

JOHANNES V. BLOM, MD
Board Certified Orthopedic Surgeon
Adult Reconstructive Surgery & General Orthopedics

PATIENT DEMOGRAPHIC INFORMATION

Chart #: _____
Date of Appt: _____

Email: _____
Cell : _____

Patient Name: _____ Home: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____

Marital Status: S M D W Primary Language: _____

Age: _____ Date of Birth: _____ Sex: M F Social Security: _____

Employer: _____ Work#: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Doctor: _____ Office #: _____

Orthopedic Problem: _____ Referring Doctor: _____

Type of Injury: Auto _____ Work _____ Slip & Fall _____ Date of Occurrence: _____

How did accident happen? _____

Spouse/Parent Name: _____ Employer: _____ Wk: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance

Name of Insurance: _____
Insured's Name: _____
Insured's Sex: Male Female
Insured's Date of Birth: _____
Relationship to Insured: _____
Subscriber ID Number: _____
Group Number: _____

Secondary Insurance

Name of Insurance: _____
Insured's Name: _____
Insured's Sex: Male Female
Insured's Date of Birth: _____
Relationship to Insured: _____
Subscriber ID Number: _____
Group Number: _____

AUTO INSURANCE

Date of Accident: _____

Patient's Name: _____ Phone #: _____

Insured Person: _____

Name of Insurance Company: _____

Policy: _____ Claim #: _____

Phone: _____ Adjuster: _____

: _____

ATTORNEY INFORMATION

Any pending litigation related to your injury? _____

Attorney Name: _____ Phone : _____

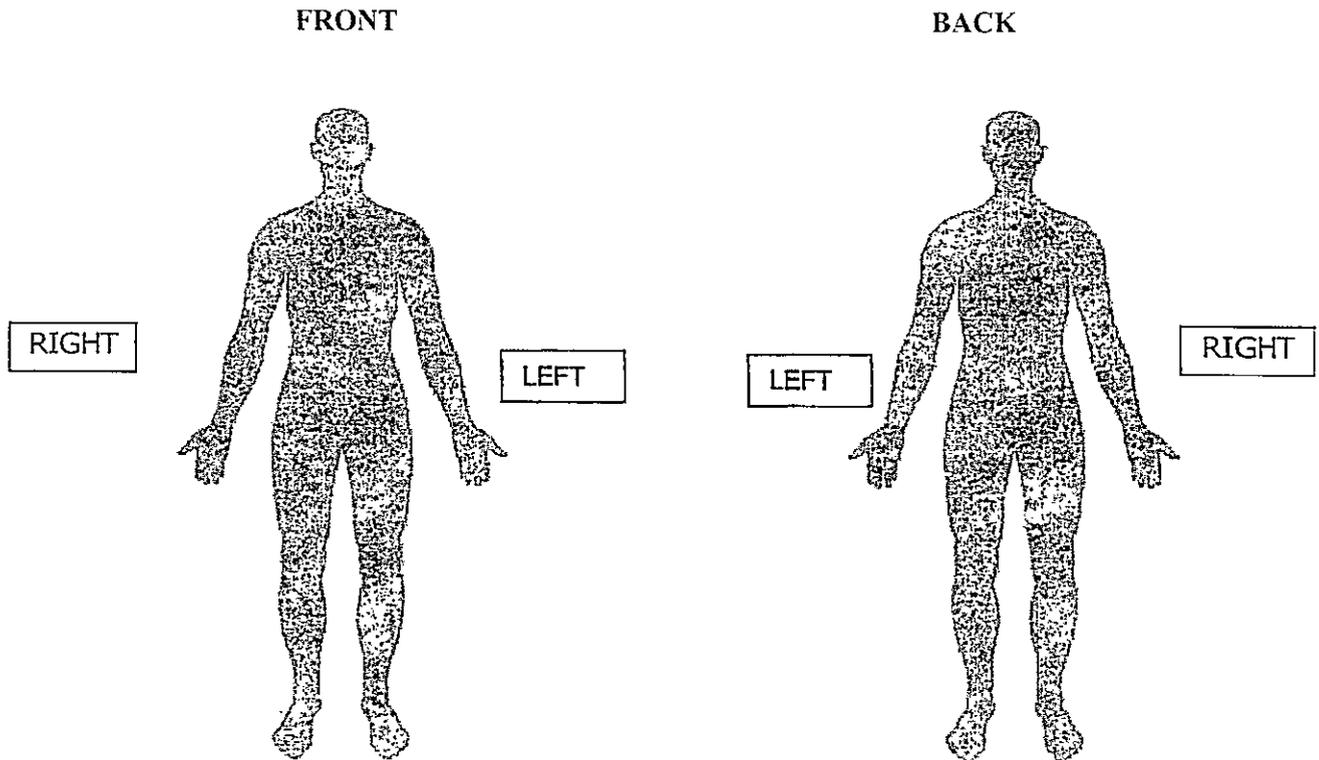
Attorney Address: _____ Fax : _____

Email : _____



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- On the following diagrams, please show where you're experiencing all of your present complaints with the letter X:



Are you experiencing any of the following symptoms?

