JOHANNES V. BLOM, MD
Board Certified Orthopedic Surgeon
Adult Reconstructive Surgery & General Orthopedics

PATIENT DEMOGRAPHIC INFORMATION

Chart #: _____
Date of Appt: _____

Email:_____
Cell :_____
Patient Name: _____ Home:_____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Marital Status: ○S ○M ○D ○W Primary Language: _____
Age: _____ Date of Birth: _____ Sex: ○M ⊙F Social Security: _____
Employer: _____ Work#:_____
Address: _____ City: _____ State: ____ Zip: _____
Primary Doctor: _____ Office #: _____
Orthopedic Problem: _____ Referring Doctor: _____
Type of Injury: Auto _____ Work _____Slip & Fall ____ Date of Occurrence:_____
How did accident happen? _____
Spouse/Parent Name: _____ Employer: _____ Wk: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance

Name of Insurance: _____
Insured's Name: _____
Insured's Sex: ☐ Male ☐ Female
Insured's Date of Birth: _____
Relationship to Insured: _____
Subscriber ID Number: _____
Group Number: _____

Secondary Insurance

Name of Insurance: _____
Insured's Name: _____
Insured's Sex: ☐ Male ☐ Female
Insured's Date of Birth: _____
Relationship to Insured: _____
Subscriber ID Number: _____
Group Number: _____

AUTO INSURANCE

Date of Accident: _____
Patient's Name: _____ Phone #: _____
Insured Person: _____
Name of Insurance Company: _____
Policy: _____ Claim #: _____
Phone: _____ Adjuster: _____
:_____

ATTORNEY INFORMATION

Any pending litigation related to your injury? _____
Attorney Name: _____ Phone : _____
Attorney Address: _____ Fax : _____
Email :_____

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Have you had or presently have any of the following health problems?

- ❑ Diabetes
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Heart attack
- ❑ Asthma/ Bronchitis
- ❑ Vascular problems
- ❑ Gout
- ❑ Urination disturbance
- ❑ Psychological Disturbance
- ❑ Swallowing difficulties
- ❑ Ulcers/ Stomach ulcers
- ❑ Thyroid
- ❑ Broken Bones: _____
- ❑ Irritable Bowel
- ❑ Rheumatoid OA
- ❑ Skin problems
- ❑ Kidney disease
- ❑ Liver Disease
- ❑ Hepatitis
- ❑ Panic/ Anxiety
- ❑ Nervous System Disorder
- ❑ HIV exposure
- ❑ Epilepsy
- ❑ Depression
- ❑ High cholesterol
- ❑ Migraine
- ❑ Dizziness
- ❑ Gastritis
- ❑ Prostatitis
- ❑ Cancer
- ❑ Other (please specify)

Do you have a pacemaker? ❑ **Yes** ❑ **No**

Can you take Aspirin? ❑ **Yes** ❑ **No**

Height: _____
Weight: _____

Allergies:
_____
_____

Do you (Please circle answer)
Yes/ No Smoke tobacco
___ packs/ day for ____ years

Yes/ No Drink alcohol
_____ drinks/ months

Medication:	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy Name:	**Pharmacy Phone Number:**
_____	_____
_____	_____

Surgeries:	**Date:**	**Surgeons:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: _____ **Date:** _____

