ORTHOPÆDIC ASSOCIATES OF SOUTH BROWARD, P.A.

(954) 961-3500 Fax: (954) 961-1835

RICHARD E. STRAIN, JR., M.D., F.A.C.S.
WARREN GROSSMAN, M.D., F.A.C.S.
STEVEN D. STEINLAUF, M.D.

Diplomates of the American Board of Orthopaedic Surgery

1 S.W. 129th Avenue, Suite #401
Pembroke Pines, Florida 33028

1150 N. 35th Avenue, Suite #390
Hollywood, Florida 33021

CONSENT FOR MEDICAL CARE: I authorize the patient's doctors to determine what kind of treatment must be done to learn more about the patient's condition. Further, I authorize the personnel of Orthopaedic Associates of South Broward, P.A. to give treatment which I may receive. I understand that medicine is not an exact science and acknowledge that no guarantee or assurance has been made as to the result of treatment, tests, or examinations.

RELEASE OF INFORMATION: I hereby authorize Orthopaedic Associates of South Broward, P.A. to disclose all or part of my records to any person or corporation which is required to pay for all or part of the physician's charge.

ASSIGNMENT OF BENEFITS: I hereby irrevocably assign payment to Orthopaedic Associates of South Broward, P.A., accepting this assignment of all medical benefits applicable and otherwise payable to me. I certify that the information given to me in applying for payment is correct and request that said payment of authorized benefits are made on my behalf. I understand that I am financially responsible for the charges for which the carrier denies payment.

PAYMENT: I understand that it is my responsibility to obtain any needed authorization for treatment according to my individual insurance policy. In the event that I fail to do so I agree to pay any and all fees / costs incurred by Orthopaedic Assocaites of South Broward, P.A. to enforce this agreement, including but not limited to collection costs, interest / service charges, court costs, and attorney's fees.

____
Print Patient Name: Last, First, Middle Initial

____
Patient's Signature

____
Date

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Policy and Procedure for Narcotic Pain Medications

The policy of this office is not to prescribe any narcotic pain medications after normal business hours (9:00 a.m. to 5:00 Monday through Friday). We will attempt to fill appropriate medication request in a timely fashion; however, the office requires at least 48-hours notice to prepare your prescriptions. Therefore, please plan ahead. In addition, any patient who knowingly obtains narcotic pain medications from other treating physicians while under the care of Drs. Strain, Grossman, Steinlauf, Chan, or Calvo without this office's knowledge may lead to dismissal from this practice. It should be noted that this is illegal and will not be tolerated.

I have read the above policy and agree to adhere to the conditions set forth.

____

Printed Name and Date Patient Signature

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, ___________________________________, have received the Notice of Privacy Practices from Orthopaedic Associates of South Broward, P.A.

____ Date _________________
Patient Signature

In lieu of patient signature, I, ___________________________________, a staff member of Orthopaedic Associates of South Broward, P.A., state that __________________________ has been given our current Notice of Privacy Practices

____ Date _________________
Staff Signature

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign this form (Initials _____)
- ❑ Communication barriers prohibited obtaining the acknowledgement (Initials _____)
- ❑ An emergency situation prevented us from obtaining the acknowledgement (Initials _____)
- ❑ Other ____(Initials _____)

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This letter is to inform all patients of Orthopaedic Associates of South Broward that Dr. Steven Steinlauf and Dr. Richard Strain do participate in a residency training program
through the University of Miami. During the course of residency training, the residents are expected to participate in all aspects of patient care. This will include evaluations in the office and in the hospital, as well as assisting Dr. Steinlauf or Dr. Strain in their surgical procedures.
Considering this, if you agree and give informed consent for the residents to participate in your care, please sign below.

We sincerely thank you for helping further the education of our future generation of orthopaedic surgeons.

____

Printed Name and Date   Patient Signature