PATIENT INFORMATION

Patient Name ______________________ (Last) ______________________ (First) ______________________ (Middle) ______________________

Appointment Date ______________________ Date of Birth ______________________

Address ______________________

City ______________________ State ______________________ Zip ______________________

Telephone Numbers: (Home) ______________________ (Work) ______________________ (Cell) ______________________

Social Security No. ______________________ Occupation: ______________________

Current Employer ______________________ Employer at time of injury ______________________

Dates of Injury (First Injury) ______________________ (Second Injury) ______________________

Emergency Contact (Name) ______________________

(Work Number) ______________________ (Home Number) ______________________ (Cell Number) ______________________

Spouse's Name ______________________ Spouse's Employer ______________________

Spouse's Work Number ______________________ (Social Security Number) ______________________

Attorney's Name: ______________________

_____**Workers' Compensation (Forms Already Completed)**

_____**Auto (Assignment of Benefits)**

_____**Liability (Forms Already Completed)**

*******I understand that I may be evaluated and treated by more than one doctor in the clinic. I understand that unless I am a Worker's Compensation patient or being seen for an independent medical evaluation, I am financially responsible for all charges whether or not paid by my insurance company. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorneys fees and the cost of collection. I hereby authorize Rogozinski Orthopedic Clinic to furnish any designated attorney of insurance all information necessary to file a health insurance claim form or to obtain reimbursement. I hereby assign all medical and/or major surgical benefits to include major medical benefits to which I am entitled, including any government sponsored program, and private insurance and any other health plans to Rogozinski Orthopedic Clinic.**

Signature of Insured or Guardian ______________________ Date ____________

Signature of Witness ______________________ Date ____________

HISTORY

Date___________________ Referring doctor________________

Name____Righthanded____Lefthanded____

Age_________________ Height_____ Weight____ Sex M/F Date of injury______________

PAST MEDICAL HISTORY

Circle any of the following you still have or have ever had:

Glaucoma
Diabetes
Blood Problems
Bleeding Tendency/Hemophilia
Jaundice/Hepatitis
Kidney/Bladder Problems
Lung/Breathing Problems

Nerve Problems
Familial Hyperthermia
AIDS/HIV Positive
Heart Problems
High Blood Pressure
Epilepsy/Convulsions
Stomach Problems/Ulcers

Sickle Cell
Gout
Polio
Cancer
Arthritis
TB
Thyroid Disease

List all previous surgeries including minor ones & dates:

_______________ _______________ _______________

_______________ _______________ _______________

_______________ _______________ _______________

List all medications including over the counter ones and dosages

_______________ _______________ _______________

_______________ _______________ _______________

_______________ _______________ _______________

_______________ _______________ _______________

Allergies: List any known allergies including medicines, food, tape, latex, eggs, poultry, etc.

_______________ _______________ _______________

_______________ _______________ _______________

SOCIAL HISTORY

Occupation__________________ Education Level____________ Time on present job_____

Are you pregnant? Yes_____ No______

Tobacco Use Yes_____No_____Amt._____ Alcohol Use Yes_____No_____Amt.______

Would you consent to a blood transfusions? Yes_____No_____

Rogozinski Orthopedic Clinic

3716 UNIVERSITY BLVD. S. / SUITE 3 • JACKSONVILLE, FL 32216 • 904/733-3529 • FAX 904/730-7687
E-mail • rogoortho@bellsouth.net

Chaim Rogozinski MD
Fellow, AAOS
Diplomate, ABOS

Abraham Rogozinski MD
Fellow, AAOS
Diplomate, ABOS

Sam Rogozinski
Chief Operating Officer

Gregory D. Cloud
Physician's Assistant - Certified

NOTICE OF PRIVACY 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.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialling activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you as described in the patient rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or payment for your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event our/your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly related to the persons involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, or other similar forms of health information.

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

Required by Law: We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: ______________________________

Account No.: ______________________________

By signing below, I acknowledge that I have received a copy of the Privacy Notice of Rogozinski Orthopedic Clinic, P.A.

____
Signature of Member or Legal Representative

____
Print Name of Patient or Legal Representative

____
Date

____
Description of Legal Representative's Authority

CONTACT INFORMATION

The contact information of the patient or legal representative who signed this form should be filled in below.

