

MICHAEL T. REILLY, M.D. F.A.A.O.S.

DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY
SPORTS MEDICINE & RECONSTRUCTIVE SURGERY
UPPER & LOWER EXTREMITIES

DAVID H. GILBERT, M.D.

DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY
HAND, WRIST, & UPPER EXTREMITY
MICROVASCULAR RECONSTRUCTION

Office: (954) 771-3334 Fax: (954) 771-1069
www.BrowardOrthopedic.com



- Photo ID
- Ins Card

Please bring completed paperwork with you to your appointment

- Michael T. Reilly, MD
- David H. Gilbert, MD

Appointment Date: _____ **at** _____

- Mon
- Tues
- Wed
- Thurs
- Fri



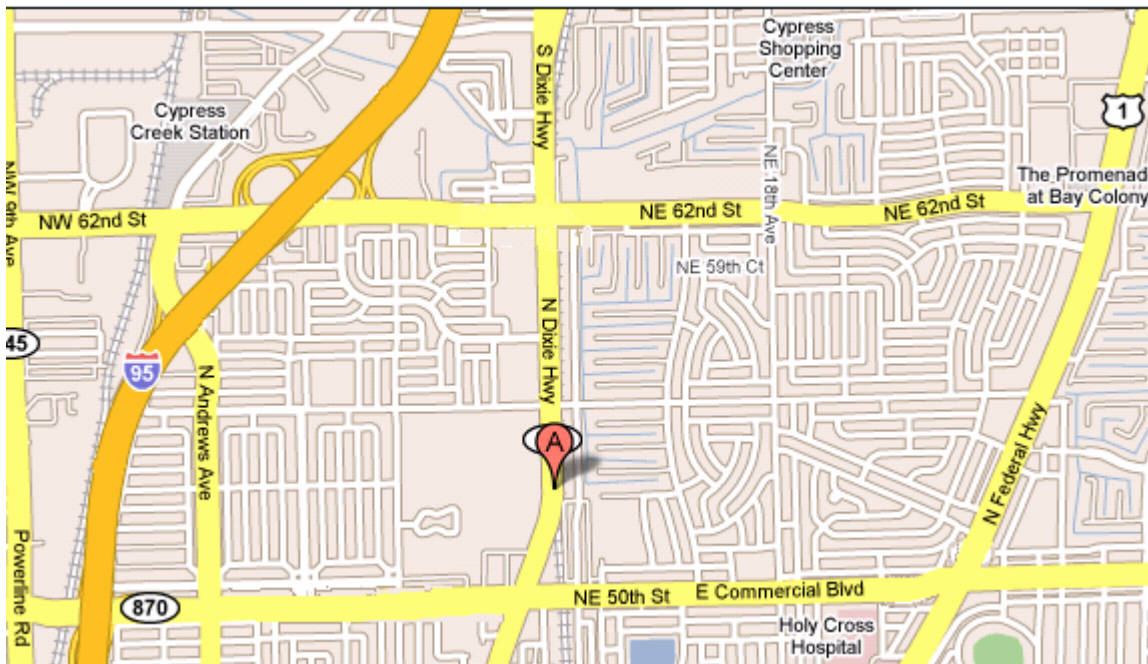
Directions to Broward Orthopedic Specialists
5301 N. Dixie Hwy, Suite 203

From North/West:

Take I-95 South and exit at Cypress Creek Road going left (east). Turn right (south) on Dixie Highway and travel (0.7 mile) to 5301 N. Dixie Hwy, Suite 203.

From South/West:

Take the Florida Turnpike or I-95 North. Exit at Commercial Boulevard East. Turn left (north) on Dixie Highway and travel (0.3 mile) to 5301 N. Dixie Hwy, Suite 203.



BROWARD ORTHOPAEDIC

SPECIALISTS

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WELCOME!

All the staff at Broward Orthopedic Specialists would like to take this time to extend a heartfelt welcome to you as a new patient to our practice. Seeing a doctor is not something that most people look forward to; however, we want you to know that you are important to us. Every effort will be made to make your visits comfortable and productive. We look forward to providing you with the best trained technical staff and physicians Florida has to offer.

Patient satisfaction is the most rewarding part of providing medical care. The goal of this practice is to deliver the highest quality orthopedic care possible in a gentle and compassionate manner. Your relationship with this office begins when you schedule your first appointment and continues with your visit and any follow-up care that may be necessary. We value this relationship with you and will always strive to improve upon it.

Enclosed you will find many papers to fill out which will help expedite your visit with us. It will save you time and you will be able to better fill out these pages in the comfort of your home rather than waiting until the day you come to the office for your first appointment.

