Theodore R. Small, MD, FACS

www.WestFloridaWeightLoss.com

1840 Mease Drive, Ste 301
Safety Harbor, Florida 33695
(727) 712-3233, Phone
(727) 712-1853, Fax

PATIENT INFORMATION FORM

** All information is kept confidential. Please answer honestly to assure the best possible treatment for you. Please complete all pages. **

(Please Print) Today's Date:_________________________

PATIENT INFORMATION:

Patient Name: __________________________________ Date of Birth: ____________ Age: __________

Street Address: _________________________________ E-Mail Address: ____________________________

City: ___________________________________ State: __________ Zip: __________

Home Phone: ________________ Work Phone: ___________________ Cell Phone: __________________

Height: _____________________ Weight: ________________________

Social Security Number: _______________________________ Sex: ☐ Male ☐ Female

Driver License Number: _________________________________ Education Level: _________________

Employer: ___________________________________ Occupation: _________________________________

Approximate Income: __________________________ Are you currently employed? ___________________

State the level of activity your job involves: ☐ Little (sedentary job) ☐ Moderately active ☐ Very active

Martial Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

SPOUSE/GUARDIAN INFORMATION:

Spouse's Name or Guardian's Name: ____

Spouse's Employer: ____________________________ Spouse's Occupation: ________________________

EMERGENCY CONTACT INFORMATION:

This information is vital to us if we need to contact you urgently. Occasionally people move or have new phone number and do not update our office.

Name: ____ Relationship: ______________________

Address: ____

Home Phone #: ______________________________ Work Phone #: ________________________________

Physician's Initials __________

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PATIENT INFORMATION FORM

PATIENT NAME: ____________________ SSN # : _____________ TODAY'S DATE _________

REFERRAL INFORMATION:

Referring Physician: ______________________________ Phone #: ______________________

Date of Referral: ________________________________ Fax #: ________________________

Address: ____

Primary Care Physician: ___________________________ Phone #: ______________________

Address: ____

Cardiologist: ____________________________________ Phone #: ______________________

Psychologist: ____________________________________ Phone #: ______________________

Psychiatrist: _____________________________________ Phone #: ______________________

Pulmonologist: ___________________________________ Phone #: ______________________

Endocrinologist: __________________________________ Phone #: ______________________

Orthopedic Surgeon: ______________________________ Phone #: ______________________

Other: ____ Phone #: ______________________

HOW DID YOU LEARN ABOUT WEST FLORIDA WEIGHT LOSS?

☐ Referring Physician
☐ Newspaper
☐ Web Site (www.WestFloridaWeightLoss.com)
☐ Dr. Small
☐ Friend or relative
☐ Morton Plant Mease Healthcare System
☐ Other _______________________

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INSURANCE INFORMATION

**** Even though we will copy your insurance cards, please complete all of the information requested below. ****

PRIMARY INSURANCE:

Primary Insurance Carrier: ________________________________ Phone #: _______________________
☐ PPO ☐ POS ☐ HMO ☐ Other ______________
Subscriber's Name: ______________________________________ Subscriber's Date of Birth: _________
Subscriber's Social Security Number: ________________________ Subscriber's ID Number ___________
Relationship to Subscriber: ________________________________
Subscriber's Employer: ___________________________________ Work Phone: ____________________

SECONDARY INSURANCE:

Secondary Insurance Carrier: ______________________________ Phone #: _______________________
☐ PPO ☐ POS ☐ HMO ☐ Other ______________
Subscriber's Name: ______________________________________ Subscriber's Date of Birth: _________
Subscriber's Social Security Number: ________________________ Subscriber's ID Number ___________
Relationship to Subscriber: ________________________________
Subscriber's Employer: ___________________________________ Work Phone: ____________________

WORKER'S COMPENSATION:

Is this a work related injury? ☐ Yes ☐ No (If yes, please provide the following information)
Claim Adjuster's Name: __________________________________ Phone #: _______________________
Date of Injury: ____
Claim Number: ____
Contact at Employer: _____________________________________ Phone #: _______________________

FINANCIAL AGREEMENT:

I authorize Surgical Associates of West Florida to bill my insurance company for services rendered. I realize that I will be responsible for co-payments and deductibles at the time of services. Any portion not covered by insurance will be billed to me. If I am uninsured, payment is expected at the time of service. If it becomes necessary to collect any balance due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

I authorize Surgical Associates of West Florida to release medical information for insurance purposes. I authorize payment to be made directly to Surgical Associates of West Florida if an assignment is indicated by my insurance company. As a courtesy, Surgical Associates of West Florida will contact insurance companies for authorization for services required. Surgical Associates of West Florida is not responsible for lapses of insurance or for incorrect information.

