South Miami
Walk-In Orthopedics
& Sports Medicine

5966 S. Dixie Hwy, Suite # 401
Miami, Florida 33143
Phone: (786) 453-2667
Fax: (786) 768-2066

Patient Name: _____ **Date of Birth:** _____
First **MI** **Last**

*Address: _____
*City, State, Zip: _____
Home Phone: _____
* Cell Phone: _____
Work Phone: _____
* Email: _____

* Sex: ☐M ☐F

☐ Single ☐ Married ☐Divorced ☐ Widowed ☐Separated.

Primary Care Physician: _____

*Emergency Contact #: _____
Name / Relationship: _____

Patient Occupation _____
Employer _____

How Did You Hear About us? Please check all that apply:
☐ Google ☐Facebook ☐Other Internet Source
☐ Family/Friend ☐ Hospital ☐Doctor ** Dr. _____

Medical Insurance: _____
ID#_____

Were You Involved in An **Accident?** □ **Yes** □ **No Date:** _____
If Yes: which one: ☐ **Auto** ☐ **Slip & Fall** ☐ **Workman Comp**
Auto/Wkmn Comp Ins. Company: _____
Claim Number: _____
Adjuster name: _____ **Phone#:** _____

If applicable:
Attorney Name: _____
Address: _____
City, State, Zip: _____
Phone #: _____

A. AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF MEDICARE BENEFITS:
I authorize and holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Furthermore, I request that payment under the medical insurance benefits either to myself or to the party that accepts assignment below. I request that the medical insurance program be made to me or to South Miami and South Florida Walk-in Orthopedics LLC. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical information about me to release it to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I understand that this is a lifetime signature authorization.
Please initial here _____ *

B. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION:
I authorize South Miami and South Florida Walk-in Orthopedics LLC to release to your company or its representatives any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care. I also authorize and request your company to pay directly to the above-named doctor the amount due to me in my pending claim for Medical or Surgical treatment or service by reason of such treatment or service.
Please initial here _____ *

C. FINANCIAL RESPONSIBILITY:
I understand that I am financially responsible for charges not covered by this authorization and for the guarantees stated above. Also, I understand that it is my responsibility as the insured to pay all copayments and co-insurance at the time of the visit.
Please initial here _____ *

D. REFERRALS AND AUTHORIZATIONS:
I understand that it is my responsibility to obtain all authorizations or referrals necessary for treatment. If an authorization or referral is not obtained by the time of the visit, the visit may be rescheduled once proper authorization has been obtained.
Please initial here _____ *

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E. CONSENT TO TREAT:

I authorize South Miami and South Florida Walk-in Orthopedics LLC to take x-rays, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I authorize the doctor(s) to perform all recommended treatment mutually agreed upon. I also agree with the use of appropriate mediation and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. I understand that all responsibility for payment for medical services provided in this office for myself or my dependents is mine. I understand that payment is due and payable at the time services are rendered unless other arrangements have been made. I understand that it is my responsibility to advise your office of any changes to the information contained in this form. **Please initial here** _____ *

F. TREATMENT OF MINORS:

I, as a parent/legal guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during such treatment, and waive any claim I may have resulting from failure to do so.
Please initial here _____ *

G. LIABILITY / WAIVER AND RELEASE:

I know and agree that South Miami and South Florida Walk-in Orthopedics LLC is not responsible for any loss or damage to personal valuables. I hereby release, discharge, and acquit South Miami and South Florida Walk-in Orthopedics LLC, its agents, representatives, affiliates, employees, or of and from any and all liability claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and /or medical services, including but not limited to ambulance, EMT, or Physician service.
Please initial here _____ *

H. INSURANCE:

As a service to you, we will file insurance claims for each of your policies. You will need to provide the clinic with all necessary insurance information. Please bring your insurance cards to every visit. Please note, your insurance policy is an agreement between you and your insurance company to pay certain amounts for your medical care. Your physician's bill is an agreement between you and South Miami and South Florida Walk-in Orthopedics LLC. You are responsible for full payment of your account, regardless of the status of your insurance claim. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. **Please initial here** _____ *

- For patients without health insurance, payment is REQUIRED at the time of your visit. **Please initial here if applicable** _____ *

I. AUTHORIZATION TO DISCUSS MEDICAL INFORMATION:

I give SMWIO permission to share appointment, medical and billing information with the listed person(s) below:

_____

J. CANCELLATION/NO SHOW POLICY:

Please be advised that SMWIO/ SFWIO requires a 24-hour notice to reschedule/cancel your appointment. If you fail to do so within the 24-hour time, you will be billed a $25 fee. Please contact the office immediately to reschedule/cancel your appointment(s). Please initial here to indicate that you have read and understood this policy. **Please initial here** _____ *

K. NOTICE OF PRIVACY:

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES. **Please initial here** _____ *

I, THE PATIENT/GUARANTOR/LEGAL GUARDIAN, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND INSURANCE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I AUTHORIZE PHYSICIAN AND INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR IT'S REPRESENTATIVE.

***PATIENT/GUARANTOR SIGNATURE x**_____ **DATE:** _____

***GUARDIAN SIGNATURE x**_____ **DATE:** _____

Patient Name: _____

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History & Physical

Patient Name: _____ DOB: _____ Reason for Visit: _____
If an injury: how did it happen (check one): ☐ Slip & Fall ☐ MVA ☐ Workman's comp ☐ Other: _____

Medical History: (check all that apply)

☐ Asthma
☐ Anxiety
☐ Anemia
☐ A-fib
☐ Arthritis
☐ Bipolar Disease
☐ COPD
☐ Cancer: _____
☐ Depression
☐ Diabetes
☐ Fracture
☐ Gout
☐ Heart Disease
☐ Heart Attack
☐ Hepatitis
☐ High Blood Pressure
☐ Headaches
☐ Multiple Myeloma
☐ MRSA
☐ Osteoarthritis
☐ Osteopenia
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Seizures
☐ Scoliosis
☐ Shingles
☐ Stroke
☐ Thyroid Disease
☐ Other: _____

Review of Systems: (check all that apply)

☐ Joint Pain ☐ Tingling ☐ Numbness ☐ Immunosuppression ☐ Joint Swelling
☐ Tremors ☐ Redness ☐ Leg Cramps ☐ Joint stiffness ☐ Blood Thinners
☐ Weight Loss ☐ Weight Gain ☐ Easy Bruising ☐ Shortness of Breath ☐ Rash
☐ Pacemaker ☐ Inflammation ☐ Delayed Wound Healing ☐ Other: _____

Family Medical History (check all that apply): ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Asthma ☐ Stroke ☐ Cancer
Smoking Status: ☐ Yes ☐ No if yes, how many packs/days: _____
Drinking Status: ☐ Occasionally ☐ Socially ☐ Daily: how many drinks? _____
**Do you have any allergies: ☐ No ☐ Yes: please list _____
Are you pregnant: ☐ Yes ☐ No

Daily Medication List:

Medication	Dosage

Past Surgeries

Procedure	Year

Pharmacy Name: _____ Address: _____ **Phone #:** _____

* **PATIENT SIGNATURE**: _____ **DATE:** _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

***SECTION A: Patient Giving Consent**

Name: _____ DOB: _____

Address: _____

Telephone: _____ S.S. #: _____

***SECTION B: To the Patient – Please read the following statements carefully**

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to conduct treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Privacy Practices

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ have had full opportunity to read and consider the contents of this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations.

* **PATIENT SIGNATURE:** _____ **DATE:** _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____ **DATE:** _____

Relationship to patient: ☐ Self ☐ Guardian ☐ Other _____

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Notice of Privacy Practices

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. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient's health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purpose and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purpose: *Required by Law:* We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. *Research:* We may use or disclose information for approved medical research. *Public Health Activities:* As required by law, we may disclose vital statistics, disease, information related to recalls of dangerous products, and similar information to public health authorities. *Health oversight:* We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities. *Judicial and administrative proceedings:* We may disclose information in response to an appropriate subpoena or court order. *Law enforcement purposes:* Subject to certain restrictions, we may disclose information required by law enforcement officials. *Deaths:* We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies. *Serious threat to health or safety:* We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. *Military and Special Government Functions:* If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes. *Workers Compensation:* We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

In any other situation we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights regarding your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights. *Request Restrictions:* You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. *Confidential Communications:* You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments. *Inspect and Obtain Copies:* In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies. *Amended Information:* If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information. *Accounting of Disclosures:* You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing **a** complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

