INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name ____

Address ____

Telephone ______________________________ Social Security___________________

SECTION B: To the Patient - Please read the following statements carefully

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Institute of Sports Medicine and Orthopaedics
Address: 21097 N.E. 27th Court, Suite 350 , Aventura, FL 33180
Telephone: (786) 629-0910 Fax: (786) 629-0920

Right to Revoke. You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature.

I, __________________________________ have had full opportunity to read and consider the contents of this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature ___________________________ **Date** _________________________________

INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS

ACKNOWLEDGEMENT OF RECEIPT OF SEPTEMBER 18, 2006 NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the Notice of Privacy Practices of Institute of Sports Medicine and Orthopaedics.

_______________________________ _______________________________

Signature Print Name

DATED: ___________________

OFFICE USE ONLY

Date acknowledgement received: ____________________________

OR

Date and reason acknowledgement was not obtained:

____
____
____
____
____
____
____

By:_________________________________

Signature

INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS

NOTIFICACION DE PRACTICAS SOBRE PRIVACIDAD

Esta notificación describe la forma como puede ser usada y revelada Ia información médica acerca de usted y la forma como usted puede tener acceso a esta informaciOn. Favor revisarla cuidadosamente. Usted tiene derecho de obtener una copia impresa de esta Notificación con solo solicitarla.

Información sobre la Salud del Paciente
Bajo las leyes federales, la información sobre su salud como paciente es protegida y confidencial. La información de salud del paciente incluye información acerca de sus smntomas, resultados de exámenes, diagnóstico, tratamiento e información médica relacionada. La informaciOn sobre su salud también incluye información sobre pagos, facturación y seguros.

Cómo Usamos la Informaciôn sobre su Salud
Nosotros utilizamos la información sobre su salud para el tratamiento, para obtener pagos, y para operaciones de atención de salud, incluyendo para fines administrativos y para evaluación de la calidad de la atención que usted recibe. Bajo algunas circunstancias, podemos tener que usar o revelar la información aün sin su permiso.

Ejemplos de Tratamiento, Pagos y Operaciones de Atención de Salud
Tratamiento : Usaremos y revelaremos la información de su salud para proporcionarle tratamiento o servicios medicos. Por ejemplo, los medicos, enfermeros y otros miembros de su equipo de tratamiento registrarán la información en su historia cilnica y la usarán para determinar el curso de atención mas apropiado. También revelamos la información a otros proveedores de atención de salud que participan en su tratamiento, a farmacias que despachan sus recetas, y a miembros de la familia que están ayudando a su cuidado.
Pagos : También usamos y revelamos la información de su salud para fines de pagos. Por ejemplo, podemos necesitar obtener autorización de su companIa de seguros antes de prestarle ciertos tipos de tratamiento. Nosotros presentamos las cuentas y lievamos registros de los pagos recibidos de su plan de salud.
Operaciones de Atención de Salud : Usaremos y revelaremos su información de salud para realizar nuestras operaciones internas normales, incluyendo la debida administración de los registros, evaluación de la calidad del trataminto y para evaluar la atención y los resultados de su caso y otros similares.

Usos Especiales
Podemos usar su información para comunicarnos con usted con *recordatorios de citas.* También podemos comunicarnos con usted para proporcionarle información acerca de alternativas en el tratamiento u otros beneficios relacionados con la salud que pueden ser de interés para usted.

Otros Usos y Revelaciones
Podemos usar o revelar información de salud identificable acerca de usted para otras razones, aün sin su consentimiento. Sujetos a ciertos requerimientos, se nos permite dar información sobre su salud sin su permiso para los siguientes fines:
Reguerida por Ley : Podemos estar obligados por ley a reportar heridas de bala, sospechas de abuso o negligencia, o lesiones y eventos similares.
Investigación : Podemos usar o revelar informaciOn médica aprobada.
Actividades de Salud Püblica : Ségun sea requerido por ley, podemos revelar estadIsticas vitales o demograficas, enfermedades, información rela cionada con productos peligrosos recogidos por el fabricante e información similar a las autoridades de salud publica.
Vigilancia de Salud : Se nos puede solicitar revelar información para ayudar en investigaciones y auditorlas, elegibiidad para programas guber namentales, y actividades similares.
Procesos judiciales y administrativos : Podemos revelar información en respuestra a una citación u orden judicial apropiada.
Fines de las Agencias del Orden : Sujeto a ciertas restricciones, podemos revelar información requerida por los oficiales de las agencias del orden.
Muertes : Podemos reportar información relacionada con muertes a medicina legal, a los medicos forenses, directores de funerarias, y agencias de donación de organos.
Amenaza grave para la salud o se~sridad : Podemos usar y revelar información cuando sea necesario para prevenir una amenaza grave para su salud y seguridad o la salud y seguridad del püblico o de otra persona.
*Fuerzas Militares **i,** Fun nciones Gubernamentales Especiales* : Si usted es miembro de las fuerzas miitares, podemos revelar información segün sea requerida por las autoridades de comando militar. También podemos revelar información a instituciones correccionales o para fines de seguri dad nacional.
Seguro de Enfermedad Pro fesional : Podemos revelar información acerca de usted para programas de seguro de enfermedad relacionadas con el tra bajo.

