

MESSIEH ORTHOPEDICS
MICHAEL S. MESSIEH, M.D. PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: ___/___/___ Age: _____ Height: _____ Weight: _____
Sex: () F () M

What are you seeing the doctor for? Please explain your reason for this visit. (Up to 2 body parts per visit) Circle your answer.

Neck	Low Back	<u>If more than one body part, list most painful below</u>
Right Shoulder	Left Shoulder	
Right Knee	Left Knee	
Right Hip	Left Hip	
Right Elbow	Left Elbow	
Right Wrist/Hand	Left Wrist/Hand	
Right Foot/ankle	Left Foot/ankle	Date Problem began: _____

Describe your current problem below:

- ____ new injury or problem (less than 6 weeks duration)
- ____ sub- acute problem (6 weeks to 3 months duration)
- ____ chronic problem (problem has been treated over time period of more than 3 months)
- ____ re-injury (you injured this same area before, received treatment, had no problems until new injury occurred)

Is your problem a result of an injury? ____ Yes, Date: _____ ____ No

****If your problem is a result of an injury, where did it occur? Please circle below****

HOME	WORK	MOTOR VEHICLE	EXERCISE	OTHER: _____
What caused your injury/problem?				
__ fall	__ fighting			
__ lifting	__ twisting			
__ throwing	__ collision/contact			
__ pulling	__ other/specify _____			

Explain in your own words how this injury or problem occurred:

****Have you talked to a lawyer concerning you injury:** ____ Yes ____ No

****Are you receiving or have you applied for Worker's Compensation concerning your injury?** ____ Yes ____ No

****Have you received previous treatment for your current problem?** ____ Yes, specify below ____ No Circle

if applies below:

Medicine	Physical Therapy	Surgery	Injections	Other _____
----------	------------------	---------	------------	-------------

Did you go to the Emergency Room? ____ Yes, date of ER visit: _____ ____ No

ON A SCALE OF 0-10 (WITH 10 BEING THE WORST PAIN IMAGINABLE), HOW WOULD YOU SCORE YOUR PAIN TODAY?

__ 0 __ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10

MESSIEH ORTHOPEDICS/MICHAEL S MESSIEH, MD
MEDICAL HISTORY INFORMATION

Patient: _____ DOB: ____/____/____

MEDICAL HISTORY: Do you have or have you ever had any of the following? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> TB |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Other/Specify _____ |
| <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Bleeding disorder | _____ if none apply please initial |
| <input type="checkbox"/> Alcoholism | |

PAST SURGICAL HISTORY:

MEDICATIONS: Please list below your current medications, both prescription and over the counter; or please supply a list.

**Pharmacy Name: _____ Location: _____ Phone#: _____

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Name: _____ Dosage: _____ Name: _____ Dosage: _____

***ALLERGIC TO ANY MEDICATIONS? _____ YES, LIST ALLERGIES: _____ . _____ NO ALLERGIES

FAMILY HISTORY:

	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer	Unknown
Father	()	()	()	()	()	()
Mother	()	()	()	()	()	()
Paternal Grandfather	()	()	()	()	()	()
Paternal Grandmother	()	()	()	()	()	()
Maternal Grandfather	()	()	()	()	()	()
Maternal Grandmother	()	()	()	()	()	()
Siblings	()	()	()	()	()	()

Employer: _____ Job title: _____

Current Work Status: () Regular () Light Duty () Not working now () Disabled () Retired

SOCIAL HISTORY:

Marital Status: () Married () Single () Divorced () Widow/Widower Are you currently living alone? () Yes () No

Do you use tobacco? () Yes () No If yes, # of packs per day: _____ () past history of smoking, how long ago? _____

Do you have children? () Yes () No if yes, # of children: _____, # of pregnancies _____

Alcohol use? () Yes () No if yes, how often: # _____ drinks per year, # _____ per day

Alcohol misuse? If more than 6 how often on one occasion? _____ never, _____ less than monthly, _____ monthly, _____ weekly, _____ daily

Drug overuse? () Yes, current () past problem () Never used

REVIEW OF SYSTEMS (do you have or have you ever had) please check ALL that APPLY:

- Chills Fever Headache Cough Reading glasses Difficulty swallowing Breathing problems
 Wheezing Chest pain Change in bowel habits Stomach problems Anemia Arthritis Swollen joints _____
 Weakness Cold extremities Rash Dizziness

OUR OFFICE POLICY

Patient Name: _____ Date of Birth: ____/____/____

BASIC POLICY: Payment is due in full at the time of service.

PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also file to most secondary insurance carriers for you. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, occasional fees may be due and payable in full from you. HMO patients, it is your responsibility to obtain authorization from your Primary Care Physician (PCP) prior to being seen and to provide our office with the name and address of your PCP.

MEDICARE PATIENTS: We bill Medicare for you. All Co-payments and/or deductibles are due at the time of service. We will also file to your secondary insurance carrier for you.

SURGERY FEES: All co-pays, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required from your carrier. Self-pay surgeries require 50% deposit prior to scheduling surgery.

NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Other provider services: Any services provided by the hospital and/or other physicians such as an assistant surgeon, first assist, nurse practitioner and physician assistant are separate and distinct from our practice.

AUTO ACCIDENT CASES: WE DO NOT ACCEPT ANY AUTO ACCIDENT CASES.

