Benjamin J. Cousins, M.D.

Patient Name: _____

Date of Birth: ___/_____/_____Age:_____ Sex: M F

Cell phone: (_____) _____

Home phone: (_____) _____

Driver License number: _____

Occupation: _____

Email: _____

Address: _____

City: _____State: _____ Zip code: _____

Social Security Number: _____-_____-_____

Marital Status: S M W D

Spouse's Name: _____

EMERGENCY CONTACT: _____

Phone number: (_____) _____

If you are the parent or financially responsible for the patient, please complete the following:

Name: _____

Relationship to patient:

_____

Date of Birth: ___/_____/_____

Phone: (_____) _____

Address: _____

City: _____State: _____ Zip code: _____

Social Security Number: _____-_____-_____

How did you hear about Dr. Cousins?

_____

Reason for your visit: _____

_____

Date of injury: _____/_____/ _____

Did your accident happen at work? Y N

Did you go to the ER? Y N

Which ER? _____

Date of Hospital Visit: _____

Primary insurance: _____

Policy number: _____

Name of Subscriber: _____

Relationship to patient: _____

Subscriber Date of Birth: ___/_____/_____

Subscriber Social Security: _____-_____-_____

Subscriber Employer: _____

Subscriber Employer Phone: (____) _____

I hereby authorize payment be made directly to my physician (s) or supplier for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/ or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature: **Date:**

_____ ____/ _____/ _____

Parent or Guardian Signature: **Date:**

_____ ____/ _____/ _____

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Medical Information

Please answer the following questions to the best of your ability. Your answers are for our records only and will be considered confidential.

Name: _____ Age: _____ Sex: M F Height: _____ Weight: _____
BMI: _____

Medical Problems:_____

_____

Prior Operations: Date: / /

_____

Date: / /

_____

Name of Physician: Phone#: ( ) -

_____

Address of physician: _____

1- Are you in good health?..... Yes or No

2-Any changes in your health in the past year?..... Yes or No

3-Have you had rheumatic heart disease?..... Yes or No

4-Damaged heart valves, artificial valve, heart murmur?..... Yes or No

5-Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis? Yes or No

6-Chest pain or shortness of breath with mild exertion?..... Yes or No

7-Diabetes?..... Yes or No

8-Lung disease, asthma, bronchitis, emphysema?.....Yes or No

9-Tuberculosis?..... Yes or No

10-Fainting's or seizures?..... Yes or No

11-Liver disease, hepatitis, jaundice?..... Yes or No

12-Thyroid problems?..... Yes or No

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13-stomach ulcer or hyperacidity?..... Yes or No

14-Kidney problems, stones, urinary tract infection?..... Yes or No

15-HIV/AIDS, blood disorders, anemia, abnormal bleeding, blood transfusions?..... Yes or No

16-Persistent swollen neck glands?..... Yes or No

17-Have you ever been treated for a growth of tumor?.....Yes or No

18-Any history of cancer?.....Yes or No

19-Do you drink alcohol on a regular basis?.....Yes or No

20-Do you smoke? .....? Yes or No If yes, how many years? _____

Allergies and Current Medications

1-Do you have any allergies?.....Yes or No

If you are allergic, please list medications that you are allergic to:

Medication	Type of Reaction

2-Have you ever taken weight reduction (diet) pills?.....Yes or No

3-Do you take medication for osteoporosis (bisphosphonates) such as Fosamax?.....Yes or No.....If so which ones?

_____

Please list any medications that you currently take including vitamins and over the counter medications:

Medication	Dose	Frequency

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4-Are there any other medical issues not covered by this form?.....Yes or No

5-Do you wish to speak to the doctor privately about anything?.....Yes or No

Women:

1-How many pregnancies:_____ Births:_____ C-Sections:_____ Miscarriages:_____
2-Are you pregnant or trying to become pregnant?.....Yes or No
3-Do you have problems associated with your menstrual period?.....Yes or No
4-Are you smoking?.....Yes or No
5-Are you taking birth control pills?.....Yes or N

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor or any staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature: _____ **Date:** ____/____/_____

For completion of the Doctor

Comments on medical history**:** _____
_____
_____
_____

_____ **Physician's Signature:** _____ **Date:** ____/____/____

Notice to Patients of Dr. Benjamin J. Cousins, M.D.

Under Florida law Statues (458.320 F.S.), physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NO TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law (459.320 F.S.).

_____ _____
Patient Signature (or Personal Representative) Date:

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SFHS South Florida Hand Surgery

BJC Plastic Surgery

_____
Printed Name

_____
Personal Representative's Authority (if applicable)

PATIENT INFORMATION FOR PHOTOGRAPHIC CONSENT

Dear Sir or Madam,

For all patients and surgeries, as a benefit for patient education, medical student/resident/fellow and academic teaching and/or learning, I wish to obtain consent/release and permission for the use of photographs, medical records, illustrations and/or other imaging records/documents which may be needed and/or useful. I pledge and promise to maintain patient confidentially and to follow HIPAA requirements and state laws appropriate. I hereby grant permission for the use of any of my medical records, illustrations, photographs, or other imaging records created in my case for use in presentations, teaching credentialing/re-credentialing or certifying purposes.

Patient Signature _____ **Date:** ___/ _____/ _____

Witness Signature _____ **Date:** ___/ _____/ _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I,_____ have reviewed/received a copy of Notice of Privacy Practices.

Signature of Patient/Guardian _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on

This Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ **Initials:** _____ **Reason:**_____

H I P A A

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PATIENT CONSENT & FINANCIAL AGREEMENT FORM

In connection with the medical services that I am receiving, I hereby authorize the release of my information and medical records, including copies of applicable hospital and medical records to:

A. Any third party payer covering the medical services of the patient.

B. Other health care professional and institutions involved in the delivery of health care to the patient

C. The proponent of any legally sufficient subpoena, or in response to a court order

D .Employees and agents of the degree necessary to facilitate the provision of healthcare services and payment for such services

E. Pharmacies

F. As otherwise required by law

I further consent that photographs may be taken of me or part of my body, under the following conditions:

A. The photograph may be taken only with consent of my physician and under such conditions and at such time as approved by him/her.

B. The photographs shall be taken by my physician or by a designated person approved by any physician

C. The photographs be used for medical records and if in the opinion of my physician, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other in the interest of medical education, knowledge, or research; provided, however that it is specifically understood that in any such publications or use I shall not be identified by name and reasonable steps are taken to preserve my identity.

D. The aforementioned photographs may be modified or retouched in any way that my physician, in his or her direction may consider desirable.

Regarding Financial Arrangements:

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must however realize that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contact.

2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are

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rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for the assistance in the management of your account.

All Patients Must Sign Below:

_____

Patient's/ guardian's signature:

_____

Print name of patient or guardian

_____

Witness/Translator:

_____

Date:

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SFHS South Florida Hand Surgery

BJC Plastic Surgery

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to Benjamin J. Cousins, M.D. (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above-named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to: (1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and, (2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient's signature Date

Benjamin J. Cousins, M.D.