

PATIENT EVALUATION

NAME: _____

- Right Left Bilateral
- Hand Wrist Elbow

Onset: gradual sudden no injury injury **Date:** _____ Work related? no yes

Emergency Department? no yes _____

How, when, and what happened? Did it swell immediately? _____

Have you had a similar problem in the past? If so, describe:

On a scale from 0-10, mark your average level of pain discomfort during the last week, with 0 being none and 10 being unbearable.

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Frequency: intermittent occasional constant rare

Radiation: no yes Where? _____

Quality: aching burning dull piercing sharp throbbing

Aggravated by: Lifting Pushing Pulling Reaching Grasping Gripping Writing Typing
 Fine finger movement Exercising Work activities Daily activities

Relieved by: Nothing Brace/splint Elevation Exercise Heat Ice Injection Massage
 Pain/RX meds Mobility Physical therapy Rest Stretching OTC meds

Other _____

Gait Aids: Not required Cane Crutches Single crutch Walker Wheelchair

Associated Symptoms: Bruising Crepitus(crackling) Decreased mobility Difficulty going to sleep
 Instability Night pain Night-time awakening Numbness Popping Spasms Swelling
 Tingling in the arms Tenderness Weakness Catching Stiffness

Hand Dominance: Right Left Ambidextrous

What has been done so far?

Surgery(type, doctor, and date): _____

X-rays and Date: _____

MRI and Date: _____

EMG and Date: _____

Other diagnostic testing and Date: _____

Injections: _____ Relief felt: None Minimal Moderate Significant

Physical Therapy: _____ Relief felt: None Minimal Moderate Significant

Brace (Describe): _____ Relief felt: None Minimal Moderate Significant

Medication taken for this problem: _____

PAIN:

During the last month, how frequently did you take medications for pain?

Never Daily Several times a week About once a week Less than once a week

How would you describe the relief from pain you received with pain medication?

Complete relief Moderate relief Very little relief No relief

Is the pain medication you take prescription or over the counter pain medication?

Prescription Over the counter I take both prescription and over the counter medication

What activities does your pain prevent you from doing? _____

heekin  orthopedic
SPECIALISTS

2627 Riverside Avenue, Suite 300, Jacksonville, FL 32204
10475 Centurion Pkwy., Ste. 220, Jacksonville, FL 32256
Phone: 904-634-0640 Fax: 904-634-0203
www.heekinortho.com

Rahul V. Deshmukh, MD
Gavan P. Duffy, MD
Christopher Goll, MD
R. David Heekin, MD, FACS
Kevin P. Murphy, MD

DATE: _____ MARITAL STATUS: M W S D AGE: _____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ SSN: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

May we contact you by e-mail? YES NO e-mail address _____

EMPLOYER: _____ OCCUPATION: _____

ARE YOU A VETERAN? YES NO

DRIVER'S LICENSE #: _____

SPOUSE: _____ SPOUSE DOB: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

HAVE YOU EVER BEEN SEEN BY A CARDIOLOGIST? YES NO NAME: _____

IS THIS ACCIDENT OR INJURY RELATED TO: AUTO JOB OTHER

DATE OF INJURY: _____

INSURANCE: _____ IS A REFERRAL REQUIRED? YES NO

Primary Card Holder's Name: _____ And DOB: _____

HOW DID YOU HEAR ABOUT HEEKIN ORTHOPEDIC SPECIALISTS?

Physician: YES NO (If yes, list name and specialty, i.e. Dr. Smith, Family Practice)

Physician Name: _____ Specialty: _____

Physician Phone: _____

Urgent Care Center: _____

Former Patient: YES NO Name: _____

Friend/family: YES NO Name: _____

Phone Book: YES NO White pages Yellow pages Online

Website: YES NO Was the website helpful? _____

Advertisement: YES NO Where was the Ad? _____

Healthfair/expo: YES NO Name and/or date of Expo _____

Other: YES NO _____

NAME: _____ DOB: _____ DATE: _____

REVIEW OF SYSTEMS:

Constitutional

- Chills
- Fatigue
- Fever
- Malaise
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss

Cardiovascular

- Chest pain
- Cyanosis
- Heart Murmur
- Irregular heartbeat/
palpitations
- Leg swelling
- Syncope

Integumentary

- Contact allergy
- Itchy skin
- Rash
- Skin Infection
- Skin lesion

Metabolic/endocrine

- Cold intolerant
- Hair loss
- Heat intolerant

HEENT

- Blurred Vision
- Double Vision
- Dysphagia
- Ear drainage
- Facial pain
- Headache
- Hearing loss
- Hoarseness
- Nasal congestion
- Ringing in ears
- Vertigo
- Vision loss

