Ronald D. Gardner, M.D.
Arthroscopic Reconstructive Surgery & Joint Replacement

Robert Martinez, M.D.
Arthroscopic Shoulder Surgery Joint Replacement

Brad Castellano, D.P.M
Foot & Ankle Specialty

W. Andrew Hodge, M.D.
Hip & Knee Joint Replacement

GardnerOrthopedics.com

3033 Winkler Ave., Ste. 100
Ft. Myers, FL 33916

Ph: (239) 277-7070 Fax: (239) 277-7071

Edward R. Dupay, Jr., D.O.
Adult Reconstruction Specialist

Vidya P. Kini, M.D.
Physical Medicine & Rehabilitation

Alan Nguyen, D.O.
Physical Medicine & Rehabilitation
Interventional Spine & Sports Medicine

Madhish Patel, D.O.
Adult Reconstruction & Arthroscopy

RESTORATIVE & ANTI-AGING CLINIC

PATIENT INFORMATION

Date: ________________________ Account #:___________________________

First Name: _______________________________ Middle Initial: ________ Last Name: _____________________________

Social Security Number: ________________________ Date of Birth: ________________ Sex: ___M___F

Home: ( ) _________ - __________ Mobile: ( ) ________ - _________ Work: ( ) ________ - _________

Preferred Contact Method: Home / Cell / Work Email Address (*please print clearly*): ________________________

Local Address: _____________________________________ City/State: ____________________ Zip Code: ___________

Northern/Other Address: ____________________________ City/State: ____________________ Zip Code: ___________

Race:	White	Black	American Indian	Asian	Native Hawaiian	Other	Decline
Ethnicity:	Hispanic	Non-Hispanic	Type-Unknown	Decline			

Reason for visit: _________________________ If an injury, how did this occur: _________________________________

Referred By: ____________________________ Primary Care Physician: ____

Employer Name: ____ Occupation: ______________________________

Spouse's Name: _________________________ Spouse's DOB: ________________ Spouse's Wk #: _____________

Health Ins. Carrier: ____ Auto Ins. Carrier: _________________________

If patient is a Minor, Parents Name: _________________________ Parents Employer: _________________________

Source of Payment (*Please Circle*): Primary Insurance Auto Self-Pay

EMERGENCY CONTACT

In the event of a medical emergency please contact:

____

First and Last Name Relationship Phone Number

The information above is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance(s). I also authorize Gardner Orthopedics to release any information to my insurance(s) required to process my claims

____

Patient/Guardian Signature Date

Please review forms, make appropriate changes and initial

*******THE SECTION BELOW IS ONLY FOR UPDATING PAPERWORK FOR YOUR SECOND AND THIRD YEAR OF TREATMENT*******

☐ Updated ☐ No Changes ___________ _____________
Patient Initial Date

☐ Updated ☐ No Changes ___________ _____________
Patient Initial Date

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Notice of Privacy Practice

You have the right to obtain a paper copy of this notice from us upon request.

Name: ________________________________Date: _______________DOB: ____________Account #:___________________

Release of Information

Do you authorize the release of appointment information, medical and financial claims information?

________Yes ________ No

If yes, this information may be released to the individual(s) listed below:

Name	Relationship	Phone Number

This Release of Information will remain in effect until terminated by me in writing.

If unable to reach me:

☐ You may leave a detailed message.

☐ Please leave a message asking me to return your call.

☐ Other: ____

When leaving message:

Please call

☐ My Home ☐ My Work ☐ My Cell

Number: _________-_________-______________ Ext: _____________

The best time to reach me is (day) ________________________ between (time) ___________ and _____________

Patient Signature: ____ Date: ________________

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CONSENT TO EXAMINATION, TREATMENT AND STATEMENT OF FINANCIAL POLICY AND RESPONSIBILITY

By my signature below I attest that I am capable of reading and comprehending this form without assistance, and have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and or interpreter to help me in completing this form, and declined any aid.

By my signature below I hereby authorize the physicians of Gardner Orthopedics with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me. I further agree to undergo examinations, x-rays, blood tests and or any other diagnostic modalities that the physician may determine to be important and or relevant to my care.

