PHYSICAL MEDICINE OF SOUTH FLORIDA

Daniel Ettedgui, DO, FAAPMR
Medical Director
Flori McGinty
Administrator

7284 West Palmetto Park Road, Suite 105S
Boca Raton, FL 33433-3406
Phone (561) 912-9580
Fax (561) 912-9506

Welcome to Physical Medicine of South Florida

We would like to welcome you to Physical Medicine of South Florida, and express our appreciation that you have chosen our practice to provide your PM&R needs. Enclosed please find our New Patient Packet forms. These need to be completed and brought with you on the day of your appointment. **Please also have your picture ID and insurance card available so that we may make a copy for your chart.**

Appointments

It is our goal to provide you with high quality, convenient medical care by a caring staff in a modern facility. At check out, we will schedule your next routine appointment. We are a specialty practice. **Generally speaking, it may be difficult to get an urgent, same day appointment with Dr. Ettedgui.** If you have a medical problem which you believe requires "same day" attention, we encourage you to call as early as possible during our business hours to schedule an appointment. If we do not have an available appointment time for you, we will place you on a cancellation list and will call you as soon as an appointment is available. **We do not accept unscheduled walk-in visits** and you will be asked to schedule your appointment on another day.

Our office hours are:

- Monday -Thursday: 9:00 AM-4:30 PM
- Friday: 9:00 AM-3:30 PM (Administrative day-no patient appointments)
- The office is closed for lunch each day from 12:30 PM-1:30 PM
- Our voicemail is available 24 hours a day, 7 days a week. Calls are checked hourly.

Cancellation of Appointments

We ask that you provide at least 24 hours advance notice to cancel an appointment so that we may schedule another person requiring care. A cancellation fee may be charged for cancellations without 24 hours advance notice. Please refer to our financial policy regarding these fees.

Referrals

Appointment referrals are ultimately the responsibility of the patient. We will fax a request to your primary care physician, and you will be notified if current authorizations have expired. If you have an HMO insurance plan which requires a referral, **you need to call the office to check on the status of your referral 3-5 days prior to your appointment.** If a required authorization is not received prior to your next scheduled appointment, the appointment **will be cancelled.**

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Prescription Refills

For routine prescription issues, you should call and speak to our front desk staff and they will route the request to the proper individual. **We require 24 hours to respond to prescription inquiries, although most issues are resolved quickly.** The State of Florida has stringent laws and regulations regarding prescriptions. Prescriptions will be refilled at your scheduled visit, and cannot be refilled without an appointment. Prescriptions for medications which are lost or stolen **will not be replaced. Prior authorizations required by your insurance company can take 5-7 days to receive a response.** All prior authorizations are processed within 24 hours of receipt.

Telephone Calls

Should you have a question and need to speak with the nurse, we are available to answer phone messages during those office hours when we are not actively providing direct patient care. This is usually at the end of the day. The nurse may need to discuss the matter with the physician before returning your call. Considerable effort is made to respond to phone messages within 24 hours of their receipt, however, with a busy office schedule, our telephone time is limited. **It is preferable that the evaluation and treatment of medical problems be conducted during a scheduled office visit or a telehealth visit with your physician where you can receive adequate care and attention.**

We thank you for allowing us to participate in your health care and hope the above information will assist you in obtaining prompt and convenient medical care.

Insurance Changes

It is your responsibility to notify us if your insurance coverage changes so that we may bill your claims correctly. If you do not disclose updated insurance information and the claim is denied, you will be personally responsible for the denied charges.

Sincerely,

The Staff of Physical Medicine of South Florida

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Financial Policy

Physical Medicine of South Florida is committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration, in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill. In order to achieve our goal of providing you with the best care possible, we need your assistance and your understanding of our financial policy.

Payment in full is due at the time services are rendered. As a courtesy to our patients, we accept cash, personal check, money order, Visa, MasterCard, Discover, and American Express.

