Miami
INSTITUTE
For Joint Reconstruction

Arturo Corces, M.D. – Orthopaedic Surgery Director, Joint Reconstructive Surgery, Implant Service.

David Font-Rodriguez, M.D. – Shoulder & Elbow Surgery, Orthopaedic Surgery Director (Shoulder Service).

Mauricio F. Herrera, M.D. – Sports Medicine, Arthroscopic Surgery.

Amar Rajadhyaksha, M.D. – Adult & Pediatric Spine Surgery.

Liam McCarthy, M.D. – Pain Management.

Gary Goykhman, D.P.M. – Podiatry.

Alejandro E. Pino, M.D. – Orthopaedia Surgery, Foot and Ankle Surgery.

OPEN DOOR POLICY

Due to the nature of the practice, the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION, has an open door policy.

Treatment areas are kept open and examining rooms doors may be kept open. If you have any questions or objections to this policy, please inform the physician or the designated health care provider.

APPOINTMENT REMINDERS

I acknowledge that this practice/facility may call for appointment reminders and/or cancellations. **If unable to keep appointment, kindly give 24 hrs. notices or a $25.00 fee will be charged.**

I authorize the use or disclosure medical information to contact you as a reminder. This contact may be by phone, in writing, e-mail, or otherwise and may involve leaving a message on an answering machine or any other device available. If you have any questions and/or objections to this policy, please inform us.

CONSENT TO PHOTOGRAPH

I authorize the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION, and its affiliates to take pictures of my (or my child's) medical or surgical procedure(s) and condition (s) and to use the pictures for treatment, scientific, educational or research purposes.

PERSONAL VALUABLES

I acknowledge that this practice/facility does not accept responsibility for any personal property. I accept the risk of loss or damage to any of my personal property.

RELATIONSHIP BETWEEN FACILITY AND PHYSICIAN

I understand and acknowledge the relationship between the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION and that of the physicians and surgeons, own and operated this facility.

USE AND DISCLOURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as a part of my health care; MIAMI INSTITUTE FOR JOINT RECONSTRUCTION originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results; diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,

- A means of communication among the many health professionals who contribute to my care,

- A source of information for applying my diagnosis and surgical information to my bill,

-A means by which a third-party payer can verify that services billed were actually provided,

- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I am giving my consent for the use and disclosure of Protect Health Information as required and/or permitted by law.

I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent or revoking this consent, the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

CONSENT AND ACKNOWLEDGEMENT FORM ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment Medicare, Medicaid or other insurance benefits otherwise payable to me for medical service rendered to me or my child directly to MIAMI INSTITUTE FOR JOINT RECONSTRUCTION. These benefits are not limited to individual Policies, Group Polices, Workers Compensation, Liability, PIP or any other policy that may cover healthcare benefits.

Where MEDICARE/MEDICAID BENEFITS are applicable, I certify that the information given by me in applying for payment under Title XVII or XIV of the Social Security Act is correct, and request that these payments of authorized benefits be made direct

ly to MIAMI INSTITUTE FOR JOINT RECONSTRUCTION on my behalf.

THIRD PARTY BENEFIT COLLECTIONS

I authorize MIAMI INSTITUTE FOR JOINT RECONSTRUCTION, to act in my behalf as attorney in fact in the collection of benefits from any responsible third-party payer through whatever means may be deemed

necessary, and the endorsement of benefit checks made payable to me and/or MIAMI INSTITUTE FOR JOINT RECONSTRUCTION or any of its providers.

RELEASE OF INFORMATION

I authorize the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION to release copies of information in their possession, as acquired in the course of me or my child's examination and/ or treatment, to my insurance carriers in connection with my treatment for the purpose of any insurance, Medicare and Medicaid payments:

- This facility and its affiliates
- Utilization review agencies or auditors
- Physician (Attending and Consulting)
- Other allied health professionals

USE OF INFORMATION

I authorized the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION, and its affiliates and authorized agents to use the information acquired in the course of me or my child (s) examination and treatment to provide me with information about the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION and its affiliates and other matters that may be of interest to me regarding me or my child's health care.

GUARANTEE OF PAYMENTS

I hereby understand that I am financially responsible for payment to MIAMI INSTITUTE FOR JOINT RECONSTRUCTION, for any charges not covered or allowed by my insurance company, and all deductibles, co-insurance, co-payments, and for any balances remaining after payments have been made by my insurance company. This includes any denial of payments due to lack of medical necessity or pre-qualification/authorization, lack of affiliation with a HMO or any other constraint in posed as a condition of my insurance coverage. I further understand and agree that if this account is placed for collections, I will be responsible for paying the balance owed to the physician plus the cost of collection fees, and/or including reasonable attorney fees if/when applicable.

I further acknowledge that I have read and reviewed the FINANCIAL POLICIES OF THE MIAMI INSTITUTE FOR JOINT RECONSTRUCTION.

CONSENT TO TREATMENT

I consent to all medical and surgical procedures and treatment, including but not limited to surgery, medical treatment, radiological examination, anesthesia, laboratory procedures, and medications that may be performed, administered or rendered by or under specific or general instructions of my physician.

I hereby voluntarily consent to rendering of medical treatment by MIAMI INSTITUTE FOR JOINT RECONSTRUCTION and/or the medical staff, which may include routine diagnostic and/or surgical procedures, x-rays, administration of injections, therapy and/or any other such medical treatment deemed necessary for the treatment and improvement of the patient's condition.

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Patient signature **Date**