

**Orthopedic Associates of Southwest Florida, P.A.**

13691 Metropolitan Parkway, S., Suite 400  
Fort Myers, Florida 33912

1203 SE 8<sup>th</sup> Avenue  
Cape Coral, FL 33990

**CONSENT TO EXAMINATION AND TREATMENT AND STATEMENT OF FINANCIAL  
POLICY AND RESPONSIBILITY/NOTICE OF HIPAA POLICY**

By my signature below I attest that I am capable of reading and comprehending this form without assistance, and have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and / or an interpreter to help me in completing this form, and declined any aid.

By my signature below I hereby authorize the physicians of Orthopedic Associates of Southwest Florida, P.A. with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me. I further agree to undergo any examinations, x-rays, blood tests and / or any other diagnostic modalities that the physician may determine to be important and / or relevant to my care.

By my signature below I authorize the doctor to treat or correct any unexpected conditions or problem found during the examination, diagnostic procedure, and/or care, treatment, therapy or remedy listed above. I agree that the doctor will explain my medical condition(s), symptom, or trauma, if known, and will explain any proposed examination, diagnostic procedure, and/or care, treatment, therapy or remedy. **I agree to ask for clarification if needed.**

By my signature below I agree that the doctor will explain other relevant and available alternatives, including associated risks, to the examination, diagnostic procedure, and/or treatment proposed. I agree that I will be provided with the opportunity to discuss relevant and available alternatives. **I agree to ask for clarification if needed.**

By my signature below I understand that there are certain risks inherent to the diagnosis and treatment of any disease, physical trauma, or condition. I agree that the doctor will discuss the risks of the specific examination, diagnostic procedure, and/or treatment proposed, including risks that are specific to me. I further agree that the doctor will explain the risks of **not** having the examination / diagnostic procedure / treatment proposed. **I agree to ask for clarification if needed.**

By my signature below I agree that I am submitting to the examination, diagnostic procedure, and/or treatment of my own free will. I further agree that I can ask questions and raise concerns with the doctor about my condition, the risks inherent to the examination, diagnostic procedure, and/or treatment, and my treatment options. I agree that my questions and concerns will be discussed and answered to my satisfaction. I further attest that I understand that I may ask questions concerning my examination or treatment, and that **I may stop treatment at any time for clarification of treatment options.**

By my signature below I attest that I have stated or noted my past medical history to the best of my ability, and further attest that I have **not taken any undisclosed medications or drugs prior to examination and/or treatment.**

By my signature below I agree that the doctor or any individual employed by the physician has not provided me a guarantee or assurance that the examination, diagnostic procedure, and/or care, treatment, therapy or remedy will cure or improve the condition(s) listed above. I further understand that the examination, diagnostic procedure, and/or care, treatment, therapy or remedy may make my condition worse.

By my signature below I agree that, as part of the examination, diagnostic procedure, and/or care, treatment, therapy or remedy provided, the doctor may obtain certain protected health information, including past medical history. I understand that this will include a review, if necessary, of past, current or future health records, including records of procedures such as physical examinations, x-rays, blood or urine tests. I understand that further information will be gleaned, as necessary, from direct and telephonic conversations with the doctor and/or the doctor's health care staff, or from my responses to any questionnaire submitted prior to the initiation of the proposed examination, diagnostic procedure, and/or care, treatment, therapy or remedy. I understand that the information sought may include, but is not necessarily limited to, the following:

- Documentation of past medical history
- Records of physical exams and procedures
- Laboratory, x-ray, MRI, and other test results
- Records of medication or drug usage
- Records of implanted or external medical devices
- Information related to diagnosis and treatment of a mental health condition
- Information about HIV/AIDS
- Information about hepatitis infection
- Information about sexually transmitted diseases
- Information about infectious diseases that must be reported to Public Health authorities

By my signature below I understand that Florida law generally requires that physicians carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. I further understand that Florida law imposes strict penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. I understand that the physician listed above has elected, pursuant to Florida law, not to carry medical malpractice insurance. I understand that this election is permitted under Florida law, subject to certain conditions, and understand that I have been provided with notice of this election pursuant to Florida law.

By my signature below **I understand and agree to pay all deductibles, co-payments, and fees due, less insurance payments.** As a courtesy to you, we will submit your claim to your insurance company. Any portion not covered by your insurance company, such as your co-insurance and/or deductible amount is due and payable at the time of service. Additionally, some insurance companies do not cover supplies, such as braces, slings, splints, etc. necessary for your treatment. You are responsible for these non-covered services.

Failure to make payment in full or failure to make arrangements for payment may result in your account being placed with a collection agency. Should it become necessary to send your account to the collection agency, collection costs may include, but are not limited to, collection agency fees, court costs, attorney fees, interest on unpaid balances and any other fees or costs associated with the collection of unpaid balance. A \$25.00 returned check fee will be added to your account for all returned checks.

