Patient Name: _____ DOB: _____ Account #: _____

I. DISCLOSURE

TOC, pursuant to applicable Federal and Florida law, makes the following disclosures: Patient is not required to obtain items of service from any of the following departments of TOC or other entities which patient may be referred. Patient may obtain items or services from a provider or supplier of patient's choice. Alternative sources are described below:

Outpatient Surgical Centers: The following Tallahassee Orthopedic Clinic III, P.L. members own an investment interest in Tallahassee Outpatient Surgery Center and Red Hills Surgical Center: Tom C. Haney, M.D.; Robert L. Thornberry, M.D.; Mark E. Fahey, M.D.; D. Christian Berg, M.D.; Garrison A. Rolle, M.D.; William H. Thompson, M.D.; Floyd R. Jaggears, M.D.; Andrew M. Wong, M.D.; Andrew H. Borom, M.D.; David A. Bellamy, M.D.; Thomas M. Park, M.D.; Aaron J. Guyer, M.D.; Hank L. Hutchinson, M.D.; W. Brad Stephens, M.D.; Hector A. Mejia, M.D.; D. Jason Oberste, M.D.; Kris D. Stowers, M.D.; and Matthew C. Lee, M.D. Patient may obtain alternative services from a provider of their choice or any of the following providers:
(a) Capital Regional Medical Center, 2626 Capital Medical Blvd., Tallahassee, FL; or (b) Tallahassee Memorial Hospital, 1300 Miccosukee Road, Tallahassee, FL.

Tallahassee Orthopedic Clinic, MRI Department: TOC MRI is wholly owned and operated by TOC. Patient may obtain alternative services from another provider or any of the following: (a) Tallahassee Diagnostic Imaging, 1623 Medical Drive, Tallahassee, FL; (b) Stand Up, 2332 Capital Circle NE, Tallahassee, FL; (c) America Health Imaging, 1925 Capital Circle, NE, Tallahassee, FL; (d) Tallahassee Neurological Clinic Open MRI Center, 2824 Mahan Drive, Tallahassee, FL; (e) Capital Regional Medical Center, 2626 Capital Medical Blvd., Tallahassee, FL; (f) Tallahassee Memorial Hospital, 1300 Miccosukee Road, Tallahassee, FL.

Tallahassee Orthopedic Clinic, Division of Orthotics and Prosthetics: TOC Division of Orthotics and Prosthetics is wholly owned and operated by TOC. Patient may obtain alternative services from another provider or any of the following: (a) Williams Orthotic-Prosthetic, 2360 Centerville Road, Tallahassee, FL; (b) Hanger Prosthetics & Orthotics, 2717 Mahan Drive, Tallahassee, FL; (c) Ambulatory Ankle & Foot Care Center P.A., 1608 W. Plaza Drive, Tallahassee, FL; (d) Rehab Engineering, 1719 Mahan Drive, Tallahassee, FL.

Tallahassee Orthopedic Clinic, Physical Therapy: TOC PT is wholly owned and operated by TOC. Patient may obtain alternative services from another provider or any of the following, but not limited to: (a) TOSPT, 1891 Capital Circle NE, Unit 2, Tallahassee, FL; (b) Tallahassee Memorial Rehabilitation Center, 1425 Village Square, Suite 3, Tallahassee, FL.

Tallahassee Orthopedic Clinic provides EMG/NCV diagnostic testing that is wholly owned and operated by TOC. Patients may obtain alternate services from another provider or any of the following but not limited to: (a) Tallahassee Neurology Associates, 2868 Mahan Drive #5, Tallahassee, FL; (b) Tallahassee Neurological Clinic, 1401 Centerville Road #300, Tallahassee, FL.

II. AUTHORIZATION

The undersigned patient, legal guardian of patient or authorized individual acting on behalf of the patient, understands and agrees as follows:

A. Consent: Tallahassee Orthopedic Clinic III, P.L. (TOC) reserves the right to designate any of its physicians, physician extenders, medical staff and/or other lawfully authorized designee to perform and administer all care and treatment to the patient.

