Edward Dieguez Jr., MD
811 State Road 206 East
South Shore Plaza, Ste. #1
Saint Augustine, Florida 32086
Phone: (904) 824-0955 Fax (904) 824-2226
E-mail: info@theorthobiologicclinic.com
www.TheOrthobiologicClinic.com

To Prospective Patients

Thanks for your interest in wanting to become a patient in our office. **To expedite your appointment,** we need your cooperation. Our goal is for the doctor to see you at the scheduled time, so please arrive to our facility 15 minutes prior to your appointment time. **We do not want our patients to just sit and wait for hours on end in our waiting room. So please be on time.**

We have prepared this **Prospective Patient Package** with information for you and some forms for you to complete before the visit. This allows the doctor to **spend more time face to face with you the patient, answering your questions and concerns during the visit.** Our goal when you visit our office is to make your experience unlike any other you may have had at a doctors office.

For Dr. Dieguez to make an accurate initial assessment of your condition, all questions must be answered in full, with all spaces completed. Please sign and date as indicated. Once you have completed all sections, return them to us ASAP so the doctor has time to review it before your visit.. **Our goal is to get you in as soon as possible. We will strive to get you in, schedule permitting, the following day or even the same day if possible.**

Our Philosophy

This is how we see it:

No insurance? Not a problem! Do you have an insurance policy that restricts your access to specialist care like HMO and Manage Care policies? Not a problem! We can help! We have developed ways to help you if you find yourself in one of these situations. We realize that with the introduction of the "Affordable Care Act", some patients out there are still finding it difficult to afford health insurance coverage. Others are now facing much higher deductibles and co-pays.

Still other have insurance policies that makes it very difficult or impossible for them to have access to specialist care and can only see a specialist if they are referred by their primary care physician. Now, do you think the above described scenario is going to change anytime soon? Not a chance! Do you know why? Because these primary care physicians are incentivized financially, by your insurance company not to make those referrals to specialist. Why? Because it increases the insurance company's cost to provide you "care." So, you find yourself with a condition that necessitates specialist care and you are not getting it when you want it. If that is your situation, **Call us!!**

We understand these issues that **many patients are facing** and we want to **do what we can to help.** Hopefully these issues will be solved soon for everyone. In the meantime, **we are here** trying to do the best we can to help you.

Our solutions!

Wanting to avoid turning down those patients in our office, prompted us to come up with some kind of affordable solution for ***patients with financial hardship.*** To take advantage of the affordable flat cash affordable rates, you will need to sign some forms and a financial hardship agreement.

1.- **Flat cash affordable rates** are available for everyone facing the above-mentioned issues if we are not participating provider with your insurance company. Examples that come to mind are Humana, GHI, Aetna, Cigna, AvMed, EHN, Connecticut General, Coventry Health, Capital Health Plan, CarePlus Health Plan, Health First Plans, Prime HealthCare, Sunshine State Health Plan, Florida Health Care Plan, Tricare HMO, Wellcare, and many, many others.

2.- **For those other procedures** more specialized that we offer in our office, such as Prolotherapy, PRP, and BMC Cell Procedures, Lipogens, and Progenekine, which are procedures that **have never been covered by insurance companies**, we have also tried to **keep them affordable** for you and **have adjusted our price much lower than the competition even with the current price hikes we are all experiencing.** These procedures are never cheap because they are time consuming and supplies are very pricy unfortunately. But to make them accessible to everyone, we offer **easy payment plans** for these more expensive procedures. Call our office to get additional information or questions and also visit our website.

Sources of Information About Our Practice

To keep you informed about new development and new treatment option that we offer, we have created **several sources** of information for you. We kindly request, that you look at these.

The first one is our Office Website. Here you will get an overview of the different modalities of treatments that we offer and different conditions we treat. You will also find an area in our website to request appointments. Visit us at: **www.TheOrthobiologicClinic.com**.

The second one is our Office Facebook Page. Here we add information often. Patient can ask questions, rate our services and stay in contact with any events planned at our office. Please we encourage you to visit us at: **www.Facebook.com/TheOrthobiologicClinic.com.** Share with friends and family member that you think may be interested in some of the treatment we provide. Let us know how we are doing. Comments are greatly appreciated.