I have read and understand the financial agreement above.

_________________________________ _______________________________ _______________
Patient / Guardian (Please Print Name) Patient / Guardian (Signature) Date

Physician's Initials _________

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CLINICAL HISTORY FORM

PATIENT NAME: ____________________ **SSN # :** _____________ **TODAY'S DATE** _________

REASON FOR YOUR VISIT

What is the reason for this visit? ____

CURRENT MEDICATIONS *(List all medications / herbal / dietary supplements / alternative medications and treatments you are currently taking)*

Medication	*Dosage*	*# Per Day / Frequency*	*Reason for Taking*

****** *Please list any other current medications on the other side of this sheet.* *******

MEDICATION ALLERGIES *(Are you allergic to any medications?)*

Medication	*Reaction*

Do you have any problems with anesthesia? ☐ Yes ☐ No

Have you had an allergic reaction to tape? ☐ Yes ☐ No

Do you have an allergy to any latex products? ☐ Yes ☐ No

PAST SURGICAL HISTORY

Check all that apply	*Year*		*Year*		*Year*
☐ Appendectomy	_______	☐ Hernia, Inguinal	_______	☐ Other ________________	_____
☐ Breast Biopsy	_______	☐ Hernia, Ventral	_______	☐ Other ________________	_____
☐ Chest Surgery	_______	☐ Mastectomy	_______	☐ Other ________________	_____
☐ Coronary Artery Bypass	_______	☐ Prostate	_______	☐ Other ________________	_____
☐ Gall Bladder	_______	☐ Vascular Surgery	_______	☐ Other ________________	_____
☐ Hysterectomy, Abdominal	_______	☐ Tonsillectomy	_______	☐ Other ________________	_____
☐ Hysterectomy, Vaginal	_______	☐ Other____________	_______	☐ Other ________________	_____

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CLINICAL HISTORY FORM (Continued)

PATIENT NAME: ____________________ **SSN #:** ____________ **TODAY'S DATE** __________

PAST MEDICAL HISTORY (Please list all major medical problems)

- ☐ Stroke
- ☐ Seizures
- ☐ Glaucoma
- ☐ Emphysema
- ☐ Asthma
- ☐ Heart Attack / Disease
- ☐ Gallstones
- ☐ Vein Trouble
- ☐ Other __________________
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Juvenile Onset Diabetes
- ☐ Thyroid
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Elevated Cholesterol/Triglycerides
- ☐ Arthritis
- ☐ Other __________________
- ☐ Kidney Stones / Disease
- ☐ Anemia
- ☐ Cancer
- ☐ Bleeding Disorder
- ☐ Diverticulosis
- ☐ Angina
- ☐ Lung Disorders
- ☐ Other ________________
- ☐ Other ________________

FAMILY HISTORY

Family Member	*Alive/Deceased*	*Age*	*Health Problems (i.e. cancer, heart disease, etc)*
Father	______________	_____	____
Mother	______________	_____	____
Brother / Sister	______________	_____	____
Brother / Sister	______________	_____	____
Brother / Sister	______________	_____	____
Children	______________	_____	____

SOCIAL HISTORY

Tobacco ☐ None ☐ Currently smoke ___ packs/day and have done so for _____ years
☐ Previously smoked _____ packs/day for _____ years. Stopped in ___________
☐ Smokeless Tobacco

Alcohol ☐ None ☐ Minimal ☐ Moderate ☐ Heavy ☐ Previously Heavy

Caffeine ☐ None ☐ 1-3 Servings Daily ☐ 3-4 Servings Daily ☐ More than 6 servings Daily

Drug Use ☐ _______________ ☐ _______________

PERSONAL HISTORY OF CANCER

Type of cancer ☐ _______________ ☐ Not applicable

When was your cancer treated? _________________

What type of cancer treatment did you receive? ☐ Chemo Therapy ☐ Radiation Therapy ☐ Surgery

