Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

Patient Registration and Insurance Form

PATIENT INFORMATION

Name: _____
Last First Middle Name

Address: _____
Street City State Zip

Home Phone: _____ **Cell Phone:** _____

Email: _____ **DOB:** _____ **SSN:** _____

(Please Circle)

Sex: Male Female **Blood type:** _____ **Organ Donor:** Yes No **Spoken Language:** _____

Marital Status: Single Married Separated Divorced Widowed **Race:** _____ **Ethnicity:** _____

Employment: Not employed Full-time Part-time Retired **Occupation:** _____

Last Degree Earned: High School College Graduate School Doctorate

Business Name Address/Phone#: _____
Street City State Zip Phone

Out of State Address/Phone#: _____
Street City State Zip Phone

Emergency Contact Name: _____
Last First Middle Name

Emergency Contact Home Phone: _____ **Cell Phone:** _____

Emergency Contact Address: _____
Street City State Zip

Relationship to Patient: _____

Primary Care Physician Name: _____ **Practice Name:** _____

Address/Phone#: _____
Street City State Zip Phone

Referring Physician Name: _____ **Practice Name:** _____

Address/Phone#: _____
Street City State Zip Phone

Pharmacy Name: _____ **Pharmacy Location:** _____

Pharmacy Phone _____

Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

Guarantor/Responsible Party Name: _____

Driver's License Number: _____ **State Issued:** _____

Is this an accident? Yes No **Date of Injury:** _____ **Motor Vehicle Accident:** Yes No

PRIMARY INSURANCE INFORMATION (if not policy holder)

Insurance Company: _____ **Phone:** _____
Policy Number: _____ **Group Number:** _____
Policy Holder's Full Name: _____ **DOB:** _____
SSN: _____ **Relationship to Patient:** _____
Policy Holder Address/Phone#: _____
Street City State Zip Phone
Employer Name Address/Phone#: _____
Street City State Zip Phone

Is the patient covered by additional insurance? Yes No

SECONDARY INSURANCE INFORMATION (if not policy holder)

Insurance Company: _____ **Phone:** _____
Policy Number: _____ **Group Number:** _____
Policy Holder's Full Name: _____ **DOB:** _____
SSN: _____ **Relationship to Patient:** _____
Policy Holder Address/Phone#: _____
Street City State Zip Phone
Employer Name Address/Phone#: _____
Street City State Zip Phone

Whom may we thank for referring you to our practice? _____

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____

Print Full Name: _____

Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

Initial Patient History Questionnaire

Please complete and bring this form with you to your first appointment.

Patient Name: _____ Todays Date: _____

Referring Physician: _____ Birth Date: _____ Age: _____

Any/All others doctors you see: _____

HISTORY OF PRESENT ILLNESS

- Location: _____ Duration: _____
  (Where on the body symptom occurs) (How long have you had symptom? Last time?)
- Severity: _____ Quality: _____
  (Severe, Worse, Slightly. Pain scale 1-10) (Character of symptoms? Burning, Aching, Sore)
- Timing: _____ Context: _____
  (When does the symptoms occur?) (What's the situation associated with symptoms?)
- Modifying Factors: _____
  (What makes the symptoms better or worse? i.e. specific movement, medication)
- Associated Signs/Symptoms: _____
  (Other things that happen when this symptom occurs)

MEDICAL HISTORY, FAMILY HISTORY, & SOCIAL HISTORY

Medical History: Please circle the correct answer for the following medical conditions.

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Respiratory Problems	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	Other problems	_____				

What is your current weight? _____ **Height?** _____

Current Medications: _____

_____

Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

DRUG ALLERGIES: _____

Past Hospitalizations/Surgeries/Injuries and Approximate Dates:

_____

_____

FAMILY HISTORY: Please list any medical problems in your relatives.

Father:_____ Mother:_____ Siblings:_____

Others:_____

SOCIAL HISTORY: **Marital Status**: Single Married Separated Divorced Widowed

Tobacco Use: Never Quit/When: _____ Daily/How much?_____

Alcohol Use: Never Rarely Moderate Daily/How much?_____

Drug Use: Never Rarely Moderate Daily/How much?_____

Occupation:_____

REVIEW OF SYSTEMS: Please circle the correct answer for the following medical conditions.

