ORTHO SPINE AMERICA

John G. Atwater, MD-PA
Sheree Ewar, ARNP

Patient Registration Form

MRN _____

PATIENT INFORMATION

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Other Name(s) Used	E-mail Address

Gender M F	SSN	Preferred Language	Driver's License

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Life Partner

Preferred Contact
- ☐ Mail
- ☐ Home Phone
- ☐ Day Phone
- ☐ Cell Phone
- ☐ Patient Portal (MyChart)

Ethnicity
- ☐ Cambodian
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Non-Hispanic

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other

Employer

☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Student ☐ Other _____

Primary Care Provider	Referring Provider

How did the injury occur? ☐ Auto ☐ Work ☐ Personal ☐ Other _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Patient is Subscriber / Policy Holder Y N	Patient is Subscriber / Policy Holder Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber / Policy Holder	Relationship to Patient
Address	City
SSN	Date of Birth
His or Her Employer	Work Phone Number

RESPONSIBLE PARTY (Guarantor)				
First Name	Last Name		MI	Date of Birth
Address	City		State	Zip
Please check primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐	
SSN	Relationship to Patient	Preferred Language	Driver's License	

EMERGENCY CONTACT (for minor child, this section may be used for other parent)				
First Name	Last Name		MI	Date of Birth
Address	City		State	Zip
Please check primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐	

I/We do hereby consent to and authorize the performance of all treatments, surgeries, and medical services deemed advisable by the physicians and staff of John G. Atwater, MD-PA, Sheree Ewar, ARNP, and affiliated medical groups to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I fully understand this agreement and consent will continue until canceled by me in writing.

Signature _____ Relationship to Patient _____

Printed Name _____

ORTHO SPINE AMERICA

John G. Atwater, MD-PA
Sheree Ewar, ARNP

1260 37th Street - Ste 102 Vero Beach, FL 32960

Ph: 772-213-9809 | Fax: 772-213-9812

www.osamds.com

John G. Atwater, MD-PA • Sheree Ewar, ARNP

Request for Access to/Authorization for Use and Disclosure of Protected Health Information

PATIENT NAME _____

DATE OF BIRTH ___/___/_____ **FORMER NAME** _____ **MEDICAL RECORD#** _____

ADDRESS _____ **CITY** _____ **STATE** ____ **ZIP** _____

DAY PHONE _____ **EVENING PHONE** _____

Type of access requested: ☐ Inspection ☐ Hard Copy ☐ Electronic Copy **(only available if SSM Health maintains the requested information electronically)**

I Hereby Authorize:

NAME	
ADDRESS	
CITY/STATE/ZIP	
PHONE	
FAX	

To Disclose My Protected Health Information To:

NAME	
ADDRESS	
Relationship	
CITY/STATE/ZIP	
PHONE	
FAX	

METHOD OF DELIVERY OF RECORDS *(please select one)*:

☐ Mail ☐ Hold for pick up by: _____

INFORMATION TO BE RELEASED *(DATES)*:

☐ Discharge Summary _____
☐ History & Physical Exam _____
☐ Progress Notes _____
☐ Lab Reports _____
☐ X-Ray Reports _____
☐ Medication Records _____
☐ Detailed Bill _____
☐ Other (specify content and dates): _____

I specifically authorize the release of information relating to:

- Substance abuse (including alcohol/drug abuse)
- Mental health or behavioral health
- HIV related information (AIDS-related testing)

x _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE / DATE

PURPOSE OF DISCLOSURE:

☐ Changing physicians ☐ Consultation ☐ Insurance/Workers' Compensation ☐ School ☐ Research ☐ At request of individual
☐ Legal (specify): _____
☐ Other (specify): _____
☐ For personal access (specify): ☐ Copy ☐ Inspection ☐ Summary

ACKNOWLEDGMENT OF UNDERSTANDING:

- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal or State privacy regulations.
- By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that if I am being requested to authorize a use or disclosure that, upon request, I will get a copy of this form after I sign it.
- I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.
- I understand that I may be required to pay the cost of creating paper copies or electronic media, mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations.

I acknowledge and understand the terms of this **Request for Access to/Authorization for Use and Disclosure of Protected Health Information**.