En cualquier otra situación, le solicitaremos su autorización por escrito antes de usar o revelar cualquier informacion de salud identificable acerca de usted. Si usted opta por firmar una autorización para detener futuros usos y revelaciones.

Derecho Individuales
Usted tiene los siguientes derechos con respecto a su informaciOn de salud. Favor contactar a la persona relacionada mas adelante para obtener la forma apropiada para ejercer estos derechos.
Solicitar Restricciones: Usted puede solicitar restricciones sobre ciertos usos y revelaciones de información sobre su salud. No estamos obligados a aceptar dichas restricciones, pero silo hacemos, debemos cumplirlas.
Comunicaciones Con fidenciales: Usted puede solicitarnos que nos comuniquemos con usted en forma confidencial, por ejemplo, enviando notificaciones a una dirección especial o no utiizando tarjetas postales sino comunicaciones cerradas para recordarle sus citas.
Ins peccionar y Obtener Copias : En la mayorIa de los casos, usted tiene derecho a leer o a obtener una copia de su información de salud. Puede existir un pequeño costo por las copias.
Modificar Información : Si usted cree que la información que aparece en su historia médica es incorrecta, 0 si falta alguna información, usted tiene el derecho a solicitar que corrijamos la información existente o que agreguemos la información faltante.
Relación de Revelaciones : Usted puede solicitar una lista de las oportunidades en las cuales hemos revelado información sobre su salud por razones diferentes al tratamiento, pagos u operaciones de atención de salud.

Nuestra Obligacion Legal
Estamos obligados por la ley a proteger y mantener la privacidad de su información de salud, a suministrale esta Notificación sobre nuestras obligaciones legales y practicas sobre privacidad en relación con información de salud protegida, y a cumplir los términos de la Notificación que se encuentre vigente.

Cambios en las Prácticas sobre Privacidad
Nosotros podemos cambiar nuestras polIticas, en cualquier momento. Antes de hacer un cambio significativo en nuestras politicas, cambiaremos nuestra Notificación y la pondremos en exhibiciOn en las salas de espera y en cada sala de examen. También puede solicitar una copia de nuestra notificación en cualquier momento. Para mayor inforrnación acerca de nuestras prácticas sobre privacidad, comuniquese con la persona indicada mas adelante.

Quejas
Si usted tiene alguna inquietud en el sentido de que hemos violado sus derechos de privacidad, o si no está de acuerdo con una decision que hernos tornado acerca de su historia médica, puede comunicarse con la persona mas adelante. También puede enviar una queja por escrito al Departarnento de Salud y Servicios Humanos de los Estados Unidos. La persona relacionada a continuación le surninistrará La dirección adecuada cuando la solicite. Usted no será penalizado de ninguna manera por presentar una queja.

Persona a Contactar
Si usted tiene alguna inquietad, solicitud o queja, favor comunicarse con:

HIPAA Compliance Officer
Dr. Steven Gorin
21097 N.E. 27th Court, Suite 350
Aventura, FL 33180
(786) 629-0910

INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS NOTIFICATION OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purpose and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment : We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment : We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations : We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to asses the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purpose:

Required by Law : We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research : We may use or disclose information for approved medical research.
Public Health Activities : As required by law, we may disclose vital statistics, disease, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight : We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes : Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety : We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions : If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purpose.
Workers Compensation : We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

In any other situation we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies : In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information : If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures : You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing **a** complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:
HIPAA Compliance Officer
Dr. Steven Gorin
21097 N.E. 27th Court, Suite 350
Aventura, FL 33180
(786) 629-0910

INSTITUTE of SPORTS MEDICINE & ORTHOPAEDICS
www.instituteofsports.com

STEVEN GORIN D.O.
BOARD CERTIFIED
ORTHOPAEDIC SURGEON
21097 NE 27th Court, #350
Aventura, FL 33180
(P) 786-629-0910
(F) 786-629-0920

Today's Date: ________________________________

Patient Name: ______________________________**Age**: __________________ **Date of Injury**:___________________________
Height: ____________________________ **Weight**: ____________________ **Are you:** ☐Left Handed ☐Right Handed or ☐Both
Who is your primary care physician?_______________________ **Did they refer you, if not then who?**___________________

1. For what part of the body are you seeking treatment? ☐ Neck ☐ Shoulder (left or right) ☐ Elbow (left or right)
☐ Hand (left or right) ☐ Back ☐ Ribs ☐ Hip (left or right)☐ Knee (left or right) ☐ Ankle (left or right) ☐ Foot (left or right)