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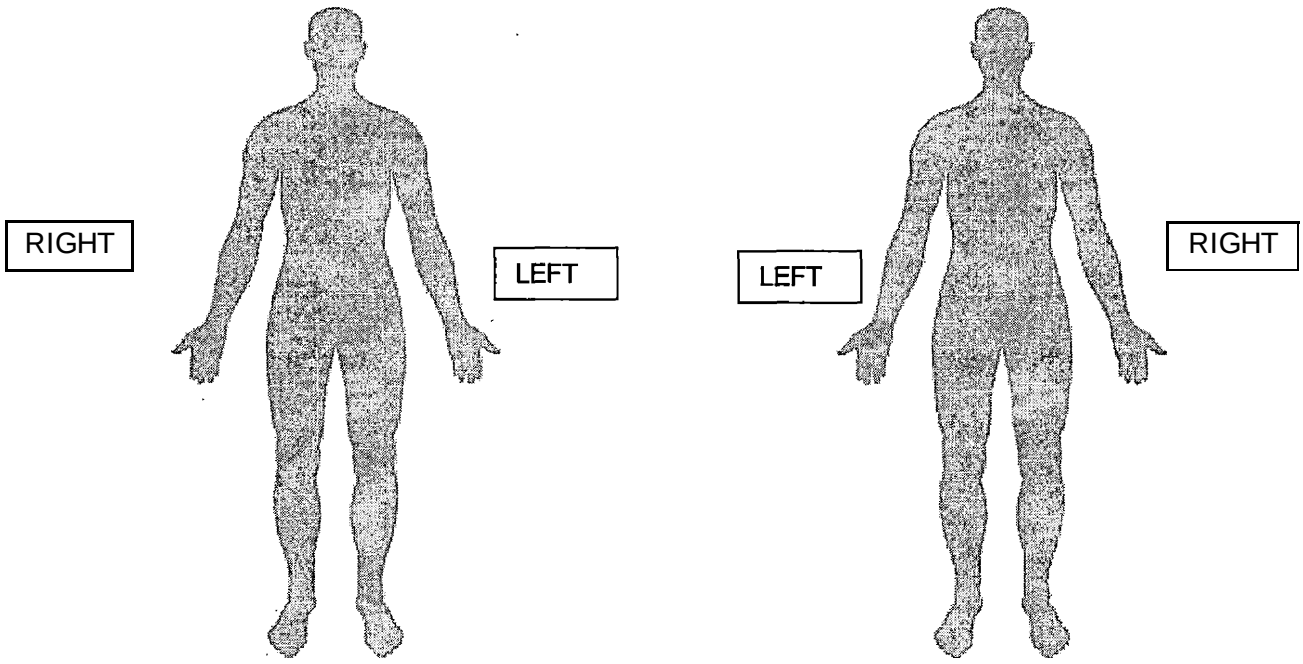
- On the following diagrams, please show **where** you're experiencing **all** of your present complaints with the letter **X**:

FRONT **BACK**



Are you experiencing any of the following symptoms?

- ☐ Arm/Shoulder pain
- ☐ Fatigue
- ☐ Leg pain
- ☐ Stomach upset
- ☐ Anxiety/Depression
- ☐ Feet/Toe numbness
- ☐ Back pain/stiffness
- ☐ Headaches
- ☐ Neck pain/stiffness
- ☐ Irritability
- ☐ Sleep difficulties
- ☐ Dizziness
- ☐ Nausea
- ☐ Hand/Finger numbness
- ☐

Circle the severity of your pain:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

Assignment of Benefits: I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my Medical Payments, Automobile Insurance (if applies), also known as Personal Injury Protection (hereinafter, PIP), policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes overdue interest and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of Information: I hereby authorize this provider to: furnish an insurer, and insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in

writing (declaration sheet) and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer; obtain copies of all medical records, including but not limited to, documents, reports scans, notes, bills, opinions, X-rays, IMEs, and MRIS, from any other medical provider or any Insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior expressed written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else are received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else are receive by the insurer the same day then the insurer is direct to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above: I have not been solicited or promised anything in exchange for receiving health care: I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service: I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

_____	_____
Patient's Name (Printed)	Patient's Signature (If patient is a minor, signature of parent/guardian)
_____	
Date	

JOHANNES V. BLOM, MD
BOARD CERTIFIED ORTHOPAEDIC SURGEON
RECONSTRUCTIVE SURGERY & GENERAL ORTHOPAEDICS

NON COVERED SERVICES

Please be advised under certain circumstances your insurance plan may not cover all services which may include but is not limited to: costing or recasting, medical supplies and or durable medical equipment the Doctor deems medically necessary for proper patient care. In this circumstance, you the patient will be responsible for such services. We will still make an effort to charge the insurance first. Upon response from the insurance company, we will bill you accordingly if necessary

I_____ have read and understood the above disclaimer and agree to any charges I may incur if my insurance plan denies coverage.