The third one is our LinkedIn page. Here we also add information often. Patient can ask questions, rate our services and stay in contact with any events planned at our office. Please we encourage you to visit us at: **https://www.linkedin.com/in/edward-dieguez-jr-md-230b9520/**

Please be aware that **we are not** one of those so called **"pain clinics"** and we do not prescribe chronic narcotic medications. With that been said, **if what you are looking for are narcotics or other controlled substances, don't expect to get them in this office.**
Don't waste my time or yours. Or your money for that matter! Here you will go out empty handed. And remember, we will not hesitate in reporting drug seekers to the authorities if we have to. **We do not prescribe Marijuana or any of its derivatives either! We are an Interventional Orthobiologic Clinic.**

We Sincerely Thank You!

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Section 1 - General Information/Patient registration

Important Note: Please understand that all questions must be answered in full, if possible, with all spaces completed, in order to expedite the process for an appointment. If the information requested is not available, please specify so. **Please print clearly.**

1) PATIENT'S FULL NAME: _____DATE OF BIRTH: _____

2) SOCIAL SECURITY NUMBER_____E-mail address:_____

3) MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____

4) PHONE (INCLUDING AREA CODE):HOME_____WORK_____CELL_____

Which of the above is best to contact you? _____

5) MARITAL STATUS: SINGLE _____MARRIED _____DIVORCED _____OTHER _____

6) PERSON TO CONTACT IN EMERGENCY: _____PHONE:_____ RELATION:_____

7) ARE THE SERVICES YOU WISH TO OBTAIN FROM THE DOCTOR ACCIDENT RELATED? YES _____ NO _____

8) ARE YOU EMPLOYED? YES ____ NO ____ SPECIFY WHERE: _____

9) IF MARRIED, IS YOUR SPOUSE EMPLOYED? YES _____ NO _____WHERE: _____

10) **Primary Insurance Information**: INSURANCE COMPANY NAME:_____

11) **Secondary Insurance Information**:INSURANCE COMPANY NAME:_____

12) Preferred Pharmacy: _____

I understand that in order to have these services properly paid by my insurance company if covered, I am responsible for the accuracy of all the above information. I have answered all of the above truthfully and to the best of my ability and I understand that I am solely responsible for any misrepresentations or errors included herein. If the above information is to change at any time, I will notify this office in writing within ten days. I also understand that the answers to the above questions may have legal implications if I have intentionally supplied false or misleading information. I authorize the release of any medical records required for claim payment. I further assign all benefits payable to Edward Dieguez, Jr., M.D. P.A. Should any insurance company fail to pay these services for reasons you did not disclosed to doctor Dieguez office, or if the doctor does not participate with an insurance company, patient or legal guardian assumes full responsibility for any balance due. Please be aware that we do not accept insurance for Acupuncture unless benefits are fully verified by our office. Regenerative procedures such as BMC Stem Cell, Platelet Rich Plasma and Prolotherapy are never covered by insurance.

PATIENT OR RESPONSIBLE PARTY: _____
(Please print name)

SIGNATURE: _____ DATE: _____
(Patient's or Responsible Party's)

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Section 2- Health Questionnaire

Patient's name:_____

Who referred you to our office: _____

Who is your primary care doctor: _____

Chief Complain: What brings you to our office today? _____

_____

Prior Diagnosis: Have you been diagnosed with any conditions?

- Heart Condition No_____ Yes_____ If so specify _____
- Stroke/TIA No_____ Yes_____ When?_____
- Emphysema/COPD Yes_____No_____ On Oxygen? Yes_____ No_____
- Seizures Yes_____ No_____ Diabetes Yes_____ No_____
- Cancer No_____ Yes_____ If so specify_____
- Major surgery Yes_____No_____ If so specify_____
- Other_____

Allergies:

- Medication allergies: Yes_____ No_____ If so specify_____
- Food Allergies: Yes_____ No_____ If so specify_____
- Environmental Allergies: Yes _____ No_____ If so specify _____

Medications you currently take:

Name	Strength	Frequency	Purpose
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Social History:

- Smoking History: Never a smoker _____ Ex-smoker_____

  Present smoker _____ Packs per day?_____

- Gender identity: Male_____ Female_____

- Sexual Orientation: Heterosexual _____ Homosexual _____ Other_____

  Please specify_____

Past Medical History:

- Enter Major events please: _____

- Ongoing Medical problems: _____

History of present illness:

- Please briefly describe the pain and include the following:

  1. Location:_____
  2. Quality: sharp_____ dull_____ aching_____
  3. Timing: Gradual _____ Acute _____ Started when _____
  4. What where you doing when it came on?_____

     _____
  5. What makes it worse? _____
  6. What make it better? _____
  7. Does the pain radiate? Yes_____ No_____ If so where to_____

