Welcome to the Joint Replacement Institute

The Joint Replacement Institute is committed to providing personalized orthopedic care combined with state of the art surgical procedures for unparalleled outcomes. The receptionists, nurses, and technical personnel of J.R.I. work as a team to provide high quality service and pride themselves in their communication skills and compassion.

We thank you for choosing Joint Replacement Institute. You are encouraged to review the information provided here as well as visit our website at jointinstitutefl.com for additional material about the practice as well as educational information.

Financial Information:

We make every effort to decrease the cost of your healthcare. Therefore, we require payment for all services at the time they are rendered. We accept cash, checks, Mastercard, Visa, American Express and Discover for your convenience. If we are a participating provider of your insurance, we will bill them. However, payment is the patient's responsibility. We will help in any way we can to assist you in handling your claim.

All payments are due at time of service. All co-pays will be collected prior to your appointment. All deductibles & coinsurance will be collected prior to surgical services. Failure to cancel appointment more than 24 hours prior will result in an office charge as it limits the ability to provide service to another patient.

Prescription Refills:

Please request all medication refills during normal business hours Monday through Thursday 8-5 and Friday before noon. **If a request is called in after noon the refill will be taken care of within 24-48 hours**. No narcotic medications will be refilled after hours or on the weekend as there is no access to patients charts to safely provide medication administration.

After Hours Care:

Patients can call 239-261-2663 24 hours a day to contact the office or leave a message. Specific instructions for after hours care is provided there or go to jointinstitutefl.com for further details. If it is an emergency call 911.

Patient Registration Form

Method of Payment Cash Check Visa/MC/DC/AE

First Name _____MI ___Last Name_____

Address_____Billing address Yes No

City _____State ____Zip _____ Home Phone _____ Cell _____

Contact Preference: Home Phone Cellphone Text E-Mail SSN: _____

Birthdate _____ Male Female Single Married Widow Declined

Alternate Phone _____ Alternate Address _____

City _____State ___Zip _____Email Address _____

CHIEF COMPLAINT TODAY _____

Who is your Primary Care Dr. _____

How were you referred to us? _____

Responsible Party: Relationship to patient _____ First Name_____MI___Last Name_____

Billing Address_____City _____State _____Zip _____

Contact Phone_____

Please be advised that we are unable to bill any insurance accepted by our office without a copy of the current insurance card. Also, in the event your insurance company denies the claim for ANY reason, you will be personally responsible for the charges incurred.

INITIAL ON EACH LINE

Surgery Cancelation Policy

A fee of $250.00 will be charged if a scheduled surgery is canceled less than 48 hours _____

Office Visit Cancelation & No show Policy

A fee of $50 will be charged if a scheduled office visit is canceled less than 24 hours from appt time _____

Additional Office Charges

A fee of $10 will be charged on CD's with x-rays or any paperwork packet that requires additional time for review

A fee of $50 will be charged for returned checks _____

Assignment of benefits

I authorize assignment of all medical insurance benefits to the named provider for medical services rendered _____

Assignment to pay for services

I agree to pay Joint Replacement Institute for all charges for services rendered today, or any future date of service in this office. I understand payment in full **and/or** co-pay **and/or** co-insurance is expected at the time services are rendered. I further understand, in the event this account is referred to an agency or attorney for collection, I will be responsible for all fees related to said collection. _____

HIPAA Release Form

Patient Name: _____ Date of Birth: _____

RELEASE OF INFORMATION

- ☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information

This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____
- ☐ Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call:

- ☐ My phone: _____
- ☐ My Work: _____
- ☐ My Cell Phone: _____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Do not leave a message

_____ _____

Signature Date

Patient Affordable Care Act

As your health care provider, Joint Replacement Institute, (JRI) has important information to share with you regarding recent changes in the Patient Affordable Care Act (PACA).
One of the new regulations requires providers who utilize electronic health records (EHR), as JRI proudly does, to request additional personal information from our patients and to report this information to the Center for Medicare and Medicaid Services (CMS). Specifically, we are to ask our patients to indicate "Race" and "Ethnicity" as part of the patient profile and then we are to submit a repo rt annually that indicates the percentage of each "Race" and "Ethnicity" that comprise our practice**. No individual or private health information will be included in this report.**

Please note that the information you provide will have no impact on the health care you receive from our JRI providers and staff as our team is committed to providing access to quality physicians and services to all of our patients.

