ORTHOPAEDIC CARE SPECIALISTS
733 US HIGHWAY ONE
NORTH PALM BEACH, FL 33408

NAME ____________________

STREET ____________________ APT ____________________

CITY ____________________ STATE __________ ZIP __________

DO YOU HAVE AN NORTHERN ADDRESS? ____YES ______NO (if so please provide on reverse side)

AGE ______________ SEX ________ DATE OF BIRTH ____________________

HOME PHONE______________ CELL ______________ WORK PHONE ______________

PHARMACY NAME ____________________ PHONE ____________________

SOCIAL SECURITY____________________ MARITAL STATUS: M S W D

SPOUSE'S NAME ____________________ SPOUSE DATE OF BIRTH ______________

NAME OF EMPLOYER____________________

IS INJURY A RESULT OF:

MOTOR VEHICLE ACCIDENT? DATE ______________

WORK RELATED ACCIDENT? DATE ______________

OTHER ACCIDENT? DATE ______________

(Please describe)

DO YOU HAVE MEDICAL INSURANCE?____________________

(Please provide us with your card)

WHO IS YOUR MEDICAL DOCTOR? ____________________

MEDIGAP AUTHORIZATION
(FOR MEDICARE PATIENTS ONLY)

I request that payment of authorized MEDIGAP benefits be made on my behalf to ORTHOPAEDIC CARE SPECIALISTS for services furnished to me. I authorize any holder of medical information about me to release to my Medigap insurance company any information needed to determine these benefits or the benefits payable for related services.

____

Signature Date

LIFETIME AUTHORIZATION
(FOR ALL PATIENTS)

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim.
I understand that I am financially responsible for all charges whether or not paid by said insurance.

____

Signature Date

MEDICAL QUESTIONNAIRE

Patient ____ Date ____________________

Do you have any allergies to medications? YES ☐ NO ☐

If yes, which medications? ____

____

____

____

WEIGHT ___________________ HEIGHT _______________________

Do you have any medical problems?

Diabetes YES ☐ NO ☐

Hypertension YES ☐ NO ☐

Heart Disease YES ☐ NO ☐

Peptic Ulcer Disease YES ☐ NO ☐

When was your last check?

Mammography ____________________________

Colonoscopy ______________________________

Pap Smear ________________________________

Please list your medications:

____

____

Have you ever had surgery? YES ☐ NO ☐

Date _________________ Operation ____

Date _________________ Operation ____

Have you ever been involved in a previous accident with injuries? Yes ☐ No ☐

Date ________________ Injury _________________________________ Work related? ______________

Date ________________ Injury _________________________________ Work related? ______________

Do you smoke? YES ☐ NO ☐

If yes, how much? ______________________________ How long? _______________________________

Do you drink alcohol? YES ☐ NO ☐

If yes, how much? ____

AGREEMENT OF PAYMENT FOR NON-PARTICIPATING PROVIDER

____
Patient's Name

____
Insured Name

____
Insurance Company

I understand that the doctors at Orthopaedic Care Specialists are not participating providers for my insurance plan. I agree that any insurance checks received by me (or insured / guarantor) for any services rendered, will be endorsed to Orthopaedic Care Specialists and sent within 10 business days.

I realize that the balance of my medical bills is my responsibility whether or not my insurance company pays and is to be paid in full.

I hereby guarantee payment of all collection charges, including reasonable attorney's fee and court costs incurred in the event that collective action is necessitated due to default in payment of said charges. I understand and acknowledge that outstanding charges for services may incur interest at *a monthly periodic rate of 1% (annual rate of 12%)*; based upon any balance that is outstanding 90 days after the date of service.