Insurance Co-Pay, Co Insurance, Deductible

Please be aware that there may be costs that are your responsibility assigned by your health insurance carrier.

- Deductible: Amount patient must pay each year for covered services before insurance benefits are applied.
- Co Pay: Set dollar amount that you pay at each visit for services. **Payment of your Co-Pay is required at the time of service.**
- Co Insurance: Your share of the cost of a covered service, usually calculated as a percentage of the allowed amount for a covered service.

"In Network" vs. "Out of Network" insurance:

- Please remember that your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company. We urge you to check with your company regarding coverage. It is your responsibility to know your individual coverage. Failure to comply could result in your being responsible for costs incurred.
- We are happy to assist you in identifying coverage for services. Feel free to ask us for assistance regarding your insurance company's address, phone or fax number, or specific descriptions and codes for services to be rendered.
- If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a *self pay* patient.
- If our office does not participate with your insurance plan, you will be responsible for payment at the time services are rendered.

Things to bring with you to EACH appointment:

- Health Insurance Card(s)
- Drivers License
- Method of Payment

Appointments:

- Please arrive for your appointment 10 minutes early.

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- If more than 15 minutes late for your appointment, you will be marked as a *No Show* and will need to reschedule your appointment.
- Many managed care plans require a referral from your primary care physician (PCP) prior to services being rendered. It is your responsibility to verify that the physician is currently under contract with your insurance plan and that you have obtained all necessary referrals **BEFORE** your scheduled appointment. (Failure to confirm this may result in your responsibility for any and all charges.) Appointments may be rescheduled at the discretion of the practice if necessary prior authorization or referrals have not been obtained in advance.
- Please inform the receptionist of any demographic changes (phone number, address, insurance information, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier.

Missed or cancelled appointments and other fees:

- If you are more than 15 minutes late for an appointment, you will be marked as a *No Show*. Three *No Shows* may result in dismissal from the practice.
- 24 hours notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a $25 *No Show* fee for regularly scheduled appointments. Appointments for procedures require longer appointment slots. All appointments for procedures which are cancelled without 24 hours prior notice will be charged a $75 cancellation fee, *no exceptions.*
- There will be a fee of $30 for any returned checks to our office.

Payments due:

- Co-pays and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are due during the check-out process.
- If you receive more than one type of service on the same day, you may be responsible for more than one co-pay.
- Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service.
- Any outstanding balance may incur a $10 monthly statement processing fee, in addition to the initial balance.
- All balances are due prior to any further service provided by our office.
- If a check is returned due to insufficient funds, we reserve the right to refuse to accept further checks for payment, and you will be charged an NSF fee for the returned check as allowed by law.
- Failure to pay balances may result in discharge from the practice.

Self-Pay patients:

- We offer a reasonable discount for our cash paying patients. We will give you an estimate of what will be due at the time of service and payment for services is due at the time of service. Please feel free to ask our front desk for a copy of our office policy.
- You may be asked to sign a waiver stating that you have no health insurance and will not be filing with any health insurance carriers. Failure to sign this waiver may result in cancellation of your appointment.

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Medicare patients:

- Please make sure you have a full understanding of your benefits and what might be your responsibility if not covered by your insurance plan.
- Medicare requires that we provide patients with a written notification whenever it is likely that you will be responsible for a bill.
- Medicare advantage plans are private fee for service (PFFS) products that are marketed as an option in place of traditional Medicare and frequently provide additional benefits. We are willing to treat PFFS patients. Co-payments will be due at the time of service. Please keep in mind that in most instances, we do not have a contract with PFFS carriers. If we have problems with claims processing, then we will have no choice but to discontinue future treatment.

Forms:

- All requests for forms to be filled out incur a $25 charge, with the exception of Social Security Disability Forms.