Although your participation is not mandatory, we would appreciate your taking a moment to answer the questions below and return this form to a member of our front office staff. The staff will update your electronic health records at that time

Patient Name:	**Patient Date of Birth:**
Please mark the answer that best describes your ethnicity:	□ Hispanic or Latino □ Not Hispanic or Latino □ Decline to answer
Please mark the answer that best describes your race:	□ American Indian or Alaska Native □ Black or African American □ Asian □ Native Hawaiian or Other Pacific Islander □ White □ Other _____ □ Decline to Answer
Please indicate your Preferred Language:	□ _____ □ Decline to Answer

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Joint Replacement Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Joint Replacement Institute. I understand that diagnosis or treatment of me by a **Joint Replacement Institute Provider** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Joint Replacement Institute** is not required to agree to the restrictions that I may request. However, if **Joint Replacement Institute** agrees to a restriction that I request, the restriction is binding on **Joint Replacement Institute** and **its Healthcare Providers**. I have the right to revoke this consent, in writing, at any time, except to the extent that **Joint Replacement Institute** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Joint Replacement Institute's** Notice of Privacy Practices prior to signing this document. The **Joint Replacement Institute's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Joint Replacement Institute.** The Notice of Privacy Practices for **Joint Replacement Institute** is also posted in the Patient Waiting Rooms. This Notice of Privacy Practices also describes my rights and the **Joint Replacement Institute's** duties with respect to my protected health information.

Joint Replacement Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have read and had the opportunity to have a copy of **Joint Replacement Institute's** Right to Privacy Statement.

Us HIPAA02-1/2/03

_____ _____

Signature of Patient or Personal Representative's Authority Date

JOINT Replacement Institute

Name: _____ **Date:** _____

Patient History

Medical History

☐ AIDS/HIV	☐ CA Breast	☐ Gout	☐ High Cholesterol
☐ Alcoholism	☐ CA Colon	☐ Heart Attack	☐ A-Fib
☐ Alzheimer's	☐ CA Lung	☐ Hypertension	☐ Acid Reflux/GERD
☐ Anemia	☐ CA Prostate	☐ Hepatitis	
☐ Rheumatoid Arthritis	☐ COPD	☐ Kidney	
☐ Asthma	☐ Depression	☐ Osteoarthritis	
☐ Blood Clot Leg	☐ Diabetes	☐ Seizures	
☐ Blood Clot Lung	☐ Drug Abuse	☐ Bleeding ulcers	
☐ Stroke	☐ Sleep Apnea	☐ Blood thinners	

Orthopedic History

☐ None	☐ Spinal Fusion	☐ Right Hip Replacement
☐ Carpal Tunnel Left Wrist	☐ Laminectomy	☐ Right Knee Replacement
☐ Arthroscopy Left Elbow	☐ Cardiac	☐ Fracture Surgery
☐ Arthroscopy Left Shoulder	☐ Carpal Tunnel Right Wrist	☐ Other:
☐ Arthroscopy Left Ankle	☐ Arthroscopy Right Elbow	
☐ Arthroscopy Left Knee	☐ Arthroscopy Right Shoulder	
☐ Arthroscopy Left Hip	☐ Arthroscopy Right Ankle	
☐ Left Hip Replacement	☐ Arthroscopy Right Knee	
☐ Left Knee Replacement	☐ Arthroscopy Right Hip	

Family History

Father Medical History

☐ AIDS/HIV	☐ Diabetes	☐ Kidney	☐ Rheumatoid Arthritis
☐ Anemia	☐ Gout	☐ Liver Disease	☐ Other:
☐ Blood Clots	☐ Heart Attack	☐ Muscle Disease	
☐ Cancer	☐ Hemophilia	☐ Osteoporosis	
☐ Coronary	☐ Hypertension	☐ Osteoarthritis	

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Mother Medical History

☐ AIDS/HIV	☐ Diabetes	☐ Kidney	☐ Rheumatoid Arthritis
☐ Anemia	☐ Gout	☐ Liver Disease	☐ Other:
☐ Blood Clots	☐ Heart Attack	☐ Muscle Disease	
☐ Cancer	☐ Hemophilia	☐ Osteoporosis	
☐ Coronary	☐ Hypertension	☐ Osteoarthritis	

