SURFSIDE Medical Center

Glenn S. Chapman III, DO
Trevor J. Tyner, DO
George A. Christakis, DO

NEW PATIENT DEMOGRAPHICS FORM

Referred By _____ Dr Patient Internet Mail Other. Date_____

Last Name_____First_____Middle_____

Address_____City_____State_____Zip_____

Mobile Phone_____Home Phone_____SS#_____

Alias_____Date of Birth____/____/____Age_____Sex_____Marital Status: S M W D Sep

Email_____Primary Care Physician_____

Pharmacy: Name_____Address_____

Pharmacy: Phone#_____Fax#_____

Emergency Contact Name_____Phone#_____Relationship_____

Race: White Black Asian Am Indian/Alaska Native Native Hawaiian Pacific Islander Other_____

Ethnicity: Non-Hispanic Hispanic Language: English Spanish French/Creole Other_____

Primary Insurance_____ID#_____Group#_____

Secondary Ins_____ID#_____Group#_____

Ins Responsible Party name_____Date of Birth_____Phone_____

Accident? Yes No Type: Auto Work Comp Slip/Fall Other_____Date of Injury_____

Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, or files a statement of claim containing any false or misleading information, commits insurance fraud and is punishable as provided in Florida Statute 817.234

Patient Signature_____Date_____

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New Patient Medical Intake Form

Patients name_____Date of Birth_____Date_____

PRESENT PROBLEM

Chief Complaint_____
Onset (when complaint began)_____
What makes better/worse?_____
Quality (dull, sharp, achy, etc.)_____
Region/Radiation (location)_____
Severity (1-10, worst being 10)_____
Timing (morning, after exercise, winter, etc.)_____
Associated symptoms (headache, tingling, etc.)_____
Studies pertinent to complaint (MRI, CT, Xray, etc.)_____
Prior therapies tried for complaint (PT, acupuncture, injections, etc.)_____
_____

HISTORY

Current Medications & dosages_____
_____
_____
Allergies (reactions to meds, foods, etc.)_____
Prior surgeries and hospitalizations (for any complaint)_____
_____
_____

Alcohol use: Never, Yes: #___ per Week Month, Type: Beer Wine Liquor
Tobacco use: Never, Yes: #___ per Day Week, Type: Cigarettes Cigars Dip/Chew
Former : Quit date_____, Years of use_____.

Family History:	Living		Age	Conditions (circle cause of death if applicable)
Father:	Yes	No	___	_____
Mother:	Yes	No	___	_____
Brothers:	Yes	No	___	_____
Sisters:	Yes	No	___	_____
GrandF:	Yes	No	___	_____
GrandM:	Yes	No	___	_____

Past Medical History (chicken pox, heart dz, liver dz, kidney dz, cancer, glaucoma, rheumatic fever, etc.)_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is *my* responsibility to inform the Doctor's office of changes in my medical status. I authorize the health care staff to perform the necessary services I need.

Patient Signature_____Date_____

SURFSIDE Medical Center

NEW PATIENT REVIEW OF SYSTEMS FORM

Patient name_____ Date_____

Please check positive all symptoms that apply to you and check negative all symptoms that definitely do not apply. If you do not recognize a term then please leave it blank.

We are aware that the list is very long but it will only be filled out on the first visit and it helps me give you the best care possible. Thank you.

General
- Fatigue
- Night Sweats
- Weight Gain > 10lbs.
- Weight loss >10lbs - unintentional
- Weight Loss >10lbs - Intentional

Skin
- New Lesions
- Rash
- Change in Wart/Mole

HEENT
- Head Injury
- Eye Pain
- Visual Disturbances
- Hearing Loss
- Ringing in the Ears
- Seasonal Allergies
- Sinus issues

Respiratory
- New cough
- Chronic Cough
- Wheezing
- Shortness of breath
- Difficulty Breathing on Exertion
- Difficulty breathing lying down

Breast
- Breast Mass
- Breast Pain

Female Genitourinary
- Urinary Complaints
- Flank Pain
- Urgency
- Frequency
- Menstrual Irregularities
- Painful Urination

Male Genitourinary
- Blood in Urine
- Hesitancy
- Flank Pain
- Excessive Urination at Night
- Painful Urination

Cardiovascular
- Chest Pain
- Murmur
- Palpatations / Irregular heart beats
- Fainting / Blacking Out
- Swelling of Extremities
- Varicose veins

