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

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 document 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** _____