MR#_____

PATIENT INFORMATION

Full Name _____ Birth Date_____ Gender: M F Race_____

Hispanic or Latino Y N Multi-Racial: Y N Preferred Language_____

Address _____ City_____ State_____ Zip_____

Email:_____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Marital Status: S M W D Sep SS# _____-____-_____ Spouse Name_____

Emergency Contact: Name_____ Relationship _____ Phone _____

Your Employer_____ Your Occupation_____

Employer Address_____ City_____ State_____ Zip_____

Spouse's Employer_____ Spouse's Occupation_____

Health Insurance _____ No _____ Yes Company _____

INSURANCE (please allow our staff to photocopy your Insurance Information and Drivers License)

This is necessary for audit and billing purposes

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I give this office the right to use my name for any in-office publications.
- Authorization may be denied or retracted by notifying the office manager.
- If your account is turned over to a collection agency for non-payment you will be responsible for any cost incurred in collections of said balance. This could include collection agency fess of up to 50% of your outstanding balance, court costs and attorney fees.

Patient's Signature_____ Date_____

Spouse's or Guardian's Signature_____ Date_____

(Authorization expires 3 years from date above)

Stanislaw Zemankiewicz M.D., PHD
Orthopedic Surgeon & Sports Medicine
1048 S. Florida Ave.
Lakeland, Florida 33803

REVIEW OF SYSTEMS

Do you have any of the following problems?

Constitutional
Recant Weight Loss Yes ___ No ___ Fevers Yes ___ No ___
Chills Yes ___ No ___ Night Sweats Yes ___ No ___

Eyes
Blurred Vision Yes ___ No ___ Glasses Yes ___ No ___

ENT
Throat Yes ___ No ___ Ear (s) Yes ___ No ___ Nose Yes ___ No ___

Respiratory
Shortness of Breath Yes ___ No ___ Wheezing Yes ___ No ___ Persistent Cough Yes ___ No ___

Cardiovascular
Chest Pain Yes ___ No ___ Irregular Heartbeat Yes ___ No ___

Gastrointestinal
Stomach Pain Yes ___ No ___ Blood in Stool Yes ___ No ___
Frequent Diarrhea Yes ___ No ___ Constipation Yes ___ No ___

Genitourinary
Blood in Urine Yes ___ No ___ Painful Urination Yes ___ No ___
Difficulty Yes ___ No ___ Frequent Urinary Infections Yes ___ No ___

Neurological
Paralysis Yes ___ No ___ Frequent Headaches Yes ___ No ___

Skin
Rash Yes ___ No ___

Blood
Easy Bruising/Bleeding Yes ___ No ___

Endocrine
Thyroid Problem Yes ___ No ___

Stanislaw Zemankiewicz M.D.,PHD
P1048 South Florida Ave.
Lakeland, Florida 33803

PAST MEDICAL HISTORY

Patient Name _____

Date Completed _____

Date of Birth _____ Sex M F

Right Handed _____ Left Handed _____

Height _____ Weight _____

DO YOU HAVE ANY OF THESE CONDITION?

Cardiac

Hypertension/High Blood Pressure Yes ___ No ___ Heart Attack Yes ___ No ___Stroke Yes ___ No ___
Blood Clots Yes ___ No ___ Arrhythmia Yes ___ No ___ Other _____

Respiratory

Asthma Yes ___ No ___ Sleep Apnea (diagnosed)Yes ___ No ___ Other _____

Gastrointestinal

Ulcer Disease Yes ___ No ___ Other _____

Endocrine

Thyroid Problem Yes ___ No ___ Diabetes Yes ___ No ___ Insulin Yes ___ No ___
Medication Yes ___ No ___ Diet Controlled Yes ___ No ___

Cancer Yes ___ No ___ Type _____ Treatment _____

Liver Disease Yes ___ No ___ Treatment _____

Neurological Disease

Seizure Disorder Yes ___ No ___ Parkinson's Disease Yes ___ No ___
Multiple Sclerosis Yes ___ No ___ Other _____

Kidney Disease Yes ___ No ___

HypertensionYes ___ No ___

HIV Aids Yes ___ No ___ Treatment _____

Allergies

a. _____
b. _____
c. _____

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CASE HISTORY

History of Present Injury/Illness

Please list below the complaint(s) you have in the order of importance. Also the length of time you have had these complaints.

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____

Is your condition(s) related to an accident? Yes ___ No ___
Date of Accident _____ Type of Accident: Auto ___ Work Related ___ Other ___

What words best describe your present condition(s) (ache, burn, tingling, etc.) _____

Circle the number that matches your level of pain at its worst 1 2 3 4 5 6 7 8 9 10

How intense is the problem? Mild Moderate Severe

When is your condition most severe? _____

When is your condition least severe? _____

Is your condition: Getting worse ___ Stay the same ___ Getting better ___ Comes & goes ___

Have you ever had the same or similar conditions in the past? Yes ___ No ___
If yes explain _____

What makes your condition feel worse? _____

What makes your condition feel better? _____

What activities are difficult because of your condition(s) _____

Have you seen any other health care provider for your present condition? Yes ___ No ___
Who? _____

Are you currently taking medications? Yes ___ No ___
Brand Name or Generic Name _____

Do you have a pacemaker? Yes ___ No ___
Are you pregnant? Yes ___ No ___
Do you smoke? Yes ___ No ___

Are you experiencing or do you have any of the following?

