Dear Patients,

This letter is being given to you in reference to your office visit and post-operative follow-up visits with our clinic and during your hospital stay. My role in this community, as an Orthopaedic Surgeon, has always been to provide the best care for my patients in a timely and efficient manner.

During your office visit or hospital stay, Austin Thompson my Physician Assistant, and I will be providing you with appropriate, efficient and personalized care. Having a qualified physician assistant on our staff and following your progression while in the hospital, provides you with continuity of care and allows me to offer my expertise and counseling to our other patients in need.

Austin Thompson is part of our medical staff and has been trained in the field of Orthopaedic surgery. As an extension of myself he is able to monitor your hospital stay and address any questions or concerns in a timely manner. On days that I do not see you, Austin and I will discuss your case thoroughly. Additionally, I personally supervise the care plans implemented and assure that the highest level of professional health care is delivered. If you are a new patient to see me and I am not here on that day, please request to see me on your follow up visit. We will try to make that happen without you asking, but if we fail to do this please notify our scheduler (813) 633-5232 extension: 6533 and have it rectified.

By working as a team, we are able to help more patients in a timely fashion, eliminate the necessity to reschedule patient appointments, and most importantly, provide the best patient care possible.

Thank you.

Sincerely,

Anthony F. Infante Jr.

Please read,

Sign & Date

Thank you
PATIENT QUESTIONNAIRE
INITIAL EVALUATION

Date: ____________________________

Patient Name: ____________________________  (Office use only) MR # ____________________________

Family/Primary Doctor: ____________________________  Phone: ____________________________

Family/Primary Doctor’s Address: ____________________________

Who referred you to Florida Orthopaedic Institute? (name & address please) ____________________________

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. **Circle the word or phrase that best describes your situation. You may select more than one answer per question.** Answer the question in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. **THANK YOU.**

Age: __________  Sex: __________  Marital Status: __________  Handed: R/L __________

Height: __________  Weight: __________

Occupation: ____________________________

What are you seeing the doctor for? ____________________________

Duration of Symptoms: ____________________________

When did the problem first start or when did the injury occur? ____________________________

Is this injury work related? __________

Have you seen a doctor in the past for this problem or injury? __________ If yes, who and when? ____________________________

Explain in your own words how this injury occurred: ____________________________

What treatment have you had? ____________________________

Would you be interested in taking part in a research study? __________
TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:

Circle anything listed below to which you are allergic:

(A) No known allergies
(B) Penicillin
(C) Tetracycline
(D) Sulfa
(E) Morphin
(F) Erythromycin

(G) Codeine
(H) Iodine/Betadine
(I) Radiographic Dyes
(J) Adhesive Tape
(K) Other (Specify): _______________________

Circle any of the medical problems listed below that you have now:

(A) I have no known medical problems.
(B) Hypertension
(C) Coronary artery disease
(D) Peripheral vascular disease
(E) Adult onset diabetes
(F) Childhood onset diabetes
(G) Past heart attack
(H) Asthma
(I) Ulcers
(J) Hepatitis A / B / C
(K) Cancer
(L) Tuberculosis

(M) Liver disease
(N) Seizure disorder
(O) Thyroid disease
(P) Emphysema
(Q) COPD/Lung problem
(R) Immune disorder
(S) Overweight
(T) Osteomyelitis
(U) Blood Clot (DVT)
(V) Osteoporosis
(W) Other (Specify): _______________________

How much alcohol do you consume?

(A) I'm a non-drinker
(B) I'm a recovering alcoholic
(C) I drink only occasionally
(D) I drink weekends only

(E) An average of 1-2 drinks per day
(F) An average of 2-3 drinks per day
(G) An average of 3-4 drinks per day
(H) More than 6 drinks a day

Do you now, or have you ever smoked cigarettes?

(A) Yes, I am currently a smoker
   I smoke (circle one) 1 2 3 ___________ packs/day
   I have smoked for ________ years

(B) No, but I used to smoke
   I smoked for ________ years

(C) No, I have never smoked

Do you now, or have you ever used drugs?

(A) Recreational
(B) Cocaine

(C) Marijuana
(D) Other (Specify): _______________________

Has anyone in your immediate family ever had any of the following? Circle the illness that apply.

