ORTHOPAEDIC ASSOCIATES
The Strength of Experience

Fort Walton Beach
1034 Mar Walt Drive
Fort Walton Beach, FL 32547

Destin
36474C Emerald Coast Parkway, Suite 3101
Destin, FL 32541

Niceville
554-D Twin Cities Boulevard
Niceville, FL 32578

PATIENT INFORMATION: **E-MAIL:**_____

LAST NAME:_____ **FIRST:**_____ **M:**_____

LOCAL ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

MAILING ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

SOCIAL SECURITY NO:_____ **DATE OF BIRTH:**_____ **AGE:**_____

HOME PHONE:_____ **SEX: □ M □ F** **MARITAL STATUS: □ S □ M □ D □ W**

EMERGENCY CONTACT PERSON:_____ **RELATION:**_____

EMERGENCY NUMBER:_____

EMPLOYMENT INFORMATION: PATIENT OR PARENT

EMPLOYER:_____ **OCCUPATION:**_____ **EMPLOYEE NAME:**_____

ADDRESS:_____ **CITY:**_____ **STATE:**_____

ZIP CODE:_____ **WORK PHONE:**_____ **EXT:**_____

RESPONSIBLE PARTY (If different from above or if patient is a minor):

NAME:_____ **SOCIAL SECURITY:**_____

MAILING ADDRESS:_____

PHONE:_____ **DATE OF BIRTH:**_____ **MARITAL STATUS:**_____

RELATION TO PATIENT: □ SPOUSE □ PARENT □ STEP-PARENT □ OTHER

HOW DID YOU HEAR ABOUT US: _____

PRIMARY CARE PHYSICIAN: _____ **REFERRING PHYSICIAN:**_____

PREFERRED PHARMACY: _____

PRIMARY INSURANCE: (Please provide copy of insurance card)

Name of Insurance _____ **Policy#** _____ **Group#** _____

Address of Insurance Company_____

Name of Policy Holder _____ **Relationship to Patient** _____

SECONDARY INSURANCE: (If applicable)

Name of Insurance _____ **Policy#** _____ **Group#** _____

Address of Insurance Company_____

Name of Policy Holder _____ **Relationship to Patient** _____

PATIENT SIGNATURE: _____ **DATE:** _____

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General Information

Orthopaedic Care

Orthopaedic care deals with issues related to the musculoskeletal system including; bones, joints, muscles, tendons, and ligaments that are affected by injury or aging.

All our physicians are board certified, and most are active surgeons. You will have a primary physician within our group. Due to areas of specialization, you may, over time, work with more than one of our physicians. One of our physicians is "on-call" every night to respond to emergencies.

Several of our physicians have a Physician Assistant (PA) that helps provide exceptional patient care during clinic and surgery. Each PA is a licensed healthcare professional with prescriptive medication authority, certified by the National Commission on Certification of Physician Assistants. All our PA's have specialty training in orthopedics.

Appointments

Appointments may be scheduled:

- **Phone** - between 8 AM and 5 PM, Monday thru Friday
- **On-line** - an appointment request may be submitted 24/7 at orthoassociates.net, on the header of each page: "Click Here to Request an Appointment"
- **Email** - an appointment request may be submitted 24/7 via sportsmed@orthoassociates.net.

When making an appointment, please specify which physician and which clinic location you are requesting. On your first visit, please remember to bring with you X-rays and/or MRI's specific to your visit.

If you are unable to attend your scheduled appointment, please contact us within 24 hours of your appointment at 850-863-2153.

Patient Information

Every patient completes a patient information questionnaire on their first visit, and then updates this information periodically, at least annually. This information becomes an essential part of your permanent medical record history.

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General Information

Emergencies

Should you have an emergency, please go directly to the nearest emergency room. Please dial 911 if you need assistance getting to the nearest emergency room.

Urgent Needs

At Night - Should you have an urgent non-emergency need for help during the night, please call our general number 850-863-2153. The answering service will contact the physician on-call.

During Business Hours – Please call our general number 850-863-2153 and we will do everything we can to address your concerns.

