# Omar David Hussamy, MD,PA – Office Policies

## Appointments & Office Hours

- Our office hours are 7:30am to 5:00pm Monday through Thursday and 7:30am to 1pm on Friday.
- For urgent matters after 5:00pm, please call our main phone number, 772-213-9800 for the provider on call**. In an emergency, call 911 or go directly to the nearest emergency room**
- **We can only see you for one condition per visit due to increased regulated documentation requirements.**

## Financial Policy

- ***Payment is due at time of service. We accept cash, Visa, MasterCard, AMEX or Discover.***
- For patients with health insurance, co-payments, co-insurance and/or deductibles will be collected at the time services are rendered. Your insurance policy is a contract between you and your insurance company. In the event of denials, errors, service caps, policy exclusions or non-covered services, the patient is responsible for payment of all services rendered. **It is the patient's responsibility to know whether our providers are in-network with their insurance plan.** Patient will be responsible for any charges incurred whether in or out of network. Please notify the office of any changes in insurance coverage before services are rendered.
- If you do not have insurance, the office staff can provide you with a cost for services which is due in full, at time of service.
- Any account balance you may have must be paid in full prior to scheduling surgery.
- We reserve the right to report any unpaid balances greater than 120 days old to a collection agency for payment recovery.
- If you have multiple primary insurance policies, you are responsible for coordinating primary vs. secondary with your insurance companies. Failure to do so will result in claim denials and refusal to pay.

## Auto Accidents/Worker's Compensation

- **See the receptionist**

## Identity Verification

- If you would like us to bill your insurance carrier, you must present a valid insurance card AND identification prior to being seen at check-in **at every visit** or payment in full will be required.

## Fees for Services

- Medical records: We have partnered with Sharecare , please contact them directly 877-548-4069.
- Copy of x-rays on disk: $10.00
- Disability, FMLA, employer-related or legal forms are $15.00, per occurrence. **(**Our physicians do NOT perform complete disability evaluations for military or worker's compensation reviews.)**
- Returned check fee: $35.00 - No **Show and/or under 24 hr notice of cancellation for Appointment: $25.00** **MRI No Show and/or under 24 hr notice of cancellation : $250** - Handicap Placards: $10.00

## Medication Refill Policy

- All requests for prescriptions must be made 48 hours in advance. Please have your pharmacy request your refill. Medication refills are only addressed during office hours. Narcotic prescriptions must be picked up in person and cannot be mailed or called in. *By signing below, you are authorizing us to view your external Rx history.

***I have read and understand the Office Policy and I agree to accept responsibility as described above. I also understand the Policy may be amended from time to time by the practice.***

| ______________________ | ______________________ | ______________ |
|---|---|---|
| Printed Name | Signature | Date |

REV: /202

## MOTOR VEHICLE ACCIDENT?

Auto Carrier: ______________________________________________

What was the date of your accident? ______________________________________________

Accident claim #: ______________________________________________

Adjuster name: ___________________________

Contact info: _____________________________

**Release & Assignment of Benefits to Omar David Hussamy, MD, PA**

I, _______________________________ (print name) hereby irrevocably assign any and all benefit rights I have under any policy of insurance, indemnity agreement or any other collateral source as defined by the Florida Statues and case law for any/or charges provided to me by Omar David Hussamy, MD, PA authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. My signature authorizes my physician to submit claims for benefits for services rendered, and my insurance carrier is authorized to verify my benefits when asked. I authorize the use of this signature on all my insurance submissions.