A sore throat that won't heal ___ Any bleeding/discharge ___ Bladder/bowel problems ___
Difficulty swallowing ___ Lump thickening anywhere ___ Night pain ___ Persistent cough/hoarseness ___
Wart/mole changes ___ Weight loss without trying ___ None of the above ___

List any surgeries you have had:
1. _____ 2._____
Have you been hospitalized for anything in addition to surgeries? Yes ___ No ____
If yes when and for what reason? _____

Have you had an X-ray, CT Scan or MRI in the last 30 days? Yes ___ No ___
If yes explain _____

Stanislaw Zemankiewicz MD, PHD
Orthopedic Surgeon & Sorts Medicine
1048 S. Florida Ave.
Lakeland, Florida 33803
863-688-2200

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a coy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____
Patient Name **(print)**

_____
Date

_____
Parent or Guardian

_____
Signature

DOB _____ MR#_____

Stanislaw Zemankiewicz M.D., PH.D.
Orthopedic Surgeon

Patient Consent Form

(Please read and sign)

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically-accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is give in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and a treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Dr. Stanislaw Zemankiewicz, Orthopedic Surgeon, may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Dr. Stanislaw Zemankiewicz will use and disclose my information for the purposes of treatment, payment and healthcare operations as described in the Notice of Privacy Practices. A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Dr. Stanislaw Zemankiewicz.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) signature Date

ACKNOWLEDGMENT OF LIABILITY
ASSIGNMENT OF BENEFITS

INSURANCE COMPANY:_____

For and in consideration of the above-mentioned provider agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services, I hereby irrevocably assign to the aforementioned medical provider (the "Provider") any Personal Injury Protection benefits I any have in accordance with Florida Statute 627.736(5). This includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred, and I authorize the "Provider" to prosecute said action and collect legal expenses as they see fit. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF BENEFITS. I hereby further give a lien to the "Provider" against any and all insurance benefits named herein, and nay and all proceeds of any settlement, judgment or verdict, which may be paid to me as a result of the injuries or illness for which I have been treated by the "Provider". This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the "Provider" and any attorney that the "Provider" chooses, and to do all things reasonable to effect payment of the bills by the insurance company to the "Provider" including, but not limited to, disclosing patient's medical condition and treatment. This assignment concerns only the bills for the "Provider" and those costs (including, but not limited to attorney's fees, court cost and interest) necessary in procuring payment from the above-named insurance company, etc. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the "Provider" will pursue collection against the insurance company in my behalf. I hereby instruct and direct my insurance company to pay my benefits by check, made payable to and mailed to the "Provider" at the address listed above. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the "Provider" at the address listed above. If this "Provider" is providing medical care related to an auto accident, "Provider" is charging a reasonable fee for necessary care related to the accident, and these bills should be paid to the full extent of the benefits available under my policy of insurance. If any portion of any charge for these services is either reduced or denied in whole or in part, my insurance company is to place funds equal to the amount of the reduced or denied charges into escrow. My insurance company is to hold the escrowed funds for "Provider", until such time as all escrowed funds are paid to "Provider", or "Provider" instructs my insurance company that "Provider" is no longer making any claim to the escrowed funds. Furthermore, I hereby give the "Provider" limited power of attorney to endorse/sign my name on any and all checks for payment to the "Provider". This agreement is intended to serve as an assignment of the patient's rights and benefits under his/her aforementioned insurance policy in favor of the "Provider". If any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

OFFICE OF INSURANCE REGULATION

Bureau of Property & Casualty Forms and Rates

Standard Disclose and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

☐99203 Detailed Exam	☐99243 Detailed Consultation	☐ 99212 Est. Patient (10 min.)
☐99204 Comprehensive Exam	☐99244 Comprehensive Consultation	☐99213 Est. Patient (15 min.)
☐Other:_____	☐99273 Confirmatory Consultation	☐ 99214 Est. Patient (20-25 min)

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the Services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in The amounts paid by my motor vehicle insurer. If entitled, my share would be at least **20%** of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name (PRINT or TYPE)	Signature	Date

The undersigned licensed medical professional or medical director if applicable, affirms the statement numbered I above and also:

A. I have **not solicited** to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for The person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant Information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that no service **has been up coded, unbundled,** or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/her own hand):*

Stanislaw Zemankiewicz MD,PHD	_____	_____
Name (PRINT or TYPE)	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or An application containing any false, incomplete, or misleading information is guilty of a felony of the third degree Per Section 817.234 (1)(b). Florida Statutes

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim

NOTICE OF EMERCENCY MEDICAL CONDITION

STANISLAW ZEMANKIEWICZ M.D., PH.D.
ORTHOPEDIC SURGEON
LIC # 47215

The undersigned licensed medical provider, hereby asserts:

1.) The below patient, has in the opinion of this medical provider, suffered an Emergency Medical Condition, as a result of the patients injuries sustained in an automobile accident that occurred on _____ (fill in date of accident).

2.) The basis of the opinion for finding an Emergency Medical Condition is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence if immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to patient health: b) serious impairment to bodily functions: or c) serious dysfunction of a bodily organ or part.

I hereby attest that I am a physician licensed under chapter 458 or chapter 459) a dentist licensed un chapter 466, a physician assistant licensed under chapter 458 or 459, or an advanced registered nurse practitioner licensed under chapter 464, and that the above facts are true and correct.

DR. STANISLAW ZEMANKIEWICZ M.D. PH.D _____ _____
Name (PRINT OR TYPE) Signature of medical provider Date

The undersigned injured person or legal guardian of such person asserts:

1.) The symptoms I reported to the medical provider are true and accurate.

2.) I understand the medical provider has determined I sustained an Emergency Medical Condition as a result of the injuries I suffered in the car accident.

3.) The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient:

_____ _____ _____
Name (PRINT or Type) Signature of injured patient/guardian Date

Address: 1048 south florida avenue Lakeland, FL 33803 tel 863 688 2200 fax 863 688 2210