Michael W. Higgins, DO, P.A.

PATIENT INFORMATION

Patients Name: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Email Address (optional): _____
Fax Number (optional): _____
Social Security Number: _____
Date of Birth: _____

Employers Name: _____
Employers Address: _____

_____
Employers Phone: _____

Emergency Contact Name: _____Relationship: _____
Emergency Contact Phone Number: _____

INSURANCE INFORMATION

Primary Insurance: _____
Policy or Claim Number: _____
Group Number: _____
Policy Holders Name: _____ DOB: _____
Relationship to Policy Holder: _____

Secondary Insurance: _____
Policy or Claim Number: _____
Group Number: _____
Policy Holders Name: _____ DOB: _____
Relationship to Policy Holder: _____

_____ _____
Signature of Patient or Guardian Date

4055 Mariner Blvd., Spring Hill, FL 34609
Phone (352) 688-6035 Fax: (352) 688-6219 WWW.HernandoOrthoSpine.com
Email: ortho4055@gmail.com

Hernando Orthopaedic & Spinal Surgery

These questions are meant to provide you with some basic information that will be used to help us to care for you. If you are unsure about how to answer a question or need help filling the questionnaire out please feel free to ask us for help. Please complete all pages. Thank you.

Today's date: _____

Patient Name: ·_____ Gender: Male Female Age: _____

Primary Care Physician: _____
PCP's Address: _____
Pharmacy Name (Required): _____
Pharmacy Phone # {Required): _____
Pharmacy Address: _____

Who referred you to this office? _____

Which hand do you write with?	Right	Left
Which side are you having trouble with?	Right	Left
Did you have an accidental injury?	Yes	No

If yes, how did you injure yourself? _____

Date of Injury or when did the problem start: _____

Is this a work-related injury? Yes No

Did this injury involve an automobile? Yes No

What is your complaint/problem/symptom? _____
_____

Treatment you have had for THIS problem or injury:

Splint/Cast/Brace _____ For how long? _____ Was it helpful? YES NO
Physical Therapy _____ For how long? _____ Was it helpful? YES NO
Medications _____ For how long? _____ Was it helpful? YES NO
Injections _____ For how long? _____ Was it helpful? YES NO
Surgery? _____ Procedure date: _____

What is your current employment status? _____

Are you unable to work because of this problem? YES NO
Are you unable to work because of other medical reasons? YES NO

Is there a possibility that you could be pregnant? Yes No Maybe

What is your current occupation? _____

If you stopped working, on what date did you stop? _____

Have you changed jobs because of your present problem/injury? Yes No

Is an attorney involved with this injury/problem? Yes No

Are you on Social Security, Disability or Worker's Compensation? Yes No

MEDICAL HISTORY:

The following is a list of common health problems.

PROBLEM	DO YOU HAVE THIS PROBLEM?		DO YOU RECEIVE TREATMENT FOR IT?	
Heart Disease	YES	NO	YES	NO
Chest Pain	YES	NO	YES	NO
High Blood Pressure	YES	NO	YES	NO
Stroke/TIA	YES	NO	YES	NO
Cancer	YES	NO	YES	NO
Brain or Spinal Cord problem	YES	NO	YES	NO
Depression	YES	NO	YES	NO
Psychiatric Problems	YES	NO	YES	NO
Alzheimer's Disease	YES	NO	YES	NO
Eye problems	YES	NO	YES	NO
Bladder problems	YES	NO	YES	NO
Prostate problems	YES	NO	YES	NO
Kidney Problems	YES	NO	YES	NO
Anemia	YES	NO	YES	NO
Blood disorder	YES	NO	YES	NO
Sickle cell anemia	YES	NO	YES	NO
Diabetes.	YES	NO	YES	NO
Thyroid disorder	YES	NO	YES	NO
Skin rashes	YES	NO	YES	NO
Psoriasis	YES	NO	YES	NO
Osteoporosis	YES	NO	YES	NO
Gout	YES	NO	YES	NO
Osteoarthritis	YES	NO	YES	NO
Rheumatoid Arthritis	YES	NO	YES	NO
High Cholesterol	YES	NO	YES	NO
Numbness in Fingers	YES	NO	YES	NO
Reflux disease	YES	NO	YES	NO
Hiatial hernia	YES	NO	YES	NO
Liver disorder	YES	NO	YES	NO
Stomach disorder/ulcers	YES	NO	YES	NO
Asthma/Breathing problems	YES	NO	YES	NO
Emphysema/COPD	YES	NO	YES	NO
Blood clot in leg	YES	NO	YES	NO

