



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. **Flagler Orthopedics and Sports Medicine** 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 Copayments** are due at the time of service. Any previous balance is expected to be paid at the time of service.
3. Patients are responsible for obtaining referrals and authorization for services rendered at Flagler Orthopedics and Sports Medicine.
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. This is not covered by insurance.
5. There is a \$25.00 fee for all disability, FMLA, and other forms/paperwork that you may need to have completed by the physician. We may ask that you schedule 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 being requested.
7. **Prescription Policy:**
 - a. If you are in need of a refill, please have your pharmacy fax a request to (386) 586-1912. Please allow 48 to 72 hours for request.
 - 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)

Date of Birth

Signature

Date

NAME: _____ **DOB:** _____ **DATE:** _____

PAST MEDICAL HISTORY

Please select if condition applies to your medical history:

- | | |
|---|--|
| <input type="radio"/> Asthma | <input type="radio"/> Hepatitis |
| <input type="radio"/> Cancer | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Osteoarthritis |
| <input type="radio"/> Depression | <input type="radio"/> Peptic Ulcer Disease |
| <input type="radio"/> Diabetes | <input type="radio"/> Renal Disease |
| <input type="radio"/> Gout | <input type="radio"/> Rheumatoid Arthritis |

Other: _____

PAST SURGICAL HISTORY

- | | |
|--|--|
| <input type="radio"/> Angioplasty With Stent | <input type="radio"/> Gastric Bypass |
| <input type="radio"/> Arthroscopy Shoulder | <input type="radio"/> Hip Replacement |
| <input type="radio"/> Coronary Artery Bypass | <input type="radio"/> Knee Replacement |
| <input type="radio"/> Carpal Tunnel Release | |

Other: _____

FAMILY HISTORY

	Mother	Father	Siblings	Children
Osteoarthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SOCIAL HISTORY

Have you ever smoked cigarettes? Yes No

Do you currently smoke? Yes No

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

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

**** If you smoke, how long have you been smoking?**

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

Do you drink alcohol?

- No
- Yes, one drink per day
- Yes, more than one drink per day
- Yes, several drinks a week
- Yes, no more than once a month

Do you have an Advanced Directive? Yes No

If No, would you like one?

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 Intolerance
- 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

Hematologic

- Bleeding
- Bruising

Respiratory

- Chest pain (Respiratory)
- Cough
- Dyspnea
- Recent Infections
- Known TB Exposure
- Wheezing

Genitourinary

- Dysuria
- Frequent Urination
- Hematuria
- Urge Incontinence
- Urinary Incontinence

Immunological

- Asthma
- Bee Sting Allergies
- Contact Dermatitis
- Environmental Allergies
- Food Allergies
- Seasonal Allergies

MEDICAL INFORMATION:

DRUG ALLERGIES:

REACTIONS:

1.	
2.	
3.	
4.	
5.	

CURRENT MEDICATIONS:

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

HEIGHT: _____ WEIGHT: _____



David M. Gay, M.D.
61 Memorial Medical Parkway
Suite 3802
Palm Coast, FL 32164

PATIENT: _____ **DOB:** _____ **SS#** _____

PATIENT CONSENT AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I, the undersigned patient, parent or legal guardian, knowing that I am (the patient is) suffering from a condition requiring medical care, do hereby present myself for treatment at Florida Hospital Flagler, **David M. Gay, M.D.** and voluntarily consent to the rendering of such care, including treatments, photographs for treatment evaluations, administration of anesthetics and performance of diagnostic and/or surgical procedures. In the event a medical device is implanted or explanted, I agree to the release of my Social Security number to the manufacturer/FDA for tracing of the device. I understand that I am under the care and supervision of my attending physician (or in the emergency department, the emergency department physician) and it is the responsibility of the hospital and its staff to carry out the instructions of such physician(s). I understand that the physicians furnishing services to me may be employees of the hospital or may be independent contractors and not employees or agents of the hospital, and that all physicians expect payment in full upon receipt of a bill and I will assist in billing appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments of examination in the office or hospital.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Florida Hospital Flagler, **David M. Gay, M.D.** and the physicians accepting this assignment of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Florida Hospital Flagler and their physicians for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent, or legal guardian, do hereby authorize Florida Hospital Flagler, its officers and employees, to release to any third party payor (such as an insurance company or government agency; Example: Blue Cross/Blue Shield of Florida or Medicare) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS or AIDS related complex) treatment information and records, in accordance with the policy of Florida Hospital Flagler, **David M. Gay, M.D.** and any applicable State or Federal Statues, concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release Florida Hospital Flagler, **David M. Gay, M.D.** from all liability that may arise from the release of the information requested.

FLORIDA LAW: Section 817.234 Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

FOR MEDICARE AND MEDICAID PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT

REQUEST: I certify that the information given by me in applying for payment under Title XVIII or /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for Florida Hospital Flagler physician(s). I understand that I am responsible for any health insurance deductibles and coinsurance.

MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES: Medicare does not (initials) _____ cover some inpatient, outpatient, and emergency services. Items not covered include, but are not limited to **INPATIENT:** (lotion, toothpaste, deodorant, etc.) **OUTPATIENT AND EMERGENCY:** medications typically self-administered, annual testing and physicals.

ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENTS ONLY): My signature only acknowledges my receipt of this message from Florida Hospital Flagler, **David M. Gay, M.D.** as dated below and does not waive any of my right to request a review of make me liable for any payment.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE IN FLORIDA HOSPITAL FLAGLER.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates himself/herself to pay the account of Florida Hospital Flagler physician(s) in accordance with the regular rates and terms of the physicians(s). Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection .

 Patient's signature

 Patient's representative/policy holder or spouse
 Indicate relationship _____

 Witness

 Date

Patient unable to sign due to: _____



**Acknowledgement of Receipt
Of HealthCare Partners Notice of Patient Privacy Practices**

By signing this Written Acknowledgment of Receipt of HealthCare Partners Notice of Patient Privacy Practices (“Acknowledgment”), I hereby expressly acknowledge my receipt of HealthCare Partners Notice of Patient Privacy Practices.

Patient or Legal Representative, Signature

Patient or Legal Representative, Printed Name (or label)

Date

Acknowledgment **NOT** obtained because:

_____ Patient or legal representative, declined Notice of Patient Privacy Practices;
 _____ Other (briefly describe) _____

Employee (Witness) Signature

Employee Printed Name

Date



COINSURANCE NOTICE TO MEDICARE PATIENTS

Dear Medicare Patient:

We would like to take this opportunity to inform you that this physician practice is a provider-based clinic. This provides increased continuity of care and improved reimbursements, thus allowing Florida Hospital to continue to provide quality medical care and services.

Your visits to this office are billed by a Central Billing Office, which is a service of Florida Hospital Flagler. You will be registered in this office as an outpatient of Florida Hospital Flagler. Any services you receive will still be billed by Florida Hospital Flagler to Medicare and any secondary insurance companies. If you have any questions regarding your service provided at this office, please call 386-671-4500 to speak with a Billing Representative.

In accordance with Medicare's laws and regulation, you will incur a co-insurance liability to Florida Hospital Flagler that you would not have incurred if this office were not provider-based. Your actual co-insurance liability will depend upon the actual services furnished by this office. For example, co-insurance balances for an average follow up visit for an established patient (99213) would be approximately \$12.06 for hospital charge and \$8.32 for the physician charge.

After the hospital and physician have been reimbursed by Medicare, co-insurance balances will be billed to secondary insurers. If co-insurance is still owed to Florida Hospital Flagler and/or physician, you will be billed. You may request an estimate of this amount of co-insurance liability by contacting your physician's office.

I have read the foregoing and understand that I will incur a liability to Florida Hospital Flagler for Medicare co-insurance as permitted by law.

Signature of Patient or Authorized Representative

Date

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name: _____ Date of Birth _____

Physician: _____ Medical Record #: _____

- I AM ENTITLED TO MEDICARE BENEFITS:
 NO - RETURN FORM TO THE FRONT DESK
 YES - PROCEED TO SECTION I.

SECTION I

Select the ONE statement that is true for you:

- I am over 65 and married... **Proceed to section II**
 I am over 65 and not married (includes widowed)... **Proceed to section III**
 I am under 65, Disabled and currently employed... **Proceed to section IV**
 I am under 65, Disabled and unemployed...

Disability Date: _____ **IV Proceed to section**

SECTION II

Select the one statement that is true for you:

- My spouse and I are both fully retired
The date of my retirement: _____
The date of my spouse's retirement: _____...**Proceed to section V**
 I work full or part-time (my spouse is retired) for a company with:
 LESS than 20 employees... **Proceed to section V**
 MORE than 20 employees... **Proceed to section IV**
 My spouse works full or part-time (I am retired) for a company with:
 LESS than 20 employees... **Proceed to section V**
 MORE than 20 employees... **Proceed to section IV**

SECTION III

Select the one statement that is true for you:

- I am fully retired...
The date of my retirement: _____...**Proceed to section V**
 I work full or part-time for a company with:
 LESS than 20 employees... **Proceed to section V**
 MORE than 20 employees... **Proceed to section IV**

SECTION IV

Select the one statement that is true for you: *(This does not apply to supplemental plans or employer plans offered during retirement.)*

- I have health care coverage through my employer. NO YES
I have health care coverage through someone else. NO YES

IF YES, list name of guardian and relationship: _____

Proceed to Section V

Patient Name: _____ Date of Birth _____

SECTION V

Is this visit related to an injury due to a fall?

YES - Did the accident occur in... your home public location other

Date of Accident: _____

OR

Is this visit related to an illness/injury due to an automobile accident?

YES - Date of Accident: _____

RETURN TO FRONT DESK AND PRESENT YOUR AUTOMOBILE INSURANCE CARD.

NO **Proceed to Section VI**

SECTION VI

Indicate which statements apply to you.

I am entitled to Worker's Compensation for this service.

I am entitled to Black Lung benefits.

I am entitled VA benefits.

I am entitled ESRD benefits.

I am entitled COBRA benefits.

I am entitled to other Federal benefits. (UMWA, Gov't research programs, Hospice) Please Explain: _____

Patient Signature _____ Date _____

Staff Signature _____ Date _____

