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

Name: _____ **DOB:** _____

Address: _____

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

Email: _____ **SSN:**_____
Spoken Language: _____ **Race**:_____ **Ethnicity**:_____
(Please Circle)
Sex: Male Female
Marital Status: Single Married Separated Divorced Widowed
Employment: Not Employed Full-Time Part-Time Retired
Last Degree Earned: High School College Graduate School Doctorate
Occupation: _____
Out of State Address/Phone:_____
Emergency Contact Name: _____
Emergency Contact Phone: _____ **Relationship:** _____

Primary Care Physician Name: _____

Primary Care Address/Phone: _____

Referring Physician Name: _____

Referring Physician Address/Phone:_____
Guarantor/Responsible Party Name: _____

PRIMARY INSURANCE INFORMATION
Insurance Company:_____
Policy Number: _____

SECONDARY INSURANCE INFORMATION
Insurance Company:_____
Policy Number: _____

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: _____

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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.

Insurance: Your insurance policy is a contract between you and your insurance company. We are contracted with most local managed care plans. To file your claims, we require the front and back of your insurance card and photo ID. We will follow their guidelines for reimbursement and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance. All co-pay, coinsurance and deductibles are due at the time services are rendered. We accept Cash, Check, Visa, MasterCard, American Express, and Discover. We will be happy to help you process your insurance claim for reimbursement.

All charges are your responsibility. Not all services are a covered benefit in all contracts. Fees for these services, along with unpaid deductibles and co-payments, are due at the end of treatment. If you have a high deductible health plan, we may collect your deductible before your surgical procedure is performed.

Collections: 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.

Cancelled Checks: Cancelled or bounced checks used to pay for services rendered by the Florida Surgical Clinic LLC will be assessed a fee of $75.00 dollars.

Self-Pay: If for whatever reason I do not have health insurance, I will be responsible for the 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.

Consent for Treatment: 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.

Authorization to Release Information: I further authorize the Florida Surgical Clinic LLC, to release to appropriate agencies, any information acquired during my or the above-named patient's examination and treatment.

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.

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/Guarantor Signature _____ Date _____

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Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies. However, you must call at least Three (3) business days prior to cancelling 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. 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 office Four (4) business days prior to the procedure to cancel the procedure or there will be a $300.00 no show fee.

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.

Patient/Guarantor Signature _____ Date _____

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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

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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;

Article 6: Not withstanding or in conjunction with the initial arbitration agreement, if this matter is not resolved within arbitration, or if the arbitration is deemed unenforceable, the parties agree the proper venues for litigation are limited to Manatee or Hillsborough Counties.

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 _____

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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 (circle all that apply):

Living Will	Do Not Resuscitate	None
Durable Power of Attorney	Refuses Blood Transfusions	

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**:_____

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Initial Patient History Questionnaire

Patient Name: _____ **DOB**: _____

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	_____				

Weight: _____ **Height:**_____

Drug Allergies: _____

Other Allergies: _____

Past Hospitalizations/Surgeries/Injuries and Approximate Dates:

_____

_____

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

Father:_____ Mother:_____ Siblings:_____

Others:_____

SOCIAL HISTORY:

Tobacco Use:	Never	Quit/When: _____		Daily/How much?_____
Alcohol Use:	Never	Rarely	Moderate	Daily/How much?_____
Drug Use:	Never	Rarely	Moderate	Daily/How much?_____

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

Constitutional			Eyes			Ears/Nose/Mouth/Throat		
Good General Health	Yes	No	Eyeglass Use	Yes	No	Hearing Loss	Yes	No
Recent weight change	Yes	No	Blurred/Double vision	Yes	No	Ringing/Tinnitus	Yes	No
Night sweets/fevers	Yes	No	Eye Disease or Injury	Yes	No	Nose Bleeds	Yes	No
Fatigue	Yes	No	Glaucoma	Yes	No	Sore Throat/voice loss	Yes	No

Respiratory			Cardiovascular			Gastrointestinal		
Shortness of breath	Yes	No	Chest Pain	Yes	No	Nausea/vomiting	Yes	No
Cough	Yes	No	Palpitations	Yes	No	Abdominal pain	Yes	No
Pain with Breathing	Yes	No	Heart Trouble	Yes	No	Rectal bleeding	Yes	No
Coughing up blood	Yes	No	Swelling hands/feet	Yes	No	Bowel problems	Yes	No

Musculoskeletal			Psychiatric			Skin/Breast		
Muscle pain or cramps	Yes	No	Insomnia	Yes	No	Change in hair or nail	Yes	No
Stiffness swelling joints	Yes	No	Confusion	Yes	No	Rashes or itching	Yes	No
Gout	Yes	No	Depression	Yes	No	Breast Lump	Yes	No
Trouble walking	Yes	No	Memory Loss	Yes	No	Breast pain/discharge	Yes	No

Neurological			Endocrine			Hematologic/Lymphatic		
Frequent headaches	Yes	No	Excessive urination	Yes	No	Bruise easily	Yes	No
Paralysis or tremors	Yes	No	Excessive thirst	Yes	No	Slow to heal	Yes	No
Convulsions/Seizures	Yes	No	Hormone problems	Yes	No	Blood Clots	Yes	No
Numbness/tingling	Yes	No	Thyroid Disease	Yes	No			

Genitourinary		
Blood in urine	Yes	No
Kidney stones	Yes	No
Menstrual Problems (F)	Yes	No
Testicle pain (M)	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: _____

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Medication List

Name: _____ Date of Birth: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Location: _____

Medication Name	Dosage and Frequency