Gastrointestinal
- Abdominal Pain
- Abdominal Mass
- Change in stool
- Change in Bowel Habits
- Constipation
- Diarrhea
- Heartburn
- Nausea / Vomiting

Musculoskeletal
- Back Pain
- Neck Pain
- Arm Weakness
- Leg Weakness
- Joint Pain
- Joint Redness
- Joint Stiffness
- Joint Swelling
- Muscle Pain
- Muscle Weakness
- Muscle Twitch
- Muscle spasms
- Calf pain / Cramps

Neurological
- Headaches
- Migraines >15 days per month
- Unusual Sensation
- Numbness / Tingling
- Focal Neurological Symptoms
- Trouble walking
- Vertigo
- Weakness

Psychiatric
- Anxiety
- Depression
- Insomnia
- Feels safe at home
- Hallucinations
- Suicidal Planning

Hematology
- Anemia
- Blood Clots
- Enlarged Lymph Nodes
- Abnormal Bleeding
- Easy bruising

Endocrine
- Cold Intolerance
- Excessive Sweating
- Excessive Thirst
- Excessive Urination
- Thyroid Problems
- Perimenopausal

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FINANCIAL POLICY

Purpose: This form allows Surfside Medical Center to treat you, bill your insurance, share information with other health care offices or facilities, and to collect on your account.

Insurances: Our office participates in Medicare and many managed care companies including Auto insurances and Workers Comp. As a courtesy we will bill all insurances. However, co-payments, co-insurances, deductibles, and non-covered services are the responsibility of the patient/guarantor and expected at the time of service. Any amounts not paid at the time of service are subject to administrative fees as outlined below. Incorrect insurance information provided or changes in policies will be the patient's responsibility.

Authorization: I authorize treatment by the providers of Surfside Medical Center. I authorize the release of any information requested by insurance companies or liable third parties and I assign all benefits or injury benefits to Surfside Medical Center. If the correct insurance is not provided then the patient acknowledges full responsibility for the bill.

Privacy: I acknowledge that I received or read a copy of the Notice of Privacy Practices in either digital or paper format.

Our Fees:

Returned check fee	$30.00
Forms (ex: FMLA, handicap tags, disability, etc.)	$15.00-35.00
Appointment cancellation with less than 24 hours' notice	$25.00
Appointment no-shows	$50.00
Co-pay, deductible's, non-covered services not paid at time of service	$10.00

Financial Policy: I hereby understand the financial policy of Surfside Medical Center. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay all reasonable attorney's fee, collection agencies fee, curt costs and any other collection related fees incurred on my account. I also understand that my employer may be contacted to verify employment status.

Special Needs: There are times when making a payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise staff prior to receiving treatment. Co-pays are exempt as required by law and you insurance company. You are required to notify us if this is a Worker's Comp or accident to avoid additional financial costs. If you are not covered by any insurance, let us know you are a self-pay and ask about our same day discounts.

Patient/Guardian name(print)_____Signature_____.

Date:_____/_____/_____. Relationship to Patient_____.

SURFSIDE Medical Center

Glenn S. Chapman III, DO
Trevor J. Tyner, DO
George A. Christakis, DO

Auto - Assignment of Insurance Benefits, Release & Demand

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I as he named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so 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. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager and mailed to the attention of the **Office Manager.** See Fla. Stat. §673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. **If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Signature: _____ Patient's Name, Please Print: _____ Date: _____
(If patient is a minor, printed name of parent/guardian.)

SURFSIDE Medical Center

Glenn S. Chapman III, DO
Trevor J. Tyner, DO
George A. Christakis, DO

HEALTH CARE PROVIDER'S LIEN

In consideration of the Health Care Providers/Provider agreement to await full payment for health care services provided to me, and for other good and valuable consideration, the receipt and sufficiency of which is acknowledged, I authorize and direct my attorneys, _____ ("Attorneys"), to pay directly to Glenn S. Chapman III, D.O. such sums from any settlement, judgment, or verdict on my claims for injuries sustained on _____ (date) as may be due and owing to Glenn S. Chapman III, D.O. . My attorney shall remit such sums to Glenn S. Chapman III, D.O. within fifteen (15) days of receipt.