_______________________________________________ ______________________

Patient's Signature (or Parent/Guardian Signature as applicable) Date

_______________________________________________

Patient Name (if patient is a minor)

## Work-Related Injury?

If you feel this visit is or may be covered by **Workers' Compensation** (did your injury occur on or near your office/jobsite or while working for your employer?) it is your responsibility to notify our office at your **first visit**. If you fail to notify our office at your first visit, *you will be responsible for paying for any related, previously billed charges and any further charges up to and if we obtain payment from the work comp insurance company.*

**I have read and fully understand this form and by my signature I am attesting that my current medical condition/injury did happen while at work and/or while at my place of employment.**

_______________________________________________ ______________________

Patient Signature (parent/guardian if patient under 18) Date

Employer: ______________________________________________

Name of Supervisor/HR Director: ______________________________________________

Supervisor/HR Phone: __________________________ Email: __________________________

What was the date of your accident? ______________________________________________

Name of Worker's Comp Insurance Company______________________________________________

Accident claim #: ______________________________________________

Adjuster name: ___________________________Contact info: __________________________

_______________________________________________ ______________________

Patient signature (parent/guardian if patient under 18) Date

_______________________________________________

Patient name (please print)

REV: 6/2020

**Patient Name:** ______________________________________ **Today's Date:** ______________________

**What are we seeing you for today**? ________________________________________________________________

**Which side is affected?** Right Left Both **Was this the result of an accident/injury?** No Yes

**If yes, please describe in detail what happened:**

___________________________________________________________________________

___________________________________________________________________________

**Date pain started?** ____________________ **The pain:** started suddenly progressively became worse

**The pain is:** constant intermittent **Does the pain move to other areas?** No Yes:

**Have you had prior surgery at site of pain?** No Yes **Type of surgery and when** __________________

**Severity of pain on a 1-10 scale:** *** **HEIGHT:** ___________ **WEIGHT:**__________***

| Yes | Yes | Yes |
|---|---|---|
| ☐ Bruising | ☐ Locking | ☐ Tingling in Arms |
| ☐ Cracking Sensation | ☐ Night Pain | ☐ Tingling in Legs |
| ☐ Decreased Mobility | ☐ Night Awakening | ☐ Tenderness |
| ☐ Difficult Sleeping | ☐ Numbness | ☐ Weakness |
| ☐ Instability | ☐ Popping | ☐ Bleeding |
| ☐ Limping | ☐ Spasms | ☐ Enlarged Bruise |
| ☐ Redness | ☐ Clicking | ☐ Warmth |
| ☐ Joint Pain | ☐ Grating | |
| ☐ Stiffness | ☐ Swelling | |

**What Makes Symptoms Worse?**

| | |
|---|---|
| ☐ **Nothing** | ☐ **Movement** |
| ☐ **Bending** | ☐ **Pushing** |
| ☐ **Climbing Stairs** | ☐ **Sitting** |
| ☐ **Standing** | ☐ **Walking** |
| ☐ **Lifting** | ☐ **Descending Stairs** |
| ☐ **Kneeling** | ☐ **Other** ______________ |

**Relieved by**

| | | |
|---|---|---|
| ☐ **Nothing** | ☐ **Injection** | ☐ **Rest** |
| ☐ **Brace/Splint** | ☐ **Massage** | ☐ **Stretching** |
| ☐ **Elevation** | ☐ **Pain/RX Meds** | ☐ **Other**___________ |
| ☐ **Exercise** | ☐ **Mobility** | |
| ☐ **Heat** | ☐ **OTC Medicines** | |
| ☐ **Ice** | ☐ **Physical Therapy** | |

**Types of Pain**

| | |
|---|---|
| ☐ Aching | ☐ Piercing |
| ☐ Burning | ☐ Sharp |
| ☐ Dull | ☐ Throbbing |
| ☐ Stabbing | ☐ Tearing |
| ☐ Shooting | ☐ Numbness |
| ☐ Discomfort | |
| ☐ Other ____________________ | |

## ARE YOU CURRENTLY EXPERIENCING? (REVIEW OF SYSTEMS)

☐ Fever ☐ Significant Weight Change ☐ Vision Problems ☐ Cough/Cold Symptoms

☐ Shortness of Breath ☐ Chest Pain ☐ Heart Palpitations ☐ Diarrhea ☐ Constipation