Gastrointestinal

- Abdominal pain
- Constipation
- Black tarry stools
- Diarrhea
- Heartburn
- Jaundice
- Loss of appetite
- Nausea
- Vomiting

Neurological

- Difficulty walking
- Dizziness
- Poor coordination
- Memory loss
- Muscle weakness
- Paresthesia
- Seizures
- Tremors

Psychiatric

- Anxiety
- Depression
- Insomnia

Respiratory

- Chest pain(respiratory)
- Cough
- Dyspnea
- Recent infections
- Known TB exposure
- Wheezing

Genitourinary

- Dysuria
- Frequent urination
- Hematuria
- Urge incontinence
- Urinary continence

Hematologic

- Bleeding
- Bruising

Immunological

- Asthma
- Bee sting allergies
- Contact dermatitis
- Environmental allergies
- Food allergies
- Seasonal allergies

MEDICAL INFORMATION:

CURRENT MEDICATIONS:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
11.	12.

DRUG ALLERGIES:

REACTIONS:

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

HEIGHT: _____ WEIGHT: _____

NAME: _____ DOB: _____ DATE: _____

PAST MEDICAL HISTORY:

Please select if condition applies to your medical history:

- | | | |
|------------------------------------|----------------------------------------|------------------------------------------|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> TB |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> High BP | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | |

Other: _____

PAST SURGICAL HISTORY

	<u>DATE</u>		<u>DATE</u>
Arthroscopic Surgery	_____	Hysterectomy	_____
Back Surgery	_____	Joint Replacement	_____
Coronary Bypass	_____	Neck Surgery	_____
Gall bladder	_____	Tonsil/Adenoid	_____
Hand Surgery	_____		

Other: _____

FAMILY HISTORY

	Father	Mother	Siblings	Children	Grandparent
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High BP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY:

Have you ever smoked cigarettes? Yes No Do you currently smoke? Yes No

--If you smoke, how many cigarettes do you smoke a day? (20 cigarettes = 1 pack)

- | | | |
|-------------------------------------------|--------------------------------------------|----------------------------------|
| <input type="checkbox"/> Less than 1 pack | <input type="checkbox"/> 1 Pack | <input type="checkbox"/> 2 Packs |
| <input type="checkbox"/> 3 Packs | <input type="checkbox"/> More than 3 packs | |

--If you smoke, how long have you been a smoker?

- | | | |
|-------------------------------------------|--------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Less than 1 year | <input type="checkbox"/> 1-5 years | <input type="checkbox"/> 6-10 years |
| <input type="checkbox"/> 11-15 years | <input type="checkbox"/> 16-20 years | <input type="checkbox"/> More than 20 years |

Do you drink alcohol?

- | | | |
|-----------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, but no more than once a month | <input type="checkbox"/> Yes, several drinks a week |
| <input type="checkbox"/> Yes, one drink a day | <input type="checkbox"/> Yes, more than one drink a day | |

Do you regularly drink beverages containing caffeine?

- | | | |
|--------------------------------------------|------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, but not everyday | <input type="checkbox"/> Yes, one cup a day |
| <input type="checkbox"/> Yes, 2 cups a day | <input type="checkbox"/> Yes, 3 cups a day | <input type="checkbox"/> Yes, 4 cups a day |
| <input type="checkbox"/> Yes, 5 cups a day | <input type="checkbox"/> Yes, 6 cups a day | <input type="checkbox"/> Yes, more than 6 cups a day |

Activity level:

- | | | |
|-----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Sedentary | <input type="checkbox"/> Vigorous |
|-----------------------------------|------------------------------------|-----------------------------------|

Type of exercise: _____

- | | | |
|--------------------------------|-----------------------------------------|-----------------------------------------|
| Frequency of exercise: | <input type="checkbox"/> 2-3 times/week | <input type="checkbox"/> 3-4 times/week |
| <input type="checkbox"/> Daily | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional |

Name: _____ DOB: _____

Authorization and Assignment of Benefits:

For the services rendered and those about to be rendered, I hereby assign to Heekin Orthopedic Specialists, all medical benefits otherwise payable to me under the described policy not to exceed the charges made to such service. I further authorize the above mentioned insurance company to pay said benefits directly to Heekin Orthopedic Specialists and further direct that they make no payment to me. In the event that I receive payment from the insurance company, I agree to endorse such payment to Heekin Orthopedic Specialists. I understand that I am directly and primarily responsible to Heekin Orthopedic Specialists for the usual and customary fee for the services rendered to me. I realize that if my insurance company fails to pay or there is a delay (more than 90 days) in their paying, it is my sole responsibility to promptly pay my bill directly. I also realize that any services not covered under my insurance company will be my responsibility to pay in full. I further understand and agree if I fail to make prompt and timely payments, I will be directly responsible for any and all cost of collection including the filing fees as well as reasonable attorney fees. I hereby authorize Heekin Orthopedic Specialists to release to my insurance company, any information acquired including the diagnosis and the records in the course of my treatment.

