

NEW PATIENT REGISTRATION

REASON FOR TODAYS VISIT/ INJURED BODY PARTS?	
REFERRED BY DOCTOR: PHONE NUMBER:	PRIMARY CARE PROVIDER: PHONE NUMBER:

PATIENT INFORMATION

Last Name:		Date of Birth:	
First Name:	Middle Initial:	Sex:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Street Address:		Martial Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partner	
City:		Social Security Number: _____ - _____ - _____	
State:	Zip Code:	Employer:	
Home Phone: () - Is it okay to leave message? <input type="checkbox"/> YES <input type="checkbox"/> NO	Cell Phone: () - Is it okay to leave message? <input type="checkbox"/> YES <input type="checkbox"/> NO	Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Other	
Work Phone: () -	Ext	Email Address (Required): May we enable the patient portal and enroll you for monthly emails? (Required): Yes / No	
Preferred Language:	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unreported/ Refused	Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African Amer. <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander	

PRIMARY INSURANCE COVERAGE / RESPONSIBLE PARTY

Insurance Company:				
Policy Holder/Responsible Party:	Policy Holder's Date of Birth:	Month	Day	Year
Policy Holders Relationship to Patient:		Policy Holders Social Security Number:		
Subscriber/ ID Number OR Claim Number			Group OR Policy Number:	

SECONDARY INSURANCE COVERAGE

Insurance Company:	Subscriber/ ID Number:
	Group or Policy Number:

ATTORNEY INFORMATION

Attorney Name/ Law Firm:	Phone Number:
	Fax Number:
Case Manager/ Paralegal Phone:	Case Manager/ Paralegal E-Mail:

EMERGENCY CONTACT

Name/ Relation:	Phone Number:
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PATIENT CONSENTS AND RESPONSIBILITIES