(A) None known
(B) Cancer
(C) Leukemia
(D) Stroke
(E) Hypertension
(F) Coronary artery disease
(G) Rheumatic fever
(H) Diabetes

(I) Hypothyroidism
(J) Colitis
(K) Bleeding tendency
(L) Asthma
(M) Tuberculosis
(N) Seizure disorder
(O) Alcoholism
(P) Other (Specify): _______________________

Have you ever had a blood clot? Yes No
Tell us about your health in general: Do you have any of the following? Circle yes or no.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td></td>
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<tr>
<td>Dizziness</td>
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<tr>
<td>Dry cough</td>
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<tr>
<td>Productive cough</td>
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<tr>
<td>Difficulty breathing</td>
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<tr>
<td>Irregular heartbeat</td>
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<td>Swelling in the legs</td>
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<tr>
<td>Lack of appetite</td>
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<tr>
<td>Nausea</td>
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<tr>
<td>Vomiting</td>
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<td>Diarrhea</td>
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<td>Constipation</td>
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<td>Abdominal cramping</td>
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<tr>
<td>Varicose veins</td>
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<tr>
<td>Bruising</td>
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<tr>
<td>Bleeding</td>
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<tr>
<td>Nose bleeds</td>
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<tr>
<td>Joint pain and/or stiffness</td>
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<td></td>
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<tr>
<td>Muscle pain or muscle cramps</td>
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<tr>
<td>Difficulty seeing</td>
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<tr>
<td>Difficulty hearing</td>
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<td>Difficulty swallowing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty sleeping</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Everything I have answered is true and correct to the best of my knowledge.

Patient Signature

Thank you for completing this patient questionnaire. It will become a part of your permanent medical record at Florida Orthopaedic Institute.
Thank you for taking the time to complete this form on your initial visit. The information provided will assist us in ensuring you receive Florida Orthopaedic Institute’s high quality care during your visit with us today. We look forward to keeping you active!

Everything I have answered is true and correct to the best of my knowledge.

Patient Signature: _______________________________ Date: __________
FLORIDA ORTHOPAEDIC INSTITUTE
LIFETIME AUTHORIZATION STATEMENT
ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT

PATIENT NAME: ________________________________  MR#: ________________________________

Florida Orthopaedic Institute is pleased that you have selected this group to provide for your medical needs.

Please review the following Lifetime Authorization Statement. Please do not hesitate to ask a staff member for clarification on any part of this document. Please sign where indicated and return it to the receptionist. If you disapprove, we certainly respect your right of refusal. However, please be aware that, without your legal signature, we cannot file with your insurance carrier for the services you are scheduled to receive. Therefore, we will have no alternative but to require that you be responsible for the cost of services rendered in full. (See reverse side for Refusal to Sign Lifetime Authorization Statement). Should you refuse this option, we have no other choice than to cancel your appointment.

Thank you in advance for your cooperation.

LIFETIME AUTHORIZATION STATEMENT/ASSIGNMENT FOR DIRECT PAYMENT

I hereby instruct and direct my current insurance carrier to pay by check made payable to:

Florida Orthopaedic Institute
13020 Telecom Parkway North
Temple Terrace, FL 33767

the medical, surgical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to Florida Orthopaedic Institute and I have agreed to pay, in a current manner, any balance of said service charges over and above this insurance payment, including applicable co-payments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to Florida Orthopaedic Institute.

A photocopy of this assignment shall be considered as effective and as valid as the original.

I understand that Florida Orthopaedic does accept assignment for Medicare and payments will be directed to Florida Orthopaedic Institute. Should my account be referred for collection procedures, I will also pay reasonable attorney’s fees and collection expenses.

INSURANCE INFORMATION

Florida Orthopaedic Institute attempts to verify benefit information with insurance companies prior to each patient’s visit. However, insurers do not guarantee the accuracy of the data they provide. Therefore, the information FOI provides the patient is only our best estimate based on the data provided by the payer. Patients are urged to contact their insurance carrier directly to verify that copays, coinsurance, deductibles, and covered services. Regardless of FOI’s estimates, the patient’s responsibility will be based on the payer’s final adjudication. Payments of any kind may be applied to any open charges on the patient’s account.

CONSENT FOR TREATMENT

I authorize Florida Orthopaedic Institute to provide treatment as necessary for which I am, or my minor child is being seen. This includes, but is not necessarily limited to, injection, fracture care, casework, rehabilitation, or any other treatment deemed proper care of my injury or illness.

