ASSIGNMENT OF BENEFITS AND MEDICAL RELEASE

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Orthopaedic Center of Venice, P.L., and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are payable to the undersigned alone or to the undersigned and the said Orthopaedic Center of Venice, P.L. , which checks, drafts, or money orders are made payable for the services which made by at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order. Furthermore, the undersigned allows Orthopaedic Center of Venice, P.L. or any of its agents to sign any paper that will be necessary to enhance, expedite and or allow payment to said provider.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Orthopaedic Center of Venice, P.L. insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.
The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by the virtue of these present.

ASSIGNMENT OF BENEFITS

I,_____ hereby authorize my third party payor to make medical benefit payments
(Name of Insured/Patient)

otherwise payable to me for the services rendered by Orthopaedic Center of Venice, P.L. but not to exceed the charges of those services, payable to and mailed directly to:

Orthopaedic Center of Venice, P.L.
241 Nokomis Ave. S., Ste. B
Venice, FL 34285

I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of unpaid benefits claimed by Orthopaedic Center of Venice, P.L. is to be set aside and not disbursed until the dispute is resolved. Furthermore, I hereby IRREVOCABLY ASSIGN to Orthopaedic Center of Venice, P.L. the rights and benefits and any and all causes of action resulting from non-payment under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Orthopaedic Center of Venice, P.L. or Dr. Julio Gonzalez.

I understand that if I have fees that are incurred by me for services rendered by Orthopaedic Center of Venice, P.L. that are not paid for by my insurance company or by me, that these fees will then be sent to a collection agency or legal entity with their own charges to be paid by me at that point. Sending these charges to a collection agency can affect my credit report or rating in the future.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 2020.

_____ _____

PATIENT SIGNATURE PATIENT NAME (PLEASE PRINT)

SELF INSURANCE

Dear Patient:

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Dr. Julio Gonzalez and Orthopaedic Center of Venice, P.L. HAVE DECIDED TO NOT CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

PATIENT/RESPONSIBLE PARTY SIGNATURE

DATE

PRINT NAME

DATE OF BIRTH

Notificacion de la Cancelacion del Seguro de la Negligencia Medica

Querido Paciente,

Bajo las leyes de la Florida, los proveedores requiren tener sequro medico de negligencia, o demostrar la responsabilidad financiera para cubrir los gastos hacia los reclamos echos por negligencia. El Dr. Gonzalez y Orthopaedic Center of Venice, P.L. han decidido no tener este seguro de negligencia. Bajo las leyes de la Florida es permitido no tener este seguro sujeto a ciertas condiciones. La ley de la Florida impune penalidades a los proveedores sin este seguro, hacia proveedores que fallen satisfacer los reclamos de juicos adversos a causa de la negligencia. Este anuncio esta provido por la ley de la Florida.

Firma del Paciente Persona Respondable

Fecha

Firma en molde

Fecha de nacimiento

MEDICAL INFORMATION RELEASE

I, _____, hereby grant permission for Orthopaedic Center of Venice, P.L. to release my information contained in my medical records to the individuals listed below. I understand this may include medical, psychiatric, drug and/or alcohol abuse, or HIV/AIDS testing information.

NAME	DATE OF BIRTH	RELATION TO PATIENT	PHONE
NAME	DATE OF BIRTH	RELATION TO PATIENT	PHONE
NAME	DATE OF BIRTH	RELATION TO PATIENT	PHONE
NAME	DATE OF BIRTH	RELATION TO PATIENT	PHONE

I understand this consent is revocable upon written notice to Orthopaedic Center of Venice, P.L., except to the extent that by the Orthopaedic Center of Venice, P.L. has been taken on this authorization, and that this authorization shall remain in force for a reasonable time. Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR part 11) prohibits making any further disclosure of it without specific written consent of the undersigned, or an otherwise permitted copy of such regulations. HIV testing, and/or AIDS related diagnosis is further prohibited from further disclosure by state regulations without the specific written consent from the patient.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PRINTED PATIENT NAME WITNESS

_____

PHYSICIAN SIGNATURE/DATE

PF-1000 NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, the results of your laboratory tests and procedures will be available in your medical record to all health care professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurers, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of the Orthopaedic Center of Venice, P.L. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to public health agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Use and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION

Appointment reminders.
Your health information will be used by our staff be members to send you appointment reminders.

