FT. LAUDERDALE: 4800 NE 20th Ter, Suite 303
Phone (954) 771-8177 • Fax (954) 771-3629
MARGATE: 2825 N. State Road 7, Suite 204
Phone: (954) 580-4080 • Fax (954) 580-4081

www.southflorthogroup.com

Meet Our Providers

Ayisha E. Livingstone, M.D.
Michael Mashura, MD
Natan Bastoky, D.O.
Arthur Segall, D.P.M.
Kelley Conley, P.T.

Specialties

Sports Medicine
Non-Surgical Treatments
Foot & Ankle
Fractures & Trauma
Hand & Upper Extremity
Neck & Spine
Total Joint Replacements
Work-Related Injuries

WELCOME TO SOUTH FLORIDA ORTHOPEDIC GROUP

We welcome you to our practice and look forward to providing you with the best possible care. The information below will help to make the process smoother.

1. If you have insurance and you have a copay and/or deductible, payment is expected at the time of your visit (this is a contractual agreement with your insurance company).
2. **This office works by appointments; however, due the nature of our practice, we sometime experience delays. Please be patient as we give every patient the same careful attention.**
3. Please make cancellation at least 24 hours before your scheduled appointment.
4. Please advise the office BEFORE your next appointment if you change insurance companies, or we may have to reschedule you (some insurances companies require preauthorization/referral prior to your visit)
5. **If your insurance requires an authorization/referral it is your responsibility to ensure it is in our office prior your appointment.**
6. Advise the office of immediately of any change in address or telephone number.
7. Please advise the front desk if you have changed your primary care physician (PCP).
8. The doctors do not discuss any financial matters. If you need special arrangements to be made, please speak with our Billing Department directly at (954) 580-4084.

WE LOOK FORWARD TO MAKING YOUR EXPERIENCE WITH US A PLEASANT ONE

HIPAA NOTICE 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

SOUTH FLORIDA ORTHOPEDIC GROUP is required by law to maintain the privacy and confidentially of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

Treatment
We may disclose your medical or health information to other healthcare professionals, coaches, and immediate family members to include spouse, parents, adult, children, guardians, and insurance companies for the purpose of treatment, payment, or healthcare operations.
Example: "On occasions, it may be necessary to seek consultation regarding your condition from the other healthcare providers associated with SOUTH FLORIDA ORTHOPEDIC GROUP."

Payment
We may disclose your medical or health information to your insurance provider for the purpose of payment or healthcare operations.
Example: "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to SOUTH FLORIDA ORTHOPEDIC GROUP, for health care services rendered. If you pay for your health care services personally, we will provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."
Workers' Compensation
We may disclose your medical or health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your medical of health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or in the event of your death.

Public Health
As required by law, we may disclose your medical or health information to public health authorities, for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your medical or health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your medical or health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or in missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Person
We may disclose your medical or health information to coroners or medical examiners.

Research
We may disclose your medical or health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your medical or health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public. In addition, we may disclose your medical or health information for military, national security, prisoner, and government benefits purposes.

Marketing
We may contact you for marketing purposes, or fund raising purposes as described below.
Example:
"It is our practice to participate in charitable events to raise awareness, foot donations, gifts, money, etc. During these times we may send you a letter, postcard, invitation, or call your home to invite you to participate in the charitable activity. It is not our policy to disclose any personal health information about your condition for the purpose of SOUTH FLORIDA ORTHOPEDIC GROUP sponsored fund raising events."

Calls at home
As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we will leave you a reminder message on your answering machine. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Health Information Rights

- You have the right to request restrictions on certain used and disclosures on your health information. However, please be advised that SOUTH FLORIDA ORTHOPEDIC GROUP is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication of delivery. (based upon patient's request)
- You have the right to inspect and/or copy your health information.
- You have the right to request that SOUTH FLORIDA ORTHOPEDIC GROUP amend your protected health information. However, please be advised that SOUTH FLORIDA ORTHOPEDIC GROUP is not required to amend your protected health information. In case you request to amend your protected health information is denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by SOUTH FLORIDA ORTHOPEDIC GROUP.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon your request.

CHANGE OR OWNERSHIP
Please be aware that in the event that SOUTH FLORIDA ORTHOPEDIC GROUP is sold or merged with another organization, your health information/records will become the property of the new owner.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES
SOUTH FLORIDA ORTHOPEDIC GROUP reserves the right to amend this Notice of Privacy Practices at any time in the future, and make the new provisions effective for all information that it maintains and until such amendment is made, SOUTH FLORIDA ORTHOPEDIC GROUP is required by law to comply with this notice.

