OSSFLA
ORTHOPEDIC SPECIALISTS
OF SOUTH FLORIDA

PLEASE PRINT

PREFERRED PHARMACY _____

ADDRESS _____

TELEPHONE _____

Welcome to our office. We are committed to providing you with the most comprehensive care possible. Please assist us in doing so by providing the following information, as well as your ***driver's license and insurance card(s).***

Today's Date: _____

Last Name: _____ First Name: _____ Middle: _____ ☐ Male ☐ Female

Soc Sec Number: ___-___-___ Date of Birth: ___/___/___ Age: _____

Address: _____ Apt./Lot #: _____

City: _____ State: _____ Zip Code: _____

Phone (H): (___) _____ Cell: (___) _____

Primary Language _____ ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

E-mail Address: _____ (If you would like to receive e-mails from our office)

Employer: _____ Phone: (___) _____

Emergency Contact: _____ Phone: (___) _____ Relationship: _____

Is your insurance through the Healthcare Marketplace? ☐ YES ☐ NO

Primary Insurance: _____ Secondary Insurance: _____

Policyholder Name: _____ Policyholder Name: _____

ID#: _____ ID#: _____

Policyholder Date of Birth: ___/___/___ Policyholder Date of Birth: ___/___/___

Primary Care Physician: _____ Phone: (___) _____

Injured on Job? ☐ YES ☐ NO Auto Accident? ☐ YES ☐ NO

☐ Other: _____ Date of Injury: _____

## INDIVIDUALS AUTHORIZED TO RECEIVE MY MEDICAL INFORMATION

I hereby authorize the designated parties below to request and receive any Protected Health Information (PHI) regarding my treatment, payment or administrative information related to treatment or payment. I understand that the identity of designated parties must be verified before the release of any information by providing proof of identification (i.e. Photo ID). **If you would like your health information/PI to be accessible to any immediate family members (i.e. spouse, child, parent), it is necessary to include them on the list below.**

Individuals Authorized to have access to my health information/PHI:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

_____
Print Patient Name

_____ _____
Patient Signature or Patient Guardian Signature Date

ORTHOPEDIC SPECIALISTS OF SOUTH FLORIDA, PA (OSSFLA)

OSSFLA pursuant to applicable Federal and Florida law makes the following disclosures: Patient is not required to obtain items of service from any of the following departments of OSSFLA or other entities to which patient may be referred. Patient may obtain items or services from a provider or supplier of the patient choice, as long as it is compliant with their insurance company's policies and procedures. Alternative sources are described below:

SURGICARE OF MIRAMAR SURGERY CENTER: The following OSSFLA members own an investment interest in Surgicare of Miramar Surgery Center, Drs. Orestes G. Rosabal, Kenneth J. Easterling, Enrique Krikorian and Tony Diaz. The patient may obtain services at an alternative facility of their choice as long as it is in keeping with the policies and procedures of their insurance company and/or Palmetto General Hospital, Memorial Hospital Miramar, Memorial Hospital West and HCA of Miami Lakes Surgery Center.

OSSFLA, PHARMACY DEPARTMENT: Patients may obtain pharmaceutical services from any other pharmacy of their choice.

OSSFLA, PHYSICAL THERAPY DEPARTMENT: Patients may obtain physical therapy services at any other facility of their choice as long as it is in compliance with the terms and conditions of their insurance company.

DISCLOSURE-MALPRACTICE

The members of OSSFLA, Drs. Orestes G. Rosabal, Kenneth J. Easterling, Enrique Krikorian and Tony Diaz, pursuant to Florida Law, have elected to not carry malpractice insurance. Under Florida Law physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments rising from claims of medical malpractice. This notice is provided to you pursuant to Florida law.

REFERRALS AND PRE-AUTHORIZATIONS

If you are enrolled in an HMO or insurance plan that requires a referral for you to see the doctor, it is your responsibility to contact your primary care physician to obtain the referral. If you do not have a referral at the time of your appointment, your visit may be delayed or rescheduled. You will be financially responsible for services rendered by OSSFLA if your HMO fails to pay for services rendered. If you provide OSSFLA a preauthorization number that is expired or is otherwise deemed as not valid, you will be fully financially responsible for services rendered by OSSFLA.