Remember to bring these important things on your initial visit to our office:

- ♥ Picture ID
- ♥ Your insurance cards
- ♥ Any studies with the report (ie. MRI, CT Scan) pertaining to your visit
- ♥ All enclosed completed forms
- ♥ Please pay special attention when filling out your forms to the section on "Current Medications" and "Allergies". **This must be filled out completely.**

Remember these important things:

- ♥ On **EACH** visit keep us updated on studies/surgeries you have had since we last saw you and (especially if you travel north) try to bring copies of your studies with the report back with you or have them mailed to us.
- ♥ Feel free to call with any questions you may have. We will always do our best to get you the information you need.
- ♥ Visit our website www.BrowardOrthopedic.com for more information.

Once again, **WELCOME** to our office. We truly hope that you will feel comfortable here and will be pleased with our services. We look forward to your visit with us.

Michael T. Reilly, MD, David H. Gilbert, MD, and Staff

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Dear Patient:

We ask that you read and sign the following page because it concerns all of us. Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company regarding your coverage. **It is your responsibility to know your individual coverage.** Failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company, not between your doctor and your insurance company.

It is our office policy to collect co-pays, co-insurance and deductibles at time of service and prior to any surgical procedures.

To assist you in finding out what coverage you have, feel free to ask for assistance in finding phone numbers or addresses of your insurance company. Many insurance companies today need referral forms from a primary care physician or group. If your insurance meets this requirement it will be your responsibility to furnish this referral at time of service. Failure to do so may require you to reschedule your appointment. Some insurance companies state you cannot go out of network. Many companies have instituted a mandatory second opinion program, and these are constantly changing day by day. It is impossible to keep up with the changes and often we are not aware of them until it is too late.

Please Sign

Please Print

PLEASE PRINT

PATIENT INFORMATION

Name: (First) _____ (MI) _____ (Last) _____
Date of Birth _____ Age _____ Sex: M F Marital Status: S M W D
Primary Mailing Address _____ City _____ State _____ Zip _____
Secondary Mailing Address _____ City _____ State _____ Zip _____
Home Phone # (_____) _____ Cell # (_____) _____
PREFERRED PHONE # TO CONFIRM APPTS / CALL BACKS/ TEST RESULTS, etc: # (_____) _____
Social Security # _____ - _____ - _____ Email: _____
Work # _____ Employer: _____
Employer's Address: _____
If Student, School Name: _____ Full Part Time
Referring Physician: _____ City: _____ Phone # _____
Friend or Relative Not Living with You: _____ Phone # _____

RESPONSIBLE PARTY or EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____
Address: (Street, City, State, Zip) _____
Phone # _____ Social Security # _____ Driver License # _____
Work # _____ Employer: _____

INSURANCE INFORMATION

Auto Health Other _____ Workers' Comp DATE OF INJURY: _____
Insurance Co: _____ Phone # _____
Group # _____ Policy or I.D. # _____
Insured's Name: _____ Relationship to Patient: Self Spouse Dependent
Insured's Employer: _____ Phone # _____
Insured's Social Security # _____ Date of Birth: _____ Sex: M F

If the patient is covered by a second insurance policy, please complete the following information below for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

SECONDARY INSURANCE INFORMATION

Insurance Co: _____ Phone # _____
Group # _____ Policy or I.D. # _____
Insured's Name: _____ Relationship to Patient: Self Spouse Dependent
Insured's Employer: _____ Phone # _____
Insured's Social Security # _____ Date of Birth: _____ Sex: M F

I hereby assign, transfer, and set over to MICHAEL T. REILLY, M.D. & DAVID H. GILBERT, M.D., PA, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This is a lifetime authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. If I fail to pay my charges, I agree to pay the cost of collection, including reasonable attorney fees. There will be a \$25 fee assessed for checks returned by the bank for any reason.

I authorize MICHAEL T. REILLY MD & DAVID H. GILBERT MD to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100 percent of my benefits, within ninety (90) days of any and all appeals or request for information. I also agree that any fines levied against my insurance company will be paid to MICHAEL T. REILLY MD & DAVID H. GILBERT MD, for acting as my personal representative.

I authorize release of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

Patient's Signature _____ Date _____

(IF MINOR, PARENT SIGNATURE)

DATE: ____ / ____ / ____

HEIGHT: _____

PLEASE PRINT

PATIENT HEALTH INFORMATION

WEIGHT: _____

ANSWER ALL QUESTIONS TO AVOID DELAYS

RIGHT HAND DOMINANT

PATIENT NAME _____

AGE: _____

LEFT HAND DOMINANT

REASON(S) VISIT _____

LIST CONTRIBUTING EVENTS OR KNOWN CAUSES FOR SYMPTOMS: _____

HOW LONG HAS SYMPTOMS BEEN PRESENT (Or date of injury?) _____

DO SYMPTOMS INCLUDE PAIN?: Yes No (If yes, check all that apply with severity of pain)

SEVERITY OF PAIN: Circle rating of 1-10 for severity of symptoms with 10 being the worst

