BAPTIST HOSPITAL, INC. – CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

1. Medical and Surgical Consent.

   a. I recognize that I have a condition requiring medical care, and I hereby consent to such medical care and treatment and such diagnostic tests at Baptist Hospital, Inc. (the "Hospital"), as the physicians and staff at the Hospital may deem necessary or advisable. I hereby consent to photographs, videos, digital images that may be recorded to document my care, any x-ray examination, laboratory procedures, urine drug screen, blood drug screen, anesthesia, medical, surgical or dental treatment or Hospital services rendered to me under the general and special instructions of the physician/dentist.

   b. I understand that if I am pregnant, my physician may determine that it is necessary to take urine or blood samples to perform drug screens, and I consent to both the taking of the samples and the performance of the screens.

   c. I understand and acknowledge that this facility participates in the education of health care personnel and that students may be involved in the care I receive.

   d. I understand that an explanation of the risks, benefits and alternatives of any medical or surgical procedure performed by my physician will be explained to me by my physician except in an emergency situation.

   e. I UNDERSTAND AND AGREE THAT, AS A PATIENT, MY ATTENDING PHYSICIAN IS DIRECTING MY CARE, AND I RECOGNIZE THAT NONE OF THE PHYSICIANS PROVIDING CARE TO ME INCLUDING, BUT NOT LIMITED TO, EMERGENCY ROOM PHYSICIANS, SURGEONS, RADIOLOGISTS, PATHOLOGISTS AND ANESTHESIOLOGISTS, ARE EMPLOYED BY THE HOSPITAL. PHYSICIANS HAVE PERMISSION TO USE THE HOSPITAL FACILITIES AND MAY TAKE EMERGENCY CALLS FOR THE HOSPITAL BUT ARE INDEPENDENT CONTRACTORS AND NOT AGENTS OR EMPLOYEES OF THE HOSPITAL EVEN THOUGH THEY MAY WEAR GARMENTS OR IDENTIFICATION THAT INCLUDE THE HOSPITAL'S NAME OR LOGO. **I EXPRESSLY AGREE TO RELEASE AND DISCHARGE THE DUTY OF THE HOSPITAL AS TO SERVICES THAT MAY BE PERFORMED BY PHYSICIANS WHO ARE INDEPENDENT CONTRACTORS, BUT NOT EMPLOYEES, OF THE HOSPITAL. I UNDERSTAND THAT BY RELEASING AND DISCHARGING THE HOSPITAL OF ITS DUTY AS TO THESE SERVICES, I AM GIVING UP THE RIGHT TO HOLD THE HOSPITAL LIABLE FOR THE POTENTIAL NEGLIGENCE OF THE PHYSICIANS.**

2. Release of Information. I authorize the Hospital to disclose all or any part of my record, including my medical records, to any person or entity that may be liable to the Hospital or me for all or part of the Hospital's charges, including, but not limited to: a) hospital or medical service companies; b) insurance companies; c) workers' compensation carriers; d) welfare or social services agencies; e) my employer; f) any entity that provides pharmaceutical products or services to the Hospital for my benefit and that offers reimbursement to the Hospital for the provision of those products and services. All such disclosures will be conducted in accordance with applicable laws. I further agree to release the Hospital, its employees, agents and assigns, and representatives from any and all liability arising out of the release of my records pursuant to this paragraph.

3. Consent for Testing and Sharing of Test Results. If, in the course of my medical care, a health care worker is exposed to my blood or other bodily fluids, I give consent for a sample of my blood to be tested for HIV or Hepatitis B antibodies. I understand and acknowledge that the health care worker will be notified of the results for purposes of his or her treatment. I will also be notified of the results.

4. Personal Valuables. I understand the Hospital is not responsible for the safekeeping of my personal belongings such as money, jewelry, dentures, hearing aids, eyeglasses, watches, credit cards, or phones.

5. Assignment of Insurance Benefits. I assign payment of all applicable insurance payments directly to the Hospital and agree that the Hospital may receive any such payment, and I further understand and agree that I will be responsible for charges

6. Medicare-Medicaid Patients Certification. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize the release of all records, including but not limited to medical records. required to act on this request and that payment of authorized benefits be made directly to the Hospital and the physicians involved in my care for any services furnished me by the Hospital and said physicians.

7. Indigent Drug Program. If I qualify and accept assistance, I agree to comply with the policies of the Hospital's drug program for indigents, which may provide me with replacement of certain medications.

8. Patient Information Packet. I acknowledge that I have been offered Hospital's Patient Admission Packet, which includes the notice of patients' rights and the Notice of Privacy Practices.