Information About treatments.
Your health information may be used to send information on the treatment and management of your medical condition that you may find of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Fund Raising. Unless you request us not to, we will use your name and address to support our fund raising efforts. If you do not want to participate in fund raising efforts, please check off the following box.

☐ **Please do not use my information for fund raising efforts.**

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

· The right to request restrictions on the use and disclosures of your protected health information.
· The right to receive confidential communications concerning your medical condition and treatment.
· The right to inspect and copy your protected health information.
· The right to receive an accounting of how and to whom your protected health information has been disclosed.
· The right to receive a printed copy of this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. These revised policies and practices will be applied to all protected health information that we maintain.

REQUEST TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Ms. Tara Link.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practice's, you can do so by sending a letter outlining your concerns to :

Ms. Tara Link
Orthopaedic Center of Venice, P.L.
241 Nokomis Ave. S. , Ste. B
Venice, FL 34285

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated for filling a complaint.

CONTACT PERSON

The name and address of the person you can contact for further information concerning our privacy practice's is:

Ms. Tara Link
Orthopaedic Center of Venice, P.L.
241 Nokomis Ave. S., Ste. B
Venice, FL 34285

ORTHOPAEDIC CENTER OF VENICE, P.L. DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices
W are also required to abide by the privacy policies and practices that are outlines in this notice.

EFFECTIVE DATE : April 26, 2004

_____ _____
Signature Date

This notice is to advise you that we have contacted your insurance company for benefits on your policy prior to your visit at Orthopaedic Center of Venice. The benefits that are quoted to Orthopaedic Center of Venice are not a guarantee of payment by your insurance company. The quote you are given by Orthopaedic Center of Venice is not a guarantee of insurance payment. If there is a balance after insurance payment, this is your responsibility and is due at that time.

PRINT PATIENT NAME	TODAY'S DATE
PATIENT SIGNATURE	PATIENT DATE OF BIRTH

Orthopaedic Center of Venice, P.L.

ORTHOPEDIC HISTORY

Name: _____ SS#: _____ Date: _____

Height: _____ Weight: _____ Date of Birth: _____ Age: _____

Chief Complaint

Why are you seeing the doctor today? _____

Past Medical History

Medical Problem(s):

1. _____
2. _____
3. _____
4. _____
5. _____

Surgical History:

	Date(s):	Procedure(s):
1.		
2.		
3.		
4.		
5.		

Allergy to Medication(s):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medication(s):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Review of Systems

Are you currently having or have you had problems with your:

	Circle		Describe All Yes Responses
Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	
Lungs, Breathing	No	Yes	_____
Digestion	No	Yes	_____
Bowel movement	No	Yes	_____
Bladder Problem	No	Yes	_____
Diabetes	No	Yes	_____
Heart Disease	No	Yes	_____
High blood pressure	No	Yes	_____
Bleeding problems	No	Yes	_____
Balance problems	No	Yes	_____
Numbness/tingling	No	Yes	_____
Blackout/fainting	No	Yes	_____
Psychological problems	No	Yes	_____
AIDS	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Polio	No	Yes	_____
TB	No	Yes	_____
Epilepsy	No	Yes	_____

Social History

Occupation: _____

Tobacco: (Packs/day)
❑ 0 ❑ 1/2 ❑ 1 ❑ 2 ❑ 3

Alcohol:
❑ None ❑ Light ❑ Moderate ❑ Heavy

Social Drugs: ❑ Yes ❑ No

Physical Activity	Frequency

Marital Status: Married Divorced Widowed Single

Children:

	Sex	Age
(e.g.)	F	7

Family History (significant medical problems in blood relatives):

Relationship (e.g. Mother)	Problem

Have you had a Bone Density Scan? Yes No If yes, when? _____

Patient Signature: _____ Date: _____

Reviewed By: _____, M.D. Date: _____