# TOMAN ORTHOPEDICS
AND SPORTS MEDICINE

**CHARLES V. TOMAN, M.D.**
Board-Certified. Fellowship-Trained. Orthopedic Surgeon
**MATTHEW D. EARHART, PA-C**
Board-Certified Physician Assistant
**CARRIE D. CULPEPPER, APRN, RNFA**
Board-Certified Advanced Practice Registered Nurse. RNFA

**Please fill out this entire packet. If something does not pertain to you please write NA.**

**Please initial the bottom of each page and sign where necessary**

**Name:** _____ **Date of Birth:** ____/____/____

If patient is under 18 - Name of parent(s)/guardian: _____

**Social Security Number:** _____ **Race:** _____

**Gender:** M / F **Marital Status:** Single / Married / Divorced / Widowed

**Phone number:** _____ **Secondary Phone:** _____

**Email address:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

- **Northern or Secondary Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Approximate Start/End at secondary address:** _____

**Emergency Contact Name:** _____ **Relation to you:** _____

**Phone Number:** _____

**Primary Care Physician:** _____ **Phone:** _____

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

## Insurance Guarantor Information (if other than yourself):

**Guarantor's Name:** _____ **Date of Birth:** _____

**Social Security Number:** _____ **Relationship to patient:** _____

**How did you hear about us:**

☐ Referral from doctor or other healthcare provider _____Please Provide Name_____ ☐ Online Search

☐ Advertisement ___Which publication/platform___ ☐ Friend/Family Member _____Please Provide Name_____

**Please complete this section if you would like us to release your protected health information to specific family members or care givers.**

**I authorize Toman Orthopedics and Sports Medicine to disclose medical information to the following people:**

**Name:** _____ **Relationship to you:** _____

**Name:** _____ **Relationship to you:** _____

**Signature:** _____ **Date:** _____

I authorize Toman Orthopedics and Sports Medicine to release my medical information for the purpose of processing insurance claims, insurance applications, filling prescriptions, fulfilling prior authorization requirements as defined by my insurance company for advanced imaging studies/scheduled procedures, to a hospital or facility at which I am having a medical procedure, and to my primary care doctor or referring physician, or other medical providers who require this information for my continuation of care. I have the right to revoke this consent in writing at any time, this revocation will be void in the instance that C.Toman, MD LLC has taken action in reliance on this consent.

**Signature:** _____ **Date:** _____

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## What brings you in today (chief complaint):

_____

_____

_____

- **Did this occur in the context of a Motor Vehicle Accident:** Yes / No

**If no, please continue to next page**

**If yes, please notify the receptionist and medical staff and provide the following information:**

Auto Accident Claim Number: _____

Auto Insurance Company: _____

Billing Address: _____

Date of Accident: _____

Name of Adjuster: _____

Adjuster's Contact Information: _____

- Please note that in the case of a motor vehicle accident claim, we require that you provide your health insurance information as a secondary form of insurance. We do this so we can bill your health insurance in the event that your benefits have exhausted or your claim is being held with the auto insurance company due to an event such as an initial hospital visit, or emergency medical care. We kindly ask that you provide the receptionist with your health insurance information to avoid incurring out-of-pocket costs. In the event that you do not have health insurance or we are non-par with your insurance policy, we will require a self-pay visit rate of $250 prior to you seeing the doctor, plus the cost of X-rays if needed. We do not accept letters of protection from insurance companies, attorneys, or any third party.

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- **Was this a work related accident:** Yes / No

**If no, please continue to next page**

**If yes, please notify the receptionist and medical staff and provide the following information:**

Workers Compensation Claim Number: _____

Workers Compensation Insurance Company: _____

Workers Compensation Billing Address: _____

Date of Accident: _____

How did the Injury Occur: _____

Name of Adjuster: _____

Adjuster's Contact Information: _____

- Please note, if you are a workers compensation patient we must receive authorization for your treatment from your adjuster or case manager prior to seeing the doctor. If this information is not available at this time, we kindly ask that you reschedule your appointment. Please be advised that we are not a contracted provider with every workers compensation company and being seen for an injury that happened at work without prior authorization can cause your claim to be delayed or denied. If your injury is the result of a work accident your health insurance may not cover your claim because it should be filed under your company's workers compensation policy. Florida law requires most employers to carry workers compensation coverage. Should you require help filing a claim with workers compensation you should contact your HR department.

