, Warnick, and/or Dr. Benfanti. We require a written request, and have a form for this purpose.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Neustadt, Beck, Hahn, Warnick, and/or Dr. Benfanti** or Children's Orthopaedic and Scoliosis Surgery Associates, LLP has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Children's Orthopaedic and Scoliosis Surgery Associates, LLP, Notice of Privacy Practices (NPP) prior to signing this document. **Dr. Neustadt, Beck, Hahn, Warnick**, **and/or Dr. Benfanti's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Children's Orthopaedic and Scoliosis Surgery Associates, LLP.

The Notice of Privacy Practices for Children's Orthopaedic and Scoliosis Surgery Associates, LLP is also provided in the lobby and on our website at www.chortho.com under the forms tab. This Notice of Privacy Practices also describes my rights and the Children's Orthopaedic and Scoliosis Surgery Associates, LLP duties with respect to my protected health information.

Children's Orthopaedic and Scoliosis Surgery Associates, LLP reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Children's Orthopaedic and Scoliosis Surgery Associates, LLP website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. I acknowledge I have received a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Rep's Authority

Parent or Personal Representative refused to sign acknowledgement

_____ Staff Initials

_____ Date

Patient and practice both receives a copy
Practice copy is to be filled in patient's chart