WELCOME TO SOUTH FLORIDA ORTHOPEDIC GROUP

TODAY'S DATE ____

PATIENT NAME ______________________________________ DATE OF BIRTH _________________

SOCIAL SECURITY # ____ ☐ MALE ☐ FEMALE

LOCAL ADDRESS ____ APT ____________________

CITY ___________________________ STATE _____________ ZIP CODE ____________________

PERMANENT ADDRES ______________________________________ APT ____________________

CITY ___________________________ STATE ______________ ZIP CODE ____________________

HOME PHONE ___________________________ CELL PHONE ______________________________

EMAIL ADDRESS ____

WOULD YOU LIKE OUR MONTHLY NEWSLETTER? ☐ NO ☐ YES

EMPLOYER'S NAME ____

REASON FOR YOUR VISIT TODAY? ____

PREFERRED PHARMACY______________________________ PHONE NO. ____________________

IS THIS DUE TO AN ACCIDENT? ☐ NO ☐ YES IF YES, DATE OF ACCIDENT ____________________

IF YES, IS THIS A **WORK** OR **AUTO** ACCIDENT? ☐ WORK ☐ AUTO ☐ OTHER _________________

PRIMARY INSURANCE _______________________________ I.D. # __________________________

SECONDARY INSURANCE _____________________________ I.D. # __________________________

RESPONSIBLE PARTY_________________________________ DATE OF BIRTH _________________

SOCIAL SECURITY # OF RESPONSIBLE PARTY ____

RELATIONSHIP TO RESPONSIBLE PARTY ____

REFERRED BY ____

YOUR MEDICAL DOCTOR ______________________________ PHONE NO. ____________________

IN CASE OF EMERGECY CONTACT____

RELATIONSHIP ______________________________________ PHONE NO. ____________________

PATIENT MEDICAL INFORMATION

PLEASE LIST ANY / ALL MEDICAL PROBLEMS ____

____

____

OPERATIONS AND DATES ____

PLEASE LIST ANY/ALL MEDICATIONS ____

____

ALLERGIES TO ANY MEDICATIONS ____

DO YOU SMOKE? ☐ NO ☐YES, HOW MUCH? ____

DO YOU DRINK? ☐ NO ☐YES, HOW MUCH? ____

HEIGHT _________________________________ WEIGHT _________________________________

AVERAGE BLOOD PRESSURE READING
SYSTOLIC (TOP NUMBER) __________ DIASTOLIC (BOTTOM NUMBER) ___________

IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS, PLEASE CHECK ALL THAT APPLY

_____ DIABETES	_____ KIDNEY DISEASE	_____ HIGH CHOLESTEROL
_____ HIGH BLOOD PRESSURE	_____ ARTHRIS	_____ STOMACH PROBLEMS
_____ STROKE	_____ INTESTINAL PROBLEMS	_____ ASTHMA
_____ HEART DISEASE	_____ GOUT	_____ PHLEBITIS (BLOOD CLOTS)
_____ THYROID PROBLEMS	_____ HEPATITIS	_____ ULCERS
_____ HIATAL HERNIA	_____ CANCER	_____ H.I.V

DO YOU HAVE A FAMILY HISTORY FOR ANY OF THE ABOVE MENTIONED CONDITIONS? ☐NO ☐ YES IF YES, PLEASE EXPLAIN:

____

____

ARE THERE ANY OTHER MEDICAL PROBLEMS THAT WE SHOULD BE AWARE OF? _____________

____

WOMEN ONLY: ARE YOU PREGNANT? ☐ NO ☐YES

PLEASE READ AND SIGN BELOW

In the event insurance is filed for surgery or other services rendered to me, I hereby authorize this office to release information to my insurance company and assign benefits directly to SOUTH FLORIDA ORTHOPEDIC GROUP.

1. **MEDICAL RECORDS RELEASE**
   I authorize the release of any/all medical information necessary to process a claim or any related claims for my physician or to my attorney.
2. **HMO AND MEDICARE PATIENTS – NON COVERED BENEFITS**
   I have been notified by my physician/supplier that Medicare/HMO is likely to deny payment for certain items (i.e. soft goods, outside x-ray review, etc.). If Medicare/HMO denies payment, I agree to be personally and fully responsible for payment.
3. **SIGNATURE ON FILE/LIFETIME AUTHORIZATION**
   The signature below is required by ALL Medicare patients.
   I request that payment of authorized Medical benefits be made to my physician/supplier for services rendered and any information needed to determine these benefits for any related services.

SIGNATURE: ____ ***DATE:*** _________________________

PAYMENT POLICY: PLEASE BE AWARE THAT PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

ACKNOWLEDGMENT OF RECEIPT

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF NOTICE OF PRIVACY PRACTICES BY ORTHOPEDIX MD CENTERS OF EXCELLENCE.

NAME: ____

PLEASE PRINT YOUR NAME

SIGNATURE: ____ ***DATE:*** __________________________

With my signature I agree that SOUTH FLORIDA ORTHOPEDIC GROUP and its collections department/agency may contact me at any of the phone numbers I have provided to discuss all balances pertaining to my account. SFOG also has permission to contact me via email if any or all of my phone number have been changed or disconnected.

FOR OFFICE USE ONLY

DATE ACKOWLEDGEMENT WAS RECEIVED: ____
OR
REASON ACKNOWLEDGEMENT WAS NOT OBTAINED: ____

____

STAFF NAME: ____________________ DATE: ______________OFFICE LOCATION:__________(EAST/WEST)

CANCELLATION POLICY

Our cancellation policy states that any scheduled appointment (either an office visit or procedure) must be cancelled with a 24 hour advanced notice, during normal operation hours (Monday through Friday; 8:30 am – 4:30 pm). Cancellations with less than 24 hour notice of scheduled appointment is noted as an **"untimely cancellation"**, and any missed appointment is labeled as a **"no show."**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to seemingly "full" appointment book.

Please be informed that it is the policy of SOUTH FLORIDA ORTHOPEDIC GROUP to monitor and manage appointment "no shows."

> Patients who fail to arrive for a scheduled appointment, without a 24 hour advanced notice, will be considered a "no show."
> Patients who consistently fail to arrive for more than (1) scheduled appointment are considered a CHRONIC "no show."

"No show" appointments will incur the following fee: Follow up appointment $30.00

Please note that this fee will not be covered by your insurance company. ***You MUST pay this fee in full*** before a future appointment can be made. Chronic "no show" patients are subject to dismissal from the practice.

By signing below, I have reviewed the above, fully understand and agree with the terms provided herein.

NAME: ____
PLEASE PRINT YOUR NAME

SIGNATURE: ________________________________ ***DATE:*** ____________________

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting South FL Orthopedic Group at (954) 771-8177.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Florida and will be in Florida during my telemedicine visit(s).

______________________________	______________________________
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
______________________________	______________________________
Witness Signature	Date