This lien applies against any and all proceeds of any settlement, judgment or verdict regarding the Claim that may be paid to my Attorneys, or to me, as the result of the injuries for which I have been treated. This lien covers, but is not limited to, all sums currently owed to Glenn S. Chapman III, D.O. , which may have incurred prior to the date of this lien, and all sums that may be incurred in the future for health care service and costs. I understand and do hereby agree, that in consideration for Glenn S. Chapman III, D.O. waiting for full payment, regardless of any fees charged previously by Glenn S. Chapman III, D.O. and/or fees accepted by Glenn S. Chapman III, D.O. through Medicare, Medicaid, and/or other health insurance, all services in connection with this incident shall be billed at the prevailing rate. This agreement shall in no way obligate Glenn S. Chapman III, D.O. to provide litigation services to me or to my Attorneys in connection with the litigation of my claim. To the extent that such services are provided, this agreement shall not obligate Glenn S. Chapman III, D.O. to await payment for such services are provided but the Provider's fees have not been paid, this lien shall cover such unpaid fees, including without limitation, fees for the preparation of any medical reports, deposition fees, trial fees or for any expert fee which is provided by Glenn S. Chapman III, D.O.

All payments made by my Attorneys pursuant to this agreement shall be the same as if paid by me, but nothing herein relieves me of the primary obligation to pay Glenn S. Chapman III, D.O. for the services rendered. I understand that although Glenn S. Chapman III, D.O. has agreed to await payment for health care services, the payments due Glenn S. Chapman III, D.O. are not contingent on any settlement, judgment, or verdict, and that I shall remain obligated to pay Glenn S. Chapman III, D.O. for any balance owing in the event that I change counsel, terminate litigation on my claim, do not recover on my claim, or recover amounts insufficient to pay Glenn S. Chapman III, D.O. in full. Furthermore, if personal health insurance is billed and payment made by insurance company, they may recoup monies paid as not being informed of litigation and other liability. In any event, any monies recouped by any insurance company after the fact will be 100% the patient's responsibility.

This lien and agreement shall be governed by the laws of the State of Florida.

Patient Signature/Date_____Witness Signature/Date_____.

In consideration of the Provider's agreement to await payment for health care services rendered to _____ (the "Client"), and other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the undersigned attorneys agree to observe and be bound by the above lien and agreements including, without limitation, the agreement to withhold and remit to Glenn S. Chapman III, D.O. the sums from insurance payments and from any settlement, judgment, or verdict recovered on the Client's behalf. The undersigned Attorneys further agree to notify Glenn S. Chapman III, D.O. in writing within fourteen (14) days if the Client changes counsel, terminates litigation on the Claim, does not recover on the Claim, or recovers amounts insufficient to pay Glenn S. Chapman III, D.O. in full.

Attorney Signature:_____ Date:_____

Glenn S. Chapman III, DO
Trevor J. Tyner, DO
George A. Christakis, DO

Date ___/___/_____

NOTICE OF INITIATION OF TREATMENT

Claim number:

Patient name:

Practice/Provider name: Surfside Medical Center
Glenn S Chapman III, DO/Trevor J. Tyner, DO/ George A. Christakis, DO

First date of service:

To Whom It May Concern,

This document shall serve as our formal Notice of Initiation of Treatment pursuant to Florida statute 627.736 (5) (b) (4). This notice is being sent, pursuant to Florida statutes, within 21 days after this facility's first examination or treatment of the above referenced claimant. This notice has been timely provided. Florida law allows statements from this provider to include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement sent.

Patient name (print) Signature (patient/guardian) Date

Sincerely,
Glenn S. Chapman III, DO, AOBNMM, CAQSM, CAQPM, RMSK /Trevor J. Tyner, DO/George A. Christakis, DO

NPI#: 1982648390 / 1013365758
FL Lic#: OS9761 / OS16926

SURFSIDE Medical Center

Glenn S. Chapman III, DO
Trevor J. Tyner, DO
George A. Christakis, DO

Patient name:_____ **DOB:**_____

PAIN MANAGEMENT AGREEMENT:

Pain Management Agreement between _____(patient name) and Dr. Glenn S. Chapman III, D.O.

The purpose of this Agreement is to prevent misunderstandings about certain medicines the patient will be taking for pain management. This is to help both the patient and their provider comply with the law regarding controlled medications. This agreement relates to my use of controlled substance for chronic pain prescribed by a physician at the Surfside Medical Center. I have been informed and understand the policies regarding the use of controlled substance that are followed by the staff at the Surfside Non-Surgical Orthopedics. I understand that I will be provided controlled substance while actively participating in this program only if I adhere to the following conditions:

1. I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to completely eliminate pain but to control my pain in order to improve my ability to function. Chronic Opioid therapy is only ONE part of my overall pain management plan.