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CLINICAL HISTORY FORM (Continued)

PATIENT NAME: ______________________ SSN #: ____________ TODAY'S DATE __________

SYSTEMS REVIEW *(Please place a check next to yes or no for each line item)*

GENERAL	Yes	No
Weight Loss		
Weight Gain		
Insomnia		
Fever		
Night Sweats		
Chills		
Fatigue		

EYES	Yes	No
Blurred Vision		
Double Vision		
Episodic Blindness		
Cataract (s)		
Glaucoma		

EARS	Yes	No
Earache		
Ringing		
Infection		
Drainage		
Pain		
Mild Hearing Loss		
Hearing Impaired		

NOSE/THROAT	Yes	No
Frequent Nosebleeds		
Hoarseness		
Sinus		
Difficulty Swallowing		
Bleeding Gums		
Sores in Mouth of Lips		
Chronic Sinus Congestion		
Allergies		
Hay Fever		

RESPIRATORY / LUNGS	Yes	No
Wheezing		
Chronic Cough		
Emphysema or COPD		
Coughing up Blood		
TB or positive skin test		
Sleep apnea		
Pulmonary Embolus		
Asthma		

INFECTIONS	Yes	No
HIV Positive		
History of Hepatitis		
Staph Infections		

CARDIO / HEART	Yes	No
Chest Pain or Angina		
Heart Skips		
Rapid Heart Rate		
Poor Circulation		
Murmur		
Heart Attack		
Shortness of Breath		
Cardiac Testing within the last year (i.e. EKG)		
Hypertension		
Pacemaker		

GI / DIGESTIVE	Yes	No
Poor Appetite		
Abdominal Pain		
Nausea		
Vomiting		
Bloating		
Heartburn or GERD		
Diarrhea		
Constipation		
Blood in Stool		
Hemorrhoids		
Crohn's Disease		
Irritable Bowel Disease		
Ulcerative Colitis		
Gallstones		

GENITO-URINARY	Yes	No
Difficulty Urinating		
Difficulty Holding Urine		
Frequent Urination at Night		
Blood in Urine		
Kideny Stones		
Herpes		
Men: Prostate Cancer		
Men: Discharge from Penis		
Women: Menopause		
Women: Hysterectomy		

MUSCULOSKELETAL	Yes	No
Pain in Joints		
Pain in Muscles		
Muscle Weakness		
Chronic Back Problems		
Swollen Ankles		
Varicose Veins		

SKIN	Yes	No
Easy Bruising		
Ulcerations		
Rash		
Itching		
Psoriasis		
Non Healing Lesions		
History of Skin Cancer		

NEUROLOGICAL	Yes	No
Dizziness		
Loss of Consciousness		
Transient Loss of Function		
Stroke		
Seizures		

EMOTIONAL	Yes	No
Anxiety		
Depression		
Psychiatric Therapy		

ENDOCRINE	Yes	No
Thyroid Disorder		
Masses		
Heat or Cold Intolerance		
Diabetes Under Treatment		
Excessive Thirst		
Excessive Hunger		

HEMATOLOGIC	Yes	No
Anemia		
Bruise Easily		
Exessive Bleeding		
Swollen Glands		
Leukemia		
Lymphoma		
Transfussions		
Blood Clots		
Phlebitis		
Deep Venous Thrombosis		
Sickle Cell		

BREAST	Yes	No
Lumps		
Cysts		
Cancer		
Breast Pain		
Family History		

Physician's Initials __________

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CLINICAL HISTORY FORM (Continued)

PATIENT NAME: ____________________ SSN # : _____________ TODAY'S DATE _________

SLEEP APNEA HISTORY

Sleep apnea is a life threatening sleep disorder, which frequently causes you to stop breathing. It can happen hundreds of times per night, while you sleep and you may not even be aware it is happening.

