



Hernando Orthopaedic & Spinal Surgery

Michael W. Higgins, D.O., P.A

PATIENT INFORMATION

Patients Name: _____

Address: _____

Home Phone: _____ Cellular: _____

Email Address (optional): _____

Fax Number (optional): _____

Social Security Number: _____ D.O.B.: _____

Employers Name: _____ Relationship: _____

Employers Address: _____

Employers Phone: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy or Claim Number: _____

Group Number: _____

Policy Holders Name: _____ D.O.B.: _____

Relationship to Policy Holder: _____

Secondary Insurance: _____

Policy or Claim Number: _____

Group Number: _____

Policy Holders Name: _____ D.O.B.: _____

Relationship to Policy Holder: _____

Signature of Patient or Guardian

Date:

These questions are meant to provide you with some basic information that will be used to help us to care for you. If you are unsure about how to answer a question or need help filling the questionnaire out please feel free to ask us for help. Please complete all pages. Thank you.

Today's Date: _____

Patient Name: _____ Gender: M F Age: _____

Primary Care Physician: _____

PCP's Address: _____

PCP's Phone #: _____

Who referred you to this office? _____

Which hand do you write with? RIGHT LEFT

Which side are you having trouble with? RIGHT LEFT

Did you have an accidental injury? YES NO

If yes, how did you injure yourself? _____

Date of injury or when did the problem start: _____

Is this a work-related injury? YES NO

Did this injury involve an automobile? YES NO

What is your complaint/problem/symptom? _____

Treatment you have had for THIS problem or injury:

Splint/Cast/Brace _____ For how long? _____ Was it helpful? YES NO

Physical Therapy _____ For how long? _____ Was it helpful? YES NO

Medications _____ For how long? _____ Was it helpful? YES NO

Injections _____ For how long? _____ Was it helpful? YES NO

Surgery? _____ Procedure Date: _____

What is your current employment status? _____

Are you unable to work because of this problem? YES NO

Are you unable to work because of other medical reasons? YES NO

Is there a possibility that you could be pregnant? YES NO MAYBE

What is your current occupation? _____

If you stopped working, on what date did you stop? _____

Have you changed jobs because of your present problem/injury? YES NO

Is an attorney involved with this injury/problem? YES NO

Are you on Social Security, Disability or Worker's Compensation? YES NO

MEDICAL HISTORY:

The following is a list of common health problems.

PROBLEM	DO YOU HAVE THIS PROBLEM?	DO YOU RECEIVE TREATMENT FOR IT?
Heart Disease	YES NO	YES NO
Chest Pain	YES NO	YES NO
High Blood Pressure	YES NO	YES NO
Stroke / TIA	YES NO	YES NO
Cancer	YES NO	YES NO
Brain or Spinal Cord Problem	YES NO	YES NO
Depression	YES NO	YES NO
Psychiatric Problems	YES NO	YES NO
Alzheimer's Disease	YES NO	YES NO
Eye Problems	YES NO	YES NO
Bladder Problems	YES NO	YES NO
Prostate Problems	YES NO	YES NO
Kidney Problems	YES NO	YES NO
Anemia	YES NO	YES NO
Blood Disorder	YES NO	YES NO
Sickle Cell Anemia	YES NO	YES NO
Diabetes	YES NO	YES NO
Thyroid Disorder	YES NO	YES NO
Skin Rashes	YES NO	YES NO
Psoriasis	YES NO	YES NO
Osteoporosis	YES NO	YES NO
Gout	YES NO	YES NO
Osteoarthritis	YES NO	YES NO
Rheumatoid Arthritis	YES NO	YES NO
High Cholesterol	YES NO	YES NO
Numbness in Fingers	YES NO	YES NO
Reflux Disease	YES NO	YES NO
Hiatal Hernia	YES NO	YES NO
Liver Disorder	YES NO	YES NO
Stomach Disorder / Ulcers	YES NO	YES NO

Asthma/Breathing Problems	YES	NO	YES	NO
Emphysema / COPD	YES	NO	YES	NO
Blood Clot in Leg	YES	NO	YES	NO
Pulmonary Embolus	YES	NO	YES	NO
Take Blood Thinners	YES	NO	YES	NO
Take Steroid Medications	YES	NO	YES	NO
Fever	YES	NO	YES	NO
Weight Loss	YES	NO	YES	NO
Appetite Loss	YES	NO	YES	NO
Frequent Falls	YES	NO	YES	NO
Ear/Hearing Problems	YES	NO	YES	NO

What are your current medications?

_____	Dosage: _____
_____	Dosage: _____
_____	Dosage: _____
_____	Dosage: _____
_____	Dosage: _____

List any medications that you are allergic to:

_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____

List all surgical procedures:

_____	Year: _____
_____	Year: _____
_____	Year: _____
_____	Year: _____
_____	Year: _____
_____	Year: _____
_____	Year: _____

Have you had problems with anesthetics?	YES	NO
Do you smoke?	YES	NO
If yes, how many packs per day?	_____	pack(s)

What is your current marital status? _____

Do you live with someone that can take care of you?	YES	NO
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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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health, or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information can be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for a hospital admission.

Healthcare Operations: We may use or disclose as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting, or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use sign-in sheet at the registration desk where you will be asked to sign your name. We may also or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, public health issues as required by law, communicable diseases; Health Oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donations, research, criminal activity, military activity, national security, Worker's Compensation, inmates. Required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with the consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have a right to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have a right to request a restriction of your protected health information.

This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved with your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. You have the right to use another Healthcare Professional.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.

You may have the right to have your physician amend your protected health information. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our private contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective January 1, 2005.

We are required by law to maintain the privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number. Signature below is only acknowledgement that you have received our Notice of Privacy Practices.

(PRINT PATIENT NAME)

(SIGNATURE OF PATIENT/GUARDIAN)

(DATE)



Hernando Orthopaedic & Spinal Surgery

Michael W. Higgins, D.O., P.A

Authorization to Release Medical Records & or Information to assigned person(s).

This authorization allows Hernando Orthopaedic & Spinal Surgery and Dr. Higgins and staff to release medical information to a person (named below) involved in the patient's medical care. Other than the named person or you, we will not discuss anything related to your care with anyone if they are not listed in this release. The only exception is other medical professionals and their offices/facilities as necessary to provide you with medical care and your insurance company as outlined in our privacy notice. If you wish family members or caretakers to have information about your care, you must fill out this form.

Patient's Name: _____
Social Security #: _____ D.O.B.: _____

Person(s) with whom you would like your medical history, test results, appointments, etc. discussed (example: spouse, children or friend):

- 1) Name: _____ Phone: _____
Relationship: _____ D.O.B.: _____
- 2) Name: _____ Phone: _____
Relationship: _____ D.O.B.: _____

Please sign this section to acknowledge and validate this form.

Patient's Name (Please Print) Or Legal Guardian/Power of Attorney (Please Print)

Patient's Signature

Legal Guardian / PPOA's Signature

****Hernando Orthopaedic & Spinal Surgery will call to confirm your office visit 1-2 days prior to the appointment. May this information or other confirmation be left on your answering machine? No test/lab results or specific medical information messages will ever be left.**

_____ YES _____ NO Initial: _____

Or if you do NOT want any family members or friends to know about your care:
_____ I would not like my care discussed with anyone other than medical professionals and offices/facilities as necessary to provide care for me.

Revocation Section-Desire to Terminate this Agreement: I understand that I may revoke this authorization at any time by notifying Hernando Orthopaedic & Spinal Surgery in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

Effective: _____ date, the authorization is no longer valid.

Patient's Signature

Legal Guardian / PPOA's Signature