SOUTHERN ORTHOPEDICS & SPINE: NEW PATIENT INFORMATION

Name: **SS#:** **Date of Accident/Injury:**

Local Address: City: State: Zip:

Home Phone: Cell Phone:

Age: Date of Birth: / / Marital Status:
MONTH DAY YEAR

If Minor, Responsible Parties:

Address: Phone:

Occupation: Business Phone: ( )

Business Name: Business City/State:

Medical Insurance (if applicable): / /

Auto Insurance (if applicable): / /
AUTO INSURANCE COMPANY POLICY NUMBER ADJUSTOR NAME

Auto Insurance (Claim Numbers). /
ACCIDENT CLAIM # INJURY CLAIM #

Do you have an attorney: If "YES," Attorney Name:

Attorney Contact (Case Manager, Paralegal, etc.):

Attorney Address or City/State:

Attorney Phone:

Referring Physician: Referring Physician City/State:

Emergency Contact : Emergency Phone:

I acknowledge that the above information is true and accurate to the best of my knowledge. I will notify Southern Orthopedics & Spine if any of the above information changes.

_____
PATIENT'S PRINTED NAME

_____
PATIENT'S SIGNED NAME

_____
SOS WITNESS

FOR OFFICE USE ONLY: Date Received_____ Date Completed_____ Initials_____

Bradenton _____ Sarasota _____

Southern Orthopedics & Spine—4016 Sawyer Road—Sarasota, FL 34233 Phone: 941-216-4700—Fax: 941-921-2414

SOUTHERN ORTHOPEDICS & SPINE: NEW PATIENT INFORMATION

SOUTHERN ORTHOPEDICS & SPINE HIPAA COMPLIANCE NOTIFICATION &

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Southern Orthopedics & Spine strives to achieve compliance with the federal guidelines regarding the Health Insurance Portability and Accountability Act (HIPAA), especially emphasizing the "Privacy Rule." We may need to provide some information to medical specialists to assist in your care (radiology company, bracing company, etc.). You may submit in writing a refusal to disclose your health information.

I, Name: _____, DOB _____, SS# _____ hereby authorize you to release my records to the office below for my continued medical care in regards to the accident I suffered on (DATE OF ACCIDENT) _____.

Southern Orthopedics & Spine
2415 University Parkway
Sarasota, FL 34243
Phone: 941-323-4880
Fax: 941-921-2414

INFORMATION TO BE DISCLOSED: (PLEASE INITIAL SELECTION)

- ☐ _____ ALL MEDICAL RECORDS
- ☐ _____ HISTORY & PHYSICAL
- ☐ _____ LAB RESULTS
- ☐ _____ XRAY & DIAGNOSTIC IMAGING
- ☐ _____ CONSULTATION
- ☐ _____ OTHER
- ☐ _____ SEXUALLY TRANSMITTED DISEASE & HIV RESULTS

EXPIRATION & REVOCATION OF AUTHORIZATION: This authorization will expire 6 months from this date unless otherwise specified by me in writing. I understand that I can revoke this authorization at any time, which I must also do in writing.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

_____ _____

SOS WITNESS SIGNATURE DATE

FOR OFFICE USE ONLY: Date Received_____ Date Completed_____ Initials_____
Bradenton_____ Sarasota_____

SOUTHERN ORTHOPEDICS & SPINE—NEW PATIENT MEDICAL HISTORY

Today's Date ____/____/____ Patient Name _____

Date of Birth ____/____/____ Referring Physician_____

Reason for Visit?_____

Were you seen in Emergency Room?
Yes ◯ No ◯

Which Hospital? _____

Is this a Motor Vehicle Accident or Personal Injury Accident?

Yes ◯ No ◯

Do you have a lawyer?