RELEASE OF MEDICAL RECORDS

I hereby authorize Florida Orthopaedic Institute to release any medical information in connection with these services to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, health care service plans, workers’ compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement; Also to the patient’s personal physician, referring physicians, or primary care physician. I am aware that any/all information contained within my medical records/chart is Property of Florida Orthopaedic Institute.

rev. 1/8/13
ASSIGNMENT AND LIEN FOR MEDICAL SERVICES RENDERED DUE TO AN ACCIDENT – RELATED TO AUTO, WORK COMP OR OTHER

If I receive or become entitled to receive any monies from any source whatsoever for my injuries, either through a lawsuit, settlement of a lawsuit or claim, aware by a court or arbitrator(s), jury verdict or payment of insurance proceeds, I hereby assign and agree to pay said funds to Florida Orthopaedic Institute (at the address listed above) to the extent of any outstanding amounts then owed by me to Florida Orthopaedic Institute for medical services before any other fees, costs or expenses are disbursed from any said funds. I further agree that the fee for the services to be performed by Florida Orthopaedic Institute shall constitute a lien on any claim or lawsuit I may have as a result of my injuries and any settlement, aware, jury verdict or insurance proceeds that I receive or become entitled to receive as a result of my injuries.

This Assignment and Lien shall be placed in my chart and a copy thereof shall constitute actual notice to my attorney, or any other person, that my medical bills to Florida Orthopaedic Institute shall be paid first from the proceeds of any such lawsuit, settlement, award, jury verdict or insurance. This authorization cannot be modified unless it is in writing and signed by both parties.

I understand that I remain personally responsible for the payment of all fees owed by me to Florida Orthopaedic Institute and that notwithstanding this Assignment and Lien, Florida Orthopaedic Institute is not required to look to any other person or entity for payment.

I have given authorization to Florida Orthopaedic Institute to forward a copy of this document to my attorney. This assignment and Lien shall be effective regardless of whether it is countersigned by any such attorney.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS ALL THE ABOVE, AND AS THE PATIENT, GUARANTOR, OR THE PATIENT'S RESPONSIBLE PARTY, AGREES TO AND ACCEPTS THE TERMS.

Signature of Patient/Responsible Party  Signature of Witness  Date

REFUSAL TO SIGN
LIFETIME AUTHORIZATION STATEMENT
ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT

I, the above named, have been presented with the Lifetime Authorization Statement/Assignment of Benefits for Direct Payment Form and have refused to sign. In doing so, I am assuming full responsibility for all charges incurred during my evaluation and treatment at FOI. I understand that these charges are due in full at the time of service.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS ALL THE ABOVE, AND AS THE PATIENT, GUARANTOR, OR THE PATIENT'S RESPONSIBLE PARTY, AGREES TO AND ACCEPTS THE TERMS.

Signature of Patient/Responsible Party  Signature of Witness  Date

rev. 1/8/13
I have read and fully understand Florida Orthopaedic Institute's Notice of Patient Information Practices. I understand that Florida Orthopaedic Institute may use or disclose my protected health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and administrative healthcare operations. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Florida Orthopaedic Institute will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my protected health information for purposes as noted in Florida Orthopaedic Institute’s Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I understand that Florida Orthopaedic Institute has the right to change its Notice of Patient Information Practices and that I may contact this organization at any time to obtain a current copy of this Notice.

Patient’s Printed Name

Signature ______________ Date ______________

☐ I want to be offered the opportunity to receive the latest advances in medical technology. To gain access to these advances, I authorize the Florida Orthopaedic Institute to use my protected health information as the basis for asking me if I would like to participate in research studies involving new medical devices, pharmaceuticals, or surgical procedures. My doctor will explain to me the pertinent details of studies that may apply to my particular condition. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

☐ I would like to learn more about the latest advances in medical technology that could benefit my medical condition and me. Research is the key that opens the door for new medical advances, and I am interested in learning what is coming in the future that may benefit me. I also grant the non-profit affiliate of the Florida Orthopaedic Institute, the Musculoskeletal Research Foundation, and access to my protected health information for pertinent educational or charitable communications. I understand I have the right to copy or inspect any information used for these purposes. I also understand his authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient’s Signature ______________ Date ______________

FOR OFFICE USE ONLY:
Patient was provided with Consent Form and Notice of Patient Information Practices but refused to sign consent form for the following reason:

____________________________

Staff Signature ______________ Date ______________

Document Flow: Patient Medical Record, Research, Scanning Station MEDICAL RECORD
Florida Orthopaedic Institute

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

Patient Name: ______________________________ MR#: ____________________________

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: ____________________________  Relationship: ____________________________
Name: ____________________________  Relationship: ____________________________
Name: ____________________________  Relationship: ____________________________
Name: ____________________________  Relationship: ____________________________
Name: ____________________________  Relationship: ____________________________
Name: ____________________________  Relationship: ____________________________

Patient Signature

______________________________

Date

______________________________

Revised: 4/1/03