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, P.A.
Your appointment is on _____ with _____.

Our office is located at:

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

Included in 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,

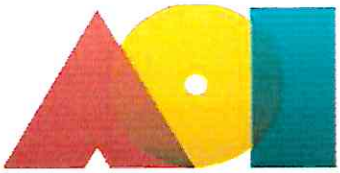
AOI Team

* 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 need to bring to your appointment:

- Completed New Patient Paperwork
- Current Health Insurance card(s)
- Current Driver's License
- List of your medications and past surgeries
- Any X-rays, MRI's, CT Scans (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 _____



ADVANCED ORTHOPEDICS INSTITUTE

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

Patient : _____

Address : _____

City/State/Zip Code : _____

Home Phone : _____ Cell Phone : _____

Work Phone : _____ Email : _____

Secondary Address : _____

_____

DOB : _____ SSN : _____ Sex : _____ Marital Status : _____

Retired? _____ Student? _____ Work: O FT O PT O Unemployed

Employer : _____ Phone : _____

Spouse : _____ Phone : _____

Parent Name (if Minor): _____ DOB : _____

Emergency Contact : _____ Phone: _____

Relation to Emergency Contact : _____

Primary Insurance : _____ Suscriber Name : _____

Insurance Address : _____

Policy # _____ Group # _____

Secondary Insurance : _____ Suscriber Name : _____

Insurance Address : _____

Policy # _____ Group # _____

Primary Care Physician? _____

Who referred you to us? _____

Pharmacy : _____ Address: _____

Allergies : O Yes O No If yes, please list: _____

_____

****

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

How will you be paying? O Check O Cash O Card

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

New Beneficary Signature Regulations in effect since April 1, 1992, allows Physicians (or other suppliers in most cases) to obtain from the beneficiary and retain in their files, a lifetime signature authorization for Physician or Supplier to submit assigned claims on 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 to 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 payable for related services."

Signature of Responsible Party : _____ Date: _____

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Please fill out this form in its entirety

PATIENT INFORMATION

Patient : **Date:**

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

Current Problem			
What are you being seen for today:			
Date of Injury or start of pain:			
Is this work related?		O Yes	O No
Is this related to a motor vehicle accident?		O Yes	O No
Pain Description			
Severity of 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	O Socially
How many drinks?	O 1-2 per day	O 1-2 per week	O 1-2 per month
History of the following?	O Anxiety	O Drug/Alchol abuse	O Depression

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

Allergies (Please list all and your reaction)	

Medications (Please list name and dosage or See attached list if you have list)	

Surgeries (Please list type and year)	

Patient Signature _____ **Date:** _____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the quality care and treatment of 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 assignments. 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.

SHAREOF 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.

PRIVATEINSURANCE- 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 remaining 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, you 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'SCOMP/THIRD PARTY - WE DO NOT ACCEPT ANY OF THESEINSURANCES. 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 for 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 PRIORCREDIT APPROVAL.

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

I have read 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 _____ DATE OF BIRTH _____

STREET ADDRESS _____ CITY, STATE, ZIP CODE _____

I hearby authorize **Advanced Orthopedics Institute** of 1400 N US HWY 441, Ste. 552, The Villages, FL 32159 to disclose my protected health information to the following people (Family, Friends, etc.) :

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Information to be released:

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

*A listing of statutory exceptions for release of HIV test results without concent is available.

Purpose for Need of Displosure :

_____ At request of individual

_____

_____

I understand that the health information disclosed, as a result of this authorization, may no longer be protected by 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 eligibily for the care benefits may be contingent on my signing this authorization.

Revoke this authorization except to the extent that the person(s) and or organization(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 patients' behalf) : Relation to Patient _____

ADVANCED ORTHOPEDICS INSTITUTE

NOTICE OF PRIVACY OF 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 Operation: We may use and disclose your health information in connection with our healthcare operations, Healthcare Operations include quality assessment and improvement activites, 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 healthcare information for treatment, payment or healthcare operations, you may give us written authorization to use your healthcare 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 meansof communication to ensure privacy.

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

Required by Law: We may use your health information when we are required 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

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.

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

QUESTIONS AND COMPLAINTS

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 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 contract information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health Services. We will provide you with the address to file your complaint with the U.S. Department of 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 to the U.S. Department of health and Human Services. A Privacy/Contact Officer has been designated for this office. The 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.

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

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

I, _____ acknowledge that I have read a copy of Advanced Orthopedics Institute of Privacy Practices. This notice describes how Advanced Orthopedics 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 reguarding my protected health information.

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

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

O Written communication
O O.K. to mail to my home address
O O.K. to mail to my work/office

O Other: _____

_____ Patient signature

_____ Date

_____ Print Name

_____ Date of Birth

For office use only

The Privacy Rule generally required healthcare providers to take reasonable steps to limit the use of disclosure of, and requests that for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to users of disclosures made pursuant to an authorization requested by an 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 premitted without prior concent in an emergency.

Record of Disclosures

Date	Disclosed to whom Address or Fax	[1]	Description of disclosure Purpose of disclosure	Disclosed by whom	[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 from loss or theft and agree that the consequences of failure to do so will result in being without the 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 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: _____Date:_____

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Appointment Cancellation Policy Agreement

Advanced Orthopedics Institute, is committed to providing timely, high-quality care. Missed or late-canceled appointments limit our ability to serve other patients.

Patients are required to provide **at least twenty-four (24) hours' advance notice** for any appointment cancellation or change. Notice must be given **by phone during regular business hours**.

For **Monday appointments or those following a holiday**, notice must be provided **by the close of business on the previous business day**.

Appointments missed or canceled without proper notice will result in a **$50.00 missed appointment fee**, which must be paid prior to rescheduling.

Patients who miss **three (3) scheduled physician appointments** may be subject to dismissal from the practice.

By signing below, you acknowledge that you have read, understand, and agree to this Appointment Cancellation Policy and accept financial responsibility for missed or late-canceled appointments.

Patient Signature: _____

Printed Name: _____

Date: _____

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

I, _____,
(Print Patent Name)

Initial _____ Acknowledge and understand that Advanced Orthopedics Institute does **NOT** accept Auto, Workers' Compensation or Third-Party Insurances.

Initial _____ Acknowledge and understand that Advanced Orthopedics Institute does **NOT** get involved with the treatement of cases where litigation is or will be pursued.

Initial _____ Represent that the current problem(s) for which treatment is sought is **NOT/** are **NOT** covered by Auto, Workers' Compensation or Third Party Liabitiy Insurances.

Initial _____ Represent that the current problem(s) for which treatment is sought is **NOT/** are **NOT** related to work injury(ies)

Initial _____ Represent that I have **NOT** been directed to Advanced Orthopedics Institute by my employer or it's Workers' Compensation insurance carrier to teat the current problem(s)

Initial _____ Represent that the current problem(s) for which treatment is sought is **NOT/** are **NOT** for auto related injury(ies)

Initial _____ Represent that the current problem(s) for which treatment is sought is **NOT/** are **NOT** the subject of any pending litigation.

Initial _____ Represent that 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

_____

Witness Date

If signed by Person Authorized to sign for patient: Relation to Patient _____