Fort Lauderdale Orthopedics and Sports Medicine
Fort Lauderdale Orthopedic Walk-In Clinic

AUTHORIZATION/CONSENT FORM

A. AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF MEDICARE BENEFITS:

I authorize and holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Furthermore, I request that payment under the medical insurance benefits either to myself or to the party that accepts assignment below. I request that the medical insurance program be made to me or to FORT LAUDERDALE ORTHO AND SPORTS MEDICINE / WALK-IN CLINIC. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical information about me to release it to Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I understand that this is a lifetime signature authorization. ______

B. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION:

I authorize FORT LAUDERDALE ORTHO AND SPORTS MEDICINE / WALK-IN CLINIC to release to your company or its representatives any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care. I also authorize and request your company to pay directly to the above-named doctor the amount due to me in my pending claim for Medical or Surgical treatment or service by reason of such treatment or service. ______

C. FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for charges not covered by this authorization and for the guarantees stated above. Also, I understand that it is my responsibility as the insured to pay all copayment and co-insurance at the time of the visit. ______

D. REFERRALS AND AUTHORIZATIONS:

I understand that it is my responsibility to obtain all authorizations or referrals necessary for treatment. If an authorization or referral is not obtained by the time of the visit, the visit may be rescheduled once proper authorization has been obtained. ______

E. CONSENT TO TREAT:

I authorize FORT LAUDERDALE ORTHO AND SPORTS MEDICINE / WALK-IN CLINIC to take x-rays, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I authorize the doctor(s) to perform all recommended treatment mutually agreed upon. I also agree to the use of appropriate mediation and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. I understand that all responsibility for payment for medical services provided in this office for myself or my dependents is mine. I understand that payment is due and payable at the time services are rendered unless other arrangements have been made. ______

I understand that it is my responsibility to advise your office of any changes in the information contained in this form. ______

F. 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 FORT LAUDERDALE ORTHO AND SPORTS MEDICINE / WALK-IN CLINIC, or any issuer 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. ______

G. TREATMENT OF MINORS:

I, as a parent/legal guardian of a minor receiving treatment hereunder, do herby agree and understand that I have been advised to remain on the premises during such treatment, and waive any claim I may have resulting from failure to do so. ______

H. LIABILITY/ WAIVER AND RELEASE:

I know and agree that FORT LAUDERDALE ORTHO AND SPORTS MEDICINE / WALK-IN CLINIC is not responsible for any loss or damage to personal valuables. I hereby release, discharge, and acquit FORT LAUDERDALE ORTHO AND SPORTS MEDICINE / WALK-IN CLINIC, its agents, representatives, affiliates, employees, or of and from any and all liability claim, demand, damage, use of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and /or medical services, including but not limited to ambulance, EMT, or Physician service. ______

I. INSURANCE:

As a service to you, we will file insurance claims for each of your policies. You will need to provide the clinic with all necessary insurance information. Please bring your insurance cards to every visit. Please note, your insurance policy is an agreement between you and your insurance company to pay certain amounts for your medical care. Your physician's bill is an agreement between you and FORT LAUDERDALE ORTHO AND SPORTS MEDICINE / WALK-IN CLINIC. You are responsible for full payment of your account, regardless of the status of your insurance claim. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. ______

For patients without health insurance, payment is REQUIRED at the time of you visit. ______

J. NOTICE OF PRIVACY:

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES. ______

K. NO-SHOW POLICY:

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That is why it is very important that you keep your scheduled appointment with us and arrive on time. As a courtesy and to help patients remember their scheduled appointments, Ft. Lauderdale Orthopaedic Surgery and Sports Medicine / Walk-in Clinic sends text messages and email reminders in advance of your appointment.

If your schedule changes and you cannot keep your appointment, please contact us with at least 24-hour notice so we may reschedule you and accommodate those patients who are waiting for an appointment.

If you do not cancel or reschedule your appointment with at least 24-hour notice, we may assess a no-show charge to your account. This no-show charge is not reimbursable by your insurance company.

You will be billed directly for no-show visits:

- $35 for Office Visits
- $35 for Physical Therapy
- $50 for MRI appointments
- $100 for Surgery and/or procedures

I understand the no-show policy of FORT LAUDERDALE ORTHO AND SPORTS MEDICINE / WALK-IN CLINIC which may be charged for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance to avoid a potential no-show charge. No-show fees must be paid in full prior to rescheduling. ______

I, THE PATIENT/GUARANTOR/LEGAL GUARDIAN, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND INSURANCE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I AUTHORIZE PHYSICIAN AND INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR IT'S REPRESENTATIVE.

Signature: ____ Date: ___________

Signature of Patient’s Authorized Representative: ___________________________ Date: ___________

(If patient is under 18 years of age)

PATIENT CONSENT TO RECEIVE OFFICE COMMUNICATIONS

Do we have permission to contact you via: (check all that apply)?
Home Phone ____________________ Cell Phone ____________________ Email ____________________

Can we leave a voice message for you via: (check all that apply)?
Home phone ____________________ Cell Phone ____________________

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

I hereby authorize FORT LAUDERDALE ORTHO AND SPORTS MEDICINE / WALK-IN CLINIC to use and/or disclose the specific information described below, only for the purposes and/or parties listed below.

Description of the specific information to be discussed:

☐ Appointment: Date & Time(s) ☐ Diagnosis ☐ Test Results ☐ Medications

☐ Summary of Medical Records ☐ Plan of care ☐ Other (Specify): __________________________

Indicate Confidential Information:

☐ Mental Health ☐ HIV Information ☐ Alcohol/Drug Information

Information to be given to:

Name: ___________________________________ Name: ___________________________________

Relationship: ______________________________ Relationship: ______________________________

Address: __________________________________ Address: __________________________________

Phone/Fax: ________________________________ Phone/Fax: ________________________________

Email: ____________________________________ Email: ____________________________________

This authorization shall remain in effect from the date signed below until (Please check one):

☐ NO EXPIRATION DATE ☐ YES EXPIRATION DATE Specify expiration date _____________

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office.
- This authorization is giving FORT LAUDERDALE ORTHO AND SPORTS MEDICINE / WALK-IN CLINIC the right to discuss my medical information with the above mentioned.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and I will not condition treatment or payment providing this authorization (except to the extent that the authorization is for research-related treatment, in which case I may refuse to provide that research-related treatment).

Signature: ____ Date: ___________

Signature of Patient’s Authorized Representative: __________________________ Date: ___________