Orthopaedic Center of South Florida

Date: _____/_____/_____

Name: _____ Account #: _____

Date of Birth: _____/_____/_____ Phone #: _____ E-Mail : _____

Primary Care Physician: _____

Referring Physician: _____

Are you Right ____ or Left ____ handed?

Why are you seeing the doctor today/location of pain? _____

If in pain, how severe is the pain using a scale from 1-10? _____

Do you experience any bowel or bladder dysfunction as related to this? _____ YES _____ NO

Does the pain awaken you while asleep? _____ YES _____ NO

Is your pain the result of an injury? _____ YES _____ NO

If Yes, how were you injured?

_____ FALL _____ CAR ACCIDENT ____ WORK ACCIDENT ____ SPORTS ____ SLIP & FALL

Describe incident: _____

Date of accident or onset, if applicable: _____/_____/_____

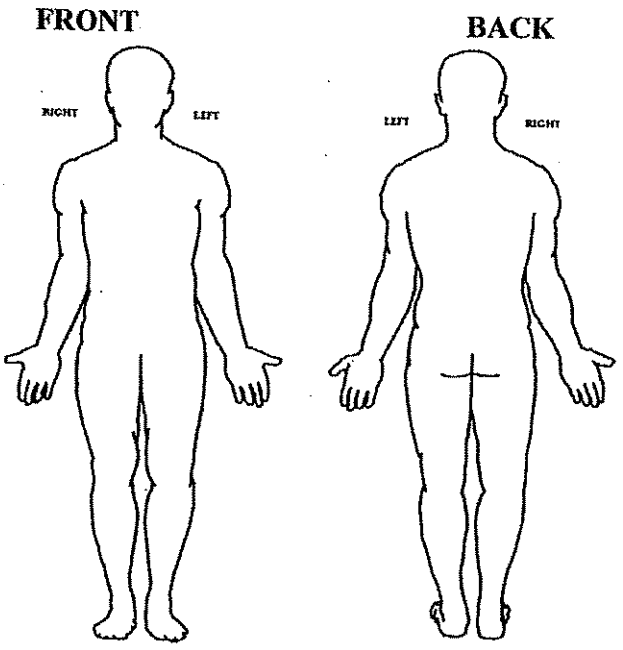
Did you go to the Emergency Room? (if yes, please indicate where) _____

Have you ever had a previous problem in this same body part? _____

Do you currently experience any arm or leg weakness? _____ YES _____ NO

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Mark area of radiation. Include all affected areas.

Numbness = = = = **Pins & Needles OOOO** **Burning XXXX** **Stabbing ////**



Orthopaedic Center of South Florida
Financial Policy & Assignment of Benefits

The purpose of this form is to help our patient(s) understand the Orthopaedic Center of South Florida, PA (OCSF) Financial Policy, provide consent for treatment, and accept financial responsibility for services rendered by OCSF.

PAYMENT IS EXPECTED AT TIME OF SERVICE

OCSF accepts the following types of payments: Cash, Personal Checks, Major Credit Cards (i.e. American Express, Discover, MasterCard, and Visa), and Care Credit with no interest for 6 months.

Electronic Check Conversion: When you provide a check as payment, you authorize OCSF to use the information from your personal check to make a one-time payment as an electronic funds transfer (EFT). Please note that when we use this information to process an EFT, funds may be withdrawn from your account as soon as the same day we received your payment.

Returned Check Fee: The return of a paper check/EFT issued to OCSF will result in a returned check fee determined at the time of processing. The fee will be assessed on the account of the patient who the check was presented for, no matter the reason. Each patient account will ONLY be allowed two returned checks/EFT's, after which payment by check/EFT will no longer be accepted. Written notification on how to resolve the returned check/EFT will be sent to the maker of the check/EFT and tot the person whose account was affected. Additionally, a hold will be placed on the patient account until the returned check/EFT has been resolved.

All patients are required and responsible for the following:

- To bring any Referral and/or Authorization required by their health insurance, either Primary or Secondary, for services rendered
- To provide OCSF with a current home address and updated insurance, when necessary
- To pay for the co-payment, deductible, and/or coinsurance at the time of service as designated by the insurance company
- To pay for any previous balance at the time of service

MEDICARE PATIENTS:
If a patient is a Medicare member, patient will be responsible to review and sign the Medicare 'ABN' Advanced Beneficiary Notice for services non-covered or not deemed Medically Necessary by Medicare, including orthotics, injections, etc. If patient has no secondary insurance, 20% coinsurance is required to be paid at time of service. The patient must notify OCSF if enrolled with any HMO/PPO.

MOTOR VEHICLE ACCIDENT PATIENTS:
If related to a motor vehicle accident, patient is to report the accident to their own automobile insurance company within 14 days of the date of accident and provide our office with the claim number. If patient does not have automobile insurance, they need to report the accident to the Automobile insurance of their household within the same time frame. If we to the file patient's health insurance as secondary coverage, co-payment, deductible, and/or coinsurance is expected at the time of service. If patient is not insured by any insurance policy, he/she may qualify for a discounted rate. However, at the time an attorney is hired, OCSF expects full charges to be paid from any settlement and a Letter of Protection will be required. If attorney fails to pay OCSF, patient will be responsible for the balance up to OCSF full charge(s).