     _____
  8. Is there numbness or weakness? Yes_____ No_____

If so Specify where_____

10. Pain Score or severity of the pain you are experiencing: Where 0 equals no pain and 10 is the worse pain imaginable.

Circle a number: 1 2 3 4 5 6 7 8 9 10

11. How does the pain affect your daily living? _____

_____

Are currently involved in or considering a lawsuit in relation to your problem? Yes _____ or No _____

Are you receiving compensation for any medical problem? _____

PATIENT SIGNATURE: _____ DATE: _____

Section 3 - Assessment for Patients with Pain

Following are questions given to patients in pain. Please answer each question as honestly as possible. Your treatment will not be determined solely by the answers provided. Thank you.

Please answer all the questions below by circling the number that most accurately matches your response. Use the following scale:

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very often

1. How often do you feel that your pain is "out of control?" 0 1 2 3 4
2. How often do you have mood swings? 0 1 2 3 4
3. How often do you do things that you later regret? 0 1 2 3 4
4. How often has your family been supportive and encouraging? 0 1 2 3 4
5. How often have others told you that you have a bad temper? 0 1 2 3 4
6. Compared to other people, how often have you been in a car accident? 0 1 2 3 4
7. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
8. How often have you felt a need for higher doses of medication to treat your pain? 0 1 2 3 4
9. How often do you take more medication than you are supposed to? 0 1 2 3 4
10. How often have any of your family members, including parents and grandparents had a problem with alcohol or drugs? 0 1 2 3 4
11. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
12. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
13. How often have you attended an AA or NA meeting? 0 1 2 3 4
14. How often have you had a problem getting along with the doctors who prescribe your medicine? 0 1 2 3 4
15. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
16. How often have you been seen by a psychiatrist or mental health counselor? 0 1 2 3 4
17. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
18. How often has your medication been lost or stolen 0 1 2 3 4

19. How often have others expressed concern over your use of medication? 0 1 2 3 4

20. How often have you felt a craving for medication? 0 1 2 3 4

21. How often has more than one doctor prescribed pain medication for you at the same time? 0 1 2 3 4

22. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4

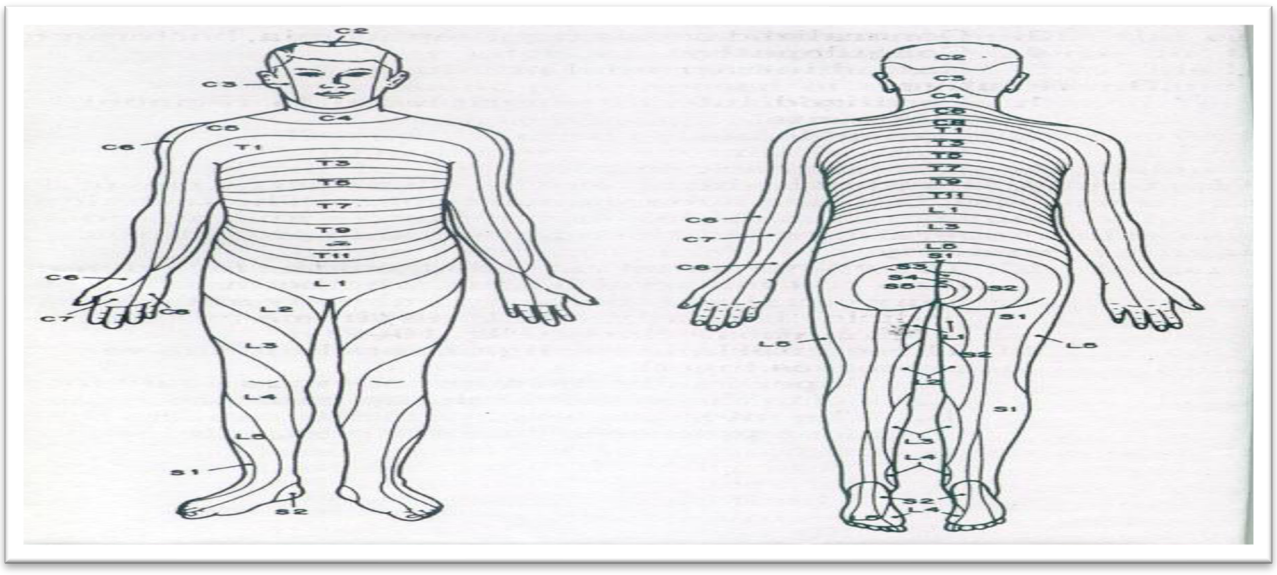
23. How often have you used illegal drugs (such as marijuana, cocaine, etc.,) in the past five years? 0 1 2 3 4

24. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Please include any additional information you wish about the answers above. Thank you.

