METRO ORTHOPEDIC SPECIALISTS, LLC
Dr. Peter J. Godleski, MD.

Preferred Pharmacy Name: _____
Address: _____
Pharmacy Phone Number: _____

Account Number: _____

PATIENT INFORMATION: (Please Print)

Patient Name: _____

Home Address: _____ Apt # _____

City: _____State: _____Zip Code: _____

Home Phone #: _____-_____-_____ Other Phone #: _____-_____-_____ Sex: ☐ Male ☐ Female

Date of Birth: _____/ _____/ _____ Social Security Number: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Partner

Occupation: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full Time Student ☐ Part Time Student

Name of Employer / School: _____

Email: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

Member ID #: _____ Phone #: _____-_____-_____

Policy holder's Name:_____ Effective Date: _____

AUTHORIZATION TO BILL INSURANCE: Patient or Authorized person's signature: I authorize Metro Orthopedic Specialists, LLC. to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed _____ Date_____

METRO ORTHOPEDIC SPECIALISTS, LLC
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Patient Name: _____

Date of Birth: _____

Review of Systems: (Please check all that apply)

PULMONARY

Blood clots of the lung ___
Asthma ___
Wheezing ___
Shortness of breath ___
Tuberculosis ___
Pleurisy ___
cough ___
Sputum ___
Rheumatic fever ___

GASTROINTESTINAL

Change about habits ___
Food intolerance ___
Constipation or diarrhea ___
Yellow jaundice ___
Abdominal pain ___
Black or blood stools ___
Heartburn ___
Nausea or vomiting ___
Pancreatitis ___
Peptic ulcer ___
Hepatitis ___

GENITOURINARY

Frequency of urination ___
Abnormal menstrual periods ___
Penile discharge ___
Impotence ___
Venereal disease ___
Pelvic pain ___
General ulcers ___
Kidney stones ___
Urinating at night ___
Pain while urinating ___
Inconstance of urine ___
Dribbling of urine ___
Urinary infection ___

NEUROLOGIC

Slower walking ___
Seizures ___
Memory change ___
Trouble making decisions ___
Headache ___
Trouble sleeping ___
Leg cramps after walking ___
Passing out ___
Loss of consciousness ___
Dizziness ___
Paralysis ___
Numbness or tingling ___
Tremors or shaking ___
Trouble walking ___
Trouble with sex life ___
Trouble rolling in bed ___
Difficulty with work ___

DERMATOLOGIC

Rash ___
Tick bites ___
Itching ___

ENT

Hoarseness is ___
Ear drainage ___
Nosebleeds ___
Mouth ulcers ___
Soft voice ___
Trouble swallowing ___
Hearing loss ___
Ringing in ears ___
Obstruction of noise ___
Bleeding gums ___

CVS

Faintness on standing ___
Chest pain or discomfort ___
Blood clots in the legs ___
Swelling in the ankles ___

PSYCHIATRIC

Depression ___
Thoughts of suicide ___
Crying spells ___
Anxiety ___
Improbable beliefs ___
Hallucinations ___
Social withdraws ___

ENDOCRINE

Thyroid disorder ___
Excess water drinking ___
Dry eyes, mouth, skin ___

HEMATOLOGIC

Bleeding ___

MUSCULOSKELETAL

Stiffness ___
Backache ___
Joint pain ___
Back pain in bed ___
Breast pain or tenderness ___
Lumps are masses ___
Back catches ___
Joint swelling ___

CONSTITUTIONAL

Fatigue ___
Weight change, loss or gain ___
Fever chills ___
loss of appetite ___

OPHTHALMOLOGIC

Visual change ___
Double vision ___
Eye pain ___

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Initiation of treatment

To whom it may concern:

This is to inform you that I was injured in a personal injury. This letter is to confirm that I intend to initiate treatment as outlined by the doctors at Metro Orthopedic Specialists, LLC.

Consent of treatment

I hereby authorize your practice and whoever the doctor needs as assistant to perform examination, physiotherapy, physical therapy and perform noninvasive diagnostic tests and if any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those contemplated. I further request and authorize the office to perform whatever treatment doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications have been fully explained to me. Acknowledged that no guaranteed has been made to me as to the result that may be obtained.

Print patient name: _____

patient signature: _____

Date: _____

For office use only

Physician name: _____

Physician signature: _____

Date: _____

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Notice of privacy act acknowledgement

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.

The health insurance portability and accountability act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable health insurance information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatments, payment and health care operations.

