WESTCHASE ORTHOPAEDICS & REHABILITATION

Patrick J. Horan, M.D.
ORTHOPAEDIC SURGERY
11603 SHELDON RD.
TAMPA, FL 33626

Telephone: (813) 792-9843
Fax: (813) 792-9853

Notice of Privacy Practices

I have read and reviewed the Patient Privacy Information provided to me. I am aware that I may request a printed copy at any time.

Your information:

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

May we leave medical information on the answering machine/voicemail of the phone number on file?

____ Yes ____ No

In accordance with the Healthcare Portability Act of 1996 (HIPAA), in order for any provider or staff member of Physical Group of Florida, Inc./Westchase Orthopaedics & Rehabilitation to discuss your condition with members of your family or other individuals that you designate, we must obtain authorization prior to doing so.

____ Check here if you **DO NOT** authorize PGF/Westchase Orthopaedics & Rehabilitation to discuss your medical or financial information with any individual. **I understand that these rights may be waived in the event of a critical episode in which I am unable to give authorization due to the severity of my medical condition.

OR

____ Check here if you would like to authorize PGF/Westchase Orthopaedics & Rehabilitation to discuss your medical or financial information with the following individuals:

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

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PJH ORTHO MD

Patient Name: _____ *DOB:* _____

Medical History:

Check symptoms you currently have or have had in the past.

☐ I currently do not have nor have had any of the symptoms listed below in the past.

Personal History

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart pacemaker
- ☐ Stroke
- ☐ Cancer

Type: _____

Active or In Remission

- ☐ Blood Clots DVT / PE
- ☐ Kidney Disease
- ☐ Hepatitis Type: _____
- ☐ TB
- ☐ Tested for HIV
- ☐ Diabetes Type I / Type II
- ☐ Seizures Type: _____
- ☐ Polio
- ☐ Asthma
- ☐ Thyroid hypo / hyper
- ☐ High Cholesterol
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis

General

- ☐ Unexplained change in wt

Loss / Gain

- ☐ Loss of appetite
- ☐ Sweats
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Chills
- ☐ Always Hot
- ☐ Always Cold
- ☐ Bruise Easily

Gastrointestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomach pain
- ☐ Heartburn
- ☐ Nausea
- ☐ Blood in stool
- ☐ Vomiting
- ☐ Difficulty swallowing

Urinary

- ☐ Burning on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Straining to urinate

Cardiovascular

- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Calf pain when walking
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

Pulmonary

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Family History

- ☐ Heart disease
- ☐ Cancer
- ☐ Bleeding problems
- ☐ Reactions to anesthesia
- ☐ Diabetes
- ☐ Arthritis RA / OA

Previous Surgeries: _____

Health Habits:

Check which substances you use and describe how much.

Caffeine ____ day / wk Tobacco ____ day / wk
Illicit Drugs ____ day / wk Alcohol ____ day / wk

A Little About You:

Height: _____ Handed: R or L

Occupation: _____

Primary Care Physician: _____

What are we seeing you for today?: _____

When did the problem first start?: _____

Is this a work related injury?: Yes or No **Is this an accident related injury?: Yes or No**

If YES, please explain: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____

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Patient Name: _____ **DOB:** _____

Pharmacy Information

Pharmacy Name: _____ Phone: _____

Street Address/Street Corner: _____ Zip Code: _____

Current Medication/Allergy List

Medication Name:	*Dosage (if known)/Frequency:*

Drug Allergies:

I certify that the above information is correct to the best of my knowledge. I will not hold the physician or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____

Filled out at follow-up appointments ONLY:
I have reviewed/updated the information above and certify this information is accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

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ORTHO MD

PLEASE READ CAREFULLY
DOCTOR-PATIENT ARBITRATION AGREEMENT

This agreement is made between Westchase Orthopaedics & Rehabilitation, Inc., Patrick J. Horan, M.D., other medical physicians, physical therapists, physician assistants, nurse practitioners, their agents, employees, servants, or any of the foregoing, referred to hereinafter as "Doctor" and _____ referred to hereinafter as the "Patient." It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians or any persons deriving their claims through or on behalf of the patient.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statutes. This arbitration shall be binding. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for under Rules 1.280-1.390, Florida Rules of Civil Procedure. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and my be forced by a court of competent jurisdiction in and for Hillsborough County, Florida. Requests for arbitration by either party must be made within the time frame set forth in section 95.11 of the Florida Statutes dealing with medical malpractice.

This agreement shall remain in effect for all treatment and/or surgery provided the patient presently and at any future date.

In witness whereof, I (we) have set our hands this date _____.

Doctor:

By: _____
(Authorized Agent)

Patient:

By: _____
(Patient Signature or Guardian/POA)

DOB of patient: _____

Account number: _____

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