- 1. CONSENT FOR GENERAL MEDICAL OR SURGICAL TREATMENT** - I hereby authorize Royal Palm Beach Rehab, Corp DBA Florida OrthoCare and the physician(s), in charge of my care to administer any treatment, receive results of tests and services rendered, administer anesthetics and medications, perform surgical procedures, injections, laboratory tests (including blood tests for any disease or condition), and to dispose of any tissues, body parts or organs removed as deemed necessary or advisable in my diagnosis and treatment. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me and with any invasive procedure there is a risk of adverse reactions, including but not limited to allergic reactions, pain, scarring, reactive synovitis and infections.
- 2. ACCESS TO CARE** – The practice hours for Florida OrthoCare are Monday through Friday from 9:00am-5:00pm. Should you have an urgent problem when our office is closed, please call 1-888-523-7981 and remain on the line to leave your message with our answering service. A returned phone call will be returned by the provider on call. In the event of a true emergency and/or life threatening medical condition, call 911.
- 3. NARCOTIC MEDICATION** – I understand I may be prescribed narcotic and sedative medication for treatment of my condition(s). I am aware that the use of such medicine has certain risks associated with it, including but not limited to: dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, sleepiness or drowsiness, constipation, nausea, itching, vomiting, tolerance to analgesia, addiction and possibly that the medicine will not provide relief from pain. (1) I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly such as, using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for themselves. (2) Physical dependence is expected as a result of using these medicines for a long time. Physical dependence is not the same as addiction. Narcotic medication should not be stopped abruptly. A planned titrating regimen with your provider to come off the medication overtime will be necessary to prevent any abstinence syndrome to develop. (3) I will not abuse any narcotic medication by taking more than the prescribed dosage, combining the medication with illegal controlled substances, prescribed or non-prescribed or excessive amounts of sedatives, including alcohol, as this may result in profound sedation and death. (4) I consent to urine and blood screens. Because narcotic medication have potential for abuse or diversion, strict accountability is necessary. Urine or serum toxicology screens will be requested and your cooperation is required. Presence of unauthorized substances may prompt discontinuance of narcotic medication. (5) I may decline narcotic medication and associated toxicology screens. I may choose to use non-narcotic pain medication such as NSAIDS or Acetaminophen.
- 4. FINANCIAL AGREEMENT** - I hereby guarantee payment of all charges incurred for services rendered at Royal Palm Beach Rehab, Corp. DBA Florida OrthoCare I understand the cost of my medical care is dependent upon the nature and complexity of my illness or injury, the determination of which can only be established by the physician or medical practitioner in charge of my care. I understand that any verbal information given to me by any center staff regarding fees and services is for informational purposes only and is in no way a contract between Royal Palm Beach Rehab, Corp DBA Florida OrthoCare and me. No verbal contracts will be made, or will be honored. **Payment is due in full upon date of service.**
- 5. PRIVATE INSURANCE** - I understand that insurance is a contract between me and my insurance company and not a substitute for payment, and that I am responsible for payment of my bill regardless of any insurance company's arbitrary determination of usual and customary rates. If there is any question regarding coverage, benefits, or payment for services provided, **I understand that it is my responsibility to resolve this.**
- 6. MEDICARE ASSIGNMENT** – Royal Palm Beach Rehab, Corp DBA Florida OrthoCare will accept payment in full for what MEDICARE pays. It is the patient's responsibility for the 20% of the MEDICARE allowable for which MEDICARE does not pay. I agree to be responsible for this 20%. If I have secondary/supplemental insurance it is to be provided to Royal Palm Beach Rehab, Corp. DBA Florida OrthoCare.
- 7. RELEASE OF LIABILITY** - In consideration for the rendition of medical services, I hereby voluntarily release, waive, and discharge Royal Palm Beach Rehab, Corp DBA Florida OrthoCare, their staff, lessors, heirs, successors and/or assigns from any and all claims, demands, damages, costs, loss of services, expenses, compensation and causes of action of any nature whatsoever connected with the rendition of medical services which I, my spouse, my heirs, my assigns, my legal representatives or my successors may have against any of them arising out of or in any way growing out of personal injuries or death having already resulted or to result at any time in the future, whether or not they are in the contemplation of the parties at the present time. I understand that this waiver includes any claims based on negligence, action or inaction of Royal Palm Beach Rehab, Corp DBA Florida OrthoCare, their staff, lessors, heirs, successors and/or assigns. I have carefully read this release and fully understand its contents. I am aware that this is a release of liability and a contract between myself and Royal Palm Beach Rehab, Corp. DBA Florida OrthoCare, and said staff, and sign it of my own free will.
- 8. ASSIGNMENT OF BENEFITS** – If Royal Palm Beach Rehab, Corp DBA Florida OrthoCare, participates with my insurance program(s), I understand that Florida OrthoCare, will, as a courtesy to me, submit the charges for my visit to my primary and secondary insurance carriers. I assign payment directly to Royal Palm Beach Rehab, Corp. DBA Florida OrthoCare. I understand that I am financially responsible for any covered or non-covered services which are not paid by my primary or secondary insurance. Any credit balance resulting from payment of insurance or other sources may be applied to other accounts owed to Florida OrthoCare, by the insured or family.
- 9. PATIENT HIPAA FORM** - I have been given the opportunity to review Royal Palm Beach Rehab, Corps. DBA Florida OrthoCare, Health Insurance Portability and Accountability Act of 1996 and the full HIPAA notice is posted in our waiting room and a copy may be also provided by calling (561) 403-1616.
- 10. NOTICE OF PRIVACY PRACTICES** – I have been given the opportunity to review Royal Palm Beach Rehab, Corps. DBA Florida OrthoCare. Notice of Privacy Practices. The full Notice of Privacy Practices is displayed in our waiting room and a copy may also be provided by calling (561) 403-1616.
- 11. USES AND DISCLOSURES OF HEALTH INFORMATION** - I understand that Royal Palm Beach Rehab, Corp. DBA Florida OrthoCare, will use and disclose my personal health information to provide treatment, process payment claims, as necessary for healthcare operations (ex. Utilization Review, manufacturers of surgically placed implants) or as required by law. This includes release of information to insurance carriers, 3rd party payers or their agents, ancillary medical providers (IE; Physical therapy, Occupational therapy, Imaging facilities, etc), other medical providers and law enforcement agencies with any right to privacy waived including any treatment for mental illness, alcohol abuse, drug abuse or HIV as may be necessary. For details of uses and disclosures refer to Florida OrthoCare's, Notice of Privacy Practices.
- 12. RIGHT TO ANCILLARY PROVIDERS/ FACILITIES** – When you are referred out for ancillary care, including but not limited to, diagnostic testing, physical therapy, chiropractic care, etc. It is within your patient rights to choose providers and/or facilities as you deem appropriate. Our recommendations are merely suggestions in efforts to provide convenient transition of care for our patients.

