JOINT IMPLANT SURGEONS OF FLORIDA
"The Best Surgeons in the Joint"

www.jointimplant.com

Consent to E-Prescribing

E-Prescribing is defined as a physician's ability to electronically send error free, accurate, and understandable prescriptions directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions –** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions –** Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification –** Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Joint Implant Surgeons of Florida, P.A., can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to Joint Implant Surgeons of Florida to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

I give consent to Joint Implant Surgeons of Florida, P.A., including its medical staff members and employees involved in my care, to access, use and disclose my protected health information for my treatment, payment for my treatment and for health care operations consistent with the federal HIPAA privacy regulation. I consent to the disclosure of my prescription medical information by any provider, pharmacy, insurer, and prescription benefits manager, specifically including any state or federal health benefits program to Joint Implant Surgeons of Florida, P.A., for the purpose of my treatment. I am aware that the privacy practices of Joint Implant Surgeons of Florida, P.A., are described in its Notice of Privacy Practices. This Consent is subject to my revocation at any time except to the extent it has already been acted on.

_____	_____
Patient Name (Print)	Patient Date of Birth
_____	_____
Signature of Patient or Legal Representative	Date and Time
_____	_____
Print Patient Representative Name	Relationship to Patient

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RECEIPT OF ACKNOWLEDGEMENT OF PRIVACY

I hereby acknowledge that I was offered to read or take with me a copy of the Privacy Policy issued by Joint Implant Surgeons of Florida, P.A., on the date indicated below. I understand that I may ask for a copy at any time.

☐ Parent ☐ Son or Daughter ☐ Legal Guardian ☐ Facility/Caretaker

☐ Other _____

To respect your privacy please tell us how we may contact you:

Home Phone:

☐ You may leave a message with the following person(s) if I am not available: _____

☐ You may leave DETAILED INFORMATION on my answering machine.

☐ You may leave your NAME and PHONE NUMBER ONLY on my voicemail and I will return your call.

Work Phone:

☐ You may call my work place.

☐ You may leave DETAILED INFORMATION on my work voicemail.

☐ You may leave your NAME and PHONE NUMBER ONLY on my work voicemail and I will return your call.

☐ You may NOT call my workplace.

Please list spouses, family, friends, caretaker, etc. that we may communicate with in regards to your personal medical and financial information. Also, please list Power of Attorney or next of kin. This will include but is not limited to: test results, appointment dates and times, and billing information. Only the names that are listed below will be able to receive your information. Do not include your physicians on this list.

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____
4. _____ Phone: _____

Unless you notify us in writing stating otherwise the above person(s) will always be able to receive information about you.

_____ _____

Patient's Signature Date

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FINANCIAL POLICY

Joint Implant Surgeons of Florida, is dedicated to providing our patients with the best possible care. We ask your help by understanding and cooperation with our financial policy. We must emphasize that as physicians, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

INSURANCES:
We participate with many insurance companies. Please check with office staff to see if we participate with your insurance plan. If we DO participate with your insurance company, all services performed in our office will be submitted, unless we have received prior notification of non-covered services. All co-pays, deductibles and co-insurance amounts are your responsibility and due at the time of service.

For elective surgeries, a surgery deposit may be required prior to the surgery.
If we DO NOT participate with your insurance company, this means that we will bill your insurance company as a courtesy. We do not accept payment from them as payment in full for the services performed. All insurance carriers have a schedule of fees from which they will pay; however, the doctor's fees may be more than what the insurance company will allow. Any balance not covered by the insurance company will become your responsibility.
For secondary insurances, we will submit your secondary insurance claim a maximum of two times. After two submissions, the balance will be billed to you.

CO-PAYS AND OUTSTANDING BALANCES:
All co-pays are due at the time of service. If your co-pay is not paid at the time of service, a $5.00 billing charge will be added to your account for each instance, unless other arrangements were made with the billing office staff. All outstanding balances on accounts are due at the time of service.

REFERRALS/AUTHORIZATION:
If your insurance has referral or authorization requirements, you are required to have prior authorization or a referral from your Primary Care Physician (PCP) prior to your visit. If this authorization or referral is not provided the day of service, you may be asked to either reschedule your appointment or pay at the time of service.

DISABILITY INSURANCE FORM COMPLETION:
Our office will complete your disability insurance claim forms. The fee for each form is $15 and must be paid in advance prior to completion of your form. **PLEASE ALLOW 7-10 Business days for completion of your disability forms.**

CHECKS RETURNED FOR INSUFFICIENT FUNDS:
If we receive a returned check for insufficient funds, we will immediately reverse the payment on your account and will also charge a $40 fee to your account.

COLLECTION ACCOUNTS:
Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event a bill goes unpaid without contacting the billing department to discuss payment options, the account will be turned over to collections. If your account is sent to our collection agency, a collection charge of 30% of the amount due may be added to the balance of your account. In the event your account is turned over to an attorney you will be responsible for any and all attorney fees plus court costs.

SELF-PAY POLICY:
Payment is expected at the time of service. Prompt pay discounts may be available, please check with billing staff for details.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY JOINT IMPLANT SURGEONS OF FLORIDA, P.A. AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____ _____

Signature of Patient/Guardian **Date**

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CONFIDENTIAL PATIENT INFORMATION

I authorize any holder of medical information or other information about me to be released to Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this doctor or supplier, any information needed for this or a related Medicare claim and/or my Private Health Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. I understand that this is a lifetime signature authorization. I understand that this authorization may be used to release medical information if necessary to process my insurance claims and pay the provider or supplier direct. Also, applies to my private and/or group health insurance as applicable.

_____

Signature of Patient or Guardian

_____

Date

**If signed by other than beneficiary, state title or relationship and the reason patient was unable to sign.

_____

_____

7331 College Parkway, Suite 300, Fort Myers, Florida 33907