☐ Urinary Incontinence ☐ Pain with Urination ☐ Joint Pain ☐ Chronic Headache

☐ Rash on Affected Limb

REV: 2/2023

**Patient Name:** ________________________________________ **Today's Date:** _______________________

| Surgical History: | Date: |
|---|---|
| | |
| | |
| | |
| | |

| Please list any treatment pertaining to today's complaint (injections, physical therapy, medications…): | Date: |
|---|---|
| | |
| | |
| | |
| | |
| | |

| Medication: | Dosage: | Direction/How Taken: |
|---|---|---|
| | | |
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| | | |
| | | |

***Additional information please write on the back of this page.***

**Family History**

| Condition: | Family Member: | Comments: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***Additional information please write on the back of this page.***

| Pharmacy: | ***All fields required*** | |
|---|---|---|
| Pharmacy Name: | Address: | Phone: |

**Primary Care Physician** : ________________________________ **Ph:** ____________________________

| Environmental Allergies: | Drug Allergies: | Food Allergies: |
|---|---|---|
| ○ None | ○ None | ○ None |
| ○ Latex | ○ ______________ | ○ Peanuts |
| ○ Adhesives | ○ ______________ | ○ Shellfish |
| ○ Other: | ○ ______________ | ○ ______________ |
| ○ ____________ | ○ ______________ | ○ ______________ |

| **PAST** MEDICAL HISTORY | ***All Fields Required*** |
|---|---|
| Name | Date: |

## Have you ever had or currently have any of the following (mark all that apply):

- ○ **AIDs/HIV**
- ○ **Tuberculosis**
- ○ **Hepatitis**
- ○ Alcoholism
- ○ Alzheimer
- ○ Anemia
- ○ Angina
- ○ Asthma
- ○ Atrial Fibrillation
- ○ Benign Prostatic Hypertrophy
- ○ Cancer
- ○ Congestive Heart Failure
- ○ COPD
- ○ Coronary Artery Disease
- ○ Crohn's Disease
- ○ Depression
- ○ Diabetes
- ○ Drug Abuse (illegal or Rx)

- ○ Deep Vein Thrombosis
- ○ Fibromyalgia
- ○ Gallbladder Disease
- ○ GERD
- ○ Gout
- ○ Heart Attack
- ○ High Cholesterol
- ○ Hypertension
- ○ Ulcerative Colitis
- ○ Juvenile Rheumatoid Arthritis
- ○ Kidney Disease
- ○ Liver Disease
- ○ Lyme Disease
- ○ Migraine Headaches
- ○ Multiple Sclerosis
- ○ Obesity
- ○ Osteoarthritis

- ○ Osteoporosis
- ○ Parkinson Disease
- ○ Peptic Ulcer Disease
- ○ Psoriasis
- ○ Peripheral Vascular Disease
- ○ Renal Disease
- ○ Rheumatoid Arthritis
- ○ Scoliosis
- ○ Seizure Disorder
- ○ Sleep Apnea
- ○ Stroke
- ○ Systemic Lupus Erythematous
- ○ Spinal Stenosis
- ○ Spondyloarthropathy
- ○ Traumatic Arthritis
- ○ Thyroid Disease
- ○ Valvular Disease

| **Social History** | **Circle your responses** | |
|---|---|---|
| Females – Any chance you may be pregnant? : Yes No | Do you live alone or with family? | |
| Receiving Hospice Care?: Yes No | Are you in Skilled Nursing or an Inpatient Rehab Facility? Yes No | |
| Activity Level: Low Moderate Active | | |
| Current Smoker ☐ Former Smoker ☐ Non-Smoker ☐ | If former how long ago did you quit? | |
| If current how often?: | How many per day: | Interestead in Quiting? Yes No |
| Do you consume alcohol?: Yes No | How Often: | How Many Drinks?: |
| Have you ever used illegal drugs?: Yes No | Type: | Currently? |
| Do you have a living Will?: Yes No No | Do you have a DNR?: | |
| Do you have a healthcare Proxy? Yes No | Name & Contact Phone: | |



REV: 2/2023