- | | |
|--|---|
| <input type="checkbox"/> Arm/Shoulder pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck pain/stiffness |
| <input type="checkbox"/> Leg pain | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Feet/Toe numbness | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back pain/stiffness | <input type="checkbox"/> Hand/Finger numbness |
| | <input type="checkbox"/> |

Circle the severity of your pain:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)



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ASSIGNMENT OF BENEFITS

PATIENT: _____

I, the undersigned Patient, have and do assign any and all rights and benefits of insurance of any and all applicable personal injury protection to Johannes V. Blom, MD PA for services and/or supplies rendered for the treatment of personal injuries I sustained on _____ date in accordance with Florida Statute 627.736.

This Assignment includes, but is not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company obligated to provide benefits including legal suit if for any reason the insurance company fails to make payments of benefits which I am due. Specifically, this assignment includes the right to collect payment for the reasonable costs connected with copying and mailing records to the insurer at the insurers request and in accordance with Florida Statute 627.737.

I hereby instruct the insurance carrier that, in the event the subject medical benefits are disputed for any reason, including medical relatedness, reasonableness, and/or necessity, that the amount of benefits claimed by Johannes V. Blom, MD PA will be set aside and not disbursed until the dispute is resolved. As part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that they may exercise their legal rights. I have read the information herein and it is true to the best of my knowledge and belief.

Patient's signature

Date

Print Patient's name



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Dear New Patient:

It is our understanding that you have come to our medical practice for medical treatment as a result of traumatic injuries you sustained.

Our medical practice is not in network with any private health insurance companies and does not accept Medicare or other governmental health insurance plans or benefits.

We have an alternative payment arrangement that will allow you to defer payments on your medical charges and make it easier for you to handle and prepare for this unexpected financial situation.

We are more than willing to answer any and all questions you may have before you sign this document. You also have the opportunity to have this document reviewed by an attorney of your choosing prior to signing same.

By signing below, you are affirming that you understand that the practice does not accept health insurance or Medicare benefits and that all of your questions on this issue have been answered satisfactorily by the medical practice.

I _____ hereby acknowledge that this medical practice does not accept any health insurance or Medicare benefits, I wish to be seen and treated by this medical practice and I understand that I am personally responsible for any medical bills incurred for my treatment.

Patient Signature

Date



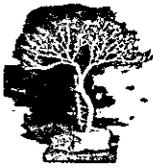
JOHANNES V. BLOM, MD

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DEFERRED PAYMENT AGREEMENT (DPA):

1. Johannes V. Blom, MD PA (hereinafter "Practice") hereby agrees to provide medically necessary care and treatment to the above patient based upon the terms and conditions of this agreement.
2. I _____, (hereinafter referred to as "Patient") understand that the Practice is not in network with any private health insurances and does not participate with Medicare. As a result, I agree to be seen and treated under this payment arrangement with the Practice.
3. The Practice agrees to provide the medically necessary medical care and treatment and to bill me at their usual and customary rate.
4. Based upon this agreement the Practice will defer collection of these medical bills as set out below.
5. I understand and agree that I am personally responsible for any and all medical charges billed by the Practice for my treatment and that if at any time, I default on this obligation, I am subject to a collection action and/or civil litigation instituted by the Practice to recover the above medical debt. My obligations under this Agreement stand alone and are not subject to any other contingency or occurrence.
6. I understand that I have the right to request, in writing (the form will be provided by the practice upon request), an estimate of medical charges to be incurred prior to undergoing any treatment or procedure at the Practice.
7. If I have retained an attorney, I request and direct the Practice to follow my direction that any and all medical records, cost estimates for medical care and treatment and/or the actual medical billings for services provided be sent directly to his/her office so that I may consult and seek their counsel throughout my medical care and treatment.
8. The Practice agrees to defer the collection on any billings provided to me for 24 months from the date of my first medical treatment without interest.

If my medical debt remains due and owing at the conclusion of that time period, I agree to pay 5% Annual Percentage Rate (hereinafter referred to as "APR") on the incurred medical debt for the third year the debt is due and owing.



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I further agree to pay an additional 5% APR for each additional year the debt remains outstanding up to five years from the date of my first treatment at the Practice or a maximum of 15% interest APR. The above interest shall be compounded annually.

