BocaCare | Boca Raton Regional Hospital
PHYSICIAN NETWORK

Authorization to Discuss Protected Health Information (HIPAA)

I _____, authorize the office of

Justin M Weatherall, MD and James R Ross, MD to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information to the following named person(s):

DO NOT list physicians, they are already included under HIPAA law

1. _____(relationship)_____
2. _____(relationship)_____
3. _____(relationship)_____
4. _____(relationship)_____

- **BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.**
- **YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE (In this case write "none" on line 1)**

Please list phone numbers where we are allowed to contact you for:
Our office will remind you of your appointment via text message and/or phone call.

- Lab results, MRI's, ultrasounds, scans, any changes of scheduled appointments, etc.

Cell #: _____

Home #: _____

Work #: _____

_____ _____/_____/_____
Patient or Guardian Signature Date

3313 W. Hillsboro Blvd Deerfield Beach Florida 33442 Phone: 954-571-9500 Fax: 954-571-9560
www.southfloridafootandankle.com

BocaCare™ | BOCA RATON REGIONAL HOSPITAL
PHYSICIAN NETWORK

Dear Patient:

We ask that you read and sign below because it concerns all of us. Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company regarding your coverage. **It is your responsibility to know your individual coverage.** Failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company, not between your doctor and your insurance company.

It is our office policy to collect co-pays, co-insurance and deductibles at time of service and prior to any surgical procedures. **PLEASE NOTE:** Any fees paid to our practice is for our surgical fees only! You are responsible for any additional facility fees, hospital fees, lab tests, anesthesiology fees, etc. We neither collect these fees nor can estimate what they will be. We are not associated with the billing departments of any hospital, outpatient center or other physician's office. If you receive a statement from them, please contact them directly in order to settle your account.

To assist you in finding out what coverage you have, feel free to ask for assistance in finding phone numbers or addresses of your insurance company. Many insurance companies today need referral forms from a primary care physician or group. If your insurance meets this requirement, it will be your responsibility to furnish this referral at time of service. Failure to do so may require you to reschedule your appointment. Some insurance companies state that you cannot go out of network. Many companies have instituted a mandatory second opinion program, and these are constantly changing day by day. It is impossible to keep up with the changes, and often we are not aware of them until it is too late.

I hereby assign, transfer, and set over to Justin M Weatherall, MD and James R Ross, MD , and all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This is a lifetime authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. If I fail to pay my charges, I agree to pay the cost of collection, including reasonable attorney fees. There will be a $25 fee assessed for checks returned by the bank for any reason. I authorize Justin M Weatherall, MD and James R Ross, MD , to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100 percent of my benefits, within ninety (90) days of any and all appeals or request for information. I also agree that any fines levied against my insurance company will be paid to Justin M Weatherall, MD and James R Ross, MD for acting as my personal representative.

I authorize release of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

I give consent to Justin M Weatherall, MD and James R Ross, MD to view my medication history.

Patient's Signature _____ Date _____
(If minor, parent to sign)

In the event of any litigation arising from the care of Justin M Weatherall, MD and James R Ross, MD and/or staff ("The Practice"), including but not limited to allegations of medical malpractice or unpaid bills/claims, "The Practice" shall be entitled to recover all reasonable costs incurred, from the non-prevailing entity/party, if "The Practice" is the prevailing entity/party (of the litigation). These costs include staff time, court costs, attorney fees, expert fees, and all other related expenses incurred in such a litigation. In the event of a non-adjudicative settlement of litigation between the parties or a resolution of a dispute by arbitration, the term "prevailing entity/party" shall be determined by that process.

Patient's Signature _____ Date _____
(If minor, parent to sign)

***Please sign BOTH signature lines above**

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