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# Medical History

**Please select any medical conditions that you currently suffer from**

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Cancer:

  _____

  _____

  _____

- ☐ Cardio: High Cholesterol
- ☐ Cardio: Ischemic Heart Disease
- ☐ Chronic Pain
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis (DVT)
- ☐ Depression
- ☐ Diabetes (Insulin Dependent)
- ☐ Diabetes (Non-Insulin Dependent)
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Parathyroid
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Low Thyroid
- ☐ Multiple Myeloma
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Therapy
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ Other:

  _____

  _____

  _____

  _____

  _____

  _____

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## Surgical History

- **Please provide the type of surgery, the name of the surgeon or medical group, the surgical facility or hospital, and year the surgery was performed. Please provide as much detail as possible**

## Orthopedic History

- **Please provide any orthopedic diagnoses/problems you have had in the past including fractures, sprains, strains, arthritic conditions, or spinal conditions. Please provide to the best of your knowledge the approximate date of onset/treatment. <u>If you have had orthopedic surgery in the past, please provide the name of the surgeon.</u>**

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## Medication List

- **Please provide a current list of any medications you are on including the dosage if available. If you have your own list you may provide that to the receptionist.**

## Allergies

- **Please list your allergies, paying close mind to allergies to medications or commonly used materials in the medical field (iodine, latex, adhesive, etc.)**

## Social History

**How often do you consume alcohol?**

- ☐ Daily
- ☐ 2-3 times a week
- ☐ 1-2 times a month
- ☐ Rarely
- ☐ Never

**Are you a smoker?**

- ☐ Current Smoker
- ☐ Past Smoker
- ☐ Never a Smoker

**Do you exercise?**

- ☐ Daily
- ☐ 3-5 times a week
- ☐ Once a week
- ☐ Once a month
- ☐ Never

# Financial Policy

**Our goal is to provide and maintain a good physician/patient relationship between you and our office. Letting you know of our policies in advance allows for open communication and for you to make an informed decision regarding your care. Please read the following carefully and do not hesitate to ask our office staff for clarification or further explanation.**

- It is the policy of Toman Orthopedics and Sports Medicine that payment is due at the time of service. We require all patients to pay their copayment, coinsurance, and/or deductible requirements at the beginning of each visit. If you receive any additional services or products that were not anticipated prior to you seeing the doctor (supplements, injections, durable medical equipment, etc.) the staff will let you know if this will incur an out-of-pocket cost and you may be expected to pay upon check out or you may receive a bill. We accept cash or credit card.

_____

**Initial**

- You understand that it is your responsibility to be knowledgeable about your health insurance policy and benefits. We will always bill your insurance company based on contracted rate we have with that carrier. We do not control these rates or values and are unable to change them due to our contractual obligation with your insurance company.

_____

**Initial**

- You understand that it is your responsibility to keep your information on file up to date. If you change insurance policies, move to a new address, or acquire a new phone number it is imperative that you notify our office. Failure to update your information with our office can result in outstanding balances. We will make every effort to contact you by phone and mail to make you aware of your balance. Balances outstanding for greater than 90 days with no payments made towards the balance will be sent to a collection agency at which point your balance will incur a 35% collection fee.

_____

**Initial**

Patient Initials: _____

- Not all services are covered by each individual insurance plan – regardless of whether or not we are a participating provider with that plan. We will make every effort to verify your insurance benefits and offer you services/notify you of non-coverage accordingly. Should you elect to receive a service that is not covered by your insurance you will be fully responsible for the cost of that service.

_____

**Initial**

- Our office has a no-show policy for appointments. Please understand that when you do not come to your scheduled appointment you have taken that time away from another patient. Your first no show appointment is forgiven, however for any other appointment that you fail to cancel by 4pm the day prior will incur a $25 fee. We understand there are outstanding circumstances to this policy and all fees are reviewed on a case by case basis.

_____

**Initial**

- Our office accepts "self-pay" or "cash-pay" patients. We only offer this to patients who do not have insurance or hold an insurance policy that we do not participate with. The self-pay rate is the same for all providers in our office. A standard visit fee of $250 applies to all appointments, and the cost of x-rays is an additional $50. Any additional services you elect to receive at your appointment will incur an additional fee. We accept cash or credit.

_____

**Initial**

**By signing this form you are agreeing to the aforementioned financial policies. You are acknowledging that you have received notice of these policies. If you have any questions regarding these policies we are happy to assist you in understanding them.**

_____ _____

**Patient Name** **Date**

_____ _____

**Signature** **Office Personnel Witness**

Patient Initials: _____