

James B. Duke, MD PA
Orthopedic Surgery
2300 SE 17th Street, Suite 500
Ocala, FL 34471
352-867-0444

Dear Patients:

Welcome to our orthopaedic office. We appreciate your confidence and will take great pride in providing you with timely, caring, and expert treatment of your orthopaedic problem. To better assist you, there are several policies that we would like to make you aware of.

1. If you have had an MRI, or CT scan of the area we are seeing you for, please bring the films or reports to your appointment. Unfortunately, we can no longer accept discs of images because they have damaged our computer systems in the past. We have the facilities to perform the necessary x-rays at our office, and will be able to take an x-ray during your visit. If Dr. Duke feels that further testing is required, our office will arrange this for you.
2. Our office tries, if possible, to evaluate only one orthopaedic problem per patient, per visit. This allows our appointment schedule to run at a manageable rate, and has proven to be the fairest to all concerned. Emergencies and exceptions do arise and some problems take longer to evaluate than others. We make every effort possible to minimize our patients' waiting time.
3. Dr. Duke's office does not evaluate any problems concerning the spine. This does include neck and low back pain. We are happy to provide our patients with names and phone numbers of spine specialists, chiropractors, or massage therapists who treat these areas. If you feel that your current problem is spine related, please let our receptionist know before your appointment.
4. Most of our new patients to the office are initially evaluated by our talented Advanced Registered Nurse Practitioner, Courtney Hart, or our Physician's Assistant, Brittany Bascom. Due to Dr. Duke's active surgery schedule, he is only able to see office patients 2 days per week. The physician extenders are able to diagnose problems, order scans, perform injections, and prescribe physical therapy and medications. They will also evaluate and prepare patient for surgery prior to seeing Dr. Duke.
5. We do not handle any cases involving current or pending litigation. If this applies to your current condition, please notify our receptionist immediately.

Thank you so much for your attention to these important matters. If you have any further questions or comments, please bring those to the attention of our receptionist. Thanks again for choosing our office and we look forward to treating you like family and caring for your orthopaedic ailment as soon as possible.

NAME: _____ DATE: _____

AGE: _____ SEX: _____ HEIGHT _____ WEIGHT _____
Primary Care Physician: _____ Cardiologist: _____

Other current treating physicians: _____

Work Comp Case Yes No Motor Vehicle Accident Yes No
Litigation pending Yes No _____
Sports in which you participate _____

Body parts affected: shoulder hip thigh knee leg
 other _____

Side affected: Right Left Dominant arm: Right Left

PAIN SYMPTOMS: Please check only significant symptoms

Pain Radiating Stiffness Popping sensation
 Aching Sharp Tenderness Throbbing
 Swelling Spasm Grinding Tingling/numbness
 Dull Burning Instability Inability to perform sports
 Weakness Soreness Night time Limited range of motion .

Date of injury (or when problem began): _____

Describe injury/injuries or problem: _____

Have you seen other doctors seen for this problem? Who and when? _____

Please list treatment for your problem: _____

Physical Therapy: Yes No. Medication: Yes No Name: _____

Cortisone shots Yes No How many? _____

Current Daily Name of drug _____ Dosage _____ Times per day _____

Medications: Name of drug _____ Dosage _____ Times per day _____

Name of drug _____ Dosage _____ Times per day _____

Name of drug _____ Dosage _____ Times per day _____

Other health or medical problems: _____

Please list all previous surgery, date and what was done:

Type of surgery: _____ Year: _____ Where done? _____

Type of surgery: _____ Year: _____ Where done? _____

Other (please list all previous hospitalizations) _____

ALLERGIES (Medicines, foods, pollens) If yes, please list: _____

Smoking status: Never smoked Quit smoking - Current smoker daily some days

Drink Yes No Amount per day _____

James B. Duke, M.D.

Patient contact information sheet

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

_____ Home Telephone (_____) _____ - _____.

_____ May leave a message with detailed information.

_____ May leave a message with call back number only.

_____ Work Telephone (_____) _____ - _____.

_____ May leave a message with detailed information.

_____ May leave a message with call back number only.

_____ Cell Phone (_____) _____ - _____.

_____ May leave a message with detailed information.

_____ May leave a message with call back number only.

_____ Written communication:

_____ May mail to home address.

_____ May fax to (_____) _____ - _____.

_____ May release Protected Health Information to the following persons.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that it is my responsibility to change this information should my circumstances change. I will notify James B. Duke, M.D. in writing of any changes to the above information.

Print Name of patient or responsible party

Date of Birth

Signature of patient or responsible party

Date of form completion

LIFETIME AUTHORIZATION

Insurance assignments and authorizations to release information form

- I. RELEASE OF INFORMATION – I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim or payment for such treatment and/or diagnosis.

- II. PHYSICIAN INSURANCE ASSIGNMENT – I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and or individual surgical and or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charges for these services.

- III. MEDICARE/MEDICAID – Patient’s certification and or authorization to release information and payment requests. I certify that the information given by me in applying for payment under title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

- IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN’S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for your payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance or third party payer within a reasonable period of time, not to exceed 30 days.

If this account is assigned to an attorney or collection and/or suit, the prevailing party shall be entitled to reasonable attorney’s fees and costs of collections.

Patient name _____ Date: _____

Patient or guardian Signature _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for users and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment of health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access of your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATIONS FOR OUR PATIENTS

To Our Valued Patients:

The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.