Pain Distribution Drawing

On the drawing below, please shade the area where you feel pain



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Section 4. Patient Consent & Authorization for Release of Protected Health Information.

Patient Name:_____ Date of Birth_____

Address:_____ City: _____ State: _____ Zip:_____

Telephone: _____ Email:_____

I, _____, hereby authorize any and all entities such as doctors,
(Print Patient's name)
hospitals, insurance companies, and other medical facilities and specifically

_____

the release, use or disclosure **of any and all** my protected health information to Edward Dieguez Jr. MD. I understand that per my request this authorization will permit the above named parties to use or disclose the health information for purposes beyond treatment, payment or healthcare operations as provided by the HIPPA act of 1996. This authorization is valid from the date I or my representative signs it, till the day I or my representative revokes it in writing by certified mail to Edward Dieguez Jr. MD. This revocation will be effective on the date it has been received and process. The revocation does not apply to actions that have been taken in reliance upon this authorization prior to the effective date of revocation. Unless I requested in writing otherwise I understand this authorization will expire on _____. If I do not specify a date or event, it will expire 90 days from the day I signed the authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient and may no longer be protected by HIPPA privacy rules after the authorized disclosure. I further authorize Edward Dieguez, Jr., M.D. and his staff to discuss my medical conditions and share information with other physicians or entities that may have participated in my care in the past or that will participate in my care in the future. I also authorize Dr. Dieguez to share the information with me the patient. I understand that some of this information may be transmitted via fax machine [or by any other electronic means.

PATIENT OR LEGAL GUARDIAN:

SIGNATURE:_____ DATE:_____

NAME:_____

RELATIONSHIP TO PATIENT:_____

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Section 5 - Our Financial Policy

***INTERVENTIONAL ORTHOBIOLOGIC MEDICINE and/or PROLOTHERAPY -** For these services we accept, Visa, Master Card, Discover card, American Express or cash.

***INSURANCE PATIENTS** – The percentage of coverage by your insurance company may be based on your insurance company's own reduced fee schedule for medical services, and may be less than actual charges, resulting in lower coverage for you and a higher balance left for you to pay. However, if we are participating preferred providers for your insurance carrier, we are bound to accept their payment as full payment, excluding co-pays, deductible and co-insurance. This situation is outside of our control. Lower coverage and higher deductibles and co-pays and co-insurance are a direct result of the plan selected by you or your employer. Please be advised that we cannot waive co-payments or deductibles or co-insurance. If you have a secondary insurance policy, sometimes they will cover you deductible but not always. Finally, be aware that there are some procedures that are not covered by some insurance because they arbitrarily considered them experimental or plainly do not want to cover them.

***INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY** – We are not privy to this contract. If we participate with your insurance company, we will inform you and we will handle your claims according to our contract with that company. We file insurance claims as a courtesy to our patients. It is our policy not to become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered or non-covered services, or usual and customary allowable charges as per your contract. You are ultimately responsible for timely payment of your account.

***MEDICARE PATIENTS** – This office accepts traditional Medicare assignment. Medicare patients are fully responsible for the yearly deductible and 20% co-payment unless your secondary insurance picks that up. Sometimes they do but not always. If not, federal law requires that we collect these amounts. If you have insurance in addition to Medicare, we also will submit this for payment. Be aware that Medicare does not cover many procedures such as Orthobiologic Procedures (PRP, BMC/MST, Lipogems etc.), Prolotherapy and some other procedure.

***NO INSURANCE** –We know that at times patients do not have insurance. If this is the case, the visit cost will be discussed prior to making the appointment. At the time of the visit if other costs are going to be incur, a payment plan may be set up. **The doctor alone makes the final decision. More importantly, cash payment does not guarantee in no way shape or form a prescription of any kind and it does not guarantee that the doctor will continue to see you after your first consultation. Additionally the fee paid is not refundable.**

***MEDICAID** – This office accepts traditional Medicaid assignment. **We are providers of Medicaid.**

***ASSIGNMENT OF INSURANCE BENEFITS** - In the event that you are entitled to any benefits of any type whatsoever arising out of a policy insuring you or any other party's liability to you, you hereby assign said benefits to Edward Dieguez, Jr., M.D. P.A. to be applied towards you bill.

