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: ____________________________________