Have you been diagnosed with Sleep Apnea? ☐ Yes ☐ No

Sleep Study Done? (If yes above) ☐ Yes ☐ No
Where was the sleep study completed? ______________________________
When was the sleep study completed? ______________________________
C-Pap: ____________________________ Bi-Pap: ________________________

Please mark, which symptoms apply:

Snorting of gasping	☐ Yes	☐ No
Loud snoring	☐ Yes	☐ No
Breathing stops, choke, or struggle for breath	☐ Yes	☐ No
Frequent awakenings	☐ Yes	☐ No
Tossing, turning, or trashing	☐ Yes	☐ No
Difficulty falling asleep	☐ Yes	☐ No
Morning headaches	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
More than three pillows used under the head	☐ Yes	☐ No
Falling asleep when at work or school	☐ Yes	☐ No
Falling asleep when driving	☐ Yes	☐ No
Excessive sleepiness during the day	☐ Yes	☐ No
Awaken feeling paralyzed, unable to move for short periods	☐ Yes	☐ No

How well rested do you feel after a full nights sleep?
☐ Not at all ☐ Somewhat ☐ Well rested

Do you feel more comfortable sleeping in an upright position? ☐ Yes ☐ No

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CLINICAL HISTORY FORM (Continued)

PATIENT NAME: ____________________ SSN # : _____________ TODAY'S DATE _________

GERD (Gastroesophageal Reflux Disease)

Diagnosed with GERD? ☐ Yes ☐ No
How often do you have reflux during the day?
☐ Every day ☐ Most days ☐ Most weeks ☐ Occasionally

Do you suffer heart burn/indigestion during the night? ☐ Yes ☐ No
How often do you have reflux during the night?
☐ Every day ☐ Most days ☐ Most weeks ☐ Occasionally

Does food or fluid reflux in the mouth? ☐ Yes ☐ No
Details: ____

Do you vomit with reflux? ☐ Yes ☐ No
Details: ____

OB/GYN

Do you have regular periods (Every 26 to 33 days)? ☐ Yes ☐ No

Do you have problems with excessively heavy periods? ☐ Yes ☐ No

Do you have excessively painful periods? ☐ Yes ☐ No

Have you had difficulty in conceiving in the past? ☐ Yes ☐ No

Do you currently have problems with infertility? ☐ Yes ☐ No

Have you suffered from excels body hair or acne? ☐ Yes ☐ No

Have you ever been told by a doctor that you have polycystic ovaries? ☐ Yes ☐ No

Have you ever had problems with pregnancy and or children? ☐ Yes ☐ No
If so, in what way? ____
____

Have you had a caesarean section? ☐ Yes ☐ No
If so, why? ____
____

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CLINICAL HISTORY FORM (Continued)

PATIENT NAME: ____________________ SSN # : _____________ TODAY'S DATE _________

WEIGHT HISTORY & WEIGHT LOSS ATTEMPTS:

This section is to be completed by the Medical Technician.

Height: _____ Feet ______ Inches Frame: ☐ Small ☐ Medium ☐ Large

BMI: __________ Ideal Weight: _________ Lbs. Overweight: ______________

Age of obesity onset: _________________ years

How many years have you been at your present weight? ______________ years

Greatest single weight loss: __________________ pounds

Weight loss was sustained for: ________________ months

DIET HISTORY (Non-Physician Supervised Weight Loss Programs):

Answer yes or no to the following and fill in the pounds lost and the time spent in each program.

Name of Diet Program	Yes	No	Pounds Lost	Number of Months
American Heart Association				
Radar Institute				
Duke University Programs				
Structure House				
Inpatient Psychiatric Programs				
Outpatient Psychiatric Programs				
Optifast				
Carefast				
Medifast				
Meridia				
Zenical				
Fastin				
Ionamin				
Phenteramine/Fenfluramine				
Redux				
Other: ____________________				

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CLINICAL HISTORY FORM (Continued)

PATIENT NAME: ____________________ SSN # : _____________ TODAY'S DATE _________

DIET HISTORY (Physician Supervised Weight Loss Programs):

Name of Diet Program	Yes	No	Prounds Lost	Number of Months
American Heart Association				
Radar Institute				
Duke University Programs				
Structure House				
Inpatient Psychiatric Programs				
Outpatient Psychiatric Programs				
Optifast				
Carefast				
Medifast				
Meridia				
Zenical				
Fastin				
Ionamin				
Phenteramine/Fenfluramine				
Redux				
Other: ____________________				

Please detail any other weight loss measures (including surgical):

____
____
____
____

Were there any particular events that lead to the significant weight gain?