LIABILITY ACCIDENT PATIENTS:
If related to a Slip & Fall accident, patient's health insurance can be filed and patient is responsible for co-pay, coinsurance, and/or deductible at the time of service. If patient is not insured by any insurance policy, he/she may qualify for a discounted rate. However, at the time an attorney is hired, OCSF expects full charges to be paid from any settlement and a Letter of Protection will be required. If attorney fails to pay OCSF, patient will be responsible for the balance up to OCSF full charge(s).

WORKER'S COMPENSATION PATIENTS:
Patient will be treated for a Worker's Comp injury as long as we are authorized as treating physician(s). Once patient reaches MMI (Maximum Medical Improvement), patient shall be responsible for co-payment designated by Worker's

Comp. If case is settled, we cannot file future claims to Worker's Comp, therefore, patient shall provide us with their health insurance information.

BILLING & COLLECTION PROCEDURES:
If eligible for Insurance benefits, it should be understood that the agreement is between the patient and their health insurance. Patient is responsible to pay for our services regardless of the status with their insurance company. OCSF files claims promptly to the insurance company for services rendered as a courtesy to the patient. If there is a patient balance, statements are mailed monthly, around the 10th of every month, for a period not to exceed three (3) months. Any balance due beyond 90 days is subject to a finance charge of 20%. OCSF reserves the right to use an outside collection agency in an attempt to collect any outstanding patient balance, and collection fees may be added.

OTHER ENTITIES:
During the course of your treatment, patient may be referred to other institutions for diagnostic testing, lab work, durable medical equipment, and/or therapy. These referrals are based solely on medical necessity and our affiliation with these institutions is based on providing our patient's with the highest quality and professional medical care possible. Comments on patient's experience of these institutions will be used to modify and improve the referral process. This notice will serve to advise our patient(s) that OCSF participates as a partner in the Centers listed below and that patient's signature acknowledges that he/she has been apprised of this information.

The Centers are as follows:

- Memorial Same Day Surgery Center West
- Outpatient Surgical Services
- ParkCreek Surgery Center
- Weston Outpatient Surgery Center

OCSF will make every attempt possible to refer our patient(s) to a facility participating with the patient's insurance plan; however, it is ultimately the patient's responsibility to find out if the facility is participating with their insurance company. OCSF will not be held responsible for any referral of a non-participating facility.

ASSIGNMENT OF BENEFITS:
The undersigned patient assigns the insurance benefits to OCSF for services rendered. The medical provider agrees to accept the irrevocable assignment benefits for services rendered to the patient. A photocopy of this assignment is to be considered valid as an original.

DIRECTION TO PAY:
The undersigned patient directs their Health Insurance to pay OCSF directly for services rendered. In the event health insurance pays the patient directly, the patient agrees to endorse and turn payment over to OCSF immediately.

RELEASE OF INFORMAITON:
The undersigned patient authorizes OCSF to furnish insurance and/or business associates with any and all information that may be necessary for treatment, for payment, or for health care operations.

CONSENT TO TREAT:
I accept treatment from any physician(s) at OCSF and/or any provider on staff. If patient is under 18, I hereby give my permission and consent for patient to be treated by a physician part of OCSF.

FINANCIAL RESPONSIBILITY:
I certify that I have read, understand, and agree to the terms and conditions indicated on this form, and I further agree to accept financial responsibility for services and/or items rendered or dispensed by OCSF deemed as patient responsibility.

Patient's Name	**Patient's Signature (if minor, Parent/Guardian)**	**Date**

Orthopaedic Center of South Florida
Acknowledgement and Consent

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control of this information. I acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information from my Health Care Provider. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

_____
Patient's Name

_____
Signature of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other: _____

Orthopaedic Center of South Florida
Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Social Security Number: _____

Section B: To the Patient

Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use of your Protected Health Information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities,and healthcare operations, of the uses and disclosures we may make of your Protected Health Information, and of other important matters regarding your Protected Health Information. A copy of our Notice accompanies the consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your Protected Health Information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Robin Fielding, CEO
600 South Pine Island Road, Suite 300, Plantation, FL 33324
Phone: (954) 473-6344 Fax: (954) 476-9077

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect our action we took in reliance of this consent before received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Acknowledgement:

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by reading this consent form, I am giving my consent to your use and disclosure of my Protected Health Information to carry out treatments, payment activities, and healthcare operations.

_____ _____

Signature Date

ORTHOPAEDIC CENTER Of South Florida

Authorization for Use, Disclosure, and Release of Health Information

Patient Name: _____ Date of Birth: _____ Account #: _____

I hereby authorize:
Orthopaedic Center of South Florida
600 South Pine Island Road
Plantation, FL

To Release Information:

_____
Name/Relationship to the patient

_____
Name/Relationship to the patient

INFORMATION TO BE RELEASED:

☐Progress Notes/Provider Notes ☐Lab Reports/Results ☐Diagnostic Test Results

☐Consultation Notes ☐Prescriptions ☐HIV Related Information

☐Behavioral Health Information ☐Alcohol and/or Drug Abuse Information

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one (1) year from the date signed.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except on the extent that the program or person which is to make the disclosure has already acted in reliance on it.
- I understand that a photocopy or fax of this form is the same as the original.

_____ _____
Patient Signature Date

_____ _____
Witness Date

600 South Pine Island Road, Suite 300, Plantation, FL 33324
(954) 473-6344
www.ocsfdocs.com