2. How did the symptom's begin? ____

3. When did the symptom's begin? ____days ago ____weeks ago ____months ago ____years ago ____unsure

4. Please describe how you were injured:____
____

5. Choose from the list to describe your symptoms: ☐ Pain ☐ Clicking ☐ Locking ☐ Catching ☐ Swelling ☐ Numbness
☐ Tenderness ☐ Bruising ☐ Popping ☐ Deformity ☐ Erythema ☐ Tingling ☐ Warmth ☐ Fever ☐ Giving way ☐ Grinding
☐ Snapping ☐ Stiffness ☐ Loss of Motion ☐ Weakness ☐ Mass ☐ Limping ☐ Arch collapse ☐ Calf Pain ☐ Instability
☐ Radiating to _________

6. How would you describe the symptoms?: ☐ Aching ☐ Burning ☐ Diffuse ☐ Dull ☐ Electric ☐ Sharp ☐ Pounding ☐Stabbing
☐ Tearing ☐ Throbbing ☐ Knifelike ☐ **OTHER:**____

7. How severe is the pain? ☐ Insignificant ☐ Mild ☐ Moderate ☐ Severe ☐ Marked
On a scale 1 – 10, with 10 being the worst pain ever and 1 NO pain, how would you rate your pain: ____________________

8. When do you get the symptoms? ☐ Nightly ☐ Daily ☐ Occasional ☐ During activity ☐ after activity ☐ Morning ☐ Daytime
☐ End of day ☐ Evening ☐ Night ☐ Rest

9. How have your symptoms gotten? ☐ Improved ☐ Unchanged ☐ Worsened ☐ Details:__________________________

10. What aggravates your symptoms? ☐ Carrying ☐ Grasping ☐ Lifting ☐ Pulling ☐ Pushing ☐ Reaching ☐ Car Driving
☐ Recreational Activities ☐ Throwing ☐ Weather changes ☐ Work ☐ Walking ☐ Walking Up Stairs ☐ Walking Down Stairs

11. What therapies have your tried? ☐ Acupuncture ☐ Bedrest ☐ Bracing ☐ Cold packs ☐ Cortisone injections ☐ Elevation
☐ Exercise ☐ Hot packs ☐ Night splints ☐ Pain clinic ☐ Physical therapy ☐ Sling ☐ Taping ☐ Warm soaks ☐ Advil ☐ Aleve
☐ Tylenol ☐ Glucosamine ☐ Chondroitin ☐ Prescription meds: ____

12. How has the therapy changed your symptoms? ☐ Improved ☐ Worsened ☐ No change

13. What are your functional limitations? ☐ Occasional ☐ Often ☐ Constant ☐ Intermittent ☐ **Other:** _______________
If work related, then are you? ☐ Full Duty ☐ Light Duty ☐ Not working

14. Do you do any form of exercise? ☐ **YES or** ☐**NO**. What types?_____________________________________
How often?____

PAST MEDICAL HISTORY: *Do **YOU** have a history of: Please mark all of those for which you have received treatment:*

☐ Migraine Headaches ☐ Ringing in ear ☐ Dizzy Spells ☐ Double or Blurred vision ☐ Sinus trouble ☐ Cataracts ☐ Pneumonia

☐ Asthma ☐ High Blood Pressure ☐ Heartburn/Reflux ☐ Diverticulitis/Crohn's ☐ Urinary Tract Infections ☐ Stroke

☐ Blood in urine ☐ Dialysis ☐ Sex. Trans. Diseases ☐ Weight Loss/Gain ☐ Anemia ☐ Cancer ☐ Diabetes ☐ Seizures ☐ Tremors

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Recurrent Back Pain ☐ Fracture ☐ Osteoporosis ☐ Gout/Pseudogout ☐ Depression

☐ Agitation ☐ AIDS/HIV ☐ High Cholesterol ☐ Hepatitis ☐ Thyroid Disease ☐ Heart Disease ☐ Other: ____________________________

PAST SURGICAL HISTORY: *Please list any and all surgical procedures you have had done:* ______________________________

____

____

____

FAMILY HISTORY: ***Please mark any of the following if any blood relative has suffered from the following:***

☐ Epilepsy ☐ Migraine ☐ Mental Illness ☐ Glaucoma ☐ Diabetes ☐ Thyroid Disease ☐ Arthritis ☐ Lupus ☐ Asthma ☐ Anemia

☐ Osteoporosis ☐ Stroke ☐ Alcoholism ☐ Hepatitis ☐ Lipid Disorder ☐ Hypertension ☐Heart Disease ☐ Cancer

☐ OTHER:____________________________________

REVIEW OF SYSTEMS: **Please mark those symptoms that you have had any which are associated with what brings you to the office? ☐ NONE**