____
Patient / Guarantor Signature   Date

ORTHOPAEDIC CARE SPECIALISTS
733 US HIGHWAY ONE
NORTH PALM BEACH, FL 33408
PHONE (561) 840-1090 FAX (561) 840-0791

CONSENT TO DISCUSS OR RELEASE INFORMATION
&
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, ____ hereby give consent to ***Orthopaedic Care Specialists*** to discuss or release my private health care information to:

____

☐ who is related to me ☐ is my care giver, unrelated to me

I fully understand and accept the terms of this consent. I have been informed of my rights according to HIPPA Regulations. I have reviewed and have had the opportunity to receive a copy of *The Notice of Privacy Practices at Orthopaedic Care Specialists.*

Signature ________________________________ Date ________________

ORTHOPAEDIC CARE SPECIALISTS ("OCS")

KNECHT MEDICAL ARBITRATION AGREEMENT™

Patient's Name: ____________________________________

Physician's Name: Patient's Physician(s) at OCS

1. Preface: Whether an existing or new patient, the patient is in need of a physician, the physician would like to help the patient and the patient understands that no one can guarantee the final outcome of any treatment since there are always risks that can lead to serious injury or death even with the best of medical care. If you question anything when reviewing this agreement, please feel free to leave and consult another physician if necessary, an attorney or call the Florida Bar at 800-342-8060 before signing this agreement.

2. Disputes & Consideration: In the unfortunate event of any claim for medical malpractice or otherwise, and in consideration for this agreement, the parties would like to (a) keep things as simple as possible; (b) enhance early resolution of their differences; (c) avoid lengthy drawn out litigation through the courts; (d) avoid the stress associated with traditional litigation and jury trials; and (e) minimize all costs, expenses and attorney's fees. Therefore, the parties voluntarily agree to the following pursuant to their constitutional right to contract:

3. Arbitration: ALL claims shall be settled by binding arbitration in Palm Beach County, Florida. There shall be two separate arbitration panels, each panel's majority decision shall be final and the parties shall have the benefit of presuit notice, investigation and discovery under the Medical Malpractice Act. The first panel shall decide liability and the second panel shall decide damages, if necessary. As for the liability panel, it shall consist of three qualified physicians as defined under paragraph 9 who shall be chosen as follows: (a) Patient will choose a physician; (b) Named Physician will choose a physician; and (c) these two physicians will choose the third physician who shall serve as the chief arbitrator. If the panel is leaning towards liability, they shall verbally advise the parties. If so, patient's physician shall have the option to (a) proceed to damages without any finding of medical malpractice or (b) request formal findings and reserve all objections. The parties shall then have sixty (60) days to settle the case. Otherwise, the damage panel shall be chosen as follows: (a) Patient will choose an arbitrator; (b) Named Physician will choose an arbitrator; and (c) the same chief arbitrator shall serve unless both arbitrators agree otherwise. The two physicians under the liability panel may serve under this panel if chosen or someone else-e.g., attorney, physician or otherwise. Subject to Florida law, non-economic damages shall not exceed the lesser of: (a) Two Hundred and Fifty Thousand Dollars (1) per person or (2) per incident regardless of the number of persons asserting a claim; or (b) the amount authorized by law. The chief arbitrator shall solely decide all evidentiary matters. The parties expressly waive their constitutional right to trial by judge or jury.

4. Intent of the Parties: Subject to Florida law, it is the parties' further intent that (a) the liability panel when appropriate shall recommend remedial education or training for the patient's physician who shall comply with same; (b) the Medical Malpractice Act, Florida law and this agreement shall be liberally construed in favor of enforcing this agreement; (c) the parties' shall bear their own costs, expenses and attorney's fees, and pay their pro rata share of these proceedings, unless the chief arbitrator finds otherwise; (d) any common law claim for punitive damages shall be waived; (e) the chief arbitrator may choose a retired state judge to provide advisory opinions for any purpose if s/he deems it necessary; and (f) if ANY provision under this agreement is held invalid in whole or in part for any reason, the remaining provisions SHALL be liberally construed in favor of enforcing this agreement. Please read reverse side.

I VOLUNTARILY AGREE TO THIS ARBITRATION AGREEMENT INCLUDING THE REVERSE SIDE. PLEASE DO NOT SIGN WITHOUT READING THIS ENTIRE AGREEMENT. THANK YOU.

