ADVANCED
ORTHOPEDICS
INSTITUTE

Alfred J. Cook, Jr., M.D.
Board Certified Orthopedic Surgeon
Specializing in Sports Medicine, Shoulder Surgery,
and Cartilage Regeneration

Date_____

We thank you for scheduling your appointment with Advanced Orthopedics Institute, PA. Your appointment is on _____ with _____.

Our office is located at:

1400 N US HWY 441 Suite 552
The Villages, Florida
32159
At the intersection of 441/27 and Bella Cruz Dr.
Located on the second floor of the Sharon Morse building

Included with this letter is new patient paperwork and a medical records release form. The release form can be helpful if you need to request medical records from your previous orthopedic doctor.

If you have any questions, please call us at (352) 751-2862.

Thank you,

AOI Team

▷ If you need to cancel or reschedule your appointment, please try to do so at your earliest convenience so we may attempt to offer your time to another patient.

Things you should bring to your appointment:

CHECKLIST

- ☐ Completed New Patient Paperwork
- ☐ Current Health Insurance card(s)
- ☐ Current Driver's License
- ☐ List of your medications and surgeries
- ☐ Any X-rays, MRI, CT Scan (please bring films on disc and a report)
  Please Note: These are not required if your test was done at Lake Medical Imaging, MIT, Leesburg Regional Medical Center, or The Villages Regional Hospital
- ☐Other_____

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Alfred J. Cook, Jr., M.D.

Patient:_____

Street Address:_____

City/State/Zip Code:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email Address:_____

Secondary address:_____

_____

Date of Birth:_____ SSN:_____ Sex:_____ Marital Status:_____

Are you: Retired?_____ Student?_____ Work Full time?_____ Work Part time?_____ Unemployed?_____

Employer:_____ Employer's Phone:_____

Spouse Name:_____ Spouse DOB:_____

Spouse's Employer:_____ Employer's Phone:_____

Parent Name (if minor):_____ Parent SSN:_____ Parent DOB:_____

Parent's Employer:_____ Employer's Phone:_____

Emergency Contact:_____ Relation:_____ Phone:_____

Primary Insurance:_____ Subscriber Name:_____

Insurance Address:_____

Policy #:_____ Group #:_____

Secondary Insurance:_____ Subscriber Name:_____

Insurance Address:_____

Policy #:_____ Group #:_____

Who is your Primary Care Physician?_____

Who referred you to us?_____

Which pharmacy and location do you prefer?_____

Do you have allergies? ☐ Yes ☐ No

If yes, please list them:_____

****

IT IS OUR POLICY THAT ALL OFFICE VISITS AND OFFICE SERVICES ARE TO BE PAID FOR AT THE TIME THESE SERVICES ARE RENDERED.

HOW WILL YOU BE PAYING? ☐ Check ☐ Cash ☐ Charge

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, WHETHER OR NOT THEY ARE PAID FOR OR SUPPLEMENTED BY INSURANCE COMPANY.

New Beneficiary Signature Regulations in effect since April 1, 1992, allow physicians (or other suppliers in most cases) to obtain from the beneficiary and retain in their files, a lifetime signature authorization for the physician or supplier to submit assigned or unassigned claims in the beneficiary's behalf.

The beneficiary must sign a brief statement substantially as follows: "I request that payment for authorized Medicare benefits and any other insurance benefits be made either to me or on my behalf to Advanced Orthopedics Institute for any services furnished me by Advanced Orthopedics Institute. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits or the benefits payable for related services."

_____ _____

Signature of Patient or Responsible Party Date

Advanced Orthopedics Institute

Please fill out this form in its entirety.

PATIENT INFORMATION

Patient Name: _____ **Date:** _____

DOB: _____ **Height:** _____ **Weight:** _____

Current Problem

What are you being seen for today: _____

Date of Injury or start of pain: _____

It this work related?	O Yes	O No
Is this the result of a motor vehicle accident?	O Yes	O No

Pain Description

Severity of your pain?	O Mild	O Moderate	O Severe
Type of pain?	O Sharp	O Dull	O Other: _____

Social History

Do you smoke cigarettes?	O Current	O Former	O Never
How long have you smoked?	O >1 year	O 1-10 years	O 10+ years
How many packs per day?	O <1 pack	O 1-2 packs	O 3+ packs
Do you drink alcohol?	O Yes	O No	
How many drinks?	O 1-2 per day	O 1-2 per week	O 1-2 per month
Do you have any history of the following	O Anxiety	O Depression	O Drug/Alcohol abuse