Effective January 2, 2007, you will be charged a \$25.00 cancellation fee if you do not cancel an appointment at least 24 hours in advance of your scheduled appointment. The fee must be paid in full before another appointment will be scheduled

## **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.**

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Our practice is required by law to abide by the terms of this Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Our office is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice you may call the office and request that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

### **HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:**

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and in order to support the business activities of the practice, including, but not limited to, use by administrative personnel reviewing the quality of the care you receive, employee review activities, training of medical students, licensing, contracting or arranging for other business activities..

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

#### **Appointment Reminders.**

We may contact you to provide appointment reminders.

#### **Treatment Information.**

We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

#### **Disclosure to Department of Health and Human Services.**

We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

#### **Family and Friends.**

Unless you object, we may disclose your medical information to family members, other relatives or close personal friends when the medical information is directly relevant to that person's involvement with your care.

**Notification.**

Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.

**Disaster Relief.**

We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

**Health Oversight Activities.**

We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

**Abuse or Neglect.**

We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

**Legal Proceedings.**

We may disclose your medical information in the course of certain judicial or administrative proceedings.

**Law Enforcement.**

We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

**Coroners, Medical Examiners and Funeral Directors.**

We may disclose your medical information to a coroner, medical examiner or a funeral director.

**Organ Donation.**

If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

**Research.**

We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.

**Public Safety.**

We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

**Workers Compensation.**

We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.

**Business Associates.**

We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

**AUTHORIZATIONS:**

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

Joan Davis, R.H.I.T.  
Orthopedic Associates of Southwest Florida, P.A.,  
13691 Metro Parkway, Ste 400  
Fort Myers, FL 33912  
Telephone: 239-768-2272 Fax: 239-768-5549

**YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:**

You have the following rights with respect to your medical information:

You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.

You have the right to receive communications from us in a confidential manner.

Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.

You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

You have the right to receive an accounting of the disclosures of your medical information made by our practice during the last six years (or following April 14, 2003), except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.

You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.

You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us or to obtain further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:

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Joan Davis, R.H.I.T.  
Orthopedic Associates of Southwest Florida, P.A.  
13691 Metro Parkway, Ste 400  
Fort Myers, FL 33912  
Telephone: 239-768-2272 Fax: 239-768-5549

**THIS NOTICE IS EFFECTIVE AS OF APRIL 14, 2003.**

**REVISION OF NOTICE OF PRIVACY PRACTICES**

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at our office and will make paper copies of the revised Notice of Privacy Practices available upon request.

By my signature below I hereby acknowledge that I have received and had an opportunity to ask questions concerning Orthopedic Associates of Southwest Florida, P.A. Notice of Privacy Practices.

**Orthopedic Associates of Southwest Florida, P.A.**

X-Ray Films: We require a 24-48 notice for copies. Copies of your x-ray films are \$7.00 per film or \$5.00 for digital x-ray disk (if available) if you would like to have a copy for your records. We will forward a copy of the films to another physician at no charge to you. Please take mailing time into consideration when requesting copies.

HMO Patients: You are responsible for notifying your Primary Care Physician of your office visit. You must bring the authorization for the visit with you and present it prior to being seen by the physician. We will have to reschedule your visit if prior approval is not received.

Forms: We require a 24-48 hour notice for forms completion. There is an \$8.00 fee per form and payment must be received IN ADVANCE.

Prescription Refills: We require a 24-48 hour notice for refill requests. Requests will not be considered during non-working hours. Please have the medication name, strength, pharmacy name and phone number available when requesting refills. Your call will be forwarded to our prescription mailbox. Please call your pharmacy to verify that the prescription is ready. Please note: you should only get pain medications from one physician. If another physician is prescribing pain medications to you, notify our office immediately.

Due to the nature of our specialty, there may be times when an emergency patient visit causes our schedule to run behind. Many times patients are taken out of order due to x-ray or nursing services. Please bear with us, every patient’s care is important to us.

By my signature below, I also authorize financial information and reports of my evaluation, treatments and any follow-up evaluations to be sent to or discussed with my referring physician, the doctor requesting consultation, my family physician(s), as well as any other healthcare providers, hospitals or outpatient facilities that I have or will identify to you or that may be involved with my care, both past and future. I authorize other healthcare providers or insurance companies to release pertinent financial and medical information requested by Orthopedic Associates of SW FL, PA., to same.

By my signature below the undersigned patient hereby assigns the rights and benefits of insurance under the applicable insurance policy for any service and/or charges provided by Orthopedic Associates of Southwest Florida, P.A. I hereby direct the benefits be paid directly to the physician on my behalf for any services furnished to me by Orthopedic Associates of Southwest Florida, P.A.

By my signature below I hereby certify that I have read and fully understand all of the words and information contained in this form, and reaffirm my consent to the examination, diagnostic procedure, and/or care, treatment, therapy or remedy proposed.

By my signature below, I permit a copy/fax of this form to serve as an original signature of authorization.

\_\_\_\_\_  
Patient or Patient’s Representative Signature

\_\_\_\_\_  
Date

Print Patient’s Name: \_\_\_\_\_

**If signed by Representative, state name of**

Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_