Billing

It is expected you will pay your portion of the clinic visit the day of your visit. We accept cash, checks, Visa, MasterCard, American Express, and Discover. Our receptionists have our clinic visit fee information, and will provide that information to you, upon request, prior to your examination. For specific billing questions, please call our billing specialists at 850-315-9244.

Insurance

We are contracted with most major commercial insurance plans, as well as Tricare Prime, Tricare Standard, and Tricare For-Life, for our military patients. Our billing process will include your primary and secondary insurance providers. For specific insurance questions, please call our Billing Specialists at 850-315-9244.

Prescriptions

New Medication - We will not prescribe new medications without an examination.

Refills – When you are under continuing care, certain medications will be refilled with a phone request. This request may take 3 business days to complete.

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General Information

Your Medical Record

We use an electronic medical record system that holds the entire history of your medical care that has been provided by our physicians and PA's. All of this information is confidential and will not be given to anyone without your specific instructions to do so. You are always welcome to request a copy of your medical record, by completing a medical release request. HIPAA requires a signed release from the patient to release records to other physicians, and even the patient. This request may take 3-5 business days to complete. You may also request a patient summary after each clinical visit when you check out.

Your X-rays/MRIs

Your medical record also includes the X-rays and MRIs that are a part of the care our physicians and PAs have provided to you. Should you need a copy of your X-rays/MRIs, we will provide them to you on a CD for a fee of $5. To request X-rays and/or MRIs, please call 850-863-2153. This request may take 3 business days to complete.

Patient Advocate

Should you have any questions or concerns that you feel have not been handled appropriately, please contact our patient advocate Mark Trippel at 850-315-9234.

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Contact Information

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1034 Mar Walt Drive
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850-863-2153

Destin
36474C Emerald Coast Parkway
Suite 3101
Destin, FL 32541

850-837-3926

Niceville
554-D Twin Cities Blvd.
Niceville, FL 32578

850-678-2249

Directions to our new Destin location:

Heading East on 98 – our office is 1 mile past the Destin Commons on the right side (The Old South Center). We are on the first floor of Building C (third building towards the back).

Heading West on 98 – at Tequesta Drive, make a U-turn. Our office will be on the right side (The Old South Center). We are on the first floor of Building C (third building towards the back).

Thank you for choosing Orthopaedic Associates for your orthopedic care.

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Cities Boulevard
Niceville, FL 32578

Authorization for Release Of Medical Information

I, _____ give Orthopaedic Associates permission to release and/or discuss my medical records or conditions with the following individual(s):

Name:	Relationship to the patient:
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient signature Date

_____
Witness signature

Orthopaedic Associates
Authorization/Consent Acknowledgment

RELEASE OF INFORMATION:
I acknowledge that records concerning the patient are the property of Orthopaedic Associates and are maintained for the use and benefit of Orthopaedic Associates and its staff in providing care and treatment to the patient. I hereby authorize Orthopaedic Associates to disclose all or any part of my patient record to my referring physician, primary care physician, admitting physician, consulting physician and /or hospital based physician. I further authorize Orthopaedic Associates and providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to Orthopaedic Associates, myself or a family member of mine, for all or part of Orthopaedic Associates charges, including but not limited to, hospital or medical service companies, insurance companies, Worker's Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations.

ASSIGNMENT OF BENEFITS:
I hereby request that my insurance company pay any/all benefits due and payable under the terms of my contract to Orthopaedic Associates. I hereby authorize Orthopaedic Associates to release such information as may be necessary for the completion of any insurance claim. Any parent or guardian who brings in a minor for treatment is and hereby agrees to be financially responsible for paying the minor's account in full. In the event that an account is referred to an outside collection agency and/or small claims suit, the responsible party will be subject to paying any/all fees associated with the collection processes. I hereby authorize Orthopaedic Associates to obtain a credit history for such collection purposes. In the event that our office must commence legal action against the patient for payment of the patient's balance, the patient agrees to be liable for attorney fees and costs incurred by the office as part of such action and any attorney fees and costs incurred by this office in order to recover on the resulting judgment.