______________________	______________________	____________
Signature of Patient or Guardian Individually and for Patient	Signature of Patient's Spouse Individually and for Patient	Date
______________________	______________________	____________
Signature of Patient's Father Individually and for Patient	Signature of Patient's Mother Individually and for Patient	Date

MEDICAL ARBITRATION AGREEMENT - CONTINUED FROM FRONT PAGE. PLEASE READ.

5. Medical Malpractice Act: In the event of medical malpractice, the parties understand that they have certain rights under state law and the Medical Malpractice Act. Over the years, there has been a lot of coverage in the media over medical malpractice and health care reform, qualified doctors leaving the state and the need for patients to have quality and affordable health care. In an effort to address some of these concerns, and acknowledging that there is no perfect solution, this is another reason why the parties have entered into this agreement.

6. Acceptance, Termination & Duration: This agreement shall be deemed accepted and 100% binding on the parties once any medical care, treatment or services are rendered by the patient's physician to the patient; the doctor-patient relationship can be terminated; and this agreement shall survive and control ALL present and future claims. By signing this agreement, you represent that you have done so voluntarily, were never pressured to sign by the patient's physician or otherwise, are mentally competent, have read or had this agreement read or translated to you by someone other than the patient's physician and have authority to sign for the patient. Other than this agreement, you are not relying on anything said by, or on behalf of, the patient's physician.

7. Duty to Defend & Indemnify: For each family member with a claim that is not bound by this agreement ("non-party"), it is the parties' intent that they shall adopt and comply with this agreement 100% so that the parties can avoid piecemeal litigation and ensure consistency, closure and finality in one forum. For each non-party claim against the patient's physician brought outside this agreement, you shall (a) defend and (b) indemnify the patient's physician against said claim(s) up to the amount the chief arbitrator deems reasonable under the circumstances.

8. Translation: English version of this agreement SHALL control over any Spanish version.

9. Meaning of Terms: In addition to customary meaning: (a) **claim(s)** mean(s) (1) ALL present and future liability claims arising out of medical malpractice, including vicarious liability and apportionment of fault between joint tortfeasors, tort, contract, statute or otherwise, and (2) ALL resulting injury, death and damages to the patient, patient's parents, spouse, children, estate, anyone else or otherwise; and (3) outstanding medical bills unrelated to medical malpractice are excluded from this agreement; (b) **damage(s)** mean ALL past and future damages under the law including without limitation ALL (1) **non-economic damages** for pain and suffering, disability, disfigurement, mental anguish, loss of capacity for the enjoyment of life, loss of consortium (spouse, children, parental or otherwise) or other non-pecuniary losses and (2) **economic damages** for medical expenses, loss of earnings or other pecuniary losses; (c) **defend** means you shall pay the attorney's fees, costs and expenses incurred by, or on behalf of, patient's physician in defending against each non-party's claim; (d) **indemnify** means you shall pay the amount of any settlement or final judgment; (e) **medical malpractice** means the negligent rendering of, or the failure to render, medical care or services; (f) **parties** mean the patient, patient's physician and anyone that signs or adopts this agreement; (g) **named physician** means the patient's physician at OCS that patient claims is liable for medical malpractice; (h) patient's physician means (1) named physician, (2) OCS and (3) their respective employees and agents and (4) each person or entity that may be responsible under vicarious liability; (i) **punitive damages** are meant to punish a defendant when the medical malpractice is gross or intentional; (j) **qualified physician** is defined under the Qualified Physician Summary which is adopted herein and available at the front desk for your review before signing; (k) **you** means the patient and anyone signing this agreement (excluding patient's physician); and (l) **vicarious liability** means (1) the patient's physician may be responsible for a claim against another person or entity or (2) another person or entity may be responsible for a claim against the patient's physician.

10. Entire Agreement: This is the entire agreement between the parties and there are no oral representations to the contrary unless all parties agree otherwise in writing.

11. Otherwise, the Medical Malpractice Act and Florida law shall control this agreement.

PLEASE DO NOT SIGN WITHOUT READING THIS ENTIRE AGREEMENT

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