____
____
____
____

Physician's Initials __________

Form Updated 5/18/06

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PATIENT INFORMATION FORM

PATIENT NAME: ______________________ SSN # : _____________ TODAY'S DATE __________

OTHER INFORMATION *(Please write below any other information not covered in this Clinical History Form that you feel the doctor or surgical staff should know about)*

____

____

____

____

____

PATIENT'S SIGNATURE

I certify that, to the best of my knowledge, the above information is complete and accurate.

Patient's Signature: ____

Today's Date: ____

Thank you for choosing Surgical Associates of West Florida to provide your surgical care.

Visit Our Web Site at **www.WestFloridaWeightLoss.com**

Physician's Initials __________

Form Updated 5/18/06

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GENERAL PATIENT / PHYSICIAN AGREEMENT

Please read the following paragraphs, initial below each paragraph that you have read, understand, and agree to the same.

CONFIDENTIALITY:

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method, and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physician level. I have read, understand, and agree with the above.

Patient/Guardian Initials: ____________________ Date: __________________

FAILURE TO FOLLOW PHYSICIAN ORDERS:

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility, thus releasing treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can included but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illness. I have read, understand, and agree with the above.

Patient/Guardian Initials: ____________________ Date: __________________

FORM COMPLETION POLICY

The ever increasing time and cost burden required to complete the multitude of forms being requested by our patients requires **Surgical Associates of West Florida** to implement the following charge policy for all forms.

- **A fee of $25.00 for each request**

Forms that will be accessed a form completion fee include FMLA (Family & Medical Leave Act) forms, Disability forms, Back-To-Work forms, and miscellaneous forms.

When your forms are completed, Surgical Associates of West Florida will contact you to let you know that your forms are complete. Prior to the completed forms being distributed to patients, Surgical Associates of West Florida will collect the related fee via cash, money order, personal check, credit card, or debit card (MasterCard or Visa logo).

Patient/Guardian Initials: ____________________ Date: __________________

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NOTICE OF PRIVACY PRACTICES

** This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. **

At **Surgical Associates of West Florida**, we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer: Pam Taylor at (727) 712-3233. This notice went into effect on April 14, 2003.

Acknowledgement: I have received a copy of **Surgical Associates of West Florida's** Notice of Privacy Practice.

______________________________	______________________________	______________
Patient / Guardian (Please Print Name)	Patient / Guardian (Signature)	Date

David G. Berry, MD, FACS
Robert S. Davidson, MD, FACS
Robert T. Roth, MD, FACS

Rick J. Schmidt, MD, FACS
Theodore R. Small, MD, FACS
Mark Zuzga, DO, FACOS, RVT

ARBITRATION AGREEMENT BETWEEN DOCTOR AND PATIENT

Please read carefully.

This agreement is made between Surgical Associates of West Florida - SAWF and their physicians extenders, agents, employees, or any of the foregoing referred to hereinafter as "doctors" and________________________________ hereinafter referred to as "patient".

It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians**, or any other legal claimant.**

Disputes and Consideration: In the unfortunate event of any claim for medical malpractice or otherwise, and in consideration for this agreement, the parties would like to (a) keep things as simple as possible; (b) enhance early resolution of their differences;(c) avoid lengthy drawn out litigation through the courts; (d) avoid the stress associated with traditional litigation and jury trials; and (e) minimize all costs, expenses and attorney's fees. Therefore, the parties voluntarily agree to the following pursuant to their constitutional right to contract:

It is understood by the patient that he or she has voluntarily selected and he or she is neither required to use SAWF, nor any of the doctors involved in their treatment and that there are other competent physicians in Florida who may act as the patient's treating physician.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever related to personal injury, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statues.

I understand that by signing this agreement I am waving my right to a jury trial, and instead, have agreed to participate in arbitration.

This arbitration shall be binding and shall be in lieu of, and instead of, any trial by judge or jury. Each party shall choose one arbitrator and these two individual selected arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for under the Florida Rules of Civil Procedure and agree to be governed by the Florida Evidence Code and Chapters, 766 &768, Florida Statutes, in any matter subject to this arbitration agreement. The panel of three (3) arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction.

Prior to commencing any action under this Doctor-Patient Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes.