MEDICARE: (for Medicare patients only)
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 all medical records to be released to the Social Security Administration or its intermediaries or carriers and request that payment of authorized benefits be made on my behalf and I assign the benefits payable for physician service to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

AUTHORIZATION FOR MEDICAL CARE AND TREATMENT:

1. I recognize that a medical condition may exists requiring medical care and I voluntarily consent to such medical care, treatment and diagnostic procedures by Orthopaedic Associates and its medical and professional staffs, associates and agents as deemed necessary.
2. I hereby authorize my physician, as provided by law to furnish medical treatment, diagnostic procedures, x-ray/MRI diagnosis or therapy as he/she considers necessary and proper in the treatment process.
3. I am aware that the practice of medicine and surgery, and the administration of medical care, are not exact sciences and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, treatments, examinations or care undertaken with Orthopaedic Associates.

ACKNOWLEDGMENT OF HEALTH INFORMATION PRACTICES
Orthopaedic Associates Notice of Privacy Practices provides information about how health information about patients may be used and disclosed. I have been offered and opportunity to review the Notice of Privacy Practices before signing this consent. I understand the terms of the Notice may change and that a copy of the revised Notice will be posted in all Orthopaedic Associates facilities. By signing this form, I acknowledge that I have been offered and or received Orthopaedic Associates' Notice of Privacy Practices.

The contents of the form have been fully explained to me and I have been given the opportunity to ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of this form in its entirety.

Termination of care may result from failure to cooperate and/or comply with Orthopaedic Associates Policy and Procedures as well as failure to cooperate and/or comply with medical care and/or treatment deemed necessary by Orthopaedic Associates' physicians and medical staff.

_____ _____

Signature of Patient or Authorize Representative/Date Witness/Date

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MEDICATION RECORD

Today's Date: _____

Patient Name (Last): _____

Patient Name (First): _____ Middle Initial: _____

Height: _____ Weight: _____ Date of Birth: _____

Patient's Family Doctor: _____

Preferred Pharmacy: _____ Location: _____

Medication (including over the counter & supplements)	Frequency

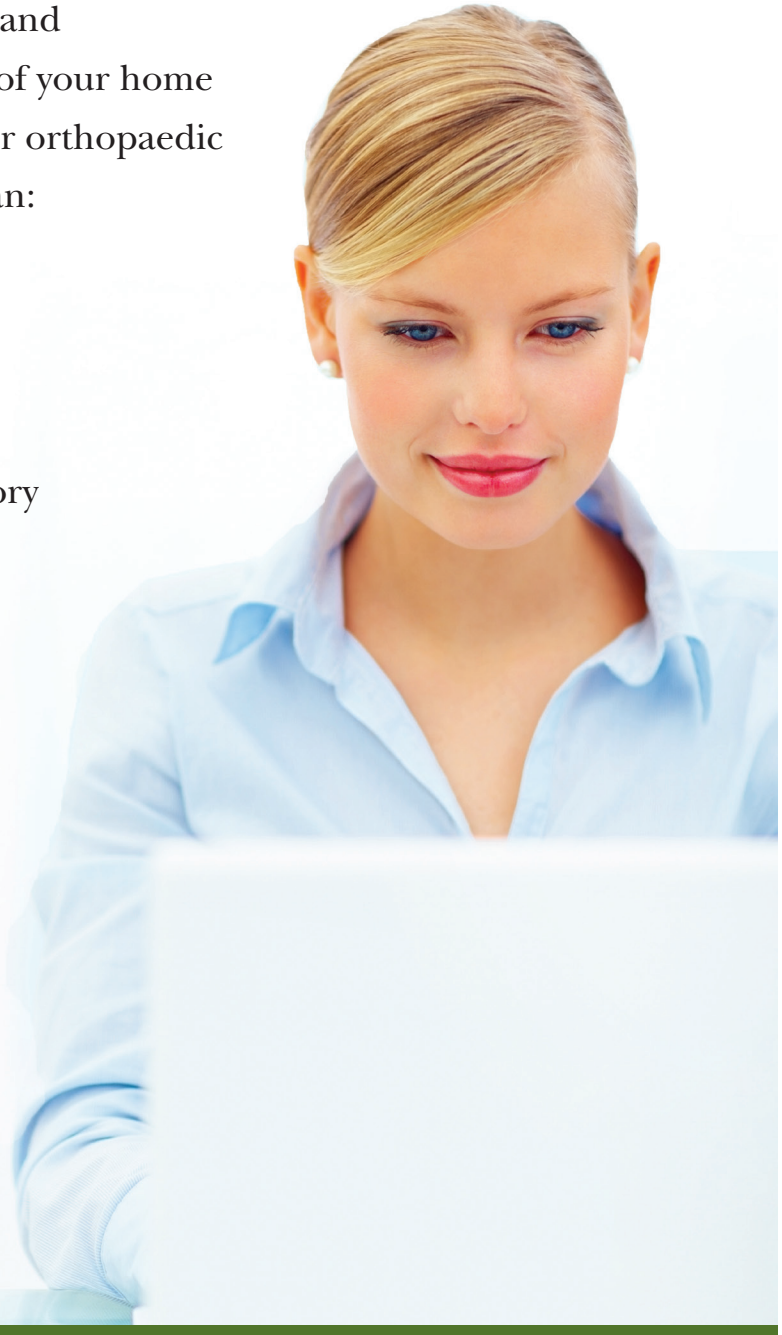
William R. Marshall, M.D. | Theodore I. Macey, M.D. | Jason W. Thackeray, M.D., F.A.C.S. | Mark J. Tenholder, M.D. | James F. Watt, D.O.
Joseph R. Agostinelli, D.P.M. | Michael L. Shawbitz, M.D. | Scot T. Williams, P.A.-C. | Rick Sneller, P.A.-C.

