ALL-PRO

Orthopedics and Sports Medicine

Dr. Jesse Shaw
17779 SW 2nd Str.
Pembroke Pines, FL 33029

2013 PATIENT INFORMATION

Name(First) _____ (M) _____ (Last) _____ Marital Status: _____

Address: _____ Apt No: _____

City _____ State _____ Zip _____

HomePhone _____ Cell Phone _____ Email: _____

DOB: _____ Age _____ Sex _____ Social Security No: _____ Occupation: _____

Language: English Race: _____ Ethnicity: _____

Employer/School _____ Business Phone: _____

Pharmacy Name _____ Pharmacy Phone: _____

If patient is a minor: Parent/Guardian name _____ DOB: _____

Who may we thank for referring you to us? _____

Primary care physican _____ Phone _____

Please list the name of a person to contact in case of an emergency other than a spouse or parent:

Name: _____ Relationship: _____ Phone: _____

Address: _____ Apt No: _____ City: _____ State _____ Zip _____

PRIMARY INSURANCE

Insurance Company: _____

ID#: _____ Group# _____

Insured's full name: _____ Insured SS# _____ Insured DOB _____

Relationship to Insured (self, spouse, child, other) _____

SECOND INSURANCE

Insurance Company: _____

ID#: _____ Group# _____

Insured's full name: _____ Insured SS# _____ Insured DOB _____

Relationship to Insured (self, spouse, child, other) _____

SIGNATURE OF PATIENT, PARENT OF LEGAL GUARDIAN: _____ DATE: 12/10/2018

ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE

INSURANCE AUTHORIZATION AND ASSIGNMENT OF DENEFITS

I bereby authorize payment of insurance benefits to be made directly to All-Pro Orthopedics ans Sports Medicine for services provided to me by All-Pro Orthopedics. I understand that i am financially responsible to All-Pro Orthopedics and Sports Medicine for charges not covered by this assignment. I authorize All-Pro Orthopedics and Sports Medicine to refund overpayment of insurance benefits where my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. This is authorization will remain in effect until revoked in writting by the undersigned

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Patient Signature: _____ Date: 12/10/2018

PATIENT CONSENT TO TREATMENT AT ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE

I give my consent for evaluation and treatment to All-Pro Orthopedics and Sports Medicine, and its staff members. I unerstand I may rescind this consent at any time, formally in writing, and then will not permit or receive further treatment. As regards the treatments which may be rendered to me at All-Pro, these may include the following:

Initial examination, follow up examination, radiographs, injections, fluid drainage, medications for pain, muscle spasm or inflammation. This will be at the discretion and judgment of me and my medical physician.

Patient Signature: _____ Date: 12/10/2018

Witness name & signature: _____ Date: 12/10/2018

Jesse Shaw, Orthopedic Surgeon www.AllProOrthopedics.com

17779 SW 2nd Street, Pembroke Pines, FL 33029
Phone 954-322-1110 fax 954-322-1099

All-Pro Orthopedics & Sports Medicine P.A
17779 SW 2nd Street
Pembroke Pines, FL 33029
Phone: (954) 322-1110
Fax: (954) 322-1099

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND CONSENT TO USE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A. to use health information about you for treatment, payment, and health care operations perposes.

NOTICE OF PRIVACY PRACTICES: ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A. has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

AMENDMENTS: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may abtain a revised notice by submittings a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: 17779 SW 2nd St, Pembroke Pines, FL 33029 Tel: 954-322-1110/Fax:954-322-1099

Acknowledgement and Consent

I have received the Notice of Privacy Practices for ALL-PRO ORTHOPEDICS AND SPORTS MEDI P.A.. They are authorized to use health information about (please print patient's name)

_____

for treatment, payment, and healthcare operations purposes consident with its Notice of Privacy Practices.

_____	12/10/2018	_____
Signature of Patient	Date	Account #

Personal representative information (if applicable):

_____	_____
Name of Personal Representative	Relationship to Patient

IDENTITY OF RECIPENTS: Provide the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

Permission to Leave Message:

○ Yes ◉ No

____Daytime Phone@# _____

____On My Home Answering Machine Phone@# _____

____On My Voicemail@# _____

____With My Designated and Authorized Person(s) Named Below:

Dr. Jesse Zisholt Shaw, D.O.

ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A

17779 SW 2nd Street
Pembroke Pines, FL 33029-3924
Phone: (954) 322-1110
Fax: (954) 322-1099
Email: orthoshaw@gmail.com

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS: I _____

Do hereby IRREVOCABLY ASSIGN to the above-named medical provider, any right or benefits under my policy of insurance with , for any service and/or charges provided by the above medical provider. Pursuant to this ASSIGNMENT OF BENEFITS, you are hereby directed to mail any and all checks directly and solely payable to the above named medical provider at the address listed on the HCFA-1500A form in box 33. As part of this ASSIGNMENT OF BENEFITS, I hereby instruct the insurance carrier that in the event the medical benefits are disputs for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE PA is to be set aside and not disbursed until the dispute is resolved.

IN WITNESS WHEREOF the undersigned has hereunto set his/her hand, this 10 day of 12, 2018

_____ _____

Patient's Signature Patient's Name (please print)

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicitied** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

		12/10/2018
Name (PRINT or TYPE)	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered I above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (Signature by his/her own hand):

Jesse Z. Shaw , D.O.		12/10/2018
Name (PRINT or TYPE)	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

LETTER OF PROTECTION
ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A.

Jesse Z. Shaw D.O.
17779 SW 2nd Street, Pembroke Pines, FL 33029-3924
Phone: (954)322-1110 Fax: (954) 322-1097

The undersigned patient ("Patient") authorizes All-Pro Orthopedics ans Sports Medicine P.A. ("The Provider") to furnish the undersigned attorney ("Attorney") a full report of examination, diagnosis, treatment, operation and/or prognosis, as filed by the Patient's doctor with respect to health care services and procedures that Patient received or may be receiving the furture with Provider (in the aggregate, "Services") and Provider's bill for services ("the Bill") as related to injury(s) that the Patient sustained as the result of an accident that **occurred on** (date of accident) (the "Accident"). With respect to the Provider providing such services to Patient:

A. Patient further authorizes and directs Attorney to: **1.** Pay directly to the Provider ny and all sums that are due and owing pursuant to the Provider's bill (at Provider's usual and customary charged) and **2.** With hold from the proceeds of any settlement, judgment or verdict (the "Award") all sums owing to the Provider equal to Obligation: and **3.** Pay Obligation owed to Provider without right of set-off after client signs closing statement and check clears trust account.

B. Patient further agrees and grants the Provider an irrevocable lien on the Award to the extent of such obligation. Additionally Patient agrees that this Letter of Protection shall be irrevocable once the Obligation arises. Finally, Patient agrees that, as a material condition of the Provider entering into this Letter of Protection and providing the services to Patient, any substitute legal counsel shall be bound by and required to execute this Letter Protection.

C. The Patient understands and further agrees that: **1.** Patient is fully responsible for the Obligation and **2.** This Letter of Protection is entered into to provide protection to the Provider in consideration of Provider agreeing to await payment for the Obligation: and **3.** Payment for any services provided to Patient by Provider is not contingent upon any award and the Provider may collect at any time for such services from any source (including, but not limited to a Patient's other party payer for health related items and services) and **4.** Patient agrees to pay all of the Provider's cost, claims, damages of any kind if this Letter of Protection is breached by Patient or if any dispute regarding it arises.

The execution of this Letter of Protection by the Attorney is a material condition of the Obligation and Provider entering into this Letter of Protection.

THE UNDERSIGNED PATIENT AGREES TO ALL OF THE FOREGOING TERMS AND CONDITIONS

_____ 12/10/2018

Signature of Patient Patient's Printed Name Date

_____ _____

Witness Signed Name If patient is a minor, name and relationship to patient

THE UNDERSIGNED ATTORNEY AGREES TO ALL OF THE FOREGOING TERMS AND CONDITIONS AND FURTHER SPECIFICALLY AGREES (1) TO WITHHOLD THE AMOUNT OF THE OBLIGATION FOR SERVICES OF PROVIDER FROM THE AWARD AND (2) IN THE EVENT THAT THERE IS COVERAGE IN THIS CASE FROM WORKERS' COMPENSATION, AN HMO, PPO, IPA OR ANY OTHER HEALTH UNSURANCE AND/OR HEALTH PLAN (IN THE AGGREGATE, THE "PAYERS") FOR WHICH THE PROVIDER HAS AGREED TO ACCEPT FULL PAYMENT AT A LEVEL THAT IS BELOW THE PROVIDER'S USUAL AND CUSTOMARY BILLED FEES, THE PROVIDER SHALL ACCEPT AS FULL PAYMENT AND APPROPRIATE AND APPLICABLE NEGOTIATED FEE SCHEDULE AMOUNT(S) FOR SERVICES RENDERED BY PROVIDER IN THIS CASE ONLY IF THERE IS NO OTHER RECOVERY FROM ANY OTHER PARTY OR PAYMENT BY SOME COLLATERAL SOURCE OTHER THAN THE PAYERS NOTED ABOVE.