I certify that I am the patient or the patient's legal representative, that I have read the foregoing, fully understand the consents and releases contained in this record, and voluntarily execute it. I understand that the consents regarding my personal health information are subject to revocation at any time except to the extent that action has been taken in reliance thereon and that said consents shall remain in effect until I choose to revoke them in writing.

Signature of Patient and/or Legal Representative

Date

FLORIDA ORTHOCARE

Patient Name: _____

Date: _____

Family Physician: _____

Account#: _____

<p><u>Allergies</u> <input type="checkbox"/> No Change since last visit. <input type="checkbox"/> New info</p> <p>Please list any medication allergies</p> <p>_____ _____ _____</p> <p><u>Medications</u> <input type="checkbox"/> No Change since last visit. <input type="checkbox"/> New info</p> <p>Please list all medications you are taking <input type="checkbox"/> Attach List</p> <p>_____ _____ _____ _____ _____ _____</p> <p>Is it possible you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Are you <input type="checkbox"/> Right Handed? or <input type="checkbox"/> Left Handed?</p> <p><u>Social History</u> <input type="checkbox"/> No Change since last visit. <input type="checkbox"/> New info</p> <p>Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many per day? _____</p> <p>Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many per week? _____</p>	<p><u>Medical History</u> <input type="checkbox"/> No Change since last visit. <input type="checkbox"/> New Info</p> <p>Have you had any of the following</p> <p>Depression/Anxiety <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease <input type="checkbox"/> Y <input type="checkbox"/> N High Cholesterol <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure <input type="checkbox"/> Y <input type="checkbox"/> N Lung Disease <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever <input type="checkbox"/> Y <input type="checkbox"/> N Stroke <input type="checkbox"/> Y <input type="checkbox"/> N Seizures/Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N Asthma <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema <input type="checkbox"/> Y <input type="checkbox"/> N Bronchitis <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease <input type="checkbox"/> Y <input type="checkbox"/> N Pancreatitis <input type="checkbox"/> Y <input type="checkbox"/> N Gout <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis <input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement <input type="checkbox"/> Y <input type="checkbox"/> N HIV Infection/AIDS <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis <input type="checkbox"/> Y <input type="checkbox"/> N Thrombosis <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatment <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N Pace maker <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Others (list):</p> <p>_____ _____ _____ _____ _____</p>	<p><u>Review of Systems</u> <input type="checkbox"/> No change since last visit <input type="checkbox"/> New Info</p> <p style="text-align: center;">Do you have any of these symptoms?</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top; padding-right: 10px;"> <p><i>General</i></p> <p>Weight change <input type="checkbox"/> Y <input type="checkbox"/> N Fever <input type="checkbox"/> Y <input type="checkbox"/> N Night Sweats <input type="checkbox"/> Y <input type="checkbox"/> N Fatigue <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><i>Immune/Allergy</i></p> <p>Hives <input type="checkbox"/> Y <input type="checkbox"/> N Rashes <input type="checkbox"/> Y <input type="checkbox"/> N Frequent infections <input type="checkbox"/> Y <input type="checkbox"/> N Swollen glands <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><i>Eyes</i></p> <p>Blurry vision <input type="checkbox"/> Y <input type="checkbox"/> N Loss of vision <input type="checkbox"/> Y <input type="checkbox"/> N Itching <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><i>Skin</i></p> <p>Rashes <input type="checkbox"/> Y <input type="checkbox"/> N Discoloration <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><i>Ear/Nose/Throat</i></p> <p>Ringing in the ears <input type="checkbox"/> Y <input type="checkbox"/> N Loss of hearing <input type="checkbox"/> Y <input type="checkbox"/> N Nose bleeds <input type="checkbox"/> Y <input type="checkbox"/> N Trouble swallowing <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><i>Digestive</i></p> <p>Abdominal pain <input type="checkbox"/> Y <input type="checkbox"/> N Nausea or Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N Bloody stools <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><i>Respiratory</i></p> <p>Shortness of breath <input type="checkbox"/> Y <input type="checkbox"/> N Wheezing <input 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easily <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><i>Endocrine</i></p> <p>Excessive thirst <input type="checkbox"/> Y <input type="checkbox"/> N Weight gain <input type="checkbox"/> Y <input type="checkbox"/> N Excessive hunger <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><i>Musculoskeletal</i></p> <p>Joint pain <input type="checkbox"/> Y <input type="checkbox"/> N Back or neck pain <input type="checkbox"/> Y <input type="checkbox"/> N Muscle weakness <input type="checkbox"/> Y <input type="checkbox"/> N Muscle pain <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><i>Urinary</i></p> <p>Incontinence <input type="checkbox"/> Y <input type="checkbox"/> N Painful urination <input type="checkbox"/> Y <input type="checkbox"/> N Blood in urine <input type="checkbox"/> Y <input type="checkbox"/> N Burning <input type="checkbox"/> Y <input type="checkbox"/> N</p> </td> </tr> </table> <p><u>Family History</u> <input type="checkbox"/> No change since last visit <input type="checkbox"/> New Info</p> <p>Has anyone in your family ever had:</p> <p>Heart Disease <input type="checkbox"/> Y <input type="checkbox"/> N If yes, who? _____ Lung Disease <input type="checkbox"/> Y <input type="checkbox"/> N If yes, who? _____ Kidney Disease <input type="checkbox"/> Y <input type="checkbox"/> N If yes, who? _____ Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N If yes, who? _____ Cancer <input type="checkbox"/> Y <input type="checkbox"/> N If yes, who? _____</p>	<p><i>General</i></p> <p>Weight change <input type="checkbox"/> Y <input type="checkbox"/> N Fever <input type="checkbox"/> Y <input type="checkbox"/> N Night Sweats <input type="checkbox"/> Y <input type="checkbox"/> N Fatigue <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><i>Immune/Allergy</i></p> <p>Hives <input type="checkbox"/> Y <input type="checkbox"/> N Rashes <input type="checkbox"/> Y <input type="checkbox"/> N Frequent infections <input 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<p><u>Surgical History</u> <input type="checkbox"/> No change since last visit <input type="checkbox"/> New Info</p> <p>Please list any surgeries you have had.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Procedure</th> <th style="width: 40%;">Year</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Procedure	Year											<p>Patient/Guarantor : _____ Date: _____</p> <p>Physician Signature: _____ Date: _____</p>	
Procedure	Year													

PHARMACY INFORMATION - REQUIRED

STORE NAME:	PHONE:
ADDRESS:	FAX:

WRITTEN DISCLOSURE FORM (F.S. 456.052)

Dr. John Papa, DC has a financial interest in the following entities:

ROYAL PALM BEACH REHAB, CORP. DBA ACTION PHYSICAL THERAPY

Offices in Miami, Broward, Palm Beach, Martin (www.actionphysical.com)

ROYAL PALM BEACH REHAB, CORP. DBA FLORIDA ORTHOCARE

Offices in Miami, Broward, Palm Beach, Martin (www.florthocare.com)

CERTIFIED SPINE AND PAIN CARE, LLC

Offices in Miami, Broward, Palm Beach (www.certifiedspineandpain.com)