Pulmonary Embolus	YES	NO	YES	NO
Take blood thinners	YES	NO	YES	NO
Take steroid medications	YES	NO	YES	NO
Fever	YES	NO	YES	NO
Weight Loss	YES	NO	YES	NO
Appetite Loss	YES	NO	YES	NO
Frequent Falls	YES	NO	YES	NO
Ear/hearing problems	YES	NO	YES	NO

What are your current medications?

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

List any medications that you are allergic to:

_____ reaction: _____

_____ reaction: _____

_____ reaction: _____

List all surgical procedures:

_____ year: _____

_____ year: _____

_____ year: _____

_____ year: _____

_____ year: _____

_____ year: _____

_____ year: _____

Have you had problems with anesthetics? YES NO

Do you smoke? YES NO

If yes, how many packs a day? _____ pack(s)

What is your current marital status? _____

Do you live with someone that can take care of you? YES NO

FAMILY HISTORY:

Has any blood relative had any of the following: (Circle "yes" or "no", leave blank if uncertain)

		Relationship			Relationship
Cancer	NO	YES_____	Depression	NO	YES_____
Tuberculosis	NO	YES_____	Psychosis	NO	YES_____
Diabetes	NO	YES_____	Suicide	NO	YES_____
Heart Disease	NO	YES_____	Leukemia	NO	YES_____
High Blood Pressure	NO	YES_____	Migraine Headaches	NO	YES_____
Stroke	NO	YES_____	Obesity	NO	YES_____
Epilepsy	NO	YES_____	Thyroid Disease	NO	YES_____
Allergies	NO	YES_____	Ulcer	NO	YES_____
Anemia	NO	YES_____	High Cholesterol	NO	YES_____
Bleeding Tendency	NO	YES_____	Kidney Disease	NO	YES_____
Asthma	NO	YES_____	Glaucoma	NO	YES_____
Chronic Lung Disease	NO	YES_____	Gout	NO	YES_____
Drug/Alcohol Problem	NO	YES_____			

Mother
[ ] Alive, Age _____
[ ] Deceased, Age _____ of _____

Father
[ ] Alive, Age _____
[ ] Deceased, Age _____ of _____

Sister(s)
[ ] Alive, Age _____
[ ] Deceased, Age _____ of _____
[ ] Alive, Age _____
[ ] Deceased, Age _____ of _____
[ ] Others

Brother(s)
[ ] Alive, Age _____
[ ] Deceased, Age _____ of _____
[ ] Alive, Age _____
[ ] Deceased, Age _____ of _____
[ ] Others

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health, or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health Information can be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for a hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting, or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public health issues as required by law, Communicable diseases; Health Oversight, Abuse or neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral directors and organ donations, research, criminal activity, military activity, national security, Worker's Compensation, inmates. Required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by raw.

You may revoke this authorization, at any time, in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Hernando Orthopaedic & Spinal Surgery

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have a right to inspect and copy your protected health information.
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have a right to request a restriction of your protected health information.
This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved with your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. You have the right to use another Healthcare Professional.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.

You may have the right to have your physician amend your protected health information. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our private contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective January 1, 2005.

We are required by law to maintain the privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____
(PRINT PATIENT NAME

_____ _____
(SIGNATURE OF PATIENT/GUARDIAN) (DATE)

Hernando Orthopaedic & Spinals Surgery

Michael W. Higgins. D.O., P.A.

Authorization to Release Medical Records & or Information to assigned person(s).

This authorization allows Hernando Orthopaedic & Spinal Surgery and Dr. Higgins and staff to release medical information to a person (named below) involved in the patient's medicale care. Other than the named person or you, we will not discuss anything related to your care with anyone if they are not listed in this release. The only exception.is other medical professionals and their offices/facilities as necessary to provide you with medical care and your Insurance company as outlined in our privacy notice. If you wish family members or caretakers to have information about your care, you must fill out this form.