Patient/Legal Representative Signature _____ **DATE** _____

Relationship _____

Records Received by _____ **DATE** _____ **ID VERIFIED** _____

ORTHO SPINE AMERICA

Initial Visit Questionnaire

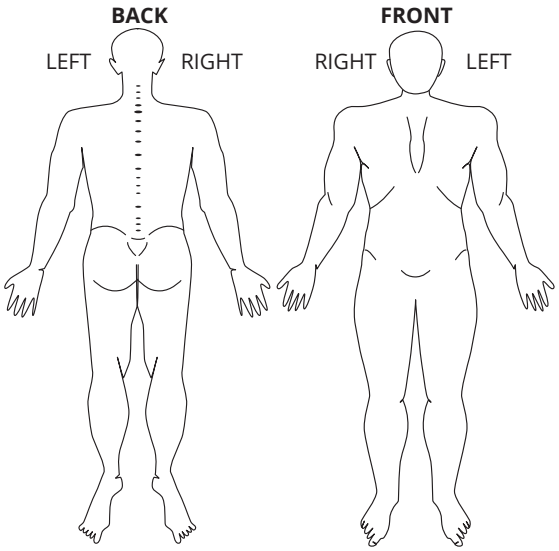
NAME _____ DOB _____ DATE _____

Ht _____ Wt _____ BP _____

1. Please circle the reason for your visit today:

PAIN **WEAKNESS** **NUMBNESS** **STIFFNESS** **SWELLING**

2. Where are your symptoms located? (Please mark "X" for pain and "O" for numbness/tingling)



3. When did your symptoms start? _____

4. Did you have an injury or a fall? _____ If yes, is the injury work related? _____

5. Are your symptoms a result of an automobile accident? _____

6. What is your current pain level? **(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)**

7. Describe your pain: ☐ **ACHING** ☐ **BURNING** ☐ **DULL** ☐ **SHARP** ☐ **STABBING** ☐ **THROBBING**

8. Are your normal daily activities restricted due to your current symptoms? _____

9. What exacerbates your pain? _____

10. What relieves your pain? _____

11. Have you had treatment for this problem prior to today's visit? _____

☐ **ER** ☐ **PHYSICIAN** ☐ **INJECTION** ☐ **PT** ☐ **SURGERY** ☐ **OTHER** _____

12. Were the treatments helpful? _____

13. Are you currently taking any medications for this problem? Please list: _____

14. Have you had any diagnostic studies including X-rays, MRI, CT scans or nerve conduction studies?

_____ Where? _____

15. Are you being treated for any chronic medical conditions? _____

16. Are you currently taking blood thinning medications? _____

17. What is your present work status? _____

18. What is your preferred pharmacy? _____

ORTHO SPINE AMERICA

John G. Atwater, MD-PA
Sheree Ewar, ARNP

STATEMENT OF POLICIES

Providing excellent orthopedic care to our patients - regardless of insurance coverage - is something we are committed to, so please read this information carefully before signing and ask the receptionist if you have any questions.

ALL INSURANCE POLICY HOLDERS

Our business relationship is with our patients, not insurance companies; however, the insurance carriers have considerable influence in this relationship. In order to file a claim with your insurance company, we must have valid insurance cards on file. It is the patient's responsibility to update our staff on any insurance changes at every visit. If current insurance information is not given to our office, you will be responsible for payment in full for any services rendered on that day.

We will file your claims with your insurance companies. All charges incurred are your responsibility if your insurance company chooses not to pay for any reason. It's important for you to read your policy handbook and to understand which services may be considered "not medically necessary." The physician may perform services that fall within this category, and this does not relieve you of the financial obligation.

Any co-pay required by an insurance company must be paid in full at the time of service. Because this is an insurance requirement, we cannot bill you for this co-pay. If you are unable to pay your co-pay, you may be required to reschedule your appointment. Any previous balance is expected to be paid at the time of service.

If you are unable to keep a scheduled clinic appointment, please call during normal business hours, 24 hours in advance, to cancel the appointment. There will be a charge of $25.00 for no-shows & cancellations within the 24-hour period.

