WELCOME TO MELI ORTHOPEDIC CENTERS OF EXCELLENCE

TODAY'S DATE _____

PATIENT NAME_____ DATE OF BIRTH_____

SOCIAL SECURITY # _____ ❒ MALE ❒ FEMALE

LOCAL ADDRESS_____ APT# _____

CITY _____ STATE _____ ZIP CODE _____

PERMANENT ADDRESS_____ APT# _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ **CELL PHONE** _____

EMAIL ADDRESS _____

WOULD YOU LIKE OUR MONTHLY NEWSLETTER? ❒ YES ❒ NO

EMPLOYER'S NAME _____ OCCUPATION _____

REASON FOR YOUR VISIT TODAY? _____

PREFERRED PHARMACY _____ PHONE NUMBER _____

IS THIS DUE TO AN ACCIDENT? ❒ NO ❒ YES IF YES, DATE OF ACCIDENT _____

IF YES, IS THIS A WORK OR AUTO ACCIDENT? ❒ WORK ❒ AUTO ❒ OTHER _____

PRIMARY INSURANCE _____ I.D. # _____

SECONDARY INSURANCE _____ I.D. # _____

RESPONSIBLE PARTY _____ DATE OF BIRTH _____

SOCIAL SECURITY # OF RESPONSIBLE PARTY _____

RELATIONSHIP TO RESPONSIBLE PARTY _____

REFERRED BY _____

YOUR MEDICAL DOCTOR _____ PHONE NUMBER _____

IN CASE OF EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE NUMBER _____

PATIENT MEDICAL INFORMATION

PLEASE LIST ANY / ALL MEDICAL PROBLEMS _____

_____

_____

OPERATIONS AND DATES _____

_____

PLEASE LIST ANY / ALL MEDICATIONS _____

_____

ALLERGIES TO ANY MEDICATIONS _____

DO YOU SMOKE? ❒ NO ❒ YES, HOW MUCH? _____

DO YOU DRINK? ❒ NO ❒ YES, HOW OFTEN? _____

HEIGHT _____ WEIGHT _____

AVERAGE BLOOD PRESSURE READING

SYSTOLIC (TOP NUMBER) _____ DIASTOLIC (BOTTOM NUMBER) _____

IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS, PLEASE CHECK ALL THAT APPLY

____ DIABETES	____ KIDNEY DISEASE	____ HIGH CHOLESTEROL
____ HIGH BLOOD PRESSURE	____ ARTHRITIS	____ STOMACH PROBLEMS
____ STROKE	____ INTESTINAL PROBLEMS	____ ASTHMA
____ HEART DISEASE	____ GOUT	____ PHLEBITIS (BLOOD CLOTS)
____ THYROID PROBLEMS	____ HEPATITIS	____ ULCERS
____ HIATAL HERNIA	____ CANCER	____ H.I.V.

DO YOU HAVE A FAMILY HISTORY FOR ANY OF THE ABOVE MENTIONED CONDITIONS? ☐ NO ☐ YES

IF YES, PLEASE EXPLAIN: _____

_____

ARE THERE ANY OTHER MEDICAL PROBLEMS THAT WE SHOULD BE AWARE OF? _____

_____

WOMEN ONLY: ARE YOU PREGNANT? ❒ NO ❒ YES

PLEASE READ AND SIGN BELOW

In the event insurance is filed for surgery or other services rendered to me, I hereby authorize this office to release information to my insurance company and assign benefits directly to **MELI ORTHOPEDIC CENTER OF EXCELLENCE.**

1. MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to process a claim or any related claims for my physician, or to my attorney.

2. HMO AND MEDICARE PATIENTS - NON COVERED BENEFITS

I have been notified by my physician/supplier that Medicare/HMO is likely to deny payment for certain items (i.e. soft goods, outside x-ray review, ect.) If Medicare/HMO denies payment, I agree to be personally and fully responsible for payment.

3. SIGNATURE ON FILE / LIFETIME AUTHORIZATION

The signature below is required by ALL Medicare patients.

I request that payment of authorized Medical benefits be made to my physician/supplier for services rendered and any information needed to determine these benefits for for any related services.

SIGNATURE: _____ ***DATE:*** _____

PAYMENT POLICY: **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. PLEASE NO EXCEPTIONS.**

ACKNOWLEDGMENT OF RECEIPT

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE **MELI ORTHOPEDIC CENTER OF EXCELLENCE** NOTICE OF PRIVACY PRACTICES.

NAME: _____

PLEASE PRINT

SIGNATURE: _____ ***DATE:*** _____

With my signature I agree that Meli Orthopedic Center of Excellence and its collections department/agency may contact me at any of the phone numbers I have provided to discuss all balances pertaining to my account. Meli Orthopedic also has permission to contact me via email if any or all of my phone numbers have been changed or disconnected.

FOR OFFICE USE ONLY

DATE ACKNOWLEDGEMENT WAS RECEIVED: _____

OR

REASON ACKNOWLEDGEMENT WAS NOT OBTAINED:_____

_____

_____

SIGNATURE: _____ NAME: _____ DATE: _____

MELI ORTHOPEDIC
CENTERS OF EXCELLENCE

FT. LAUDERDALE: 4800 NE 20th Terrace, Suite 303
(954) 771-8177 • Fax: (954) 771-3629 Fax

MARGATE: 2964 N. State Road 7, Suite 205
Phone: (954) 580-4080 • Fax: (954) 580-4081

CANCELLATION POLICY

Our cancellation policy states that any scheduled appointment *(either an office visit or procedure)* must be cancelled with a 24 hour advanced notice during normal operating hours (Monday through Friday; 8:30am - 4:30pm). An "untimely cancellation" is noted as a cancellation provided to our office with less than a 24 hour notice of the scheduled appointment. **These missed appointments are labeled as a "no show."**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Please be informed that it is the policy of Meli Orthopedic Center of Excellence to monitor and manage appointment "no shows."

Patients who fail to arrive for a scheduled appointment, without a 24 hour advanced notice, will be considered a "no show."

Patients who consistently fail to arrive for more than (1) scheduled appointment are considered a CHRONIC "no show."

"No show" appointments will incur the following fees

- **Follow up appointment: $30**

Please note: This fee will not be covered by your insurance company. You MUST pay this fee in full before a future appointment can be made. Chronic "no show" patients are subject to dismissal from the Practice.

By signing below, I have reviewed the above, fully understand and agree with the terms provided herein.

Patient Signature x _____ Date _____

Printed Name _____

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