Patient's Name: _____

Social Security #: _____ D.O B.: _____

Person(s) with whom you would like your medical history, test results, appointments, etc. discussed (example: spouse, children or friend):

1) Name: _____ Phone: _____
Relationship: _____ D.O.B.: _____

2) Name: _____ Phone: _____
Relationship: _____ D.O.B.: _____

Please sign this section to acknowledge and validate this form.

Patient's Name (Please Print) Or Legal Guardian/Power of Attorney (Please Print)

_____ _____

_____ _____

Patient's Signature Legal Guardian / PPOA's Signature

**Hernando Orthopaedic & Spinal Surgery will call to confirm your office visit 1-2 days prior to the appointment. May this information or other confirmation be left on your answering machine? No test/lab results or specific medical information messages will ever be left.

_____ YES _____ NO Initial: _____

Or if you do NOT want any family members or friends to know about your care:

_____ I would not like my care discussed with anyone other than medical professionals and offices/facilities as necessary to provide care for me.

Revocation Section-Desire to Terminate this Agreement: I understand that I may revoke this authorization at any time by notifying Hernando Orthopaedic & Spinal Surgery in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

Effective: _____date, the authorization is no longer valid.

_____ _____

Patient's Signature Legal Guardian / PPOA's Signature

4055 Mariner Blvd. Spring Hill, FL 34609 Phone: (352) 688-6035 Fax: (352) 688-6219
www.HernandoOrthoSpine.com

Hernando Orthopaedic & Spinals Surgery

Michael W. Higgins. D.O., P.A.

Patient Portal User Agreement

Hernando Orthopaedic & Spinal Surgery provides this site in partnership with e-MDS for the exclusive use of its established patients. The patient portal is designed to enhance patient - physician communications. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the patient portal, the user agrees to provide factual and correct information.

The information on the patient portal is maintained by Hernando Orthopaedic & Spinal Surgery at its current physical facility 4055 Mariner Blvd., Spring Hill, Fl. 34609.

The patient portal does provide the following services:

- Review Patient's medical summary, medication list, treatment history and visitation dates
- Waiting list requests
- Limited communication regarding on-going treatment

The patient portal is not intended to provide internet based diagnostic medical services. Also following limitations apply:

- No internet-based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules and SEES the doctor.
- No Emergent communications or services. Any emergent conditions should be seen by Urgent Care, Emergency Department, or 911·.
- No request for narcotic pain medication will be accepted.
- Request for re-fill medications.

The patient portal is provided as a courtesy to our valued patients. While some offices charge for this convenience on an annual basis, we are focused on providing highest level of service and health care. However, if abuse or negligent usage of patient portal persists, we reserve the right at our own discretion to terminate patient portal offering, suspend user, or modify services offered through the patient portal.

The patient portal is provided in partnership with e-MDS, our EHR software vendor and provider. The data is stored at Hernando Orthopaedic & Spinal Surgery. The date is on HIPM compliant VPN with high level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent that it is possible, Hernando Orthopaedic & Spinal Surgery has undergone rigorous IT implementation and security standards exceeding industry recommendations.

Please read our HIPAA policy for information on how private health information (PHI) is used at Hernando Orthopaedic & Spinal Surgery. All new and established patients have signed HIPAA agreement form and have been given a copy of our HIPAA policy. If you do not recall having signed HIPAA agreement form or need to reacquaint with our HIPAA policy, a print or electronic copy will be provided to you for your review.

Once you have signed the **Patient Portal Consent Agreement** and have provided Hernando Orthopaedic & Spinal Surgery with legitimate email address that is secure, you will be given our system generated unique user identification and password. The site may be accessed by:

1. Directly by going to the URL: https://www.gotomyclinic.com/hernandoorthospine
2. Upon acceptance by our patient portal system, on the email reply, it will contain your unique user id and password along with PDF **Patient Users Guide**.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of patient portal and agree that I understand the risks associated with online communications between my physician and patient, and consent to the conditions outlined here in. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Hernando Orthopaedic & Spinal Surgery should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered with clarity.

_____

Patient Signature Print Name Date

EMAIL ADDRESS: _____