Minor patients:

- The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor as well as the payment in full for services provided.
- Parent(s) or guardian(s) must have an Authorization for Medical Treatment form signed each time a minor arrives unaccompanied for an appointment.
- In compliance with HIPAA regulations, we are unable to discuss any details of services rendered or to produce an itemized bill for any parties that are not the patient, unless otherwise documented.
- Both parents/legal guardian(s) are responsible for payment for services rendered to the minor patient. A copy of this financial policy and all statements will be provided to each parent if living in separate residences.

Auto accidents/workers' compensation:

- Motor Vehicle Accidents (MVAs) will be filed to your auto insurance as a courtesy to you. Failure to receive payment within 30 days of the date of service may result in your responsibility to pay.
- Our office will send appropriate workers' compensation claim forms for services rendered on your behalf as a courtesy. If a claim is denied, we will expect payment in full from you within 30 days of receipt of our bill (a good faith deposit of 25% is required for a longer term of repayment).

Lab/hospital charges:

- Any service(s) provided by a lab or hospital is a contract between you and that lab or hospital. Any dispute with that lab or hospital should be handled with that lab or hospital and is not the responsibility of our practice. We will be happy to provide contact information to assist you in contacting the appropriate entities.
- It is your responsibility to know which procedures your insurance will and will not cover at these facilities and to request an Explanation of Benefits (EOB) from your insurance carrier.

Procedures:

- Some procedures are deemed as non-covered under your particular plan. All charges for non-covered services will be your responsibility.

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Collections and outstanding balances:

- Any outstanding balance after 60 days of the date of service may be referred to an outside collection agency. Accounts referred to an outside collection agency shall be liable for all fees and commissions charged by the agency, which shall be in addition to the total outstanding amount owed by the Customer. Fees will be added to the total balance due at the time of write-off.
- Patients with unpaid delinquent accounts or accounts which have been sent to collections may be discharged from our practice.

Payment plans:

- Our office will be happy to work with you in order to pay any balance due to our practice.
- Please contact our billing department to work out a payment plan with our practice.
- Please allow 5 mail days prior to each due date for each payment to be received by our practice.
- Please mail all payments to our office:

  Physical Medicine of South Florida
  7284 West Palmetto Park Road, Ste 105S
  Boca Raton, FL 33433
- Or pay by credit card over the phone: 561-912-9580, X 7001

Refunds:

- Refunds are issued to the appropriate party.
- Patient refunds will not be processed until all active or past due charges are paid in full.
- Refunds less than $5.00 will not be issued, unless requested, and will credit to your account at our practice.

Please call your insurance company to learn about your coverage, should you have questions or concerns. Doing so will pave the way for a positive doctor to patient relationship and will confirm treatment options available. We ask that you read and sign this document to confirm your understanding of the financial policy of Physical Medicine of South Florida.

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AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I authorize payment of medical benefits to Daniel Ettedgui, D.O., PA for services rendered. I verify that the information I have reported is correct. I further authorize release of my complete medical record as requested to insurance carrier(s), consulting/treating physicians, hospitals, attorneys or any other parties deemed reasonable and necessary by Dr. Ettedgui and his staff. I understand that all topics discussed during my treatment are documented and therefore will be released. I permit a copy of this authorization to be used in place of the original. I acknowledge that I am financially responsible for all charges incurred. **Should these charges become delinquent, I will be responsible for all cost of collection, including court costs, attorney's fee and interest.**

I have read and understand the practice's financial policy and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

MEDICARE LIFETIME AUTHORIZATION:

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I assign the benefits payable for physician services. I understand that I am responsible for my health insurance deductible and coinsurance.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Print Patient Name

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES RECEIPT
HIPAA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____ **Date of birth:**_____

Purpose of consent: This consent form allows Physical Medicine of South Florida to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Notice of Privacy Practices: Physical Medicine of South Florida has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. The notice was provided prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Physical Medicine of South Florida. **Please read and initial the following statements**:

_____ I hereby authorize that Physical Medicine of South Florida may leave voicemail or text messages to confirm appointments, and/or may speak to other members of my household and leave messages regarding my appointments.

_____ I hereby authorize that Physical Medicine of South Florida may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my healthcare provider.