Family History

Mother	O Cancer	O Heart Disease	O Stroke	O Arthritis	O Diabetes	O Osteoporosis
Father	O Cancer	O Heart Disease	O Stroke	O Arthritis	O Diabetes	O Osteoporosis
Grandparents	O Cancer	O Heart Disease	O Stroke	O Arthritis	O Diabetes	O Osteoporosis

Allergies (Please list all allergies and your reaction)	

Medications (Please list name of medications and dosage) or O See attached List (If you have a premade list)	

Surgeries (Please list surgery type and year)	

Patient Signature _____ Date _____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the quality care and treatment for all of our patients. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

REGARDING INSURANCE

MEDICARE – We accept Medicare assignment. We also accept SOME Medicare Replacement plans. Please check with the Receptionist before seeing the doctor to make sure your Replacement plan is one that we accept. This means that we have agreed in contract to accept the fees and bill according to Medicare allowed amount. The patient is responsible for the annual deductible and 20% of the approved amount at the time of service except when there is a supplemental policy to pay these amounts.

MEDICAID – We do not accept Medicaid as a form of payment. If you have Medicaid as your healthcare coverage you will be responsible for the charges at the time services are rendered.

SHARE OF COST – It is our policy that the patient will be responsible for any charges incurred at the time of service. Upon payment, a receipt will be given with detailed charges that can be turned into the case worker for reimbursement.

PRIVATE INSURANCE – It is the patient's responsibility to verify with the receptionist that their insurance is one that we accept prior to seeing the doctor. Failure to do so will make the patient responsible to 100% of the charges incurred. All co-pays and deductibles are due at the time of service. In the event, that there is a remaining balance on our account after insurance has paid, payment is due within 30 days of the insurance payment. If payments are not made within 30 days of the insurance payment, then the account will be submitted for collections. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between yourself and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the service provided may be non-covered services and not considered reasonable and necessary under your insurance policy contract.

REFERRAL/AUTHORIZATIONS – Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

SELF PAY – If you do not fall within any of the categories above, we require FULL PAYMENT AT THE TIME OF SERVICE. You will be considered a Self-Pay patient and upon the first visit, a $400 CASH OR CREDIT CARD advance is required. We DO NOT ACCEPT checks for this. After the first visit you may pay by cash, check, Visa, Master Card, Discover, American Express, or CareCredit. Your cash advance will be held until you check out. At that time, your will be asked to pay the remaining balance, if applicable. Please be advised that the $400 cash advance is only an estimate and charges may either be less or more than $400 depending on the services received.

SURGERY PATIENTS – It is the patient's responsibility to check with our Financial Counselor PRIOR to surgery to make financial arrangements.

AUTO/WORKER'S COMP/THIRD PARTY – WE DO NOT ACCEPT ANY OF THESE INSURANCES. If you fall under any of these three categories, then you are considered a Self-Pay patient and are responsible for all charges at the time of service.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

For your convenience we accept CASH, CHECK, CREDIT, OR DEBIT CARDS. If necessary, and if you qualify, WE OFFER AN EXTENDED PAYMENT PLANWITH PRIOR CREDIT APPROVAL.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient's Name (please print)_____ Date_____

Patient or Responsible Party's Signature_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name _____ Birth Date _____

Street Address _____ City, State, Zip Code _____

I hereby authorize Advanced Orthopedics Institute of 1400 North US Highway 441, Suite 552, The Villages, FL 32159 to disclose my protected health information to the following people: (Family, Friends, etc)

_____ _____

_____ _____

Name _____ Relation to patient _____

Information to be released:

_____ All
_____ X-ray Reports/MRI
_____ Laboratory Reports
_____ Allergy Records
_____ Medicare History, Examination Reports
_____ Surgical Reports
_____ Hospital Records including Reports
_____ Prescriptions
_____ Drug Abuse
_____ other: (Please specify)_____

*A listing of the statutory exceptions to release of HIV test results without consent is available.

Purpose for Need of Disclosure:

_____ At the request of the individual

_____

_____

I understand that the health information disclosed, as a result of this authorization, may no longer be protected by the federal privacy standards and my health information might be disclosed without obtaining my authorization.

I understand that I have the right to:

Receive a copy of this authorization.

Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.

Revoke this authorization except to the extent that the person(s) and or organizations(s) listed above have already made in reference in this authorization.

This authorization will remain in effect until the following date(s):_____

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative (authority to act on patient's behalf): Relation to patient _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND
PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I, _____ acknowledge that I have read a copy of Advanced Orthopedics Institute Notice of Privacy Practices. This notice describes how Advanced Orthopedics Institute may use and disclose my protected health information, utilize certain restrictions on the use and disclosure of my healthcare information, and upholds rights I may have regarding my protected health information.

