Dr. David Ethier

Greetings,

We at Belleview Orthopedic Center are pleased you chose us and we welcome you to our practice. That we might serve you better and lessen any anxiety; additional information is provided below.

We encourage you to arrive approximately 15 minutes prior to your scheduled appointment to allow time to process your paperwork. Please bring your insurance cards and photo identification for us to copy. The new patient packet of forms attached are for your convenience to complete prior to your arrival to make your visit less hectic. If you need help with completing the forms our friendly staff will gladly assist you.

X-rays are a vital tool in assessing the musculoskeletal system and a picture is worth a thousand words. If you have or are able to obtain your X-rays, CT scans, or MRI's; bring them with you. If current X-rays are needed they can be performed on site and can be used to compare with older radiographs you may bring.

Please bring a written list of your medications and doses or bring the bottles so we can accurately record and evaluate your medication needs.

We do not accept credit cards so please bring check or cash as payment is collected at time of service.

Sincerely yours,

DAVID B. ETHIER, MD

11531 SE US Hwy 301, Belleview, FL 34421 O: 352-307-7678, F: 352-307-7677 W: BelleviewOrthopedics.com

DAVID B. ETHIER, MD, P.A.

PATIENT INFORMATION FORM

PATIENT'S NAME:______________________________DATE:_________AGE:______

REFERRED BY:_____________________FAMILY PHYSICIAN:___________________

1. What is the reason for today's appointment (area of pain or complaint)?
   Please describe:____

____

____

2. Was this Sudden or Gradual in onset?_________Date or approx.date started:______
3. Due to an accident? ☐No ☐Yes Auto-What State?_____Work Injury?____________
   Other?____________If "yes"- Describe Accident:_____________________________

____

4. Have you had treatment for this problem by a Physician or self? ☐No ☐Yes
   Please Explain:____

____

5. Does anything help or improve condition?___________________________________
6. What seems to make condition worse or aggravate it?_________________________

____

7. Have you had any previous injury or pain in this same area? ☐No ☐Yes When?____

____

8. Any current medical problems being treated by another Physician?_______________

____

9. Any previous serious illnesses?____

____

10. List all previous surgeries:____

____

11. **ARE YOU ALLERGIC TO ANY MEDICATIONS?:**___________________________

____

12. List **ALL** medications (Prescription & Non-Prescription) you are currently taking:

Name of Medicine	Dosage	How Often	Name of Medicine	Dosage	How Often
(1)____________		________	(2)____________		________
(3)____________		________	(4)____________		________
(5)____________		________	(6)____________		________

ADDITIONAL NOTES:____

____

____

____

DAVID B. ETHIER, MD, P.A.

PATIENT REGISTRATION FORM

NAME:________________________ ☐M ☐F **DATE OF BIRTH:**________________

Home Phone# (__)__________Cell Phone # (___)_________Soc.Sec.#____________

Home Address:____________________Apt/Lot____City:_______State:___Zip:_____

Mailing Address:_______________________City:________State:____Zip:_________

PATIENT'S EMPLOYER:_____________Work Phone:(__)_____Occupation:_________
ARE YOU A STUDENT:____ ☐ Full time ☐ Part Time Name of School:____________

PARENT/SPOUSE NAME:_____________________Social Security #:____________
Employer:_________________Work Phone:_________Occupation:______________

EMERGENCY CONTACT:NOT LIVING WITH YOU: Friend or Relative Name:________
How related:____________Phone #: ___________ Address:_____________________

INSURANCE: Do you have Medical Insurance? ☐ No ☐ Yes
If you were injured at work,will this be covered by Work Comp?___if yes, Date of Injury:
______ Employer (if different from above):_______________Phone #:______________
Do you have Report of Injury Form? ☐No ☐Yes Ins.Co.Name:________Phone#:_____

Is there a Law Suit Pending? ☐No ☐Yes **Do you anticipate filing a Law Suit for this Injury?** ☐No ☐Yes

PLEASE PROVIDE INSURANCE CARDS FOR US TO MAKE COPIES

PRIMARY INSURANCE:____________________GROUP/POLICY#:_______________
Policy Holder's Name:__________________DOB:__________SSN:_______________
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
SECONDARY INSURANCE:__________________GROUP/POLICY#:_____________
Policy Holder's Name:__________________DOB:__________SSN:_______________
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

NOTE: ALL FEES ARE THE ULTIMATE RESPONSIBILITY OF THE PATIENT, REGARDLESS OF INSURANCE:______ (PLEASE INITIAL)

DAVID B. ETHIER, MD, P.A.

MEDIGAP POL: I request that payment of Authorized MEDIGAP benefits be made on my behalf to Dr. David B. Ethier, M.D, P.A. I authorize any holder of medical information about me to release to the insurance company any information needed to determine these benefits and make payable these benefits for related services. I understand that I do not need to provide my supplemental insurer with information concerning this medical claim, because my signing this authorization will cause medicare payment authorization to cross cover automatically.

**Signature_______________________________Date:______________

RELEASE OF INFORMATION: I Authorize any holder of medical or other information about me to be released to my Physician, insurance carrier, SSI administration, or the billing agent, for this or a related claim. I agree these records may be sent by fax. **This authorization places no restrictions on any information to be released, including treatment for alcohol or drug abuse. **I permit a copy of this authorization to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that insurance is considered a method of reimbursement and a contract between myself and my insurance company, and is not a substitute for payment. I understand and agree it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by assigned insurance within a reasonable period of time not to exceed 60 days. In the event of non-payment, the patient shall be responsible for all cost incurred in collecting the amount due for services rendered, including reasonable attorney's fees, with the amount due and the costs accruing interest at the rate of 20% per annum.

<u>*WE MUST HAVE THE SIGNATURE OF THE RESPONSIBLE PARTY FOR SERVICES RENDERED.</u>**

**Signature_______________________________Date:_________________

DAVID B. ETHIER, MD, P.A.

P.O. Box 4118, 11531 S. U.S. Hwy 301, Belleview, Florida 34421

PATIENT CONSENT FORM (45 CFR 164.506)

Our Notice of Privacy Practices provides detailed information about how we may use and disclose your PHI. You have a legal right to review out Notice of Privacy Practices about disclosures of your PHI before you sign this consent and we encourage you to read it fully. By signing this form you are acknowledging that you have read out Notice of Privacy Practices.

We reserve the right to change the terms of our Privacy Notice and to make the new notice provisions effective for all PHI that we maintain. If we change our notice, you may obtain a copy of the revised notice by notifying out privacy official.

You have the right to request us to restrict how we use/disclose your PHI for the purposes of treatment, payment, and/or healthcare operations. All requests must be made in writing, space is provided below. We are *not* required to grant your request. However, if we decide to grant your request we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we have already used or disclosed you PHI in reliance on your consent.

Specific restrictions or instructions:

I have read the Notice of Privacy Practices and grant consent for use and disclosure of my protected health information as specified in the Notice with the exception of the above restrictions.

Signature:____________________Printed Name:____________________Date:_____

Relationship, If Minor Patient:________________________

DAVID B. ETHIER, MD, P.A.