AS THE PATIENT YOU HAVE A RIGHT TO OBTAIN THE SAME ITEMS/SERVICES AT ONE OF THE ABOVE-LISTED LOCATIONS OR AT A DIFFERENT LOCATION OF YOUR CHOICE. YOU MAY OBTAIN THESE SAME ITEMS/SERVICES AT THE FOLLOWING LOCATIONS WHERE DR. JOHN PAPA, DC, DOES NOT HAVE A FINANCIAL INTEREST:

MIAMI-DADE COUNTY

- Pain Medicine, Baptist Health, 13101 S. Dixie Highway, Suite 400, Miami, FL 33156
- Advanced Institute for Pain Management, University of Miami, 1120 NW 14 Street, 9th Floor, Suite 101, Miami, FL

BROWARD COUNTY

- American Pain Experts, 1164 E. Oakland Park Blvd., Suite 201, Oakland Park FL, 33334
- Broward Health Pain Management, 2100 E Sample Road, Suite 203, Lighthouse Point, FL 33064

PALM BEACH COUNTY

- National Pain Institute, 5365 West Atlantic Avenue, Suite 504, Delray Beach, FL 33484
- Resolute Pain Solutions, 4510 Donald Ross Road, Palm Beach Gardens, FL 33418

MARTIN COUNTY

- Pain Management, Martin Health, 509 Riverside Dr., Suite 203, Stuart, FL 34994
- Resolute Pain Solutions, 2100 SE Ocean Boulevard, Suite 100, Stuart, FL 34996

Patient Signature

Date

The 2018 Florida Statutes

[Title XXXII](#)
REGULATION OF PROFESSIONS AND
OCCUPATIONS

[Chapter 456](#)
HEALTH PROFESSIONS AND OCCUPATIONS:
GENERAL PROVISIONS

[View Entire Chapter](#)

456.052 Disclosure of financial interest by production.—

(1) A health care provider shall not refer a patient to an entity in which such provider is an investor unless, prior to the referral, the provider furnishes the patient with a written disclosure form, informing the patient of:

(a) The existence of the investment interest.

(b) The name and address of each applicable entity in which the referring health care provider is an investor.

(c) The patient's right to obtain the items or services for which the patient has been referred at the location or from the provider or supplier of the patient's choice, including the entity in which the referring provider is an investor.

(d) The names and addresses of at least two alternative sources of such items or services available to the patient.

(2) The physician or health care provider shall post a copy of the disclosure forms in a conspicuous public place in his or her office.

(3) A violation of this section shall constitute a misdemeanor of the first degree, punishable as provided in s. [775.082](#) or s. [775.083](#). In addition to any other penalties or remedies provided, a violation of this section shall be grounds for disciplinary action by the respective board. **History.**—s. 1, ch. 86-31; s. 84, ch. 91-224; s. 13, ch. 92-178; s. 92, ch. 97-261; s. 76, ch. 2000-160.

Note.—Former s. 455.25; s. 455.701.

REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE: _____

TO/ PROVIDER: _____

ADDRESS: _____

CITY/ STATE/ ZIP: _____

PHONE: _____ FAX: _____

**** I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:**

PHYSICIAN'S NAME: _____

TO/ PROVIDER: _____

ADDRESS: _____

CITY/ STATE/ ZIP: _____

PHONE: _____ FAX: _____

REQUESTING PATIENT INFORMATION:

NAME:	DOB:
ADDRESS:	CITY/ STATE/ ZIP CODE:
SOCIAL SECURITY NUMBER:	SIGNATURE:

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RELEASE OF INFORMATION

PATIENT NAME:	
DOB:	

RELEASE OF INFORMATION : I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE FOLLOWING PRIVATE INDIVIDUALS WHICH WE MAY DISCUSS YOUR PROTECTED HEALTH INFORMATION. PLEASE NOTE – IF A PERSON(S) IS NOT LISTED HERE; WE WILL NOT SHARE ANY OF YOUR PROTECTED INFORMATION:

NAME:	
CONTACT NUMBER:	
RELATIONSHIP:	

NAME:	
CONTACT NUMBER:	
RELATIONSHIP:	

NAME:	
CONTACT NUMBER:	
RELATIONSHIP:	

X _____
Signature of Patient and/or Legal Representative

X _____
Date