JOI Beaches - Patient History

Patient Name:_____ Age:____ Height:_____ Weight:_____

Hand Dominant: _____Left _____Right Blood Pressure: _____/_____

Referring Dr. _____none ____ Primary Care Dr. _____ none ____

What body part is the doctor examining today? _____ _____ Left _____Right

Date of Pain/Injury/Accident onset: ___/___/___ Previous Injury to this body part? NO YES when _____

If you have been treated for this previously? ___No ___Yes Where/by whom_____

Place of employment: ___NA _____ Occupation:_____

Where did it happen: (home, school, beach, store, gym...)_____

Brief description of how it happened & symptoms: _____

_____

_____

_____

ALLERGIES: _____none _____

Pharmacy Name:_____ Pharmacy Location:_____

MEDICATIONS: _____none _____

_____

_____

_____

X_____ _____/_____/_____

(Patient / Guardian Signature)

JOI Acct # _____

Authorization to Disclose Medical Information Form

Patient Name: _____ **DOB:** _____

Section A: DISCLOSURE OF MEDICAL AND BILLING INFORMATION

I authorize JOI to disclose any and all medical and billing information to the following individuals listed below. Individuals may consist of a spouse, family member, parents of minors or other dependents and can be updated at anytime.

	NAME	RELATIONSHIP	PHONE
1.	_____	_____	_____
2.	_____	_____	_____

___ I do not wish to list anyone at this time

Section B: URGENT AND EMERGENCY CONTACT

Please list those who we may contact for urgent and emergency situations. This list can be updated at anytime.

	NAME	**RELATIONSHIP**	**PHONE**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Section C: PATIENT CONTACT

_____ Yes, JOI may contact me by phone and leave messages _____ No, JOI may not leave messages

Preferred method for appointment reminders: Cell_____ Home_____ Text_____ Work_____

My Baptist Connect Patient Portal

JOI account #_____

My Baptist Connect makes it easy to view and download your health information, including:

- Summary of today's visit
- List of any ongoing health conditions
- Current medication list
- Any medications you are allergic to
- Vital signs

Speak with any office staff about enrolling in the patient portal.

The My Baptist Connect website is a safe and secure way for Baptist Health patients to stay connected to their personal health information online. You can view, download and print your personal medical information anytime.

Entering your own health information is simple – plus, you can track results over time.

Mybaptistconnect.com

_____Yes, I would like to enroll in the portal at this time:

Name: _____

Date of Birth:_____/_____/_____

Email address:_____ (Required for portal invitation)

_____ No need to enroll me, I am already enrolled

_____ No thank you, I do not wish to enroll at this time

1577 Roberts Drive, Suite 225, Jacksonville Beach, FL 32250

PRESCRIPTION POLICY

The physicians at JOI-Beaches treat musculoskeletal injuries and perform orthopaedic related surgeries which can be painful. At times, these require narcotic prescription medications. Because of this, we have a standard prescription protocol we follow to optimize your care.

To minimize possible drug interaction and to avert side-effects from narcotic use, it is our policy to provide narcotic prescriptions only for the initial 90 days immediately following an injury or surgery. Pain that persists and lasts longer than 90 days may lead to chronic pain syndrome and may be associated with significant complications and potential drug interactions.

If you are prescribed narcotics for your injury or surgical procedure and are in need of a refill, we kindly ask that you call our office between the hours of 8:00 a.m. to 3:00 p.m. Monday – Thursday and 8:00 – 12:00 on Fridays. Please allow 24-48 hours for us to authorize and process your refill request. Due to government guidelines, narcotics cannot be called into your pharmacy and require you to pick up a written prescription from our office. In those cases, we will notify you when your prescription is ready for pickup, or if your request has been denied. For medications that can be called into your pharmacy, check with them for pickup.

By signing below, I acknowledge an understanding of this policy.

_____

Print Patient Name

_____

Patient Signature

_____

Date

JACKSONVILLE ORTHOPAEDIC INSTITUTE Beaches

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____

Date of Birth: _____

Patient Gender: ☐ Male ☐ Female ☐ Decline to Answer

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Race: ☐ American Indian/Alaska native ☐ Asian

☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander

☐ White ☐ Refused to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Answer

Jacksonville Orthopaedic Institute
Jacksonville Beach, Florida

The JOI-Beaches surgeons are pleased to offer orthopaedic care to you and your family. In order to serve you better and expedite our care, we ask that you familiarize yourself with our office protocols outlined below.