By my signature below I authorize the doctor to treat or correct any unexpected conditions or problem found during the examination, diagnostic procedure and or care, treatment therapy, or remedy listed above. I agree that the doctor will explain my medical condition(s), symptom, and or trauma, if known, and will explain and proposed examination, diagnostic procedure, and or care, treatment, therapy or remedy. **I agree to clarification if needed.**

By my signature below I agree that the doctor will explain other relevant and available alternatives, including associated risks, to the examination, diagnostic procedure, and or treatment proposed. I agree that I will be provided the opportunity to discuss relevant and available alternatives. **I agree to ask for clarification if needed.**

By my signature below I understand that there are certain risks inherent to the diagnosis and treatment of any disease, physical trauma, and or condition. I agree that the doctor will discuss the risks of the specific examination, diagnostic procedure, and or treatment proposed, including risks that are specific to me. I further agree that the doctor will explain the risks of not having the examination, diagnostic procedure or treatment proposed. **I agree to ask for clarification if needed.**

By my signature below I agree that I am submitting to the examination, diagnostic procedure and or treatment of my own free will. I further agree that I can ask questions and raise concerns with the doctor about my condition, the risks inherent to the examination, diagnostic procedure and or treatment and my treatment options. I agree that my questions and concerns will be discussed and answered to my satisfaction. I further attest that I understand that I may ask questions concerning my examination or treatment and that **I may stop treatment at any time for clarification of treatment options.**

By my signature below I attest that I have stated or noted my past medical history to the best of my ability, and further attest that I have **not taken and undisclosed medications or drugs prior to examination and or treatment.**

By my signature below I agree that the doctor or any individual employed by the physician has not provided me a guarantee or assurance that the examination, diagnostic procedure and or care, treatment, therapy or remedy will cure or improve the condition(s) listed above. I further understand the examination, diagnostic procedure and or care, treatment, therapy or remedy may make my conditions worsen.

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Name: ______________________________Date: ______________DOB: ___________Account #:________________

By my signature below I agree that, as part of the examination, diagnostic procedure, and/or care, treatment, therapy or remedy provided, the doctor may obtain certain protected health information, including past medical history. I understand that this will include a review, if necessary, of past, current or future health records, including records of procedures such as physical examinations, x-rays, blood or urine tests. I understand that further information will be gleaned, as necessary, from direct and telephonic conversations with the doctor and/or the doctor's health care staff, or from my responses to any questionnaire submitted prior to the initiation of the proposed examination, diagnostic procedure, and/or care, treatment, therapy or remedy. I understand that the information sought may include, but is not necessarily limited to, the following:

- Document of past medical history
- Records of physical exams and procedures
- Laboratory, x-ray, MRI and other test results
- Records of medication or drug usage
- Records of implanted or external medical devices
- Information related to diagnosis and treatment of a mental health condition Information about HIV/AIDS
- Information about hepatitis infection
- Information about sexually transmitted diseases
- Information about infectious diseases that must be reported to Public Health Authorities

By my signature below I understand that Florida law generally requires that physicians carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. I further understand that Florida law imposes strict penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. I understand that doctors of Gardner Orthopedics have elected, pursuant to Florida law, not to carry medical malpractice insurance. I understand that this election is permitted under Florida law, subject to certain conditions, and understand that I have been provided with notice of this election pursuant to Florida law.

By my signature below **I understand and agree to pay all deductible, co-payments, and fees due, less insurance payments**. As a courtesy to you, we will submit your claim to your insurance company. Any portion not covered by your insurance company, such as your co-insurance and/or deductible amount is due and payable at the time of service. Additionally, some insurance companies do not cover supplies, such as braces, slings, splints, etc. necessary for your treatment. You are responsible for these non-covered services. **Please be advised, all no-show appointments will result in a $25 charge.**

Failure to make payment in full or failure to make arrangements for payment may result in your account being placed with a collection agency. Should it become necessary to send your account to the collection agency, collection costs may include, but are not limited to, collection agency fees, court costs, attorney fees, interest on unpaid balances and any other fees or costs associated with the collection of unpaid balance. A $35.00 returned check fee will be added to your account for all retuned checks.

I agree that Gardner Orthopedics may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

____ ___________________
Patient or Patient's Representative Date