9. Emergency Care. I understand that if I come to the Hospital's dedicated emergency department seeking care, I will be screened for an emergency medical condition and, if I have an emergency medical condition, the Hospital will provide stabilizing treatment, admit me to the Hospital as an inpatient, or transfer me if medically needed. The screening and the stabilization will be provided **regardless of my ability to pay.** I certify that the Hospital has not withheld, delayed, or conditioned screening or stabilizing care based upon my signing or refusing to sign this paragraph or based upon any payment related concerns.

10. Obligation to Pay My Hospital Bill. I acknowledge that I am financially responsible for my Hospital bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by my health insurance, and I agree to pay them promptly. If my insurance does not pay my claim after reasonable attempts by the Hospital, I may be responsible for paying my entire bill to the Hospital.

11. Financial Assistance. **I understand the Hospital has financial assistance programs available to those individuals who are unable to pay for their care, based upon a determination of financial need.** By signing below, I acknowledge that the Hospital's financial assistance policy is available to me on the Hospital's webpage or, will be made available to me upon request from the person who provided me this form. I understand I may be asked to provide my personal financial information and/or submit to a credit check in order to qualify for the financial assistance program. If I do not qualify for a financial assistance program, I understand that I may be able to enter into a payment plan with the Hospital.

12. Patient Contact. I authorize the Hospital, its service providers (including service providers contacting me about obtaining potential financial assistance for my account(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using prerecorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

_____

Patient or Patient's Representative (if patient is minor or unable to sign) Relationship to Patient Date and Time

_____

Witness

If patient is a minor, the parent must also complete the following:

The undersigned guarantees and agrees to pay to the Hospital on demand for any and all indebtedness of the patient to the Hospital relating to services provided pursuant to this consent form.

_____

Guarantor Date and Time

_____

Guarantor (Print Name)

Revised 6/2019

Andrews Institute Orthopaedics & Sports Medicine

Patient Consent and Responsibility Agreement

Welcome to Baptist Physician Group, LLC ("BPG"). We understand you have many choices when it comes to health care and we are glad you chose our medical group. We look forward to providing you with quality health care that is accessible, comprehensive, team-based, coordinated, and focused on your health and safety. Please review the following patient responsibilities, sign and return.

CONSENT FOR TREATMENT. I consent to all services as ordered or performed by my BPG physician, advanced practice provider, or their assistants and designees. This care may include, but is not limited to, medical examination and treatment, administration of drugs or vaccines, nursing care, laboratory, and x-ray procedures. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me about the results of any treatment.

OBLIGATION TO PAY MY BPG BILL: I understand that all charges for services rendered are due and payable at the time of service. If I have health care insurance, I agree to pay for any deductibles, co-payments and the patient responsibility portion of the fee at the time of service. I acknowledge that I am financially responsible for my provider bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by a third party payor, and I agree to pay the bill promptly.

MEDICAL INSURANCE: I authorize BPG to bill my health plan or other applicable insurer or third party payor and I assign to BPG all of my rights and claims for reimbursement by a third party payor. I authorize BPG to release to all third party payors any medical information that is required in order for BPG to receive payment for its services to me. I will inform my provider of any changes in address or phone number for myself and/or responsible party, present my photo ID and all insurance identification cards upon request. I understand I may be responsible for the entire provider bill if my third party payor refuses to pay after reasonable attempts to collect from the third party payor.

APPOINTMENTS: I agree to bring a list of all medications I am currently taking to each appointment. I agree to check in on time for my appointment. I understand that if I am late for my appointment, I will be rescheduled for the next available appointment time and understand there may not be an appointment available the same day. I agree to notify the office at least 24 hours in advance of my appointment if I find I must cancel my appointment. I understand that failure to notify the office 24 hours in advance may result in a $25.00 missed appointment fee, which cannot be billed to insurance. I understand my patient/physician relationship may be terminated if I miss more than three appointments.

AUTHORIZATIONS AND REFERRALS: I understand that I am responsible for notifying the practice if my third party payor requires pre-authorizations for tests or for referrals to specialists. I understand the BPG office staff may assist me with scheduling referrals or diagnostic testing, but failure to obtain necessary authorizations before the scheduled appointment may result in the visit/test needing to be rescheduled and/or charges being billed directly to me.

FINANCIAL ASSISTANCE: I understand there are financial assistance programs available for patients who are unable to pay for their care based upon a determination of financial need in accordance with Baptist Health Care's Financial Assistance Policy. I understand it is my responsibility to contact a Patient Account Specialist at BPG's business office at (850) 469-2000 to request financial assistance or access the policy and application at https://ebaptisthealthcare.org/PatientFinancialResources. I agree to provide my personal financial information and/or submit to a credit check to determine if I qualify for financial assistance. If I do not qualify for financial assistance and do not have insurance third party payor, I understand and agree that I will pay in full for all services at the time of service. If I do not have insurance, I may be eligible for a discount when full payment is made at time of service.