_____ 12/10/2018

Attorney Signed Name Attorney's Printed Name Date

ALL-PRO ORTHOPEDICS

NEW PATIENT MEDICAL HISTORY FORM

Patient name: _____ Height: _____ Weight _____

Race: ○ Caucasian○ African American○ Hispanic ○ Asian ○ other _____

Ethnicity: ○ Hispanic ○ Non-Hispanic○ other _____

Preferred Language: ○ English○ Spanish○ Chinese○ other _____

Preferred Parmacy: _____

Preferred Source: Doctor (Name): _____Other (ex. Google Search): _____

Chief Complaint

Dominant Hand: ○ Right ○ Left○ Ambidextrous

Description of Sysptoms: (select only ONEprimary sysptom and ONE affected area)

○ Pain ○ Numbness/Tingling○ Fracture○ Stiffness○ Other

Shoulder	○ Right○ Left	Pelvis	○ Right○ Left	Neck	○
Upper Arm	○ Right○ Left	Hip	○ Right○ Left	Upper back	○
Elbow	○ Right○ Left	Thigh	○ Right○ Left	Mid Back	○
Forearm	○ Right○ Left	Knee	○ Right○ Left	Low Back	○
Wrist	○ Right○ Left	Lower Leg	○ Right○ Left	Buttocks	○
Hand	○ Right○ Left	Ankle	○ Right○ Left	Tail Bone	○
Thumb	○ Right○ Left	Foot	○ Right○ Left		
Index	○ Right○ Left	Great Toe	○ Right○ Left		
Middle	○ Right○ Left	2nd Digit	○ Right○ Left		
Third	○ Right○ Left	3rd Digit	○ Right○ Left		
Little	○ Right○ Left	4th Digit	○ Right○ Left		
		4th Digit	○ Right○ Left		

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident

○ No Injury○ Injury○ Injury at Work○ Auto Accident○ Sport Injury○ Prior Surgery

How long have the sysptoms been present (ex. 2 days, 4 months) _____

Describe the onset: ○ Acute (sudden)○ Chronic condition (> 3 months)

Onset date: (mm/dd/yyyy) _____

2. Are you represented by an attorney ○ Yes○ No

Attorney Name _____

Will there be any legal actions with respect to this problem? ○ Yes○ No

3. Have you had a problem like this before? ○ Yes○ No

Describe: _____

_____

4. Have you been seen in an ER? ○ Yes○ No

Treating ER: (ex. St. Luke's Health) _____ Date: (mm/dd/yyyy) _____

Patient Name: _____

History of Present Illness (continued)

5. Race the pain (10 being the most pain):

○ 1○ 2○ 3○ 4○ 5○ 6○ 7○ 8○ 9○ 10

6. Do the symptoms wake you from sleep?

○ Yes○ No

7. Please describe the symptoms:

○ Sharp○ Dull○ Stabbing○ Throbbing○ Aching○ Burning○ Shooting

8. What is the timing of the symptoms?

○ Constant○ Intermittent (comes and goes)

9. Is the problem getting better or worse?

○ Getting better○ Getting worse○ Unchanged

10. What makes the symptoms worse?

○ Squatting○ Kneeling○ Sitting○ Bending○ Stairs○ Twisting○ Moving○ Lying in bed○ Running○ Walking○ Athletics○ Standing○ Gripping○ Lifting○ Reaching Overhead

11. Are there any other symptoms associated with this problem?

○ Redness○ Bruising○ Swelling○ Numbness○ Stiffness○ Limping○ Clicking○ Locking○ Popping○ Tingling○ Weakness○ Giving way

Prior Testing / Treatment

How you had any prior tests? ○ None○ X-rays○ MRI○ CT Scan○ Never Test (EMG/NCV)○ Bone Scan

How you had any prior treatment for this problem? ○ Yes○ No

Type of treatment	Status of symptoms after treatment (select only those that apply)	Date of treatment
Ice	○ Improved○ Worsened○ Unchanged	
Heat	○ Improved○ Worsened○ Unchanged	
Rest	○ Improved○ Worsened○ Unchanged	
NSAIDs	○ Improved○ Worsened○ Unchanged	_____
Muscle Relaxers	○ Improved○ Worsened○ Unchanged	_____
Chiropractor	○ Improved○ Worsened○ Unchanged	_____
Physical Therapy	○ Improved○ Worsened○ Unchanged	_____
HomeExerciseProgram	○ Improved○ Worsened○ Unchanged	_____
Surgery	○ Improved○ Worsened○ Unchanged	_____
Injections	○ Improved○ Worsened○ Unchanged	_____
Bracing	○ Improved○ Worsened○ Unchanged	_____
TENS unit	○ Improved○ Worsened○ Unchanged	_____