Signature

Date

Medicare Certification for Payment: (Lifetime Authorization)

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 any holder of medical and other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be payable to Heekin Orthopedic Specialists for my behalf. I also assign the benefits payable for physician service to the physician furnishing the services and authorize such physician to submit a claim to Medicare in my behalf.

Signature

Date

Heekin Orthopedic Specialists
Statement of Policies

The following policies are established for mutual convenience and benefit. Please read them carefully and sign at the bottom to indicate your agreement of the statement of policies.

1. **Heekin Orthopedic Specialists** strictly provides orthopedic services only. Patients are expected to have or arrange for a Primary Care Physician. Our practice does not treat chronic pain.
2. **Deductibles and Co-Pays** are payable at the time of service. Any previous balance is expected to be paid at time of service.
3. Patients are responsible for obtaining referrals and authorizations for services rendered at Heekin Orthopedic Specialists
4. If you are unable to keep a scheduled clinic appointment, please call during normal business hours, 24 hours in advance to cancel the appointment. Failure to do so may incur a \$30.00 charge to your account for the missed appointment.
5. There is a \$25.00 fee for all disability, FMLA, and other forms/ paperwork that you need to have filled out by the physician. We may ask that you make an appointment to complete these forms.
6. There is a fee for any reports or records requested by attorneys, insurance companies, disability companies, etc...This charge will be determined by the information requested.
7. **Prescription Policies:**
 - a. If you are in need of a refill, please have your pharmacy fax a request to 904-634-0203. Please allow 48 to 72 hours.
 - b. No refills will be given on Friday after 2:00 PM
 - c. No pain medication will be given to post-operative patients after 90 days of surgery.
 - d. Our physicians **DO NOT** prescribe pain medications to chronic pain patients. Patients with chronic pain syndrome are referred to pain management specialists for long term management.

I acknowledge that I have carefully read and understand the Statement of Policies, and agree to abide by them.

Name (please print)

DOB

Signature

Today's Date

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

At *Heekin Orthopedic Specialists*, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Yours Health Record/Information

Each time you visit *Heekin Orthopedic Specialists*, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- *Basis for planning your care and treatment,
- *Means of communication among the many health professionals who contribute to your care,
- *Legal document describing the care you received,
- *Means by which you or a third-party payer can verify that services billed were actually provided,
- *A tool in educating health professionals,
- *A source of data for medical research
- *A source of information for public health officials charged with improving the health of this state and the nation,
- *A source of data for our planning and marketing,
- *A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of *Heekin Orthopedic Specialists*, the information belongs to you. You have the right to:

- *Obtain a paper copy of this notice of information practices upon request,
- *Inspect and copy your health record as provided for in 45 CFR 164.524,
- *Amend your health record as provided in 45 CFR 164.528,
- *Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- *Request communications of your health information by alternative means or at alternative locations,
- *Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- *Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Heekin Orthopedic Specialists is required to:

- *Maintain the privacy of your health information,
- *Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- *Abide by the terms of this notice,
- *Notify you if we are unable to agree to a requested restriction, and
- *Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all

protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information about your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Marybeth Cohran at (904) 634-0640.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights

U.S Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509 F, HHH Building
Washington, D.C 20201

Examples of Disclosures for Treatment, Payment and Health Operations

2627 Riverside Ave Ste 300 Jacksonville, FL 32204
10475 Centurion Parkway, Ste.220 Jax, FL
32256 Phone (904) 634-0640 Fax (904) 634-0203 www.heekinortho.com

We will use your health information for treatment. For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded and used to

determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations:
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts and business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business

associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from offices: We may call your home or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care. We may mail to your home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. We may email to your home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Open treatment areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our privacy officer.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and

established protocols to ensure the privacy of your health information has approved their research.

Funeral directors:
We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation or organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorization by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney,

provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Patient

Name: _____

DOB: _____

Patient

Signature: _____

Name(s) of others authorized to discuss or request medical information:
