Hand & Wrist Center

A part of North Florida Surgeons

Richard D. Curtis, M.D. Jose A. Baez-Lorenzo, M.D.
1715 Eagle Harbor Pkwy., Suite-A
Fleming Island, Florida 32003
(904) 215-2422(p), (904) 215-6122(f)

Reviewed By: _____

Date: _____

Appt. Date: _____

Time: _____

Paperwork:
Mailed/Faxed/E-Mailed/Internet

LAST NAME: _____ FIRST NAME_____ M.I._____

DOB: _____ Age: _____ Sex: _____ SS#: _____

Patient Address: _____

City: _____ State: _____ Zip:_____

Primary # (cell/work/home): _____ E-Mail: _____

Secondary # (cell/work/home): _____ Employer: _____

Living Will: ☐ **Yes** ☐ **No** Marital Status (please check one): ☐ Married ☐ Divorced ☐ Single ☐ Widow ☐ Separated

Race (please check one): ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ American Indian ☐ Other

Reason For Visit:_____ **Right / Left?** _____ **When/D.O.I?**_____

How?_____ **Where?** ☐ **Work** ☐ **Home** ☐ **Auto** ☐ **Other:** _____

What tests and/or treatments have you had for the above problem? _____

Pt. Instructed to bring: EMG/NCS X-Ray's Notes Other: _____

Who Referred You Here/How Did You Hear About Us?_____

Primary Care Physician (please include the physician's first name):_____

* **Primary Insurance Coverage:** _____

Policy Holder's (subscriber's) name: _____ DOB: _____

Policy Holder's SSN: _____ Sex: ☐ Male ☐ Female

Your relationship to the policy holder: _____

ID #: _____ Group #: _____

Secondary Insurance Coverage: _____

Policy Holder's (subscriber's) name: _____ DOB: _____

Your relationship to the policy holder: _____ ID # _____

Emergency Contact(s) and Person(s) you permit to obtain Medical Records and Prescriptions on your behalf.

Contact Name: _____ Relationship: _____ Phone #: _____
Contact Name: _____ Relationship: _____ Phone #: _____

I certify that, to the best of my knowledge, the above information is complete and accurate.

Signature: _____ **Date**: _____

Patient Name: _____ **Date**: _____

♦**Past and Present Medical History to include Cancer:** ☐ **None – Have never been on medication or under treatment for anything.**

_____ _____
_____ _____
_____ _____
_____ _____

♦ **Please list all previous surgical procedures and dates:** ☐ **See Attached** ☐ **None – I've never had surgery**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

KNOWN DRUG/NON-DRUG ALLERGIES and REACTIONS: Allergist: _____
(Iodine, Shellfish and/or IVP Dye, Adhesives/Tape, Latex, Benzoin)

_____ _____ _____
_____ _____ _____

PHARMACY INFORMATION

Name: _____ Location: _____ ☐ Retail ☐ Mail Order
Phone: _____ _____

♦ **Please list all current medications and dose if known, including any vitamins or herbal remedies.** ☐ See Attached

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

♦ **FAMILY HISTORY:**

Member	**Age**	**State of Health**	**Significant Current Problems or Cause of Death.**
♂Father	_____	_____	_____
♀Mother	_____	_____	_____
♂Brother	_____	_____	_____
♀Sister	_____	_____	_____

♦ **SOCIAL HISTORY:**

Blood Transfusions: (please check one): I will accept blood products in an emergency ☐ Yes ☐ No
Have you ever had transfusion reactions? ☐ Yes ☐ No

What is/was your occupation? _____ ☐ Retired
☐ Disabled. Reason: _____

Dominant Hand: ☐ **Right Hand** ☐ **Left Hand** **Approximate: Height**_____**ft.** _____**in. Weight** _____**lbs**
(Which one do you write with?)

☐ **Current Tobacco User:** ☐ **Former Tobacco User** ☐ **Never used Tobacco**
Type: ☐ Cigarettes ☐ Cigars ☐ Smokeless Amount/day: _____ **Years used:** _____ Quit Date: _____

☐ Consume alcohol: Type: _____ Amount/day: _____
☐ Use recreational drugs: Type: _____ Amount/day: _____
☐ Consume caffeine: Beverage: _____ Amount/day: _____

Patient Name: _____ **Date**: _____

Review of Systems: Please mark "Yes" for any symptom or condition you have ever had or have been treated for.
This includes symptoms related to your current hand and/or wrist problem.

GENERAL: Primary Care Doctor: _____

Fever	□ Yes	□ No
Chills	□ Yes	□ No
Night Sweats	□ Yes	□ No
Recent Weight Gain _____lbs	□ Yes	□ No
Recent Weight loss _____lbs	□ Yes	□ No
Exercise Intolerance	□ Yes	□ No
History of Cancer	□ Yes	□ No
Type: _____		

EYES: Ophthalmology: _____

Dry Eyes	□ Yes	□ No
Irritation	□ Yes	□ No
Vision Changes	□ Yes	□ No
Wear glasses/contact lens	□ Yes	□ No
Glaucoma	□ Yes	□ No
Cataracts	□ Yes	□ No

EARS, NOSE & THROAT: ENT: _____

Difficulty Hearing	□ Yes	□ No
Requires Hearing Aid	□ Yes	□ No
Ear Pain	□ Yes	□ No
Frequent Nose Bleeds	□ Yes	□ No
Sinus Pressure/Congestion	□ Yes	□ No
Sore Throat	□ Yes	□ No
Bleeding Gums	□ Yes	□ No
Snoring	□ Yes	□ No
Dry Mouth	□ Yes	□ No
Loose or Broken Teeth	□ Yes	□ No
Dentures	□ Yes	□ No
Mouth Breathing	□ Yes	□ No

CARDIOVASCULAR: Cardiologist: _____

Chest Pain/Angina	□ Yes	□ No
Palpitations	□ Yes	□ No
Known Heart Murmur	□ Yes	□ No
Light Headed on Standing	□ Yes	□ No
Cardiac Testing within the past year	□ Yes	□ No
Which Tests?		
□ EKG □ Stress Test □ Other: _____		
High Blood Pressure (Hypertension)	□ Yes	□ No
High Cholesterol (Hyperlipidemia)	□ Yes	□ No
Mitral Valve Prolapse/Valve Problems	□ Yes	□ No
Atrial Fibrillation	□ Yes	□ No
Raynaud's	□ Yes	□ No
Acute MI (Heart Attack) – when? _____	□ Yes	□ No
Stent Placement	□ Yes	□ No
Pacemaker	□ Yes	□ No

RESPIRATORY: Pulmonologist: _____

Chronic Cough	□ Yes	□ No
Wheezing	□ Yes	□ No
Shortness of Breath	□ Yes	□ No
Asthma	□ Yes	□ No
COPD/Emphysema	□ Yes	□ No
Sleep Apnea	□ Yes	□ No
Using: CPAP/BiPAP?		
Pulmonary Embolism	□ Yes	□ No

DIGESTIVE: Gastroenterologist: _____

Abdominal Pain	□ Yes	□ No
Nausea/Vomiting	□ Yes	□ No
Change in Appetite	□ Yes	□ No
Black/Tarry Stools	□ Yes	□ No
Frequent Diarrhea	□ Yes	□ No
GERD	□ Yes	□ No
Crohn's Disease	□ Yes	□ No
Irritable Bowel Syndrome	□ Yes	□ No

GENITOURINARY: Nephrologist: _____

Difficulty Holding Urine	□ Yes	□ No
Difficulty Urinating	□ Yes	□ No
Increased Urinary Frequency	□ Yes	□ No
Blood in Urine	□ Yes	□ No
Incomplete Emptying	□ Yes	□ No
Kidney/Renal Disease	□ Yes	□ No
On Dialysis	□ Yes	□ No

MUSCULOSKELETAL: Orthopedist: _____

Muscle Aches	□ Yes	□ No
Muscle Weakness	□ Yes	□ No
Joint Pain	□ Yes	□ No
Chronic Back Problems	□ Yes	□ No
Swelling in the Extremities	□ Yes	□ No
Fibromyalgia	□ Yes	□ No
Gout	□ Yes	□ No
Lupus	□ Yes	□ No
Osteoporosis/Osteopenia	□ Yes	□ No
Arthritis	□ Yes	□ No
Type: _____		

INTEGUMENTARY (skin) Dermatologist: _____

Rash or itching	□ Yes	□ No
Skin Lesions (non-healing)	□ Yes	□ No
Dry Skin	□ Yes	□ No
Psoriasis	□ Yes	□ No
Eczema	□ Yes	□ No
History of skin cancer	□ Yes	□ No

Patient Name: _____ **Date**: _____

NEUROLOGICAL: Neurologist: _____

Loss of Consciousness	□ Yes	□ No
Seizures/Convulsions	□ Yes	□ No
Dizziness	□ Yes	□ No
Migraine Headaches	□ Yes	□ No
Multiple Sclerosis	□ Yes	□ No
Alzheimer's	□ Yes	□ No
Parkinson's	□ Yes	□ No
Neuropathy	□ Yes	□ No
Previous Stroke/TIA - when? _____	□ Yes	□ No

PSYCHIATRIC

Sleep Disturbances	□ Yes	□ No
Anxiety	□ Yes	□ No
Depression	□ Yes	□ No

Other: _____

ENDOCRINE Endocrinologist: _____

Fatigue	□ Yes	□ No
Excessive Thirst	□ Yes	□ No
Hair Loss	□ Yes	□ No
Increased Hair Growth	□ Yes	□ No
Cold Intolerance	□ Yes	□ No
Thyroid Disorder	□ Yes	□ No
Diabetes Mellitus	□ Yes	□ No

□ Insulin Dependent □ Non-Insulin Dependent

HEMATOLOGICAL

Swollen Glands	□ Yes	□ No
Easy Bruising	□ Yes	□ No
Easy Bleeding	□ Yes	□ No
Taking Blood Thinners	□ Yes	□ No
Anemia	□ Yes	□ No
Sickle Cell Anemia	□ Yes	□ No
Thromboembolic Disease	□ Yes	□ No
DVT of Lower Ext.	□ Yes	□ No

ALLERGIC/IMMUNOLOGIC

Runny Nose	□ Yes	□ No
Itching	□ Yes	□ No
Hives	□ Yes	□ No
Frequent Sneezing	□ Yes	□ No

INFECTIONS

HIV	□ Yes	□ No
Hepatitis, A Virus	□ Yes	□ No
Hepatitis, B Virus	□ Yes	□ No
Hepatitis, C Virus	□ Yes	□ No
Recent Staph Infection	□ Yes	□ No

When: _____ Body Part/Where: _____

MRSA □ Yes □ No

When: _____ Body Part/Where: _____

Please list any additional information you may think is relevant to your healthcare:

_____

_____

_____

_____

_____

*Disclaimer: We appreciate your taking the time to fill out the Review of Systems section of this form. Many of the above symptoms and medical conditions may be related to your current hand problem(s) and will be considered in the diagnosis, treatment and decision making. However, as any of the above medical conditions may be relevant, they should ultimately be reviewed and treated by your primary care physician and/or the appropriate physician/specialist in that field.

By signing below you attest that the above medical history is complete and accurate to the best of your Knowledge.

♦**Patient Signature**: _____ Date: _____

NORTH FLORIDA SURGEONS, P.A.
FINANCIAL AGREEMENT

PATIENT INFORMATION

DATE: _____

PATIENT'S NAME: _____
Last First M.I.

ADDRESS: _____

BIRTHDATE: ____/____/____ **DAYTIME TELEPHONE NUMBER:** _____
Month Day Year

SOCIAL SECURITY #: _____ **CELL PHONE*:** _____

E-MAIL*: _____

*If you provide your e-mail and/or cell phone to us, we may use such information to contact you by e-mail and/or text for marketing of services provided by North Florida.

PRIVACY NOTICE ACKNOWLEDGMENT

North Florida Surgeons, P.A. consists of wholly-owned subsidiaries where medical services are provided (collectively referred to herein as "**North Florida**"). I acknowledge that I have received and read a copy of **North Florida** Privacy Notice ("Notice") to review. **North Florida** has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location and on their website at www.nflsurgeons.com at all times. **North Florida** will provide me with a copy of its most recent Notice upon my request.

E-MAIL CONSENT

I acknowledge that I have received and read a copy of **North Florida** E-mail Consent. I understand that if I want to correspond with **North Florida** by e-mail that I must agree to the terms of the E-mail Consent, check the appropriate box and sign below.

☐ **I WANT** to correspond with **North Florida** by e-mail. I understand the risks associated with the communication of e-mail between **North Florida** and me. I consent to the conditions outlined in the E-mail Consent. Any questions I may have had were answered to my satisfaction.

Patient Signature: _____ **Date:** _____
Parent, Guardian or Legal Representative Signature: _____
Relationship to Patient: _____

☐ **I DO NOT** want to correspond with **North Florida** by e-mail.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is my responsibility to provide **North Florida** with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). **North Florida** is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay patient and be financially responsible for the total amount of the services provided. I will notify **North Florida** immediately upon any change in my insurance.

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at **North Florida**. I am responsible for any applicable deductible or co-payments prior to the provision of services. **North Florida** will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. **North Florida** may file a claim for payment with my insurance company as a courtesy to me. If the insurance company fails to pay **North Florida** in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to **North Florida**. Should the account be referred to a collection agency or attorney for collection, the undersigned agrees to pay the collection agency's fee (based on a percentage of your account balance, the current percentage is 33%) and all costs of collection, including a reasonable attorney's fee.

CREDIT CARD ON FILE

I provide a valid credit card (the credit card has not expired and has not reached its available credit limit) to be retained on file to pay any balance owed for my medical services. In the event that my credit card expires or has reached its limit, I am responsible to provide a new valid credit card. I further understand that the billing address for the credit card on file must match the address that appears on my monthly credit card bill or bank statement. I agree to pay such total amount charged in accordance with the agreement governing the use of such credit card. I hereby authorize **North Florida** to charge my credit card for payment of the medical services rendered. If I have entered into a payment plan, I authorize **North Florida** to charge my credit card to pay the payments owed under the payment plan.

Exact name as it appears on credit card: _____

Circle Card Type: __ VISA __ M/C __ AMEX __ DISCOVER

Card #: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Verification #: _____

[*Visa & MasterCard number appears as 3 digit number on the back of the card. American Express number appears as a 4 digit number printed on the front of the credit card after and to the right of the card number.]

Expiration Date: _ _ / _ _

Cardholder's Signature: _____ Date: ___ / ___ / ___

NON-COVERED SERVICES WAIVER

I understand that charges for my care will be filed with my insurance carrier as a courtesy by **North Florida**. There may be a service that I desire that is not covered under my insurance plan ("Non-Covered Services"). I understand that I will be financially responsible for the cost of any Non-Covered Services. A separate waiver will be completed for each Non-Covered Service. If I have Medicare, I will complete an Advance Beneficiary Notice ("ABN") form.

INSURANCE WAIVER

I understand that if I do not have a copy of a current insurance card and valid referral, if required, that I can be seen as a "Private Pay" patient. I agree that neither **North Florida** nor I will file a claim for the visit. A waiver will be completed for each visit that I am seen as a Private Pay patient. I will be required to pay the total cost of the visit in advance.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to **North Florida**. I hereby authorize **North Florida** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

ASSIGNMENT OF MEDICARE BENEFITS

I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or surgical procedures rendered to patient, directly to **North Florida**. I hereby authorize **North Florida** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an ABN.

ARBITRATION

THIS ARBITRATION AGREEMENT is made between **North Florida Surgeons, P.A.**, for and on behalf of itself and its subsidiaries, affiliated professional associations, physicians (including physicians providing medical services through a subsidiary of North Florida Surgeons, P.A.), agents, employees, servants, or any of the foregoing, referred to hereinafter as "Doctor" and the above referenced patient ("Patient"). It is the intention of the parties to this Arbitration Agreement to bind not only themselves, but also their heirs, personal representatives, guardians and any persons deriving claims through or on behalf of the patient.

It is understood by the Patient that he or she is not required to use **North Florida Surgeons, P.A.** or any Doctor and that there are numerous other physicians located near Patient who are qualified to provide care to Patient.

In the event of any controversy or dispute, which might arise between Doctor and the Patient, regardless of whether the dispute concerns the medical care rendered, including any negligence claim relating to the diagnosis, treatment, or care of the Patient, or payment of surgical fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

Other than what may be in conflict with this Arbitration Agreement, the laws of the State of Florida shall apply to any dispute between Doctor and the Patient. The Florida Rules of Civil Procedure shall apply for discovery purposes only.

Prior to commencing any action under this Arbitration Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes. Any arbitration under this Arbitration Agreement must be commenced by the filing of an application for arbitration within the applicable statute of limitations for the controversy or dispute at issue.

This arbitration shall be in lieu and instead of any trial by Judge or Jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. All arbitrators shall be selected from the following Florida counties: Alachua, Clay, Duval, Nassau, St. Johns and Volusia. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties and may be enforced by a court of law if necessary. Arbitration shall be conducted in Duval County, Florida.

In the event that either party to this Arbitration Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, including the appointment of the arbitrator and hearings to resolve the dispute, despite the refusal to participate or the absence of the opposing party. The arbitrators shall render a binding decision without the participation of the party opposing arbitration or despite his or her absence at the arbitration hearing.

ARBITRATION - Continued

Except for legal reporting requirements, all arbitration proceedings and outcomes under this Arbitration Agreement will be confidential and private. The parties shall be required to attend non-binding mediation in Duval County, Florida prior to arbitration.

The Patient understands that the Patient has a constitutional right under Article 1, Section 21 of the Florida Constitution of Access to Courts as follows: "The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay." The Patient understands and acknowledges that signing this Arbitration Agreement waives this constitutional right.

Should any sentence(s) of this Arbitration Agreement be declared unenforceable or in conflict with the law, the sentence(s) shall be severed and the validity of the remaining parts and provisions shall not be affected by such holding.

The Patient has had an opportunity to read this Arbitration Agreement, or to have it read to him or her if necessary. The Patient understands English or has had this Arbitration Agreement translated for him or her by _____. The Patient has had an opportunity to ask questions about this Arbitration Agreement. The Patient understands this Arbitration Agreement and has no unanswered questions.

Patient Initials: _____

ARBITRATION - Continued

The Patient has not been coerced or compelled to sign this Arbitration Agreement, and does so of his or her own free will. The Patient may consult with an attorney before signing this Arbitration Agreement.

BY SIGNING THIS ARBITRATION AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE TERMS AND CONDITIONS.

Patient Signature: _____ **Date:** _____

Parent, Guardian or Legal Representative Signature: _____

Relationship to Patient: _____

Witness Signature: _____

Physician Signature: _____

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED IN THIS AGREEMENT.

Patient Signature: _____ **Date:** _____

Parent, Guardian or Legal Representative Signature: _____

Relationship to Patient: _____

Witness Signature: _____

HAND & WRIST CENTER

1715-A Eagle Harbor Pkwy.
Fleming Island, FL 32003
Phone: (904) 215-2422
Facsimile: (904) 215-6122

To better meet you expectations, please be advised of the following office policies:

Co-pays and account balances are due at the time services are rendered unless prior arrangements have been made.

If you need any kind of work/school note, tell Dr. Curtis/Dr. Baez **while he is seeing you** so that it will be ready when you leave.

If Dr. Curtis/Dr. Baez orders tests, he will want to review the results with you at the time of your next appointment, Please verify several days prior to the follow-up appointment that the results are in, otherwise the appointment will need to be rescheduled until we can get the results.

Prescription refills may take up to 48 hours to process, allow time. Some types of prescriptions are not allowed to be "called in". If you are unable to pick up your prescription, make sure that you name the person who is going to pick it up for you on your privacy list.

If you have paperwork that you need Dr. Curtis/Dr. Baez to fill out, there is **a $30 charge** per document. It could take up to 2 weeks for the document to be completed, allow time.

If you need to cancel or reschedule an appointment, please give as much notice as possible (at least 24 hours) to allow us to call another patient who may be waiting for an appointment.

Arranging surgery is a time intensive process that requires coordination between you, our office, the doctors, a surgery center, an anesthesiologist, and sometimes a medical equipment vendor. If you need to cancel or reschedule a surgery, as a courtesy to everyone involved, please give as much notice as possible (at least three days). We may be able to fill your time slot with someone who is waiting or an emergency surgery.

A patient is automatically discharged from the practice after 90 days if they have failed to show up for an appointment or called to reschedule a missed appointment. Please keep in touch!

PLEASE advise the front desk IMMEDIATELY of any changes in your personal or insurance information!

Patient accounts are billed monthly. If you need to make payment arrangements please call. Accounts that go to collection agency are charged a collection fee on the outstanding balance.

Please sign to indicate that you have read and understand the above policies. THANK YOU!

X_____ Date _____