Limitation of Damages: Patient agrees that in the event of any dispute with the Doctor, for any reason whatsoever, including any negligence claim relating to the diagnosis, treatment, or care of the Patient or any other personal injury claim, Patient's non-economic damages (including, but not limited to, damages for pain and suffering) shall be limited to a maximum of $250,000 per incident and shall be calculated on a percentage basis with respect to capacity to enjoy life, pursuant to the formula contained in Florida Statutes, Section 766.207. For example, if the Patient's injuries resulted in a 50% reduction in his or her capacity to enjoy life, this would warrant an award of not more than $125, 000 in non-economic damages. This limit applies regardless of the number of claimants or defendants in the arbitration proceeding. This limitation of damages provision does not limit or restrict in any way the Patient's right to seek all economic damages actually incurred by the Patient, including any medical expenses and lost wages.

ARBITRATION AGREEMENT BETWEEN DOCTOR AND PATIENT

Please read carefully.

Duty to Defend and Indemnify: For each individual or entity with a claim that is not bound by this agreement ("non-party"), it is the parties' intent that they shall adopt and comply with this agreement 100% so that the parties can avoid piecemeal litigation and ensure consistency, closure, and finality in one forum. For each non-party claim against the patient's physician brought outside this agreement, you shall (a) defend and (b) indemnify the patient's physician against said claim(s) up to the amount the chief arbitrator deems reasonable under the circumstances.

Severability Clause: If any provision of this Agreement shall be held invalid under any applicable laws, such invalidity shall not affect any other provision of this Agreement that can be given effect without the invalid provision. Further, all terms and conditions of this agreement shall be deemed enforceable to the fullest extent permissible under applicable law, and, when necessary, the court is requested to reform any and all terms or conditions to give them such effect.

By signing below, the patient confirms that:

- The Patient has had an opportunity to read this Doctor-Patient Agreement, or to have it read to him or her if necessary.
- The Patient indicates that they understand English or has had the Doctor-Patient Agreement translated for him or her by __________________________.
- The Patient has had an opportunity to ask questions about this Doctor-Patient Agreement.
- The Patient understands this Doctor-Patient Agreement and has no unanswered questions.
- The Patient has not been coerced or compelled to sign this Doctor-Patient Agreement, and does so if his or her own free will.
- The Patient is also aware that they may consult with an attorney before signing this Doctor-Patient Agreement.

This agreement shall remain in effect for all treatment and surgery provided to the patient, presently and at any future date.

BY SIGNING THIS DOCTOR-PATIENT AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature:____ Date:________________________

Parent, Guardian or Legal Representative Signature:____

Physician Signature:____

David G. Berry, MD, FACS
Robert S. Davidson, MD, FACS
Robert T. Roth, MD, FACS

Rick J. Schmidt, MD, FACS
Theodore R. Small, MD, FACS
Mark Zuzga, DO, FACOS, RVT

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____

Address:____

City:_________________________________State:_______________________Zip:______________________

I hereby consent to the release and disclosure of my personal health information to:

Name (Individual or Organization): ____

Address: ____

City: _______________________________State: __________________________ Zip: ___________________

I authorize the use or disclosure of the above named individual's health information as described below. Surgical Associates of West Florida is authorized to make this disclosure for the purpose of :

_____Continuing Medical Care _____Personal Use
_____Information for Insurance Co. _____Information for Attorney
_____Other (please specify)____

This authorization for release includes my personal health information consisting of:

_____Initial Evaluation _____Operative Reports _____Medical Status
_____Progress/Office Notes _____Discharge Summary _____Work Status
_____Diagnostic Imaging Reports _____Laboratory Reports
_____Other (please specify)____

______(initial) I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclose of the above information about or medical records of my medical condition to those persons or agencies named above. I understand that the disclosure of my personal health information as provided for herein will now constitute an authorized use or disclosure of my personal health information (PHI) pursuant to 45 C.F.R. § 164. I also understand, upon disclosure to the above recipient, my PHI will no longer be protected by the federal regulations governing the privacy of individual identifiable health information and that Surgical Associates of West Florida will not be able to restrict the disclosure of the my PHI by the intended recipient who is not affiliated with Surgical Associates of West Florida.

<u>This authorization will expire one year from the date of this request</u>. This authorization is not valid if not filled out completely.

____ ____________________________
Signature of Patient, Guardian, or Personal Representative Date

Social Security Number: _________________________ Date of Birth: ________________________