2. I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication at the DOSE and **FREQUENCY** prescribed by my provider. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the discontinuation of opioid therapy.

3. I will attend all appointments, treatments and consultations as requested by my providers. I will attend all pain appointments and follow pain management recommendations. I understand that failure to keep appointments may lead to discontinuation of treatment.

4. I will tell my providers about the level and description of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve my pain.

5. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine, and other pain control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize functioning and improve coping with my condition. If treatment for my condition is available, I agree I will not refuse the treatment just so the opioids will be continued. I understand that I have the right to refuse any procedure, but that does not mean that my provider must continue to prescribe narcotic or opioids medications.

6. The risks and benefits of taking opioid medications have been explained to me. I understand them. Opioids can cloud judgments and affect reflexes and motor skills. The patient will not participate in activities that would endanger themselves or others while using these medications.

7. I agree I will not use any illegal controlled substances, including marijuana, cocaine, Heroin, etc. I agree I will not use any prescription medications obtained illegally, or obtain them from friends or relatives.

8. I agree I will not abuse alcohol. If my provider advises, I will not use any alcohol.

9. I agree I will not share, sell or trade my medication with anyone.

10. I agree to protect my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. I will report stolen medication to the police and to my provider and will produce a police report of this event.

11. I agree I will not attempt to obtain any opioid medicines from another doctor or provider without informing the Surfside Medical Center doctor first. I agree to have my opioid prescriptions filled only at_____(Pharmacy).

12. I agree that refills of my prescriptions for pain will be made only at the time of an office visit or during regular office hours. No routine refills will be available during evenings, after 4 pm, or on weekend, holidays, or through the emergency

room. Medications will not be mailed or refilled without being seen at monthly pain clinic appointment (if patient is receiving his opioids from the pain clinic).

13. I am responsible for keeping track of the amount of medications left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications.

14. I agree to bring in all unused pain medicine when requested.

15. I will submit urine for drug testing if requested by my provider to determine my compliance with their program of pain control.

16. I authorize the Surfside Medical Center to cooperate fully with any official, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.

17. I will accept generic brands of my prescription medications.

18. I understand that I may become tolerant to, addicted to or have complications from the opioid medications. If this occurs, the medication may be changed or tapered and other methods of pain control may be used. If necessary, I will permit referral to addiction specialists.

19. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will agree to gradually taper my medication as directed by the prescribing physician.

20. I understand that if I violate any of the above conditions, my provider may choose to stop writing opioids prescribed for me. Discontinuation of the medications will be coordinated by the provider and may require specialist referrals.

21. I understand that if I am verbally or physically abusive to any staff member or engage in any illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities pharmacies and other authorities such as the local police department, drug enforcement Agency, etc. as deemed appropriate for the institution.

22. Understanding that suddenly stopping some pain medicines can cause problems such as: withdrawal symptoms, heart attack, stroke, seizures, permanent damage, disability or death.

All of my questions and concerns regarding treatment have been adequately answered.

Medication Refill information:

1. Advance notice of 5-7 business days is required for all **non-opioids** refills of the prescriptions.

2. Requests for scheduled refills for **non-opioids** must be telephoned to the pharmacy only during regular office hours Monday-Friday (8:30 am – 4:00 pm). Refills will not be made at night, on holidays, or on weekends. Most controlled substance cannot be telephoned in to the pharmacy.

3. I will be given a (30) thirty days supply each month.

4. All hard copies of the opioids prescriptions must be hand delivered to the pharmacy by myself or Eprescribed.

- **This agreement will supersede all other agreements**
- By signing below I indicate that I understand AND agree to ALL the terms of the above agreement. I have received a Copy of this for my own records.

Patient(print)_____ Signature_____

Witness(print)_____ Signature_____

Provider(print)_Glenn S. Chapman III, DO/ Trevor J. Tyner, DO/George A. Christakis DO_ Signature_____

Date_____/_____/_____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

Office visit, Manual therapy, Theraputic exercise, Theraputic ultrasound, Electrical stimulation
Osteopathic manipulation, X-ray, Diagnostic ultrasound, Injections

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Glenn S. Chapman III, DO/Trevor J. Tyner, DO/George A. Christakis, DO Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Glenn S. Chapman III, DO
Trevor J. Tyner, DO
George A. Christakis, DO

SWORN AFFIDAVIT FOR AUTOMOBILE

STATE OF FLORIDA)

) ss.