***CHANGES OF INSURANCE COVERAGE** – It is your sole responsibility to notify our office of any changes in insurance coverage prior to having any service rendered to you. Failure to do so will automatically make you responsible of all charges. These charges will become due and payable immediately and our billing company will do whatever it takes to collect the amount owed..

***I REALIZE ALL PAYMENTS ARE DUE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE** – Failure to keep my account current may result in the doctor not being able to provide additional services. In the case of default on payment of my account, I agree to pay and additional 33% for collection costs, in addition to court costs, and reasonable attorney fees incurred while attempting to collect the account balance or any future outstanding account balances.

SIGNATURE OF RESPONSIBLE PARTY:_____

NAME OF RESPONSIBLE PARTY: _____

PATIENT NAME: _____ DATE:_____
(Please print)

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Section 6 – Office Policies and Procedures

1.- Appointments: Dr. Dieguez sees patient by appointments only on Tuesdays, Wednesdays and Thursdays from 8:30 AM to 4:30 PM. The office staff will be here taking call and messages and scheduling appointments Mondays. We are closed Fridays. Also, we close for lunch from noon to 1:00PM daily. If you need to be seen right away, please call the office first to see if we can accommodate you. For emergencies call 911 or go to the nearest emergency room.

2.- Missed or cancelled appointments: You are asked to confirm your appointment at least 48 hours in advance and you must notify our office 24 hours in advance during business hours if you are not going to be able to attend. If you do not cancel during that time and miss your appointment, you will be charged a $50.00 fee. A repeat offense may result in dismissal from the practice. If you are more than fifteen minutes late to your appointment you may need to reschedule or wait a while till the doctor see the next patient and see if he can squeeze you in.

3.- Communications: The office staff can provide patients' their medical records when requested. Please allow seven business days. We can also provide messaging access to the doctor.

4.- Medication refills: Each request requires a comprehensive chart review by a physician, and review of the Florida Prescription Drug Monitoring Program (PDMP) database as indicated. When calling for a refill be sure to include the name of the pharmacy and the phone number. You need to call our office (904) 824-0955 five business days in advance prior to needing a refill. If you have not been seen in a while, or if the doctors feel he needs to see you we will let you know so you schedule an appointment before the prescription is issued or refilled. Refill messages received after 1:00 pm will be handled on the following business day.

With your cooperation, we will be able to better serve you and all of our patients. Thank you.
I fully understand, acknowledge and agree to abide by the above policy and procedures:

PATIENT'S NAME: _____
(Please print)

SIGNATURE: _____ DATE: _____

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Section 7 – HIPPA Compliance Patient Consent Form

Our notice of privacy practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The term of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment , payment or healthcare operations. We are not required to agree with this restrictions, but if we do, we shall honor this agreement. The HIPPA (Health InsurancePortability and Accountability act of 1996) law allows for the use of information for treatment, payment or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or sent a text to communicate or confirm your appointment? ---------- Yes No

May we leave a message on your answering machine at home or on your cell phone? ----------Yes No

May we discuss your medical condition with any member of your family? ---------- Yes No

Please print names and phone number or email address of friends or family if applicable

_____ _____ _____

Print Name: _____ Date:_____

Signature: _____

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Section 8 - Authorization to Release Medical Information to Patient's Family or Friends

PATIENT NAME: _____
(Please print)

I hereby give my consent to **Edward Dieguez, Jr., M.D.** and his staff to discuss my medical condition—including, but not limited to, laboratory/radiology reports, procedures, treatment plans and medication regiment—with the individual (family or friend) listed below. I understand that this consent will remain in effect until or unless I provide further written notice.

PATIENT NAME:_____

RELATIONSHIP:_____

ADDRESS:_____

PHONE: _____

PATIENT' SIGNATURE: _____DATE: _____

WITNESS: _____ SIGNATURE: _____

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Section 9 – Acknowledgment

I am aware that all of the information I have provided on this Prospective Patient Information packet (Sections 1 – 9), including the foregoing authorizations for release of information about myself, will be utilized by Dr. Dieguez and staff to do a preliminary evaluation of my case and see if, at his sole discretion, he feels he can be of service to me or not. Additionally, this information will expedite my appointment at the moment of arrival at the office avoiding long wait time.

I have provided to the best of my knowledge, truthful information in the foregoing questions and release forms. After a prompt review of the above information by Dr. Dieguez, I will be contacted by Dr. Dieguez office regarding an appointment.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____