Constitutional			**Ears/Nose/Mouth/Throat**			**Eyes**		
Good General Health	Yes	No	Hearing loss/Ringing	Yes	No	Wear glasses/contacts	Yes	No
Recent weight change	Yes	No	Sinus Problems	Yes	No	Blurred/double vision	Yes	No
Night sweets/fevers	Yes	No	Nose bleeds	Yes	No	Eye Disease or injury	Yes	No
Fatigue	Yes	No	Sore throat/voice loss	Yes	No	Glaucoma	Yes	No
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest Pain	Yes	No	Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Palpitations	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart Trouble	Yes	No	Wheezing/asthma	Yes	No	Rectal bleeding	Yes	No
Swelling hands/feet	Yes	No	Coughing up blood	Yes	No	Bowel problems	Yes	No

Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

Musculoskeletal			**Neurological**			**Integumentary**		
Muscle pain or cramp	Yes	No	Frequent headaches	Yes	No	Change in hair or nail	Yes	No
Stiffness swelling joints	Yes	No	Paralysis or tremors	Yes	No	Rashes or itching	Yes	No
Joint pain	Yes	No	Convulsions/Seizures	Yes	No	Breast Lump	Yes	No
Trouble walking	Yes	No	Numbness/tingling	Yes	No	Breast pain/discharge	Yes	No

Endocrine			**Hematologic/Lymphatic**			**Allergic/Immunologic**		
Excessive thirst/urination	Yes	No	Bruise easily	Yes	No	Food Allergies	Yes	No
Thyroid disease	Yes	No	Slow to heal	Yes	No	Aspirin allergies	Yes	No
Hormone problem	Yes	No	Enlarged glands	Yes	No	Antibiotic allergies	Yes	No

Genitourinary	**Male only**		**Genintourinary**	**Female Only**		**Psychiatric**		
Blood in urine	Yes	No	Blood in urine	Yes	No	Insomnia	Yes	No
Kidney stones	Yes	No	Kidney stones	Yes	No	Confusion	Yes	No
Sexual problems	Yes	No	Sexual Problems	Yes	No	Depression	Yes	No
Testicle pain	Yes	No	Menstrual problems	Yes	No	Memory loss	Yes	No

PATIENT STATEMENT: To the best of my knowledge, the above information is accurate and complete

Signed:_____Date:_____

PHYSICIAN STATEMENT: I have reviewed the questionnaire with the patient

Signed:_____Date:_____

Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

Florida Surgical Clinic LLC
Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Thank you for choosing Florida Surgical Clinic LLC as your health care provider. We are committed to providing you the best available medical care. Our staff will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy and assignment of benefits as well as complete our Patient Information Form prior to seeing the physician. Payments for service are due at the time services are rendered. We accept check, Visa, MasterCard, American Express, and Discover. We will be happy to help you process your insurance claim for reimbursement. In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. We are, however, contracted with most local managed care plans. We will follow their guidelines for reimbursement and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.

2. All charges are your responsibility -- whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, or limit your coverage by design.

3. Fees for these services, along with unpaid deductibles and co-payments, are due at the end of treatment.

4. If you have a high deductible health plan, we may collect your deductible before your surgical procedure is performed.

5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. After all, if your insurance does not pay, you are responsible for payment.

6. If your insurance company does not pay in full within 60 days, we require you to pay the balance by check, Visa, MasterCard, American Express, or Discover.

7. Returned checks and balances older than 90 days are subject to collection agency placement, collection fees, and reasonable attorney's fees. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so that we may assist you in the management of your account.

The Florida Surgical Clinic LLC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Florida Surgical Clinic LLC, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to the Florida Surgical Clinic LLC, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize the Florida Surgical Clinic LLC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize the Florida Surgical Clinic LLC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Self-Pay

If for whatever reason I do not have health insurance, I will be responsible for services rendered here at Florida Surgical Clinic LLC. I agree to pay Florida Surgical Clinic LLC, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

Cancelled Check Policy

Cancelled or bounced checks used to pay for services rendered by the Florida Surgical Clinic LLC will be assessed a fee of 75 dollars.

Patient/Guarantor Signature _____ Date _____

Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies. However, you must call at least two (2) business days prior to canceling your appointment. If you arrive but do not have the proper paperwork, identification, or unable to pay the required payment your insurance plan requires you to pay at the time of the visit, it will be considered a "No Show" visit. It is the patient's responsibility to know what is required payment by the insurance plan they have chosen. A "No Show" visit is when the patient is unable to complete an appointment with the physician, nurse practitioner, or registered vascular technologist. No shows will be assessed a fee of $75.00 dollars.