Patient signature _____ Date _____

LIABILITY CASES

I_____ understand that in the event that I seek legal representation at any time during or after my treatment with Johannes V. Blom, MD in relation to the incident/accident that occurred on _____ I will immediately inform and provide the office with my attorneys contact information.

I also understand that my health insurance will not be billed for services rendered in relation to said incident/accident. Any/all future or outstanding medical bills will be provided to my attorney and my responsibility to pay by means of settlement, judgment or verdict obtained.

Patient Signature _____ Date_____

AUTO RELATED ACCIDENTS

I_____ Understand that under Florida Law, claims must be submitted to the auto insurance carrier as primary insurance if injury was sustained in the Auto accident.

Patient Signature _____ Date_____

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X-RAY COPIES

All X-rays taken by this office are the property of JOHANNES V.BLOM, MD, PA. Under no circumstances can originals be taken out of this office. All originals will be maintained in this office at all times.

If copies are requested, at least a 24 hour notice will be required and there will be a $10.00 per film charge for materials, payable in advance. Your consideration is appreciated

_____
Patient's Signature (If patient is a minor, signature of parent/guardian)

CANCELLATION FEE POLICY

We value your time and patience when you come to visit the office. In return we ask that you please understand that we strive to serve you as efficiently as possible and need your help to do so. We ask that you please provide us with a 24 hour notice if you need to cancel or reschedule your appointment. This helps us to serve other patients who also requite our services. In the event that you do not show and do not call to cancel/reschedule there will be a $25 no show fee charged to you at your next visit.

We appreciate your understanding of this matter and look forward to serving you.

I, _____, have read and understood the above policy. I understand that I will be charged if I fail to provide a 24 hour notice of cancellation.

Signature: _____ _____
(patient/parent/conservator/guardian) Date

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BOARD CERTIFIED ORTHOPAEDIC SURGEON
RECONSTRUCTIVE SURGERY & GENERAL ORTHOPAEDICS

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my healthcare, this facility originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provide with a notice of information practices that provide a more complete description of information used and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations

I understand that this facility is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent this organization may refuse to treat me as permitted by section 164.506 of the code of federal regulations.

I further understand that this facility reserves the right to change this notice and practices and prior implementation, in accordance with section 164.520 of the code of federal regulations. Should this facility change their notice they will send a copy of any revised notice to the address I've provided.

I understand that as a part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my information to another entity and I consent to such disclosure for these permitted uses including disclosures via fax

I authorize this facility to discuss my treatment, payment, and healthcare operations with the following person/people:

I fully understand and accept/decline the terms of this consent.

_____ _____

Patient Signature Date

JOHANNES V. BLOM, MD
BOARD CERTIFIED ORTHOPAEDIC SURGEON
RECONSTRUCTIVE SURGERY & GENERAL ORTHOPAEDICS

NOTICE

UNDER FLORIDA LAW, PHYSICIANS ARE GENERALLY REQUIRED TO CARRY MEDICAL MARLPRACTICE INSURANCE OR OTHERWISE DEMONSTRATE FINANCIAL RESPONSIBILITY TO COVER POTENTAIL CLAIMS FOR MEDICAL MALPRACTICE. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MARPRACTICE INSURANCE. THIS IS PERMITTED UNDER FLORIDA LAW SUBJECT OT CERTAIN CONDITIONS. FLORIDA LAW IMPOSES PENATIES AGAINST NON-INSURED PHYSICIANS WHO FAIL TO SATISFY ADVERSE JUDGMENTS ARISING FROM CLAIMS OF MEDICAL MALPRACTICE. THIS NOTICE IS PROVIDED PURSUANT TO FLORIDA LAW.

