

Patient Name

Bennett Orthopedics & Sportsmedicine
Regenerating the Youth in You!



- Low Blood Count
- Ulcers
- Communicable Dis.
- Diabetes
- Hi Blood Pressure
- Stroke
- Heart Attack
- Chest pain
- Seizures
- Emphysema
- C.O.P.D.
- Renal failure
- Liver Failure
- Cancer
- Vascular Problems
- Emotional Problems

Bennettorthopedics.com

PHARMACY, ADDRESS, PHONE, FAX

FAMILY DOCTOR

ADDRESS

PHONE, FAX

HAVE YOU BEEN SEEN BY ANYONE FOR THIS PROBLEM?
CIRCLE ONE: YES NO IF YES, PLEASE EXPLAIN:

WHAT MEDICATIONS ARE YOU TAKING? INCLUDE DAILY FREQUENCY AND AMOUNT.

Name	Daily	Milligrams

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? PLEASE LIST.

Name	Reaction

HAVE YOU HAD ANY SURGERY? PLEASE LIST.

Type	Year

DO YOU SMOKE?

DO YOU DRINK ALCOHOL?

ANYTHING WRONG WITH YOUR:

- HEART
- LUNGS
- LIVER

- KIDNEYS
- CLOTTING
- SKIN

- NERVOUS SYSTEM
- MUSCLES
- BONES

Family History?

orthoff\bennettorthopedics\pmh.xls

Office Manager

Appointments

Physician

Bennettorthopedics1@verizon.net

Bennettorthopedics2@verizon.net

Bennettorthopedics@verizon.net



Bennett Orthopedics & Sportsmedicine

Regenerating the Youth

In You!

William F Bennett MD
Specializing in:
Shoulders/Knees

Arthroscopy
Cartilage Regeneration
Minimally Invasive
Joint Replacement
PRP
Stem Cells

A.) CONSENT TO TREATMENT

I am entering a Doctor/Patient relationship with William F. Bennett MD today and am consenting to allowing him to obtain information through questioning, the laying of hands-on by way of a physical exam, and any other ancillary tests needed to arrive at a diagnosis of my problem. I understand that as a competent adult I do not have to accept the recommendations that my Doctor instructs me even if there may be grave bodily injury to myself. If, I should forego his recommendations or refuse treatment, or I am consistently non-compliant with his recommendations, Dr. Bennett, may, elect to end the Doctor/Patient relationship that has been established. Dr. Bennett will provide me with a list of alternative physicians who can provide my continued care. I also understand that I may at any time end this relationship with my physician.

William F. Bennett MD

Date

Patient Signature

B.) RELEASE OF INFORMATION

I am attaching my signature hereunder to allow for any information about my medical condition and my insurance policies to be released at any time to third party insurers for the purpose of accurate billing.

William F. Bennett MD

Date

Patient Signature

C.) ALLOWANCE FOR THIRD PARTY INSURERS TO PAY DIRECTLY (WILLIAM F. BENNETT MD PA)

By signing below, I agree that all payments regarding the delivery of services, reimbursement for durable medical goods and reimbursement for casting procedures and materials, by William F. Bennett MD, be paid directly to his attention at his business address.

William F. Bennett MD

Date

Patient Signature

D.) If you have not met your deductible or if for some reason your insurance company does not pay your bill in full, you are responsible for paying the balance. If your account ends up in collections, you will be responsible for the Doctor's fee schedule rates and not the managed care rates. Our terms are net 30 days. Late charges of 1.5% per month (18% APR) will be assessed on past-due accounts, and collection charges and/or attorney fees may be added.

I have read and understand the above and agree that I am ultimately responsible for my bill and understand that the submission of my bill to my insurance company is done as a courtesy to me. I will not hold Bennett Orthopedics & Sportsmedicine responsible for any clerical errors; however, Bennett orthopedics & Sportsmedicine will work with me to facilitate any corrections needed.

William F. Bennett MD

Date

Patient Signature

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1250 S. Tamiami Tr.
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Sarasota, FL. 34239
p-941-953-5509
f-941-953-5510
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PATIENT CONSENT FORM(HIPAA)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name - _____ Patient or Representative

Relationship to Patient (if other than patient): _____ Date: __/__/__

Witness _____

Printed name - _____ Practice representative

Date: __/__/__

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date:

Patient: _____ Date of Birth: _____

S.S.# _____

Facility/Doctor in which records requested from: _____

Facility/Doctor in which records to be released to: _____

I understand that the records contain information regarding my medical condition and treatment, and possibly could include material pertaining to psychiatric or psychological diagnoses/treatment, infectious/contagious disease information (including HIV/AIDS), confidential information, and/or information about drug or alcohol abuse or treatment of same.

I understand that I, as the patient, have the right to inspect and copy information being disclosed. I further understand that this authorization is subject to revocation by the undersigned at any time, except to the extent that action has already been taken by facility in which this authorization has been presented to and in reliance upon this authorization. Unless otherwise stated below, this authorization shall automatically expire thirty (30) days from the date set forth below.

I hereby release Florida Orthopedic and Sports Medicine Institute, Inc. and Dr. William F. Bennett, M.D., P.A. and its employees, agents, officers and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information also authorized by this document.

I understand that in certain circumstances a fee may be required for photocopying, postage, etc.

I understand that if I wish another person to pick up my records on my behalf, I must specifically name them below and will advise them they will be required to present photo identification, i.e., driver's license, before my records will be released to them.

Name: _____ Relationship: _____

Notice to Receiving Agency, Facility or Person: _____

A patient's medical record is privileged information, which is protected by State and Federal Laws. This information may not be redisclosed to other persons or organizations without a separate written authorization from the patient.

Signature of patient _____ Date _____

Signature of parent/guardian if under 18 _____ Date _____

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Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. Procedure below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Procedure below.

Procedure	Reason Medicare May Not Pay:	Estimated Cost
Est. as New Patient		

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Procedure listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the Procedure listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I **can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I **cannot appeal if Medicare is not billed.**

OPTION 3. I don't want the _____ listed above. I understand with this choice I am **not responsible for payment, and I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.