MEDICARE PATIENTS

Secondary insurance will be filed by this office, if we have a contract with your insurance, as a courtesy. If your secondary insurance is out of network, the remaining 20% will be due at the time of service. If the secondary amount remains unpaid by your insurance after 60 days, the unpaid balance will become your responsibility.

UNINSURED OR OUT OF NETWORK PATIENTS

If our practice does not have a contract with your insurance company, or if you are an uninsured patient, you (or responsible party for minors) are responsible for payment in full at the time the services are rendered. There may be a need to arrange a payment plan for any elective surgical procedure at the time the procedure is scheduled. Customarily, our policy requires 50% of the surgeon's fee paid prior to scheduling.

PRESCRIPTION POLICIES:.

If you are in need of a refill, please call the office phone during normal business hours, which are M-Th 8am-5pm. Please allow up to 48 hours to process the request. Replies to requests will only be called in during normal business hours. No refills will be called in after 5pm on weekdays, or on the weekends.

RETURNED CHECKS

Any returned check will be subject to a $35.00 service fee. This will need to be resolved before any future treatment is scheduled.

PAPERWORK

There is a $15.00 charge for any additional paperwork unassociated with your health insurance. Examples: disability forms, FMLA forms, work stats notes, etc. There is a fee for any reports or records requested by attorneys, insurance companies, disability companies, etc. The charge will be determined by the information requested.

There is a charge to have X-ray & MRI images copied. This fee is $10.00 for a disc.

SUPPLIES

All supplies are non-returnable/non-refundable.

Please be sure you want the supply offered before you take the item from our office. Your insurance may not cover the cost of the supply (depending on the provisions of your policy). Supplies may also be purchased from other vendors, but this office cannot be responsible for fitting/adjusting these items. Please ask the reception desk if you have questions about the cost of the supply item.

I acknowledge that I have carefully read and understand the statement of policies and agree to abide by them.

Name (please print) - Parent name if patient is a minor _____

Date of Birth _____

Signature _____ Date _____

ORTHO SPINE AMERICA

John G. Atwater, MD-PA
Sheree Ewar, ARNP

Name _____ DOB _____

Authorization and Assignment of Benefits

For the services rendered and those about to be rendered, I hereby assign to John G. Atwater, MD-PA and Sheree Ewar, ARNP all medical benefits otherwise payable to me under the described policy not to exceed the charges made to such service. I further authorize the insurance company to pay said benefits directly to John G. Atwater, MD-PA and Sheree Ewar, ARNP, and further direct that they make no payment to me. In the event that I receive payment from the insurance company, I agree to endorse such payment to John G. Atwater, MD-PA or Sheree Ewar, ARNP. I understand that I am directly and primarily responsible to John G. Atwater, MD-PA and Sheree Ewar, ARNP for the usual and customary fee for the services rendered to me. I realize that if my insurance company fails to pay or there is a delay (more than 90 days in their paying), it is my sole responsibility to promptly pay my bill directly. I also realize that any services not covered under my insurance company will be my responsibility to pay in full. I further understand and agree if I fail to make prompt and timely payments, I will be directly responsible for any and all costs of collection, including filing fees and reasonable attorney fees. I hereby authorize John G. Atwater, MD-PA and Sheree Ewar, ARNP to release to my insurance company any information acquired, including diagnosis and the records in the course of my treatment.

Signature _____ Date _____

Medicare Certification for Payment: (Lifetime Authorization)

I certify that the information given by me in applying for payment under the title XVII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or related to Medicare claims. I request that the payment of authorized benefits be payable to John G. Atwater, MD-PA or Sheree Ewar, ARNP on my behalf. I also assign the benefits payable for physician service to the physician furnishing the services and authorize such physician to submit a claim to Medicare on my behalf.

Signature _____ Date _____

ORTHO SPINE AMERICA

Patient HIPAA Acknowledgment and Designation Disclosure Form

I. ACKNOWLEDGMENT OF PRACTICE'S HIPAA PRIVACY NOTICE:

By subscribing my name below, I acknowledge that _____ has provided a copy of the HIPAA Privacy Notice, and that I have read (or had the opportunity to read if I so choose) and understand my rights, asked questions regarding my rights, received answers to my satisfaction, and I agree to its terms.