At the conclusion of the five-year period, unless I have negotiated a payment agreement with the Practice, collection proceedings and/or civil litigation shall begin for the recovery of the entirety of the medical debt and associated interest that remains outstanding.

9. I, the Patient, enter into this Agreement freely and voluntarily. I have had an opportunity to ask any and all questions of the Practice and I have been provided with satisfactory responses to those questions.
10. Additionally, I have had an opportunity to have this Agreement reviewed by an attorney of my choice prior to signing it.

Patient/Legal Guardian (if patient is a minor): Practice Representative:

Signature

Signature

Date: _____

Date: _____



JOHANNES V. BLOM, MD
BOARD CERTIFIED ORTHOPAEDIC SURGEON
RECONSTRUCTIVE SURGERY & GENERAL ORTHOPAEDICS

X-RAY COPIES

All X-rays taken by this office are the property of JOHANNES V. BLOM, MD, PA. Under no circumstances can originals be taken out of this office. All originals will be maintained in this office at all times.

If copies are requested, at least a 24 hour notice will be required and there will be a \$10.00 per film charge for materials, payable in advance. Your consideration is appreciated

Patient's Signature (If patient is a minor, signature of parent/guardian)

CANCELLATION FEE POLICY

We value your time and patience when you come to visit the office. In return we ask that you please understand that we strive to serve you as efficiently as possible and need your help to do so. We ask that you please provide us with a 24 hour notice if you need to cancel or reschedule your appointment. This helps us to serve other patients who also require our services. In the event that you do not show and do not call to cancel/reschedule there will be a \$25 no show fee charged to you at your next visit.

We appreciate your understanding of this matter and look forward to serving you.

I, _____, have read and understood the above policy. I understand that I will be charged if I fail to provide a 24 hour notice of cancellation.

Signature: _____
(patient/parent/conservator/guardian)

_____ Date



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**PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR
TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

I, _____, understand that as part of my healthcare, this facility originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future 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 understand and have been provide with a notice of information practices that provide a more complete description of information used and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations

I understand that this facility is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent this organization may refuse to treat me as permitted by section 164.506 of the code of federal regulations.

I further understand that this facility reserves the right to change this notice and practices and prior implementation, in accordance with section 164.520 of the code of federal regulations. Should this facility change their notice they will send a copy of any revised notice to the address I've provided.

I understand that as a part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my information to another entity and I consent to such disclosure for these permitted uses including disclosures via fax

I authorize this facility to discuss my treatment, payment, and healthcare operations with the following person/people:

I fully understand and accept/decline the terms of this consent.

Patient Signature

Date



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 RECONSTRUCTIVE SURGERY & GENERAL ORTHOPAEDICS

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the NOTICE OF PRIVACY PRACTICE OF JOHANNES V. BLOM, MD, PA. Our NOTICE OF PRIVACY PRACTICE provides information about how we may use and disclose your protected health information. We encourage you to read it in full

If you have any question about our Notice of Privacy Practices, please contact our Compliance Officer at:

3702 Washington Street, Suite 202
 Hollywood, FL 33021
 (954) 964-6114

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at the above address.

I acknowledge receipt on the Notice or Privacy Practices of Johannes V, Blom, MD, PA.

Signature _____
 (Patient/parent/conservator/guardian) _____ Date _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained:

Signature of provider representative: _____ Date _____

An acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:
- _____
 There was a medical emergency (the staff member will attempt to obtain acknowledgement at the next available opportunity).

Other reason(s): _____

Johannes V. Blom, MD

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, Date of Birth ____/____/____,
Authorize to release my medical records to:

To release to: _____
Name of Hospital, Physician or Facility

Street Address

City State Zip Code

Phone# Fax#

Any medical information concerning my treatment, including psychological, psychiatric, drug abuse, alcoholism, AIDS, Aids testing and care of hospitalization which may be in your care.

Date Patient Signature



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ELECTRONIC COMMUNICATION CONSENT FORM

Texting Consent:

As part of our practice's communications with you, we can send you SMS (text) Messages directly to your phone.

- I **consent** and accept to receiving text **messages**. I understand I can withdraw my consent at any time. Please provide your cellular number: _____
- I do not consent to receiving any text messages.
-

Email Consent:

The use of email is limited to setting up or canceling appointments and for sending appointment reminders. Due to security, details of one's case cannot be discussed via email. Email may also not be used as a means of providing services. You also agree not to use the clinic email address when trying to contact the clinic or your service provider in the event of an emergency, as our clinic cannot guarantee a rapid response via email.

By signing, you are also aware that email is not a guaranteed or secure way of sending and receiving information and that you may not hold our clinic or your service provider responsible for any breach of confidentiality that results from the use of the email addresses listed below.

- I **consent** and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

Email: _____

- I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Print name of Patient: _____ Date: _____

Patient Signature