I wish to be contacted in the following manner (check all that apply)

- ☐ Home Telephone:_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

- ☐ Work Telephone:_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

- ☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail my work/office address
- ☐ O.K. to fax to this number

- ☐ Other:_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

For office use only

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to whom Address or fax number	(1)	Description of disclosure/ Purpose of disclosure	By whom disclosed	(2)	(3)

1. Check this box if the disclosure is authorized.
2. Type key: T=Treatment records; P=Payment information; O=Healthcare operations
3. Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

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Prescription Policy

This agreement between the Patient: _____and Prescribing Advanced Orthopedics Institute Provider is for the purposes of establishing agreement on clear conditions for prescription and use of pain control medications prescribed by the Provider for this Patient. Provider and Patient agree that this document is essential in maintaining the trust and confidence necessary in a Provider-patient relationship.

The patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Provider to the Patient.

I understand that the reduction in the intensity of my pain and the improvement in my quality of life are the goals for this medication.

I realize that all the medications have potential side effects and I will have any recommended laboratory studies required to keep the regimen as safe as possible.

I will not use any illegal controlled substances and I will not share, sell or trade any medication for money, goods or services. I will safeguard my medications form loss or theft and agree that the consequences of failure to do so is that I will be without my prescribed medication for some time.

I will not fill the prescription for pain medications from any other healthcare provider without telling them I am taking pain medication by the Provider. If another provider prescribes the pain medications for me, I will inform the Provider, in order to avoid duplication.

I agree that I will use my medication at a rate no greater than the prescribed rate, and that use of my medication at a greater rate will result in my being without medication for a period of time.

I agree to call and request a refill within 2 days of my medication running out.

Acknowledgement of Driving Impairment: I acknowledge that while I am under the care of my Provider, I may be prescribed medication that could impair my ability to operate a motor vehicle, machinery, or other equipment. I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is a question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform such activity until my ability to perform said activity has been formally evaluated, or I have not used any medication for at least four days. As such, I will refrain from operating a motor vehicle under the influence of prescribed medication that impairs judgment. I will arrange for proper transportation and use the proper precautions when taking prescribed medications.

Provider and patient agree that this agreement is essential to the provider's ability to treat the patient's pain effectively and failure of the patient to abide the terms of this agreement may result in the withdrawal of the prescribed medication.

Patient Signature:_____Date:_____Witness:_____

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Appointment Cancellation Policy Agreement:

Advanced Orthopedics Institute, PA is committed to providing exceptional care. Unfortunately, when one patient cancels or misses appointments without giving enough notice, they prevent another patient from being seen. Please call us at 352-751-2862 by 2:00 p.m. on the business day prior to your scheduled appointment to notify us of any changes or cancellations. If your appointment is on Monday, the cut off time to provide notice is 2 pm on Friday. This gives the staff enough time to offer the appointment to another patient.

If timely prior notification is not given by you, you will be charged $50.00 for the missed/cancelled appointment, which must be honored prior to rescheduling. In the event that you no show for the physician's visit on three (3) occasions, you may be dismissed from the practice.

By signing and dating below, you acknowledge and agree that you are consenting to these terms and to your personal financial liability for missed/cancelled appointments.

Please sign below to consent to these terms.

Patient's signature: _____ **Date:** _____

Print name: _____

01/03/2023

ACKNOWLEDGEMENTS AND REPRESENTATIONS RELATED TO AUTO/ WORKERS' COMPENSATION/ THIRD PARTY INSURANCES

I,_____,

(PRINT Patient name)

Initial_____ I acknowledge and understand that Advanced Orthopedics Institute does **NOT** accept Auto, Workers' Compensation, or Third-Party Insurances.

Initial_____ I acknowledge and understand that Advanced Orthopedics Institute does **NOT** get involved with the treatment of problems where litigation is being or will be pursued.

Initial _____ I acknowledge that my current problem(s) for which treatment is sought is **NOT** covered by auto, worker's compensation, or third-party liability insurance(s).

Initial_____ I acknowledge my current problem(s) for which treatment is sought is **NOT** for any work-related injuries.

Initial_____ I have **NOT** been directed to Advanced Orthopedics Institute by my employer or its workers' compensation insurance carrier to treat the current problem(s)

Initial_____ My current problem(s) for which treatment is sought is **NOT** for auto-related injuries.

Initial_____ My current problem(s) for which treatment is sought is **NOT** the subject of any pending litigation.

Initial_____ An attorney has **NOT** been retained in anticipation of litigating the current problem(s) for which treatment is sought.

_____

Patient or Person Authorized to Sign for Patient Date

_____

Witness Date

ADVANCED ORTHOPEDICS INSTITUTE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization : In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.