Sibling History

☐ AIDS/HIV	☐ Diabetes	☐ Kidney	☐ Rheumatoid Arthritis
☐ Anemia	☐ Gout	☐ Liver Disease	☐ Other:
☐ Blood Clots	☐ Heart Attack	☐ Muscle Disease	
☐ Cancer	☐ Hemophilia	☐ Osteoporosis	
☐ Coronary	☐ Hypertension	☐ Osteoarthritis	

Social History

Normal

Hand Dominance ☐ Right ☐ Left Height_____ Weight_____

Substances:

Tobacco	Alcohol	Caffeine	Illicit Drugs Type
☐ Y ☐ N ☐ Former	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

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Please check all that pertain to you or check "Neg"

Constitutional ❐Neg
____Weight Loss or Gain
____Weakness
____Fatigue
____Fever

Cardiovascular ❐Neg
___High Blood Pressure
___Chest Pain
___Rheumatic Fever
___Pacemaker

Musculoskeletal ❐Neg
___Joint Pain
___Arthritis
___Muscular Weakness
___Stiffness
___Muscular Pain

Eyes ❐Neg
___Glasses or Contacts
___Blurred Vision
___Glaucoma
___Cataracts
___Excessive Tearing

Respiratory ❐Neg
___Shortness of Breath
___Cough
___Wheezing
___Asthma
___Bronchitis

Skin ❐Neg
___Rashes
___Sores
___Lumps
___Dryness
___Itching

ENMT ❐Neg
___Ears ringing
___Earaches
___Hearing Aid
___Frequent Colds
___Nasal Discharge
___Hay Fever
___Nosebleeds
___Dentures
___Bleeding Gums
___Frequent Sore Throats

Endocrine ❐Neg
___Thyroid Trouble
___Excessive Sweating
___Excessive Thirst

Gastrointestinal ❐Neg
___Heartburn
___Rectal Bleeding
___Abdominal Pain
___Gallbladder trouble
___Hepatitis

Neurologic ❐Neg
___Headache
___Dizziness
___Seizures
___Loss of Sensation
___Vertigo

Hemolymphatic ❐Neg
___Anemia
___Easy Bruising
___Easy Bleeding
___Swollen Glands

Genitourinary ❐Neg
___Blood in Urine
____Urinary Infections
____Kidney Stones
____Burning on Urination
____STD

Psychiatric ❐Neg
___Nervousness
___Depression
___Mood Change

Immunologic ❐Neg
___Reaction to Drugs
___Skin Rashes
___Reactions to Foods

Pharmacy Information

Patient Name: _____ **DOB:** _____

Name of Pharmacy: _____

Pharmacy Phone Number: _____

Pharmacy Address or cross-street: _____

JOINT Replacement Institute

Allergies

Medication	Reaction	Medication	Reaction

Medications

Name	Dose	Frequency

TO OBTAIN MEDICAL RECORDS FROM ANOTHER DR AUTHORIZATION

Date: _____

Patient Name: _____DOB: _____SS#: _____

I Hereby Authorize: _____

_____

_____

To release copies of the following:

_____Medical Records _____Medical Records & X-Rays _____X-Rays _____Psych Eval

_____HIV/AIDS Treatment _____Hepatitis C Testing _____Alcohol/Drug Abuse Eval

To: JOINT REPLACEMENT INSTITUTE

Purpose of Release: _____Continuing Care _____Insurance _____Litigation _____Personal

This Authorization expires on the following date: _____(If no date is specified, this release expires one (1) year from today's date.)

I understand there will be a $10.00 charge for x-rays and agree to pay for the copies at the time of pick-up.

_____

Patient Signature

TO RELEASE MEDICAL RECORDS FROM JRI AUTHORIZATION

Date: _____

Patient Name: _____DOB: _____SS#: _____

I Hereby Authorize: Joint Replacement Institute

To release copies of the following:

_____Medical Records _____Medical Records & X-Rays _____X-Rays _____Psych Eval

_____HIV/AIDS Treatment _____Hepatitis C Testing _____Alcohol/Drug Abuse Eval

To: _____

_____

_____

Purpose of Release: _____Continuing Care _____Insurance _____Litigation _____Personal

This Authorization expires on the following date: _____(If no date is specified, this release expires one (1) year from today's date.)

I understand there will be a $10.00 charge for x-rays and agree to pay for the copies at the time of pick-up.

_____

Patient Signature