Yes No

Are you disabled? Yes ☐ o ☐

Any x-rays, MRIs, or CTs related to injury? Yes ◯ No ◯

Performed where? _____

Family History (Parents or Siblings)

Check all that apply

- ☐ AIDS/HIV
- ☐ ALCOHOLISM
- ☐ ARTHRITIS
- ☐ BLEEDING DISORDERS
- ☐ CANCER
- ☐ DIABETES
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ KIDNEY DISEASE
- ☐ STROKE
- ☐ TB
- ☐ OTHER_____

Medical History (Personal)

Check all that apply

- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA/COPD
- ☐ BACK DISORDERS
- ☐ BLEEDING DISEASE
- ☐ BLOOD CLOTS
- ☐ CANCER/WHERE?_____
- ☐ COLITIS/DIVERTICULITIS
- ☐ DIABETES
- ☐ BROKEN BONE/WHAT?
- ☐ _____
- ☐ GALLBLADDER DISEASE
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ HEART ATTACK/WHEN?__
- ☐ _____
- ☐ HEPATITIS
- ☐ HIATAL HERNIA
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV
- ☐ KIDNEY DISEASE/STONES
- ☐ STROKE
- ☐ THYROID DISEASE

Other Problems

Check all that apply

- ☐ Abnormal Heartbeat
- ☐ Anesthesia Difficulties
- ☐ Calf Cramps
- ☐ Chills/Fever
- ☐ Diarrhea
- ☐ Ear/Nose/Throat
- ☐ Hearing Loss
- ☐ Heart/Chest Pain/Angina
- ☐ Indigestion/Heartburn
- ☐ Intestinal Bleeding
- ☐ Joint Pain/Stiffness
- ☐ Leg/Skin Ulcers
- ☐ Muscle Weakness
- ☐ Recent Weight Loss
- ☐ Shortness of Breath

Previous Surgeries

Check all that apply

- ☐ APPENDIX
- ☐ BACK
- ☐ BONE/JOINT/WHERE?
- ☐ _____
- ☐ CANCER/WHERE?
- ☐ _____
- ☐ GALLBLADDER
- ☐ HEART BYPASS/STENT
- ☐ HYSTERECTOMY
- ☐ PROSTATE
- ☐ TONSILS
- ☐ OTHERS/LIST_____
  _____

Social History

Married ☐ Single ☐ Divorced ☐

Do you live alone? Yes ☐ No ☐

Do you SMOKE? Yes ☐ Packs a day ____
No ☐ When did you quit?
_____

ALCOHOL? Social ☐ Heavy ☐ Never ☐

AGE _____ MALE ☐ FEMALE ☐

HEIGHT_____ WEIGHT _____

PHARMACY NAME
_____

PHARMACY PHONE
_____

CURRENT MEDICATIONS
_____
_____
_____

ARE YOU ON BLOOD THINNERS?

YES ☐ NO ☐ WHAT?_____

ALLERGIES—LIST ALL _____

_____
_____
_____

Patient's/Guardian's Signature:

_____

OFFICE USE ONLY

MD SIGNATURE DATE

_____ _____

_____ _____

_____ _____

Bradenton ___ Sarasota ___

Southern Orthopedics & Spine

Southern Orthopedics & Spine,LLC 4016
Sawyer Road, Sarasota, FL 34233 Phone:
941-216-4700
Fax: 941-921-2414
Email: info@sosorthoandspine.com

LETTER OF PROTECTION

Subject: IRREVOCABLE LIEN to Southern Orthopedics & Spine:

TO MY LEGAL REPRESENTATION:
I hereby authorize Southern Orthopedics & Spine, LLC (hereafter, SOS), its assigns, or its subcontracted medical providers to furnish you, my attorney, with full reports of the medical services rendered me in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to SOS sums as may be due and owing for medical services rendered me both by reason of this accident and by reason of any other bills due SOS and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect SOS. I further hereby give lien on my case to SOS or its assigns against any and all settlement, judgment, or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have received treatment or injuries in connection therewith.

I understand that I hold direct and full responsibility to SOS all medical bills submitted by SOS for services rendered and that in consideration of SOS waiting for payment. I further understand that such payment is contingent on any settlement, judgment, or verdict by which I may eventually recover said fees.

This Letter of Protection is subordinate to attorney fees or costs.

