FT. LAUDERDALE: 4800 NE 20th Ter, Suite 303
Fort Lauderdale, FL 33308
Phone (954) 771-8177 ▪ Fax (954) 771-3629
www.southflorthogroup.com

Meet Our Providers

Ayisha E. Livingstone, MD
Natan Bastoky, DO
Arthur Segall, DPM.

Specialties

Sports Medicine
Non-Surgical Treatments
Foot & Ankle
Fractures & Trauma
Hand & Upper Extremity
Neck & Spine
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 appointment; however, due the nature of our practice, we sometimes 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 your appointment (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 Business Office directly at (954) 580-4084.

Thank you for trusting us with your orthopedic care. 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.

PATIENT INFORMATION

Patient Name: ____ Date of Birth: _____________________

Social Security #: ____ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Local Address: ____ Apt #_____________

City: _______________________________________ State: _________ Zip Code: ___________________

Permanent Address: ____ Apt #: __________

City: ____ State: ___________ Zip Code:___________

Home Phone: __________________________________ Cell Phone: ____________________________

Email Address: ____

INSURANCE INFORMATION

Primary Insurance: ________________________________ ID#: ________________________________

Secondary Insurance: ________________________________ ID#: ______________________________

Responsible Party: ___________________________________ Date of Birth: _______________________

Social Security #: ________________________________ Relationship to Patient: __________________

How were you referred to us? ____

Primary Medical Doctor: ____

PCP Phone #: __________________________________ Fax #: ___________________________________

Emergency Contact: ____

Relationship to Patient: ________________________ Phone:___________________________________

Is today's visit a result of an accident or injury? ☐ No ☐ Yes – Date: _____________________

If yes, is this a work or auto accident/injury? ☐ Work ☐ Auto ☐ Other __________________

ADVANCED DIRECTIVES

Do you have a living will or advance directives? ☐ No ☐ Yes

If yes, what type of advance directive? ____

____ I do not wish to have a living will or advance directive at this time.

I acknowledge that I have been given information regarding advance directives and that it is my responsibility to provide our office with a copy of advance directive documents for my medical records. I understand that I can change my mind at any time regarding advance directives and living will.

Patient/Guardian Signature: ____ Date: ________________

Patient Name: ____ Date of Birth: __________________

MEDICAL INFORMATION

Reason for Today's Visit: ____

Height: ____ Weight: __________________________

Occupation:____________________________________ Employer: ____________________________

Do you smoke? ☐ No ☐ Yes – How much? __________________________________

Do you drink alcohol? ☐ No ☐ Yes – How much/how often? ________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have any of the following conditions? * Please check all that apply.

☐ Diabetes	☐ Kidney Disease	☐ High Cholesterol
☐ High Blood Pressure	☐ Arthritis	☐ Stomach Problems
☐ Stroke	☐ Intestinal Problems	☐ Asthma
☐ Heart Disease	☐ Gout	☐ Phlebitis (Blood Clots)
☐ Thyroid Problems	☐ Hepatitis _______	☐ Ulcers
☐ Hiatal Hernia	☐ Cancer	☐ HIV/AIDS

Is there a family history of any of the above-mentioned conditions? ☐ NO ☐ YES

If yes, please list which condition(s): ____

____

Have you ever had **any** surgery in the past? ☐ NO ☐ YES

Please list—Type, dates, surgeon: ____

____

Are you allergic to any medication(s) ☐ None ☐ Penicillin ☐ Iodine ☐ Codeine ☐ Sulfa

☐ Other: ____

List medications that you are taking: ____

____

Pharmacy:______________________________Phone:____________________City:________________

Women Only: Are you pregnant? ☐ No ☐ Yes

Patient/Guardian Signature: ____ Date: _______________

Patient Name: ____ Date of Birth: _________________

PLEASE READ AND SIGN BELOW

Payment Guarantee: The undersigned patient and guarantor, if any, hereby agree to pay all charges to South Florida Orthopedic Group (hereinafter referred to as "Practice") in accordance with the regular rates and terms of the Practice and agree to pay for any charges not covered by any third-party payer. The Practice files insurance as a courtesy to the patient, but the patient is ultimately responsible for payment of the total incurred charges. The undersigned agree that if this account is turned over to a collection agency or attorney, that the undersigned patient and guarantor, if any, shall be obligated to pay the outstanding balance plus all costs of collection including reasonable attorney fees. The undersigned agree that any overpayments collected on this account may be applied directly to any delinquent account for which the undersigned patient is legally responsible. The undersigned patient and guarantor, if any, hereby agree that they are jointly and severally liable to pay the entire balance due and that the Practice is relying upon the undersigned(s) to pay in treating the patient.

Consent to Medical and Surgical Treatment: The undersigned hereby consents to all medical care and services, surgical treatment, examinations, tests and procedures, including but not limited to x-ray examination, laboratory and diagnostic procedures and tests, anesthesia, which a Physician, their employees, nurses, associates or designees may deem advisable to the undersigned patient during this treatment.

Assignment of Insurance Benefits: I hereby authorize payment directly to South Florida Orthopedic Group, (hereinafter referred to as “Practice”) and assign to them any and all rights and benefits that I or the patient may have under any policy of insurance including medical, automobile, personal injury protection, workers compensation, or any other coverage and further direct any such insurance company to make payment of benefits directly to Practice. I understand that I am financially responsible to Practice for charges not covered by this assignment.

Lifetime Signature Authorization: I hereby authorize South Florida Orthopedic Group to furnish to my insurance company or their representative, or Social Security Administration or the Center for Medicare and Medicaid, or Medigap or its intermediaries or to the billing agent of the Practice any information needed for this claim or related claims. I permit a copy of this authorization to be used in place of the original.

Cancellation Policy: Our cancellation policy states that any scheduled appointment must be cancelled with a 24-hour advanced notice during normal operating hours, Monday through Friday 8:00am - 5:00pm. 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 a fee:

Follow up appointment $30 Procedure appointment $150

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.

Notice of Privacy Practices: I have been provided information by the South Florida Orthopedic Group regarding their privacy practices.

Patient Name: ____

Patient Signature: ____ Date: ________________

Resp. Party Signature: ____

Relationship to Patient: ______________________________________ Date: _________________

If patient is under age 18, I hereby give my permission for ______________________________ to be treated by Practice.

Patient Name: ____ Date of Birth: _________________

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 practice 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/Guardian Signature Date

_____________________________________ _________________________________

Witness Signature Date