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		**KIDNEYS**		**NERVOUS SYSTEM**	
LUNGS		**CLOTTING**		**MUSCLES**	
LIVER		**SKIN**		**BONES**	

Family History?

orthoff\bennettorthopedics\pmh.xls

Office Manager
Bennettorthopedics1@verizon.net

Appointments
Bennettorthopedics2@verizon.net

Physician
Bennettorthopedics@verizon.net

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In You!

William F Bennett MD
Specializing in:
Shoulders/Knees

Arthroscopy
Cartilage Regeneration
Minimally Invasive
Joint Replacement
PRP
Stem Cells

1250 S. Tamiami Tr.
Suite 303
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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.) <u>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.</u>

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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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 _____ does not pay for procedures listed below, you may have to pay. Unfortunately insurance companies do not pay for everything, even some care that you or your health care provider have good reason to think you need.
We expect your insurance company may not pay for the procedures listed below:

Procedure Code	Estimated Cost	Expected Ins. Payment
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

Please choose one of the following options (we cannot choose for you):

___**Option 1:** I want the procedures listed above. You may ask to be paid now, but I also want _____ billed for an official decision on payment, which is sent to me by my insurance company. I understand that if my insurance does not pay, I am responsible for payment, but **I can appeal to my insurance company**. If my insurance company does pay, you will refund any payments I made to you, less co-pays or deductibles.

___**Option 2:** I do not want the procedures listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance company would pay.**

You may choose to have the Basic Procedure alone with/without "PRP" and Dr Bennett will only perform this primary procedure, as requested by you the patient. This is not the best recommended medical approach to your condition as noted by Dr. Bennett. He can't work towards optimizing your outcome without all procedures and as such you may end up with a less than optimal outcome.

The doctor deems you need all of these procedures. With the evolving medical insurance climate, many insurers are not paying for anything beyond the first procedure performed at the same setting. If they by chance do pay for multiple procedures, often 10% of the allowed amount is received.

However, the doctor cannot perform medically indicated procedures for free or 10% allowed amount and as such is asking you to sign the ABN notice. If this issue occurred, the doctor will accept 50% of the 2nd and 3rd procedures and 25% of any further procedures of the disclosed allowed amount above as payment in full.

Patient Name (Print):_____

Patient Signature:_____ Date:_____

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