_____ I hereby authorize that Physical Medicine of South Florida may disclose my personal health information to the person I have listed as an emergency contact.

_____ I hereby authorize that Physical Medicine of South Florida may disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

Patient information: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that Physical Medicine of South Florida has the right to refuse me services if I refuse to sign this consent or if I revoke this consent.

This authorization shall be in effect until revoked by the patient. My signature confirms that I have received the Notice of Privacy Practices.

Patient Signature: _____Date: _____

For Use by Privacy Officer Only:

Practice: _____ Accepts _____ Denies

Privacy Office Signature: _____ *Date:* _____

Controlled Substance Contract for Treatment of Chronic Nonmalignant Pain
Physical Medicine of South Florida
7284 West Palmetto Park Road, Suite 105S • Boca Raton, Florida 33433
Daniel Ettedgui D.O.
Medical Director

Controlled substance medications (narcotics, tranquilizers and barbiturates) are very useful, but have a high potential for misuse and abuse. Therefore, local, state and federal government closely controls them. These medications are given to assist pain tolerance, and to improve function and/or the ability to work. Because Dr. Ettedgui is prescribing such medication to help you manage your pain or anxiety, you agree to the following conditions:

1. **I am responsible for my controlled substance medications.** If the prescription or medication is **lost**, **misplaced** or **stolen,** or **if I use it sooner than prescribed**, I understand that it will not be replaced. Refills of controlled substance medication will be made only at the time of an office visit.

2. **I will not request or accept controlled substances or anxiety medications from any other physician or individual** while I am receiving such medication from Dr. Ettedgui. If I am treated with controlled substance medication in an emergency room, urgent care, or hospital it is my responsibility to advise Dr. Ettedgui at my office visit or before my next prescription refill.

3. **I will cooperate in doing urine toxicologies when requested.** I understand this screening is done on a random basis, and prescriptions will not be issued unless a sample is provided. Failure to provide a sample will be documented as non-compliance. Any lab fees related to toxicologies are patient responsibility.

4. **I will not use any illegal controlled substances, drink alcohol, share, sell, or trade my medication with anyone.** I understand this may result in being discharged from the practice.

5. **I understand that if I fraudulently forge or misuse a prescription**, my prescriptions and/or treatment with Dr. Ettedgui may end immediately.

6. **I understand the risks of using opioid/narcotics include but are** not limited to risk of addiction, risk of abuse, physical dependency, and improper use may result in overdose. Some side effects may include but are not limited to respiratory depression, constipation, nausea/vomiting, dizziness, difficulty urinating, confusion, weakness, drowsiness, and even death.

7. **I acknowledge the potential for tolerance and the psychological dependence (addiction) of controlled substances.** I understand that addiction is rare and tolerance is common and is related to the physical dependence created by these medications. With the development of tolerance, there may be a need to increase the dose of medicine to achieve the same effect. This may occur if I am on the medication for an extended period. Therefore, when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

8. **I understand that the main treatment goal is to improve my ability to function**. I also understand that my controlled substance medication will not completely eliminate my pain or anxiety. It is intended to improve pain or anxiety tolerance. I understand that only by following a healthier life-style can I hope to have the most successful outcome regarding my treatment.

9. **I understand that if I violate any of the above conditions,** my prescriptions and/or treatment with Dr. Ettedgui may end immediately. If the violation involves obtaining controlled substances from another individual, **I may be reported to my primary physician (If applicable), other physicians involved in my care, local medical facilities/pharmacies and other authorities.**

10. I understand Dr. Ettedgui may change my treatment during any time that I continue to be under his care based upon new information and developments in the science of pain management.

11. I have read this contract. Dr. Ettedgui and/or his staff have provided it to me. In addition, I fully understand the consequences of violating this contract.

Primary Pharmacy_____ **Phone #** (_____) _____-_____

Patient Signature _____ **Date** _____

Physician Signature _____ **Date** _____