Other/Comments

_____
_____
_____
_____
_____

_____

Patient Name: _____

Select all previous Hospitalizationa/surgeries: ☐ None

☐ Aneurysm (Brain) Surgery
☐ Aortic Bypass / Vascular Surgery
☐ Appendectomy
☐ Cataract (Eye) Surgery
☐ Cholecystectomy (Gallbladder)
☐ Heart Surgery
☐ Hernia Repair
☐ Hysterectomy
☐ LAP Band/Gastric Bypass Surgery
☐ Lumpectomy
☐ Mastectomy
☐ Malignancy/Cancer
☐ Stents

Orthopedic on side:	Right	Left
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
Total Shoulder Replacement	○	○

Spinal Surgery - Indicate Level: _____

Other Surgery

_____
_____
_____
_____
_____

Other Orthopedic Surgery

_____
_____
_____
_____
_____

Medical Questions
Mark all that currently apply:

○ Meta in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you talking blood thinners: ○ Yes ○ No

Review of Systems
Please indicate if you have experienced any of the following symptoms in the last 6 months?

○ None of all

	None	Comment
1. GI ○Heartburn, Ulcers ○Nausea, Vomiting ○Blood in Stool	○	
2. ENDO ○Fever ○HeatorColdIntolerance ○Night Sweats	○	
3. CON ○Weight Loss ○Loss of Appetite ○Fatigue	○	
4. EYE ○Blurred Vision ○Double Vision ○Vision Loss	○	
5. ENT ○Hearing Loss ○Hoarseness ○Trouble Swallowing	○	
6. CV ○Chest Pain ○Palpitations	○	
7. RS ○Chronic Cough ○Pneumonia ○Shortness of Breath	○	
8. GU ○Painful Urination ○Blood in Urine ○Kidney Problems	○	
9. SK ○Frequent Rashes ○Skin Ulcers ○Lumps ○Psoriasis	○	
10. NEU ○Frequent Falls ○Loss of Coordination ○Numbness ○Change in Bowel ○Change in Bladder ○Dizziness	○	
11. PSY ○Depresion/Anxiety ○Drug/AlcoholAddiction ○Sleep Disorder	○	
12. HEM ○Easy Bleeding ○Easy Bruising ○Anemia	○	

Patient Name: _____

Family History

Have any direct relatives had any of the following disorders? ○ None for all

Father

○ None	○ Diabetes	○ Heart Disease	○ Hypertension
○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer

Comments (ex. Cancer type) _____

Mother

○ None	○ Diabetes	○ Heart Disease	○ Hypertension
○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer

Comments (ex. Cancer type) _____

Sibling

○ None	○ Diabetes	○ Heart Disease	○ Hypertension
○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer

Comments (ex. Cancer type) _____

Social History

Do you use tobacco? ○ Daily ○ Occasionally ○ Former smoker ○ Never ○ Unknown

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Marital Status: ○ Married ○ Single ○ Divorced ○ Windowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled

If no, what date did you last work? _____

Please list work restriction, if any: _____

Occupation _____ Employer _____ ○ Student

Patient Name: _____

Pain Diagram

Do you have any allergies? ○ Yes ○ No If Yes, Please list below:

Medication, Relevant Food, or "Seasonal"	Reaction

Latex allergy? ○ Yes ○ No

Please list all medications you take on a regular basis: ○ None

Medication	Dosage and Frequency (e.g. 20 mg, once/day)

Do you have a personal history of any of the following? ☐ None

☐ AneurysmWhere:	☐ Emphysema	☐ Kidney Disease
☐ Angina (Chest Pain)	☐ Epilepsy	☐ Kidney Stones
☐ ArthritisType:	☐ Heart Attack	☐ MRSA Infection
☐ Asthma	☐ Hepatitis Type:	☐ Pacemaker
☐ Bone or Joint Infections	☐ HIV / AIDS	☐ Phlebitis (Blood Clots)
☐ Cancer Type:	☐ High Cholesterol	☐ Pulmonary Embolism
☐ Chemotherapy / Radiation	☐ Hypertension	☐ Reaction to Anesthesia Type:
☐ COPD	☐ Hyperthyroidism	☐ Seizures
☐ Congestive Heart Failure	☐ Hypothyroidism	☐ Stomach Ulcers
☐ Diabetes Type:	☐ Last A1C:	☐ Stroke / TIA
		☐ Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

_____

_____

_____

_____

_____
Signature

12/10/2018
Date