NOTICE OF PRIVACY PRACTICES: By signing below I acknowledge that I have received, read and understand the OSSFLA Notice of Privacy Practices.

AUTHORIZATION

The undersigned patient, legal guardian of patient or authorized individual acting on behalf of the patient, understands and agrees to the following:

I. CONSENT: Orthopedic Specialists of South Florida, PA, (OSSFLA), reserves the right to designate any of its physicians, physician extenders, medical staff and/or other lawfully authorized designee to perform and administer all care and treatment to the patient. I consent to allow OSSFLA to leave a voice message for appointment reminders or a reminder to return a phone call. These messages will not include PHI information.

II. RELEASE AND MEDICAL INFORMATION:

A. Workers Compensation Patient: OSSFLA is hereby granted by patient the authority to release to the patient's insurance carrier, employer, attorney, their designated representative or referring physician, all medical information regarding the workplace injury in connection with any treatment rendered to patient by OSSFLA.

B. Insurance Carrier/Health Maintenance Organization: OSSFLA is hereby authorized to release to the patient's insurance carrier, all medical information necessary to process payment of claims for services rendered by OSSFLA.

C. Governmental Benefits: OSSFLA is hereby authorized to release all medical information necessary to process governmental claims, including, but not limited to, Medicare, Medicaid, Tricare, ect. for services rendered by OSSFLA.

D. Electronic Records: I acknowledge that OSSFLA generates and maintains electronic medical records. I acknowledge and agree that electronic records have the same force and effect as original written records and signatures.

III. FINANCIAL RESPONSIBILITY

Unless otherwise stated herein, the undersigned shall pay to OSSFLA such sums as are now or may become due for services rendered to or on behalf of the patient by OSSFLA. In the event that the patient/undersigned fails to pay the account balance within 60 days of the due date, OSSFLA may refer the account to an attorney or collection agency for recovery of sums due to OSSFLA. In that event, OSSFLA shall be entitled to recover attorney's fees and/or collection costs (40%). At the request of the financially responsible party OSSFLA will arrange for reasonable payments plan options.

**THE UNDERSIGNED ACKNOWLEDGES THAT THEY HAVE READ AND FULLY UNDERSTAND THE FOREGOING DISCLOSURE AND AGREE TO BE BOUND BY THE OBLIGATIONS HEREUNDER AND CONSENT TO THE AUTHORIZATIONS DESCRIBED ABOVE.**

I acknowledge, understand and agree that above information shall remain in force and effect from this date forward , through the current and all future courses of treatment unless and until revoked or modified by me, in writing to OSSFLA. I also acknowledge, understand and agree that I must provide OSSFLA with updated information regarding my personal and insurance information and that I will complete and sign such documentation for OSSFLA.

DATE _____ PATIENT OR LEGAL GUARDIAN _____

ASSIGNMENT OF BENEFITS

I, the undersigned insured of beneficiary of an insurance policy, assign to Orthopedic Specialists of South Florida, PA any and all rights I have under any policy of insurance and under Florida law, including without limitation, any and all claims for attorney's fees, costs, interest and/or damages pursuant to Section 624.155 of the Florida Statues. This AOB supersedes any request for the insured to reserve benefits for lost wages; I request that payment of authorized State, Federal or private insurance carrier benefits be made to OSSFLA for any covered services furnished by OSSFLA. I acknowledge that OSSFLA objects to any reductions or partial payments by the insurer. If my insurance carrier pays me directly, I agree to forward all funds to OSSFLA within 10 working days. I agree that I am responsible for paying all non-covered or unpaid amounts unless provided by law. I acknowledge, understand and agree that this AOB and Direction to Pay Benefits Owed shall remain in full force and effect from this date forward, through the current and all future courses of treatment.

DATE _____ PATIENT OR LEGUAR GUARDIAN _____

Submit