Sharp 1 2 3 4 5 6 7 8 9 10 Dull 1 2 3 4 5 6 7 8 9 10

Burning 1 2 3 4 5 6 7 8 9 10 Stabbing 1 2 3 4 5 6 7 8 9 10

FREQUENCY OF PAIN: CONSTANT INTERMITTENT PROGRESSIVE NOT PROGRESSIVE

DO SYMPTOMS INCLUDE? SWELLING WEAKNESS NUMBNESS

DECREASED RANGE OF MOTION PINS/NEEDLES SENSATION

IF APPLICABLE, IS THE JOINT? POPPING LOCKING CLICKING INSTABILITY/GIVING WAY

WHAT ACTIVITIES WORSEN YOUR CONDITION? _____

PAST TREATMENT OF YOUR CURRENT PROBLEM? (Check all that apply)

ICE TREATMENT PHYSICAL THERAPY INJECTIONS (How many?) _____

HEAT TREATMENT REST (Specify amount of time) _____

RELATED PAST SURGERIES? (Specify with dates) _____

MEDICATIONS (For current problem) _____

OTHER MEDICATIONS YOU ARE CURRENTLY TAKING (List) _____

Do you have drug allergies? No Yes (List) _____

MEDICAL HISTORY

HAVE YOU BEEN DIAGNOSED TO HAVE ANY OF THE FOLLOWING? (You **MUST** answer **Yes or No** to all questions)

- Yes No ALCOHOLISM
- Yes No ARTHRITIS (Location) _____
- Yes No ASTHMA
- Yes No BLOOD CLOTS
- Yes No BLOOD DISEASES---- Anemia Leukemia
- Yes No BLOOD TRANSFUSION (When) _____
- Yes No BRONCHITIS
- Yes No CANCER (Type) _____
- Yes No CATARACTS
- Yes No COLITIS
- Yes No DIABETES
- Yes No DIVERTICULITIS
- Yes No DRUG ADDICTION
- Yes No EMPHYSEMA
- Yes No EPILEPSY
- Yes No FRACTURES/BROKEN BONES (Where?) _____
- Yes No GLAUCOMA
- Yes No GOUT
- OTHER _____
- Yes No HEART DISEASE--- Mitral Valve Prolapse Murmurs
- Abnormal Rhythm Congestive Heart Failure
- Heart Attack (MI) How many? _____
- Yes No HEPATITIS -----If Yes: A B C
- Yes No HERNIA ----- Inguinal Hiatal
- Yes No HIGH BLOOD PRESSURE
- Yes No HIGH CHOLESTEROL
- Yes No HIV POSITIVE
- Yes No KIDNEY DISEASE---- Kidney Stones Kidney Cysts
- Yes No LATEX ALLERGY
- Yes No LIVER CIRRHOSIS
- Yes No OSTEOPOROSIS
- Yes No PARKINSONISM
- Yes No PEPTIC ULCERS
- Yes No PROSTATE--- Enlarged Inflammation Cancer
- Yes No PSORIASIS
- Yes No STROKE
- Yes No THYROID DISEASE

(PLEASE TURN OVER AND COMPLETE BACK SIDE) →

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CONSENT & ACKNOWLEDGMENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you consent to the use and disclosure of your protected health information (see definition below) by *Michael T. Reilly, M.D. & David H. Gilbert, M.D.*, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Privacy Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting *Michael T. Reilly, M.D. & David H. Gilbert, M.D.* at (954) 771-3334 and requesting a revised Notice. We will also post any revised notice at the office of *Michael T. Reilly, M.D. & David H. Gilbert, M.D.* and our website (BrowardOrthopedic.com). You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

*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.

This information will not be sold to outside entities for marketing purposes.

Signature / Acknowledgment

Name of Patient or Guardian (PLEASE PRINT)

Date

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Authorization to Discuss Protected Health Information

I _____, authorize the office of Michael T Reilly, MD & David H. Gilbert MD to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information to the following named person(s): **DO NOT list physicians**, they are already included under HIPAA law

- 1. _____ (relationship) _____
- 2. _____ (relationship) _____
- 3. _____ (relationship) _____
- 4. _____ (relationship) _____

❖ **BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.**

❖ **YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE (In this case write "none" on line 1)**

Please list phone numbers where you would like us to contact you for:

- Results – Labs, MRI's, Ultrasounds, Scans, etc
- Changes on scheduled appointments

- 1. _____
- 2. _____

Patient Name: _____

Date of Birth: ____/____/____

Patient or Guardian Signature

_____/_____/_____
Date

MICHAEL T. REILLY, MD

NAME: _____

DATE: _____

Mark the areas on diagram where you feel your described sensations. Mark areas of radiation. Include all affected areas. **[Use appropriate symbol below]**

SYMBOL

NUMBNESS / PINS & NEEDLES = O
PAIN / DISCOMFORT = X