RETURN CHECK POLICY: I understand I will be responsible for all service charges and collection fees associated with collecting any bad check I write, and will pay these fees upon notice.

BUSINESS HOURS: I understand unusual circumstances will sometimes require the office hours to be changed without notice. I understand the pre-recorded telephone message will let me know when to call back for routine requests and what to do in case of an urgent medical need (one that does not require emergency treatment). I understand that I should call 911 in the event of a medical emergency or proceed to the closest emergency room for treatment.

PRESCRIPTIONS AND/OR REFILLS: I understand that requests for new medication and/or refills should be made during my visit with my provider. If I need a prescription refill between visits, I agree to contact the practice or my pharmacy and allow 48 to 72 business hours to process. I understand refill requests will only be processed during office hours. I understand that narcotic prescriptions are highly regulated and may require a signed narcotics agreement between me and my provider.

PATIENT FORMS COMPLETION: I understand that an office visit may be necessary if I request the provider complete certain forms for me. There may also be a nominal fee, payable in advance, for the completion of these forms. I understand these requests may take up to 14 days for processing.

PATIENT PORTAL: I understand this practice may have a patient portal to offer me a secure online website for convenient 24-hour access to my personal health information. This is an optional program using a secure username and password. Recent doctor visit notes, medications, contact information and health records can be viewed and printed. The office staff can provide more information regarding the patient portal which may be accessed at: https://ebaptisthealthcare.org/PatientPortal.

WIRELESS COMMUNICATION: By providing a wireless or mobile telephone number, I give permission to my provider to use this number for contact. Contact includes receiving calls and messages, including pre-recorded messages and calls via an automatic telephone dialer from the practice and its authorized agents.

NOTICE OF PRIVACY PRACTICES: I understand that Baptist Health Care's Notice of Privacy Practices provides information about how my health information may be used and disclosed. I have been offered and (if requested by me) received a copy of the Notice of Privacy Practices.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND CONSENT TO TREATMENT BY BPG AND I AGREE TO ABIDE BY THE ABOVE PATIENT RESPONSIBILITIES.

Patient/Personal Representative Signature	**Date**
Print Patient/Personal Representative Name	**Personal Representative's relationship to patient:**

Dear New Patient,

Welcome! Thank you for the opportunity to assist you with your orthopaedic problem. The following information will help you prepare for your visit with Dr. Brothers.

Please bring all past medical records and any study results related to your current problem to your first visit. If you have had X-rays, MRI, CT scan, or other imaging, we need both a report and a disc with the images. You can obtain these from the facility where you had them done, or have them forwarded to our office prior to your appointment. (Imaging within the past 6 months only) Or our office will order you new x-rays prior to your appointment.

If you cannot make your appointment, please notify our office.

If you need language translation or interpreter assistance, please notify us in advance so we can make arrangements.

Please complete the enclosed new patient papervvork prior to your first appointment. You may return it via email or fax (850) 939-4675, or present it at check in. Please bring your current insurance card and driver's license to your first appointment.

We appreciate the opportunity to provide you with orthopaedic care as well as your cooperation in following the above guidelines.

Should you have any questions, please do not hesitate to call our office at (850) 939-4672.
We look forward to treating your orthopaedic needs.

Sincerely,

Dr. Anthony J. Brothers and his "awesome" staff

Patient name: _____

Anthony J. Brothers, M.D. / Orthopaedic Surgeon
Baptist Medical Park – Navarre (MOB)
8880 Navarre Pkwy., Suite 201 / Navarre, FL 32566
P 850.939.4672 / F 850.939.4675

NAME: _____ DOB:_____ DOS:_____TIME_____

INSURANCE:_____ REFERRAL FROM:_____

CHIEF COMPLAINT : _____

VITALS: HT: WT: BMI: BP: / P: T:

HISTORY:

PAIN LEVEL: _____/10

SHOULDER: RT LT BILATERAL
INSPECTION/PALPATION:
TTP _____
PROM /AROM:
IR _____/_____
ER _____/_____
ABD _____/_____
FLEX _____/_____

RC TESTING:
SUPRA____/5, INFRA_____/5, SUBSCAP_____/5 , T. MINOR____/5

NEER HAWKINS CROSSOVER SPEEDS O'BRIENS
EMPTY CAN BELLY PRESS
RELOCATION ANT APPR POST APPR

KNEE: RT LT BILATERAL
ATROPHY CREPITUS
GAIT: _____
EFFUSION: NONE / MILD / MOD
MED/LAT JOINT LINE TENDERNESS
AROM: FLEX _____ EXT _____