GENERAL HEALTH:: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

EYES/EAR/NOSE/THROAT/MOUTH: ☐ glaucoma ☐ dentures ☐ eyeglass use

CARDIOVASCULAR: ☐ Chest pain ☐ shortness of breath ☐ unable to walk one flight of stairs ☐ ankle swelling ☐ fainting

RESPIRATORY: ☐ bronchitis ☐ cough **GASTROINTESTINAL:** ☐ Nausea ☐vomiting ☐ diarrhea ☐ constipation

GENITOURINARY: ☐ frequency of urination ☐ burning urination **SKIN AND BREAST:** ☐ psoriasis ☐ infections ☐ keloid's

FAMILIAL MUSCULAR DISEASES: ☐ familial skeletal dysplasia's ☐ scoliosis

NEUROLOGICAL: ☐ seizures ☐ strokes ☐ weakness ☐ numbness **HEMATOLOGICAL/LYMPHATIC:** ☐ anemia ☐ leukemia

ALLERGIC/IMMUNOLOGICAL: ☐ HIV infection ☐ AIDS ☐ LATEX allergy

SOCIAL HISTORY

Do you drink alcohol? ☐None ☐Socially ☐Minimal ☐Moderate; # drinks/day______________________________

Do you smoke cigarettes? ☐None ☐Socially ☐Minimal ☐Moderate; # packs/day____________________________

Do you use any illicit drugs?____

Highest Level of Education?________________________ If in school, where and what grade are you in?________________________

Current Housing Situation (# of stairs):_____________________________________

MEDICATIONS: Please list ALL the medications you currently take: ____

____

____

____

ALLERGIES:____

____

I, THE PATIENT OR GUARDIAN, CERTIFY THAT ALL THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE..

PATIENT/GUARDIAN SIGNATURE ______________________________

*DATE*_________________

*PHYSICIAN SIGNATURE*______________________________________

STEVEN GORIN D.O.
BOARD CERTIFIED
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(P) 786-629-0910
(F) 786-629-0920

PATIENT REGISTRATION FORM

Date:_______________

Patient Name:____
Last First MI Date of Birth

Address___________________________
City, State, Zip___________________________
Home Phone___________________________
Cell Phone___________________________
Work Phone___________________________
E-Mail___________________________

Primary Insurance Company
Carrier Name___________________________
Member's Name___________________________
Member's ID___________________________
Group #___________________________
Patient Relation to Subscriber___________________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Male ☐ Female

SS#___________________________
Driver's License #___________________________

Referred By___________________________
Primary Care Physician___________________________
Preferred Pharmacy/#___________________________
Emergency Contact#___________________________
Name/Relationship___________________________

Patient Occupation___________________________
Patient Employer___________________________

Secondary Insurance
Carrier Name___________________________
Member's Name___________________________
Member's ID___________________________
Group #___________________________
Patient Relation to Subscriber___________________________

Responsible Party (if not patient)
Name___________________________
Address___________________________
City, State, ZIP___________________________
Phone___________________________
SS#___________________________

A. AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF MEDICARE BENEFITS
I authorize any 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 who accepts assignment below. Furthermore, I request that payment under the medical insurance program be made to me or to **INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS.** 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.

I request that payment of authorized MEDIGAP benefits be made on my behalf to **INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS,** for any services furnished me by (physician/supplier). I authorize any holder of medical information to release to **INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS,** any information needed to determine these benefits or the benefits payable for related services.

B. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION
I authorize **INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS** 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 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 copayments and coinsurance at the time of the visit.

D. APPOINTMENT POLICY
I understand that I will be charged a fee for appointments not canceled within 24 hours. This includes canceled appointments, rescheduled appointments, and missed appointments ("no-shows"). Appointments may be canceled via telephone or website. The fee is $50.00 but is subject to change at the discretion of **INSTITUTE OF SPORTS MEDICINE & ORTHOPAEDICS**

Please initial here _____

E. REFERRALS AND AUTHORIZATIONS
I understand that it is my responsibility to obtain all authorizations or referrals necessary for treatment. **INSTITUTE OF SPORTS MEDICINE & ORTHOPAEDICS,** does not accept faxed authorizations or referrals. If an authorization or referral is not obtained by the time of the visit, the visit will be rescheduled and considered a same-day cancellation, resulting in a fee. (SEE ABOVE)

F. MEDICAL MALPRACTICE
Under Florida law physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Dr. Steven Gorin has decided to NOT carry medical malpractice insurance. According to Florida statuette 458.320 (5)(g)(1), this is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Please initial here _____

I, THE PATIENT OR GUARANTOR, 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 PRACTICE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR ITS REPRESENTATIVE.

PATIENT or GUARANTOR SIGNATURE ________________________________ *DATE* ______________________________