_____ _____
Patient Signature Date Patient Name (Please Print)

_____ _____
SOS Representative Date SOS Representative (Please Print)

Southern Orthopedics & Spine, LLC /
4016 Sawyer Road, Sarasota, FL 34233
941-216-4700 / 941-921-2414 (Fax)
www.sosorthoandspine.com / email: info@sosorthoandspine.com

IRREVOCABLE LETTER OF DIRECTION AND PROTECTION

Date: _____ Attorney Name _____

Address

Dear Attorney:

I, _____ (client) hereby irrevocably direct my attorney, or any subsequent attorney(s) and law firms that may represent me, to place an assignment, consensual lien, and security interest against any and all of the settlement proceeds due to me from the legal claim(s)/case(s) in which you represent me, after payment of any and all legal fees and reimbursable costs, and to protect and satisfy this assignment, consensual lien and security interest up to the full amount of the reasonable and necessary health care charges owed to Southern Orthopedics & Spine, LLC (hereafter, SOS), by me, before releasing any funds to me. If any dispute arises over the amount owed SOS, I instruct you NOT to release any funds to me until that dispute is resolved. If a check is sent in my name, I hereby grant you a limited, irrevocable power of attorney to endorse and deposit my check into your trust account and pay SOS, in full, before releasing any funds to me.

In the event that you no longer represent me, I instruct you to provide SOS with any insurance, attorney or other information requested that will allow SOS to protect its interest and to follow my irrevocable instructions. This letter may be executed in counterparts, each of which shall be deemed an original and all of which shall together constitute an agreement. By signing the acknowledgment below, you acknowledge that this letter is from me and that you will comply with this Irrevocable Letter of Direction.

Date: _____ Client Signature: _____

ATTORNEY ACKNOWLEDGMENT AND LETTER OF PROTECTION

I, _____, (attorney) acknowledge receipt of this Letter from my client.

_____ (client) claim(s)/case(s) is/are still pending against a viable defendant and should I no longer represent said client, I will contact Southern Orthopedics & Spine, LLC (hereafter, SOS), without delay, and provide applicable insurance, attorney information and any other information requested by SOS.
My fee agreement is on a contingency basis and I will honor my client's Irrevocable Letter of Direction, assignment, consensual lien and security interest, subordinate to attorney fees and costs, as per instructions above. I fully expect and anticipate any settlement check will be sent to me from the defendant and/or insurance company, and not to the plaintiff, and I agree that all disbursements of funds, including plaintiff's share of proceeds, will be through my attorney trust account.
Notwithstanding any of the above, I, _____, (attorney) agree to protect the reasonable and proper health care charges of SOS. That when recovery is made in this claim(s)/case(s), whether by suit, settlement, trial, or otherwise, I, _____, (attorney) will pay all the reasonable and proper outstanding bills of SOS, involved in the treatment of _____ (client).

Date: _____ Attorney Signature: _____

A Letter to the Patient from Southern Orthopedics & Spine

Southern Orthopedics & Spine is devoted to providing premier, specialized care to injury and accident patients. SOS and its surgeons want to ensure that every accident and injury patient receives the best possible plan of care, so they can hopefully recover from their injuries and have the lifestyle they enjoyed before their accidents. Although SOS surgeons specialize in surgery, a majority of patients are nonsurgical. Despite SOS surgeons specializing in surgery, however, they have a network of local medical relationships—physical therapy, physiatry, hospitals, ambulatory surgery centers, chiropractic care, urgent care, internal medicine, labs, home health, durable medical equipment—to tailor plans of care to give injury and accident patients the best possible outcome.

For the reasons listed above, your surgeon is limited to seeing you four times in clinic: I) 1 Initial Consultation; II) 3 Follow-ups/Post-Surgical visits. If our surgeons cannot help you by then, SOS will hopefully place you with a medical provider who can help based upon the surgeon's recommendations. Some exceptions apply, of course, but not without authorization by SOS (contact information provided below).

Southern Orthopedics & Spine, LLC
4016 Sawyer Road
Sarasota, FL 34233
Phone: 941-216-4700
Fax: 941-921-2414
Email: info@sosorthoandspine.com

At your service,

Southern Orthopedics & Spine, LLC