- Treatment means providing, coordinating, managing healthcare and related services by one or more health care providers. An example of this would include a physical examination.
- Payments refers to such activities as obtaining reimbursement for services, confirming coverage, billing or collecting activities and utilization review period an example would be sending a bill for your visit to your insurance company for payments.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment, improvement activities, auditing functions in cost management analysis as well as customer service. An example would be internal quality assessment review period

We may contact you to provide appointment reminders along with test results, treatment and medication information. This information may be left on your voicemail, answering machine and or sent to you via fax only with your written consent.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to your privacy officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. This information may only be discussed with your written consent.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information the right to obtain and we have the obligation to provide you a paper copy of this notice from us at the time of service.

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Notice of privacy act acknowledgement

I understand that under health insurance portability and accountability act of 1996 HIPAA, I have certain rights to privacy regarding my protective health insurance. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from 3rd party payers.
- Conduct normal health care operations such as quality assessment and physician certifications.

I acknowledge that I have received your notice of privacy practice containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to change at any time the address above to obtain a current copy of notice of privacy practices.

I understand that I may request that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Do you have power of attorney?	Yes: _____	No: _____	Initials: _____
Do you have advanced directive?	Yes: _____	No: _____	Initials: _____
Do you want a copy of patient rights?	Yes: _____	No: _____	Initials: _____

Print patient name: _____

Patient or legal Guardian signature: _____

Date: _____

Office use only

I attempted to attain the patient signature in acknowledgment of this notice of privacy practices acknowledgement, but was unable to do so as documented below;

Reason: _____

Initials: _____

Date: _____

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Release of patient records authorization

(Please initial all sections)

_____I authorized the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorized the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of insurance coverage.

_____I understand and agree that billing an accident policy are arrangements between an insurance carrier and me. Furthermore, I understand that **Metro Orthopedic Specialists, LLC** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid to directly to **Metro Orthopedic Specialists, LLC** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

_____I hereby authorize **Metro Orthopedic Specialists, LLC** to release a copy of my patient records or X Rays containing protected health information to **my insurance company and or attorneys representing me in this case**. This authorization is given pursuit to Florida statue 456. 057 and HIPAA regulations. I understand that Florida statue 456.057(10) makes clear that my 3rd party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the express written consent of the patient or the patient's legal representatives

Patient signature: _____

Print patient name: _____

Date: _____

Please do not fill anything in this section: (*For office use only*)
Name of facility records are being requested: _____
Fax or Email: _____
Requesting the following records, labs, radiology:
_____

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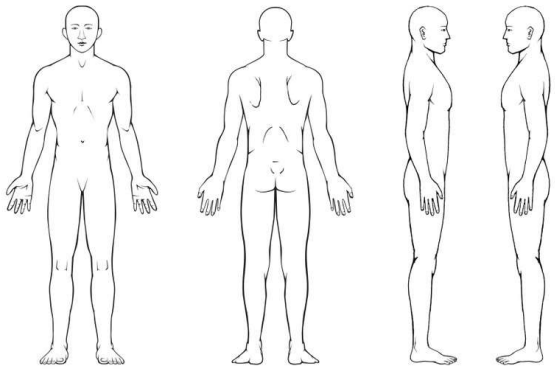
CURRENT CONDITION

Using the following drawings please indicate areas of chief complaints for which you are seeking treatment:



List of current medications:

_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

METRO ORTHOPEDIC SPECIALISTS, LLC
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Primary Care Physician: _____

Phone Number to PCP: _____

MEDICAL HISTORY

Please indicate which of the following conditions apply to you or your family's medical history

YOU	FAM	CONDITION	YOU	FAM	CONDITION
		Allergies			Artificial Implants
		Arthritis			Blood Disorders
		Endocrine disorders, diabetes, osteoporosis, thyroid, etc.			Heart/ Circulatory Disorders
		Eyes/Vision Disorders			HIV Disorders
		Eyes/Vision Disorders			Kidney/ Urinary Disorder
		Liver Disease			Muscle Disorders
		Lung/Respiratory Disorders			Stomach/ Intestinal Disorders
		Nervous Disorders, multiple sclerosis, Alzheimer's, epilepsy, etc			
		Alcohol abuse, drug abuse, illegal drug use or recreational drug use.			
		Psychiatric problems			
		Suicide or attempt to			

Have you had any surgical operations in the past? Explain:

_____

_____

_____

Current Medications: _____

_____

Are you allergic to any medications? If so, explain: _____

Any history of illicit drug use?

Prior to this occurrence, have you been in an auto accident? Yes / No when? _____

Describe: _____

Have you had any other personal injury or accident? Yes / No when? _____

Describe: _____

Is there any possibility that you may be pregnant? Yes / No

How far along? _____

Patient Signature: _____ Date: _____