Patient Name _____ Signature _____
Please Print **Patient / Parent / Guardian**

Phone _____ Date _____

II. DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ Last four digits of his/her SSN or password (required): _____ Phone: _____

Print Name: _____ Last four digits of his/her SSN or password (required): _____ Phone: _____

Print Name: _____ Last four digits of his/her SSN or password (required): _____ Phone: _____

I, _____ , acting on behalf of my minor son/daughter _____
Parent/Guardian (print) **Name of Patient**

as legal Personal Representative in all matters. If representative is a court appointed legal guardian, a copy of court documents must be provided and kept in medical records.

III. REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternativemeans that I have listed below.

Home / Cell Telephone Number:

_____

☐ **OK to leave message with detailed information**
☐ **Leave message with call back numbers only**

Written Communication Address:

_____

☐ **OK to mail to address listed above**
☐ **E-mail me at:** _____

Work Telephone Number:

_____

☐ **OK to leave message with detailed information**
☐ **Leave message with call back numbers only**

Fax Communication:

_____

☐ **OK to Fax to the number listed above**

Other: _____

Patient Name _____ Signature _____ Date _____
Please Print **Patient / Parent / Guardian**

Witness _____ Date _____

ORTHO SPINE AMERICA

John G. Atwater, MD-PA
Sheree Ewar, ARNP

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

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.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this notice, and we reserve the right to change the terms of this notice. We will post a revised notice and make paper electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

Your Rights:

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices:

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services
- Raise funds

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For Treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a fracture and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment {such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To Obtain Payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an Insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For Health Care Operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or attorney for audit purposes. In addition, unless you object, we may use your health information to send you appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us and then send you a reminder to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service may interest you.

To Help with Community Outreach: Furthermore, we may want to use information found in your medical record, such as your name, address, phone number and treatment dates, to contact you for our fundraising purposes. For example, in order to provide more charity care or otherwise improve the health of your community, we may want to raise additional money and therefore may contact you for a donation. You have the right to opt out of these communications at any time.

To Comply with the Law and Address Workers' Compensation, Law Enforcement, and Other Government Requests: We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons or similar process.

We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to court orders. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.

In order to avoid a serious threat to health or safety, we may disclose medical Information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.

We may disclose your medical information as authorized by law relating to workers compensation or similar programs.

We may disclose your medical information in the course of certain judicial or administrative proceedings.

To Help with Public Health and Safety Issues: We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

To Work with a Medical Examiner, Organ Procurement Organization, or Funeral Director: We may disclose medical information relating to an individual death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

To Do Research: In certain circumstances, we may disclose medical information to assist medical/psychiatric research.

To Comply with Privacy Rules: If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about you to those people. We may also share medical information with these people to notify them about your location, general condition, or death.

Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission in writing at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact the Privacy Officer. A short list of your rights are listed on page one, and below we have elaborated on your rights. Specifically, the following:

- You have the right to ask that we limit how we use or disclose your medical information. For example, for services you request no insurance claim be filed and for which you pay privately, you have the right to restrict disclosures for these services for which you paid out of pocket. You have the right to ask that we send you information at an alternative address or by an alternative means. We will consider your request, but we are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so. To request confidential communications, you must make your request in writing, Attn: Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason

as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.

- In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization, or for other reasons for which we are not required to keep a record of disclosers. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.
- You have a right to receive a paper copy of this Notice and/or an electronic copy from our website, osamds.com/privacy-notice. If you have received an electronic copy, we will provide you with a paper copy of the notice upon request.

IV. Questions and Complaints.

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us at the office via phone or by mail.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer. You also may file a written complaint with the Secretary of the U.S Department of Health and Human Services at the Office for Civil Rights' Region IV office. We will provide the mailing address at your request.

We will take no retaliatory action against you if you make any complaints, whether to us or to the Department of Health and Human Services. We support your right to the privacy of your health information.

If you have questions about this Notice or any complaints about our privacy practices, please contact our Privacy Officer, either by phone or in writing at:

John G. Atwater, MD-PA
Sheree Ewar, ARNP
Attn: Privacy Officer
1260 37th street Suite 102
Vero Beach, FL 32960
(772) 213-9809

Effective Date: This notice was effective of February 25, 2019.