Address:

____

____

____

Telephone:

______________________________ (Daytime)

______________________________ (Evening)

Rogozinski Orthopedic Clinic

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Chief Operating Officer

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MEDICAL RECORDS RELEASE

DATE:____

TO:____

____

____

I HEREBY AUTHORIZE YOU TO RELEASE TO:

Rogozinski Orthopedic Clinic
3716 University Blvd. South
Suite 3
Jacksonville, Florida 32216

ANY INFORMATION ON________________________________

INCLUDING THE DIAGNOSIS AND RECORDS OF MY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD EXTENDING:

FROM:____________________TO:____________________

SIGNATURE:______________________________________

WITNESS:_______________________________________

memorialhospital
MEMORIAL HEALTH

INFORMATION AND CONSENT FOR TESTING FOR INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS

Laboratory tests are now available which may detect evidence of infection with the human immunodeficiency virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS). We will refer to this virus as the "AIDS virus". Because of the AIDS "epidemic" and the worldwide concern for the spread of the AIDS virus, the use of these laboratory tests for testing some people is recommended by the Federal government and other healthcare agencies. The purpose of these tests is to identify those individuals who are infected so that they may take appropriate measures to prevent spread of the virus to others.

Available tests includes an enzyme linked immunoassay and Western Blot procedure. For the purpose of this document, the enzyme linked immunoassay will be referred to as the "Screening Test" and the Western Blot assay will be referred to as the "Confirmatory Test". Both of these tests are done on blood samples. These tests detect antibodies to the AIDS virus. The presence of these antibiodies indicates that an individual has been infected by the AIDS virus. This document will address the following issues: Florida reporting requirements and anonymous test sites, and the two primary concerns about these blood tests for AIDS; the "false positive" result of the Screen Test and the need to keep the results of these tests confidential.

1. State Reporting Requirements and Anonymous Test Sites

We are required by Florida law to report to the Duval County Public Health Department any confirmed positive HIV test results and confirmed AIDS cases. Although we do not perform anonymous testing at this facility, there are locations throughout the city that can do testing anonymously. We will be glad to provide you with a list of these locations at your request.

2. Concerns About "False Positive" Blood Tests

As with all screening tests, the blood tests for AIDS are not perfect. The Screening Test may be positive when, in fact, the individual is NOT infected by the AIDS virus. We call this situation a "false positive" test. In order to know if an individual is truly infected with the AIDS virus, the Confirmatory Test must be performed. For this reason, any blood sample having a positive Screening Test will usually be subjected to the Confirmatory Test as well. Most people truly affected with the AIDS virus are positive with both the Screening Test and the Confirmatory Test. It is important to understand that an individual who has a positive Screening Test but a negative Confirmatory Test is probably not truly infected with the AIDS virus. Also, most individuals who have a positive Screening Test and who do not belong to a high risk AIDS group will probably be considered to have a "false positive" reaction until the Confirmatory Test has been completed. All the reasons for having a "false positive" test are not known; however, these reactions can be seen in women who have had multiple children or transfusions and in individuals with autoimmune disorders such as lupus, etc. Thus, one must realize that these tests are not perfect and that some individuals will have positive tests when they are not really infected. Therefore, one must wait for all test results before knowing whether one is actually infected with the AIDS virus.

Finally, on very rare occasions, individuals who are infected with the AIDS virus may have a negative blood test.

3. **Concerns About Confidentiality of Test Results**

The second major concern is for confidentiality of the test results. The need for confidentiality exist because patients who have AIDS or who are infected with the AIDS virus have suffered numerous social adversities. These adversities include discrimination when applying for a job, loss of family and friends and loss of insurability. Because of these facts, it is of the utmost importance that the Screening Test and the Confirmatory Test results be kept confidential by yourself, your doctor and our institution. Although we strive to accomplish this goal, we cannot guarantee that this information will be kept strictly confidential.

Therefore, before agreeing to have the Screening Test performed, you should fully understand the following:

- We are required by Florida law to report all positive test results to the Duval County Public Health Department. They also strive to maintain strict confidentiality with information we send to them. Also, there are anonymous testing sites available in the city.
- If your Screening Test is positive, we will automatically perform a Confirmatory Test.
- The Screening Test and the Confirmatory Test are excellent but are not perfect. Some individuals will have positive test results but will not truly be infected with the AIDS virus. Rarely, an individual may be infected with the virus but have negative test results.
- We will attempt to keep your test results strictly confidential. However, this cannot be guaranteed. If these results should become know to others, i.e., where you have signed a release permitting others to have access to your medical records), adverse situations including job discrimination, loss of job, loss of friends and family, and loss of insurability may occur.
- If you are found to be infected with the AIDS virus, you can then take the appropriate measures to prevent the spread of the virus to others.

I hereby certify that I have read the above information and that I understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I therefore, grant permission for the Hospital, or it's agent, to performance both Screening and Confirmatory Tests for infection with the AIDS virus and for documentation regarding the tests, including this consent to be placed in my medical record.

Signed: ______________________________ ***Date:*** ____________

Witness: ______________________________ ***Date:*** ____________

Comments: ____

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Memorial Hospital Jacksonville, Florida **INFORMATION AND CONSENT FOR TESTING FOR INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS**	**PATIENT LABEL** **CONHIV01** **897063**