If you have a surgical procedure scheduled with the surgeon, you must contact the clinic four (4) business days prior to procedure to cancel the procedure or there will be a $300.00 no show fee. This is due to blocking off the surgeon's time, reserving a procedure room/operating room, renting or prepositioning equipment, the amount of man hours and personnel involved in scheduling a procedure.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Lifetime Authorization

I hereby assign all medical and surgical benefits allowable and otherwise payable under my current insurance policy for services rendered and authorize and direct my insurance carrier(s) to issue payment directly to Florida Surgical Clinic LLC. I understand that I am responsible for any amount not covered by insurance, including applicable co-payments, deductibles, non-covered services, and unauthorized services, and agree to pay in a current manner.

I understand that Florida Surgical Clinic LLC does accept assignment for Medicare and payments will be directed to Florida Surgical Clinic LLC.

Should my account be referred for collection procedures, I also agree to pay reasonable attorney's fees and collection expenses.

I certify that I have read and understand the above, and as the patient, guarantor, or patient's responsible party, agree to and accept these terms.

_____ _____

Signature of Patient/Responsible Party Date

_____

Print Name/Relationship

Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

Physician-Patient Arbitration Agreement

Preface: I, Jenna Kazil, M.D., have decided under Florida Law to practice with malpractice insurance. Under this practice, this Arbitration Agreement ("Agreement") should be read carefully and fully understood. If you have any questions before or after reading and signing this statement, please ask the staff or my office manager. Please read this document clearly. Thank you for your consideration.

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary, authorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by the Florida Arbitration Code, Chapter 682, and not by a lawsuit except as Florida law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties and must be made within the time frame set forth in F.S.95.11 dealing with medical malpractice. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. Arbitration shall take place within 30 days after the completion of discovery as provided in the Florida Rules of Civil Procedure (Rules 1.280-1.390) and the decision of the arbitration panel shall be binding upon all parties for all purposes. The time for responding to discovery requests shall be 10 days. All discovery shall be completed within 2 months after the appointment of the panel of arbitrators, unless the time for discovery is extended for good cause by the panel. The arbitration panel shall decide any disputes regarding discovery. The arbitration panel is expressly authorized to award all reasonable fees and costs, including attorney's fees, to the prevailing party against any party who has violated this Agreement. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity

Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

shall supplement, not supplant, any other applicable statutory or common law provisions. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and join in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Florida statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Florida Rules of Civil Procedure provisions relating to arbitration.

Article 5: **Retroactive Effect**: If the patient intends this Agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below;

Effective as of the date of first medical services _____

Patient's or Patient's Representative's Initials

Article 6: Compliance with Florida Law: The parties agree that unless otherwise stated within the agreement, the arbitration will be conducted in accordance with Florida Statue 766.207.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and effect and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this **Arbitration Agreement**.

Signature _____ **Date**_____

Print Full Name _____

Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

Patient Privacy Notice Acknowledgement Form

Patient consent to use and disclosure of health information for treatment, payment, or healthcare operations per HIPAA and FIPA regulations.

Florida Surgical Clinic LLC within its Privacy Policy has provided me the opportunity to review the information regarding the use and disclosure of my health information, and its compliance with HIPAA regulations. You should review our Privacy Policy for a more complete description of the potential release and use of such information, and you have the right to review such notice prior to signing this Consent Form. I understand I have the following rights and privileges: The right to review the provided HIPAA information prior to acknowledging this consent; the right to reject or revoke the use or disclosure of my health information; and the right to request restrictions as to how my health information may be used or disclosed for treatment or payment. We reserve the right to change the terms of our practice's privacy policy at any time. If we do make changes to the terms of our practice's privacy policy, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

TO BE COMPLETED BY THE PATIENT – PLEASE PRINT

PATIENT NAME: _____

RESTRICTIONS: _____

List the **full names and relationships** of those whom we **MAY** discuss your protected health information, including billing inquiries. (**Example**: Spouse, Children, Caregiver)

_____

List the **full names and relationships** of those whom we **MAY NOT** discuss your protected health information, including billing inquiries.

_____

COMMUNICATION:

May we leave a message at your home using doctor's/practice name: Y/N

May we leave a message at your work using doctor's practice name: Y/N

DO YOU HAVE ANY OF THE FOLLOWING ITEMS (check all that apply):

- ☐ Living Will
- ☐ Durable Power of Attorney
- ☐ Do Not Resuscitate
- ☐ Refuses Blood Transfusion
- ☐ None

READ AND SIGN:

I understand that as part of treatment, payment or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law. I fully understand and accept the information of this consent.

Patient/Guardian Signature_____ **Date**_____

Print Name of person signing_____

If other than the patient signing, are you the legal guardian, custodian or have a Power of Attorney for this patient, for treatment, payment or healthcare operations?

Yes { } **No** { } **Relationship**:_____