B. Release and Medical Information:
   1. Workers' Compensation Patient: TOC is hereby granted by patient authority to release to patient's insurance carrier, health maintenance organization, employers, attorney, their representatives or referring physician, all medical information regarding workplace injury in connection with any treatment rendered to patient by TOC.
   2. Insurance Carrier/Health Maintenance Organization: TOC is hereby authorized to release to patient's insurance carrier/HMO or other similar plan, all medical information necessary to process payment claims for services rendered by TOC.
   3. Governmental Benefits: TOC is hereby authorized to release all medical information necessary to process governmental claims, including, but not limited to Medicare, Medicaid, Tricare, Vocational Rehabilitation, for services rendered by TOC.
   4. I acknowledge that Tallahassee Orthopedic Clinic generates and maintains electronic medical records and agrees to such. I acknowledge and agree that all such electronic records and any electronic signatures shall have the same force and effect as original written records and signatures. I further acknowledge that I am entitled to a copy of my records in paper form upon request and reasonable payment for such copies.
   5. By signing below, I agree to allow Tallahassee Orthopedic Clinic to review any prescription history available to my electronic health record.
   6. I acknowledge and authorize that my personal health information may be used for a program with CMS for sharing, treatment and outcome.

C. Financial Responsibility:
   Unless otherwise stated herein, the undersigned shall pay to TOC such sums as are now or may become due for services rendered to or on behalf of patient by TOC. In the event that Patient/undersigned is financially responsible for medical services rendered to patient by TOC and the patient or undersigned fails to pay account balance within 30 days from the due date, TOC may refer the account to an attorney or collection agency for recovery of sums due to TOC. In that event, TOC shall be entitled to recover attorney's fees and/or collection costs (28%), in addition to balance owed and payable to collection agency and/or attorney.

   Preauthorizations: In the event that patient at time of appointment with TOC fails to obtain the required preauthorization number, patient's appointment may be rescheduled or canceled. Patient shall be financially responsible for services rendered by TOC if patient's HMO/insurance carrier fails to pay the claim for services rendered. Likewise, if patient provides to TOC a preauthorization number that has expired or otherwise is not a valid preauthorization number and patient's insurance carrier/HMO fails to pay the claim, the patient shall be fully financially responsible for services rendered by TOC.

THE UNDERSIGNED ACKNOWLEDGES THAT THEY HAVE READ AND FULLY UNDERSTAND THE FOREGOING DISCLOSURE AND AGREE TO BE BOUND BY THE OBLIGATIONS HEREUNDER AND CONSENT TO THE AUTHORIZATIONS DESCRIBED ABOVE.
I acknowledge, understand and agree that Sections I and II of this Form shall remain in full force and effect from this date forward, through the current and all future courses of treatment, unless and until revoked or modified by me in writing provided to TOC. I also acknowledge, understand and agree that I must provide TOC with updated information regarding my personal and insurance information and that I will complete and sign such documentation as required by TOC.

_____ _____
DATE PATIENT OR PARENT/LEGAL GUARDIAN

ASSIGNMENT OF BENEFITS

I, the undersigned insured or beneficiary of an insurance policy, assign to Tallahassee Orthopedic Clinic III, P.L. (TOC) any and all rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest and/or damages pursuant to Section 624.155 of the Florida Statutes. This AOB supersedes any request by the insured to reserve benefits for lost wages. I request that payment of authorized State, Federal or private insurance carrier benefits be made to TOC for any covered services furnished to me by TOC. I acknowledge that TOC objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by TOC shall be done under protest, at the risk of the Insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. If my insurance carrier pays me directly, I agree to forward all funds to TOC within 10 working days. I agree that I am responsible for paying all non-covered or unpaid amounts unless otherwise provided by law, regulations or TOC's contractual relationships. I agree to be responsible for the full amount of the charges from the date services are rendered which my third party payer does not pay for within 60 days. I acknowledge, understand and agree that this Assignment of Benefits and Direction to Pay Benefits Owed shall remain in full force and effect from this date forward, through the current and all future courses of treatment. I also acknowledge, understand and agree that I will complete and sign such documentation as required by TOC in order to complete or perfect its rights to any and all benefits payable to me for medical services provided to me by TOC. A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
DATE PATIENT OR PARENT/LEGAL GUARDIAN

I acknowledge and understand the TOC Notice of Privacy Practices and have received, read and understand the TOC Financial Policies brochure.

_____ _____
DATE PATIENT OR PARENT/LEGAL GUARDIAN

PATIENT INFORMATION

Tallahassee Orthopedic Clinic complies with applicable Federal civil right laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.