PATELLA (APPREHENSION / GRIND) MCMURRAY
VARUS / VALGUS STRESS
ANT DRAWER / LACHMAN POST DRAWER

IMAGING: PACS_____

KNEE 2V 3V 4V
VARUS/VALGUS

OUTSIDE_____ _____

SHOULDER
ACROMION: I II III

IMPRESSION/DX:

OTHER:

PLAN:
MRI / MRA / CT / BONESCAN
DME
US CSI / LUBRICANT
PT / OT
SAMPLES/ RX OF _____
SURGERY:
REFERRAL TO: _____

NOTES: Last CSI/MU ____/_____/_____

FRACTURE CARE: / /

Patient Demographics:

Patient Name: _____ _____

First MI Last Preferred Name

SSN#: _____ Birth Date: _____ Sex: Male Female

Address: _____ _____ _____ _____

Street Address City State Zip Code

Home #: _____ Cell #:_____ Work #: _____

Marital Status: Married Single Divorced Widowed

Race: African American Asian White Hispanic Other

Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Email Address: _____

How were you referred to our practice? (Circle)

Friend/Relative: _____ Physician Newspaper Radio Healthsource

Guardian Information: (If Patient is a Minor)

Name: _____ Relationship to Patient: _____

SSN#: _____ Birth date: _____ Sex: Male Female

Address: _____ _____ _____ _____

Street Address City State Zip Code

Home #: _____ Cell #: _____ Work: _____

Payment Information:

Form of Payment: Health Insurance Auto Insurance Worker's Compensation Self Pay

Primary Insurance

Primary Insurance Company: _____ Insured's Name _____

Policy #: _____ Group #: _____ Insured's Date of Birth: _____

Secondary Insurance

Secondary Insurance Company: _____ Insured's Name _____

Policy #: _____ Group #: _____ Insured's Date of Birth: _____

Self-Pay Agreement

I agree to pay for medical services rendered at Andrews Orthopaedic and Sports Medicine facilities. I understand that there are payment plans available at my request.

X _____ Date: _____

Release of Information: I authorize Andrews Orthopedic and Sports Medicine Center to release medical information requested by my health insurance, Medicare, or third- party payers in order to assist in the payment of claims.

X _____ Date: _____

Medical History: **Height: _____** **Weight: _____**

Check if you have had any of these **medical problems** in the PAST:

MAJOR ILLNESS	YES	NO	**MAJOR ILLNESS**	YES	NO
Anemia			Immune Deficiency		
Arthritis: Type _____			Liver Disease		
Heart Arrhythmia			Kidney Disease		
Asthma			MRSA (resistant staph)		
Bleeding Problems			Neuropathy		
Cancer: Type _____			Paralysis		
Chest Pain/ Angina			Peripheral Vascular Disease		
Deep Vein Thrombosis			Psychiatric Illness: Type _____		
Diabetes			Pulmonary Embolism		
Gall Bladder Disease			Reflux		
Gastric Ulcers			Skin Ulcer/ Breakdown		
Glaucoma			Steroid Use		
Gout			Stroke		
Heart Attack			Thyroid Disease		
Heart Failure			Tuberculosis- TB		
Heart Murmur			Urinary Infections		
Hepatitis B			Valve Disorders (heart)		
Hepatitis C			Wound Healing Problems		
High Blood Pressure			OTHER: _____		
HIV/AIDS					

Please list any **operations/surgeries** you have had:

SURGERY/ REASON	**YEAR**	**SURGERY/REASON**	**YEAR**
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any **Medication** that you are currently taking:

MEDICATION	**DOSE**	**DOCTOR**	**MEDICATION**	**DOSE**	**DOCTOR**
1)			5)		
2)			6)		
3)			7)		
4)			8)		
5)			10)		

Do you have any **allergies** to medications/substances? Yes No

Pharmacy name and location:

Family Medical History- Please list major illnesses that affect immediate family:

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Social History:

Alcohol use: Yes No Drinks per week: _____

Cigarette use: Yes No Packs per day: _____ Years_____

Smokeless tobacco use: Yes No Years: _____

Illicit Drugs: Yes No Type: _____

Review of Symptoms- Please mark any of the symptoms that apply to you TODAY:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/ Easy Bruising		
Shortness of Breath			Cuts that don't stop bleeding		
Rash			Anxiety		
Wound Healing Problem			Depression		
Fever/Chills			Other:		

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

Notice of Privacy Practices: I am aware that Andrews Orthopaedic and Sports Medicine Center has a "Notice of Privacy Practices" in accordance with Baptist Health Care's privacy policies. I understand that a copy is available to me and I agree with these policies.

X_____ Date: _____