WORKER'S COMPENSTATION CASES: WE DO NOT ACCEPT ANY WORKER'S COMPENSATION CASES.

MEDICAL RECORDS FAX: I authorize Messieh Orthopedics, Inc./Dr. Michael S. Messieh, to transmit my medical records electronically. If they are received by another party in error, I absolve Messieh Orthopedics, Inc of any and all liability relating to such submission of said records. I give permission for Messieh Orthopedics, Inc to send my records to my primary care physician.

APPOINTMENT FORMS: 24 hour notice is required for all appointment cancellations. Multiple failures to notify the office of cancellation and/or no show of appointments may result in a cancellation fee and/or your termination of care.

**CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION
FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE**

I hereby give consent to Messieh Orthopedics, Inc., Dr. Michael S. Messieh, to provide whatever treatment he/they deem necessary to the patient. I certify that the information I furnish is true and correct. I am fully aware that it is a felony to falsify any information relating to my medical condition.

I hereby authorize Messieh Orthopedics, Inc., Dr. Michael S. Messieh to submit a claim to my insurance carrier, or its intermediaries for all covered services rendered by the physician. I also authorize my insurance carrier, or it's intermediaries to issue payment directly to the physician. A photocopy of this assignment is considered to be as valid as an original.

I hereby authorize Messieh Orthopedics, Inc., Dr. Michael S. Messieh to release any medical information in connection with these services to any person or corporation which is or may be liable for any or any portion of the charges, including insurance companies, health care plans, worker's compensation carriers, adjusters or attorneys to the extent necessary to obtain. Also, to the patient's personal physician, referring physicians or primary care physician. I am aware that any/all information contained within my medical records/chart is property of Messieh Orthopedics, Inc., Dr. Michael S. Messieh. I further agree that I am responsible for payment of any remaining balance after insurance payments have been made, including any collection costs or legal fees occurred to collect these balances.

BINDING ARBITRATION

I AGREE THAT any dispute will be resolved by binding arbitration. When the patient and the physician agrees to arbitration, they agree to give up their constitutional rights to have a potential medical malpractice claim resolved in court. Binding arbitration means that the physician and the patient agree to litigate outside the court system any claims that may arise from rendering or failing to render medical care and treatment before an arbitration panel. The arbitration panel is required to follow the state law and their decision is binding upon the parties. The patient has had an opportunity and ability to know and understand the terms of the agreement before signing and agree that the terms are reasonable and fair. I understand that a video from FPIC explain the purpose and fundamentals of the arbitration agreement is available for viewing.

Signature of Patient: _____ Date: _____

Signature of Responsible Person (if other than patient): _____ Date: _____

MESSIEH ORTHOPEDICS, INC
Michael S. Messieh, M.D.
Acknowledgement of Receipt of Notice of Privacy

Page 5

Notice

Messieh Orthopedics, Inc reserves the right to modify the privacy practices outlined in the notice.

Signature I have read and understand the Notice of Privacy Practices for (Messieh Orthopedics, Inc)

_____ **Name of Patient**
(print)

_____ **Signature**
of Patient

_____ **Date**

_____ **Signature of Patient**
Representative (Required if the patient is a minor or an adult who is unable to sign this form)

_____ **Relationship**
of Patient Representative

I have chosen to receive a copy of the Privacy Act: _____ **Yes** _____ **No**

MESSIEH ORTHOPEDICS
MICHAEL S. MESSIEH, M.D.
841 Oakley Seaver Dr. Ste 1B
Clermont, FL 34711
Fax# 352-243-6855

Page 6

PATIENT AUTHORIZATION TO DISCLOSE AND RELEASE HEALTH INFORMATION

Name: _____ DOB: ___/___/___ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby consent to the release and disclosure of my personal health information from:

(Individual or Organization): _____

Address: _____

City: _____ State: _____ Zip: _____

For the following purpose (s):

- Continuing Medical Care Personal Use
 Information for insurance carrier Information for Attorney
 Other (please specify) _____

My authorization for release includes my personal health information consisting of:

- Initial Evaluation Operative Reports Medical Status
 Progress/Office Notes Discharge Summary Work Status
 Xray Only Xray report only Both Xray films/disc and Report
 Non-Messieh Orthopedics Inc films Other (please specify) _____
 All of the Above

Mail to above address Fax to above fax# Call when records are ready

I understand that the information outlined in this release will be disclosed according to the instructions of this release within five (5) business days of Messieh Orthopedics having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and is no longer protected by the Privacy Regulations (45 C.F.R. 164). This authorization will expire one year from the date of this request. This authorization is not valid if not filled out completely.

Patient Signature: _____ Date: _____

For Office use only:

Document flow: _____ patient's medical record scanned This authorization was revoked on _____ (date).

VIDEO/PHOTO RELEASE FORM MESSIEH ORTHOPEDICS

I, _____, hereby grant permission to Messieh Orthopedics/ Michael Messieh, MD, the rights of my image, in video or still, and of the likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for ANY USE which may include but is not limited to:

- Presentations
- Courses
- Online/Internet Videos
- Media
- News (Press)

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting. I will be consulted about the use of the photographs or video recording for any purpose other than those listed above. There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name _____

Phone _____

Signature _____ Date _____