P 850-863-2153 F 850-863-8085 www.orthoassociates.net

Our online Patient Portal is easy and convenient!

Access your Orthopaedic Associates medical and appointment information from the comfort of your home or office. You can easily manage many of your orthopaedic needs. With our online Patient Portal, you can:

- View your patient summary
- View your visit summary
- Complete and update your medical history
- Make an appointment



Try the Orthopaedic Associates Patient Portal by adding your email to your account at the front desk today!

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Correspondence Authorization

I wish to be contacted in the following manner (check all that apply):

- ☐ **Home phone** _____
- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

- ☐ **Cell phone** _____
- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

- ☐ **Work phone** _____
- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

- ☐ **Written Communication:**
- ☐ Can mail to Home address
- ☐ Can mail to work address
- ☐ Can fax to this number _____
- ☐ Can email to the email address _____

- ☐ **Appointment Reminders:**
- ☐ Home phone
- ☐ Cell phone
- ☐ Text
- ☐ Email

_____ _____
Patient or Legal Guardian if a minor Date

The patient's condition prohibits the individual from signing at this time. This information will be obtained as reasonably practical after the patient's condition improves.

_____ _____
Orthopaedic Associates Representative Date

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Patient Pain Medication Consultation Form

Pain Medication

- You may be prescribed pain medication to help control pain for the next 7 to 10 days following surgery or for an acute painful condition. After 10 days, the dosage of narcotics will be decreased over a 2 to 4 week period. You will then be placed on non-narcotics such as anti-inflammatory medication. This treatment period will be discussed at your follow up visit.

After Surgery

- For all patients who continue to have pain following surgery or have a condition that requires ongoing pain medication, the office has a consulting service to help with chronic pain. Chronic pain management patients will be referred to this service.

Refills

- You are expected to take your medication exactly as it is prescribed. In the event that you run out of this medication early, the office will not be able to refill the prescription unless your doctor or physician's assistant examines you.
- The office will not re-write prescriptions for pain medication that are lost, stolen, destroyed, or misplaced.
- To get a prescription refill, please call the main office at (850)315-9260 and leave the information on the prescription line. Please allow 48 to 72 business hours, excluding holidays and weekends to process the request. Once the refill request is processed, the patient will receive a call. Please check with your pharmacy before calling the office to check the status of a refill request.

_____ _____

Print Name Signature

_____ _____

Date Authorized Representative