HIPAA Compliance Officer
Fabian Morales MD and Michael Rosselli MD
5966 S Dixie Highway, Ste 401
South Miami, FL 33143
(786) 453-2667

Sports and Wellness
INSTITUTE OF MIAMI

5966 S. Dixie Hwy, Suite # 401
Miami, Florida 33143
Phone: (786) 453-2667
Fax: (786) 768-2066

Patient Name: _____ DOB: _____

CONSENT OF TREATMENT & AUTHORIZATION TO RELEASE INFORMATION

☐ I hereby authorize South Miami and South Florida Walk-in Orthopedics LLC, through its appropriate personnel, to perform or have performed upon me or the above-named patient, appropriate assessment and treatment procedures relating to the diagnosis stated by my referring physician.

☐ I further authorize South Miami and South Florida Walk-in Orthopedics LLC to release to appropriate agencies any information acquired during my or the above-named patient's examination and treatment.

PATIENT SIGNATURE: _____ **DATE:** _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____ Relationship to patient: ☐ Self ☐ Guardian ☐ Other

APPOINTMENT REMINDER AUTHORIZATION

☐ I authorize South Miami and South Florida Walk-in Orthopedics LLC to send me appointment reminders electronically via text message to my mobile phone number. I understand that this service is offered free of charge. However, standard text message rates from my mobile carrier may apply. Please activate text message reminders for the patient/mobile phone number below: **MOBILE #:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____ Relationship to patient: ☐ Self ☐ Guardian ☐ Other

Sports and Wellness
INSTITUTE OF MIAMI

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Wellness Questionnaire

Muscle Tone, Core Strength, and Body Wellness

1. Are you experiencing
    - muscle weakness or loss of tone? ☐ Yes ☐ No
    - building muscle and reducing fat without invasive procedures? ☐ Yes ☐ No
    - improving muscle tone and body contouring? ☐ Yes ☐ No
2. Are you interested in exploring treatments
    - improve your confidence and overall wellness? ☐ Yes ☐ No
    - Weight loss? ☐ Yes ☐ No

Pelvic Floor Health

3. Do you experience urinary incontinence, leakage, or weak pelvic muscles?
    - ☐ Yes ☐ No

Skin Health and Hair Loss

4. Do you have concerns about the following:
    - hair thinning or hair loss? ☐ Yes ☐ No
    - uneven skin texture, fine lines, or acne scars? ☐ Yes ☐ No

South Miami Walk-In Orthopedics & Sports Medicine

Sports and Wellness INSTITUTE OF MIAMI

South Florida Walk-In Orthopedics & Sports Medicine

5966 S. Dixie Hwy, Suite # 401
Miami, Florida 33143
Phone: (786) 453-2667
Fax: (786) 768-2066

www.miamisportsandwellness.com

Ph: (786) 408-8384
Fax: (786) 408-6350

11050 Griffin Road, Suite # 104
Davie, FL 33328
Phone: (954) 686-8850
Fax: (954) 686-8280

CONSENT FOR COMMUNICATION

Patient Name: _____Date of Birth: _____

Phone Number: _____Email Address: _____

By signing below, I, the undersigned, consent to receive marketing communications from South Miami Walk-In Orthopedics and Sports Medicine, including its associates, Dr. Michael Rosselli, Dr. Fabian Morales, Dr. Jiodany Perez, and the Sports and Wellness Institute of Miami.

Methods of Communication:

I understand that these communications may be delivered through the following methods:

- Email
- Text Messages (SMS)
- Phone Calls
- Direct Mail

Your Privacy:

The protection of your privacy is important to us. We are committed to safeguarding your personal information in accordance with applicable privacy laws and regulations. We will not sell or share your information with any third parties without your express consent.

I have read and understood the South Miami and South Florida Walk-in Orthopedics LLC Privacy Policy, it's available upon request and I agree to the terms outlined therein.

Right to Withdraw Consent:

I understand that I may withdraw my consent to receive marketing communications at any time by:

- Clicking the "unsubscribe" link at the bottom of any email communication.
- Replying "STOP" to any text message.

Consent:

By signing below, I acknowledge that I have read and understood this Consent for Marketing Communication. I understand that this consent is voluntary and that I may revoke it at any time without affecting my treatment or services received from South Miami Walk-In Orthopedics and Sports Medicine, its associates, or Sports and Wellness Institute of Miami.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____ Relationship to patient: ☐ Self ☐ Guardian ☐ Other