_____ _____

PATIENT SIGNATURE DATE

JOHANNES V. BLOM, MD
BOARD CERTIFIED ORTHOPAEDIC SURGEON
RECONSTRUCTIVE SURGERY & GENERAL ORTHOPAEDICS

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the NOTICE OF PRIVACY PRACTICE OF JOHANNES V. BLOM, MD, PA. Our NOTICE OF PRIVACY PRACTICE provides information about how we may use and disclose your protected health information. We encourage you to read it in full

If you have any question about our Notice of Privacy Practices, please contact our Compliance Officer at:

3702 Washington Street, Suite 202
Hollywood, FL 33021
(954) 964-6114

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at the above address.

I acknowledge receipt on the Notice or Privacy Practices of Johannes V, Blom, MD, PA.

Signature_____ _____
(Patient/parent/conservator/guardian) Date

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: _____ _____
Date

An acknowledgement was not obtained because:

☐ Patient refused to sign.
☐ Patient was unable to sign or initial because:

☐ _____
There was a medical emergency (the staff member will attempt to obtain acknowledgement at the next available opportunity).

Other reason(s):_____
_____
_____

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NOTICE OF SMOKING CESSATION

Doctors generally advise to quit smoking before and after operations because smoking decreases the level of blood flow. Smoking constricts the blood vessels. When the blood vessels are narrowed down, the oxygen supply to the cells gets reduced. Even the ability of the hemoglobin to move the oxygen lowers down. All these delay the wound healing, process.

Smoking which reduces the blood flow results in the loss of skin during the process of healing. Because smoking delays wound healing it causes death to the skin leaving bad and ugly scars. Smoking also increases the risk of coughing after the surgery. This may lead to unwanted bleeding.

It is important to understand the smoking affects the healing of bones. Bones are nourished by blood much like other organs and tissues in your body. Nutrients, minerals, and oxygen are all supplied to the bones via the blood stream. Smoking elevates the levels of nicotine in your blood and this causes the blood vessels to constrict. Because of the constriction of the vessels, decreased levels of nutrients are supplied to the bones. This in turn inhibits bone healing after surgery for fractures.

General anesthesia and surgery can cause stress. During surgery there is a possibility that the patient may experience pain. Changes may take place in his/her blood pressure. The patient may also suffer from loss of blood and other unfortunate events during surgery. Smoking should be avoided before surgery because smoking, apart from causing stress can compound the above problems too.

I have read and understand the effects and risks of smoking before and after surgery.

_____ _____

Patient Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, Date of Birth _____/_____/_____,
Authorize to release my medical records to:

To release to: _____
Name of Hospital, Physician or Facility

_____
Street Address

_____

City State Zip Code

_____ _____
Phone# Fax#

Any medical information concerning my treatment, including psychological, psychiatric, drug abuse, alcoholism, AIDS, Aids testing and care of hospitalization which may be in your care.

_____ _____
Date Patient Signature

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RECONSTRUCTIVE SURGERY & GENERAL ORTHOPAEDICS

ELECTRONIC COMMUNICATION CONSENT FORM

Texting Consent:
As part of our practice's communications with you, we can send you SMS (text) Messages directly to your phone.

☐ I **consent** and accept to receiving text **messages.** I understand I can withdraw my consent at any time. Please provide your cellular number:_____

☐ I do not consent to receiving any text messages.

_____

Email Consent:

The use of email is limited to setting up or canceling appointments and for sending appointment reminders. Due to security, details of one's case cannot be discussed via email. Email may also not be used as a means of providing services. You also agree not to use the clinic email address when trying to contact the clinic or your service provider in the event of an emergency, as our clinic cannot guarantee a rapid response via email.

By signing, you are also aware that email is not a guaranteed or secure way of sending and receiving information and that you may not hold our clinic or your service provider responsible for any breach of confidentiality that results from the use of the email addresses listed below.

☐ I **consent** and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

Email: _____

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Print name of Patient: _____ Date: _____

Patient Signature