COUNTY OF PALM BEACH)

BEFORE ME, the undersigned authority, personally appeared the below patient, who after being duly cautioned under oath, deposes and says:

1. My name is _____(Patient's name) and I make this affidavit upon personal knowledge. The below is true and correct.
2. I am a resident of the State of Florida, over the age of 18, and competent.
3. I am a patient of Surfside Medical Center.
4. I was injured in an automobile accident on _____(Date).
5. The treatment I received from this provider was related to my car accident.
6. It was my express intention to assign my PIP benefits to Surfside Medical Center. I signed an assignment of benefits form which is attached as Exhibit "1".
7. On the date of the accident described above my personal injury protection insurance company was _____Automobile Insurance Company, which was in full force and effect.

FURTHER AFFIANT SAYETH NAUGHT:

X_____

PERSONALLY APPEARED before me, the undersigned authority, duly licensed to administer oaths and take acknowledgments, the above patient, who, being by me first duly sworn, deposes and says that he/she has read the foregoing affidavit, and the information contained herein is/are true and correct based on personal knowledge, information and belief.

_____as identification.

SWORN TO AND SUBSCRIBED before me this ____day of _____, 20__ .

Notary Public_____

Glenn S. Chapman III, DO
Trevor J. Tyner, DO
George A. Christakis, DO

NOTICE OF PRIVACY PRACTICES - HIPAA

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Surfside Medical Center ("SMC"), we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule and is effective March 1, 2013. It applies to all PHI as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit SMC; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your health information.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of SMC, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. We maintain an electronic medical record ("EMR"), you have the right to access your EMR in a machine readable electronic format and to direct us to send a machine readable copy directly to a third party. SMC will charge you a reasonable cost-based fee for the cost of supplies and labor of copying.
- Amend your health record which you believe is not correct or complete. SMC is not required to agree to the amendment if SMC did not create the information or if it is correct or complete.
- Obtain an accounting of disclosures of your health information.
- Communications of your health information by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).
- Place a restriction to certain uses and disclosures of your information. In most cases SMC is not required to agree to these additional restrictions, but if SMC does SMC will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by

law). SMC must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Obtain a copy of your health care information in paper or a machine readable electronic format.

Our Responsibilities

SMC is required to:

- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your health information without your written authorization, except as described in this Notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the SMC Privacy Officer at:

Surfside Medical Center.
4600 N. Ocean Blvd
Boynton Beach, FL 33435
Telephone: (561) 330-4300
www.surfsidemedicalcenter.com

If you believe your privacy rights have been violated, you can file a written complaint with SMC Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, SMC operates an EMR. This is an electronic system that keeps health information about you. SMC may also provide a subsequent healthcare provider with health information about you (e.g., copies of various reports) that should assist him or her in treating you in the future. SMC may also disclose health information about you to, and obtain your health information from, electronic health information networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

SMC may use a prescription hub which provides electronic access to your medication history. This will assist SMC health care providers in understanding what other medications may have been prescribed for you by other providers.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to provide services on our behalf and disclose your health information to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail, in person, or by text, in reference to any items that assist SMC in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist SMC in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany the patient into the exam room, it is considered implied consent that a disclosure of the patient medical data is acceptable.

Open treatment areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

To Avert a Serious Threat to Health or Safety: We may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual.

Coroners, Medical Examiners and Funeral Director: In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Fund Raising: We may contact you as part of a fund-raising effort. We may also disclose certain elements of your PHI, such as your name, address, phone number and dates you received treatment or services at SMC, to a business associate or a foundation related to SMC so that they may contact you to raise money for SMC. If you do not wish to receive further fundraising communications, you should follow the instructions written on each communication that informs you how to be removed from any fundraising lists. You will not receive any fundraising communications from us after we receive your request to opt out, unless we have already prepared a communication prior to receiving notice of your election to opt out.

Sale of your PHI: SMC may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.

Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

As Required by Law: We may use or disclose your health information if we are required by law to do so.

Acknowledgment of Receipt of Notice

I acknowledge that I have had the opportunity to review a copy of SMC Notice of Privacy Practices ("Notice"). I understand that I am responsible to read this Notice and notify SMC, in writing, of any request for restrictions in the use or disclosure of my PHI. I understand SMC has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.jaxspine.com. SMC will provide me with a copy of its most recent Notice upon my request.

Please sign and return a copy of this Notice to SMC.

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

Name(s) of others authorized to discuss or request medical information:

Name: _____

Name: _____