Appointments:

- We are happy to fax, mail or email our paperwork to you. It can also be located online at www.joibeaches.com
- We treat patients by appointment only. If you are unable to keep a scheduled appointment, please call during normal business hours, at least 24 hours in advance.
- Please arrive at least 20 minutes ahead of time to process paperwork/IPAD and keep your appointment on time.
- Be certain to bring your insurance cards, social security number, driver's license, & guarantor information.
- Remember to bring all x-rays, MRI's, reports and doctor notes that pertain to your current health issue. Our physician's need these to ensure a thorough medical evaluation and treatment plan.
- Please bring a list of all medications you are taking (dosages included please).

Co-pays, Deductibles and Self Pays

- Outstanding balances, co-pays and deductibles are collected at the time of your visit.
- Patients who are 'self pay' are asked to pay in full at the time of service or will be asked to reschedule.

Referrals:

- Some insurance companies require a referral from your primary care doctor **prior** to an appointment with a specialist. If your insurance company requires an authorization, and you are unable to secure the authorization before your appointment with us, please notify us immediately. We will gladly reschedule your appointment when the referral is received by our office.

Prescription Requests:

- Please call **at least 24 hours before running out of your medication**. We ask that you leave your first and last name, date of birth, the medication you will need and the ***pharmacy name and phone number*** where you would like the prescription filled.
- Requests may take 24 - 48 hours to process with your pharmacy. Always check with the pharmacy after 6:30 p.m. before attempting to repeat your request to our office.
- **Prescriptions requested on Friday after 12:00 noon will not be processed until the following Monday.**
- **Please Note: Our office does not fill prescriptions after hours or on weekends due to medical/legal requirements.**
- Our physicians do not treat chronic pain patients. Patients are expected to have or arrange for a primary care physician to address chronic pain issues.

Voice Mail Messages:

- Our clinical staff is assisting patients during business hours. Please indicate the urgency of your need to our operators. When you are transferred to voicemail leave your first and last name, date of birth, a phone number where you can easily be reached and a detailed message stating your needs.

Completion of Insurance, Disability or Supplementary forms

- Please complete the patient portion of the forms before submitting them to our office.
- Bring the forms to your office visit and have them collected at our front desk for processing.
- A $20 pre-pay fee is due ***for each form the office is asked to complete***. This is not covered by your insurance company.
- Allow 7 - 10 business days to complete your forms. Upon completion, we will gladly fax them to your insurance company.

Medical Record Request:

- In order to be compliant with federal requirements, a signed release form is necessary to obtain your medical record. Forms can be faxed, mailed or picked up at our office.
- Please allow 7 - 10 business days to process.
- A **$10 pre-pay fee is charged for each CD requested** of x-rays.

Calling After Hours:

- **Call 911 for any emergency situation.**
- Please call after hours with urgent matters only.
- Routine matters will be handled the next business day.

Thank you for choosing JOI-Beaches to serve your health care needs

JOI-BEACHES MEDICAL RECORD RELEASE FORM

I CONSENT TO THE RELEASE & DISCLOSURE OF MY PERSONAL HEALTH INFORMATION TO:

NAME/ORGANIZATION:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

FOR THE FOLLOWING PURPOSE:

_____ CONTINUING MEDICAL CARE _____ PERSONAL USE

_____ INFORMATION FOR ATTORNEY _____ INFORMATION FOR INSURANCE CO.

___OTHER (please specify)_____

THIS RELEASE FORM INCLUDES COPIES OF MY MEDICAL HEALTH INFORMATION CONSISTING OF:

_____ INITAL EVALUATION _____ OPERATIVE REPORTS _____ MEDICAL STATUS

_____ PROGRESS NOTES _____ DISCHARGE SUMMARY _____ WORK STATUS

_____ X-RAY/MRI FILMS _____ OTHER (specify)_____

THERE IS A $10 PRE-PAY FEE FOR EACH DISK.
WE DO NOT MAIL X-RAY/MRIS DISKS, PATIENT PICK UP ONLY.

I understand that the information outlined in this release will be disclosed according to the instructions of this release within 5 – 7 business days from the date that JOI/Beach Division has received this authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the federal HIPAA Privacy Rule.
This authorization will expire one year from the date of the request. This authorization is invalid if not filled out completely by the patient or legal guardian.

PATIENT NAME:_____ DOB:____/____/____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PATIENT SIGNATURE:_____ DATE:_____
(or parent of minor child or legal personal representative of patient)

FOR OFFICE USE ONLY: CHART NO._____ **DR.: L W Y VT H**
(CIRCLE ONE)

☐ **REVOCATION - THIS AUTHORIZATION WAS REVOKED ON** _____
Revocation letter /document must be attached. **(DATE)**