SOUTH FLORIDA SURGICAL SPECIALISTS, LLC
GENERAL & LAPAROSCOPIC SURGERY * SURGICAL ONCOLOGY
DIPLOMATES AMERICAN BOARD OF SURGERY

MARK S. SHACHNER, M.D., F.A.C.S. BERNARD J. ZARAGOZA, M.D., F.A.C.S. ALAN S BASSIN, MD.,F.A.C.S.
MELVIN E. PANN, M.D., F.A.C.S. NIRANJAN J. SHINTRE, M.D.

Patient: Mr., Mrs., Ms. _____
Last Name **First** **Initial**

Address: _____

_____
City **State** **Zip**

Home Phone Number _____ **SS#** _____
Date of Birth _____ **Age** _____
Patient's Employer _____ **Occupation** _____
City of Employment _____ **Phone #** _____
Spouse's Name _____ **Spouse's Birthday** _____
Spouse's Employer _____ **Phone #** _____
Nearest Relative _____ **Phone #** _____
Referred By: _____ **Primary Physician** _____
Phone# _____
Primary Insurance _____ **ID#** _____ **Group#** _____

Address: _____
***** If you are not the primary policy cardholder WE NEED THE FOLLOWING INFORMATION**
Primary Card Holder Name _____ **DOB:** _____ **SSN:** _____

_____

Secondary Insurance: _____ **ID #** _____ **Group #** _____

I give permission to Mark S. Shachner, M.D., F.A.C.S./ Bernard J. Zaragoza, M.D., F.A.C.S. Alan S. Bassin, M.D., F.A.C.S., Nirjan J. Shintre or Melvin E. Pann, M.D., F.A.C.S. administer medical treatment to me, and I authorize the release of all medical information necessary for my treatment.
Signed _____
I authorize the release of my medical or other information necessary to process an insurance claim.
I authorize payment of medical benefits to go directly to South Florida Surgical Specialists, LLC.
I authorize photocopies of this form to be valid as the original.
Signed _____ **Date** _____
By Signing below you are giving permission to be contacted via Internet by South Florida Surgical Specialists, LLC
Signed _____ **E-Mail Address** _____
Payment is expected when services are rendered.
If you are An HMO or PPO a co-Payment will apply for each visit.

***** PLEASE SUPPLY BELOW emergency phone numbers so we may contact you in case of an emergency. These numbers are not to include home or work numbers *****
1.) _____ **2.)** _____

3001 Coral Hills Drive • Suite 320 • Coral Springs, Florida 33065
Office 954-755-0111 • Fax 954-755-2209

South Florida Surgical Specialists, LLC
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Surgical Oncology

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CONSENT FOR PARTICIPATION BY RESIDENTS AND/OR MEDICAL STUDENTS

I have been informed that Dr. Mark S. Shachner,/ Dr. Bernard J. Zaragoza,/ Dr. Alan S. Bassin,/Niranjan J. Shintre, M. D.,. and or Dr. Melvin E. Pann has been appointed to the clinical faculty of the North Broward Hospital District – Nova Southeastern University College of Osteopathic Medicine ("NBHD – NSU/COM"), and may have the rank of Clinical Instructor to Professor. Dr. Mark S. Shachner,/ Dr. Bernard J. Zaragoza, Dr. Alan S. Bassin,// Dr. Melvin E. Pann may, from time to time, request that the resident's and or medical students under his supervision participate in my care.

Please Check Below:

_____ I **hereby** consent to such participation by residents or medical students in my care.

_____ I **do not** consent to such participation by residents or medical students in my care and treatment.

_____
Date

_____
Signature

_____
Please Print Your Name

_____

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OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.
All patients must complete our Information and Insurance form being seeing the doctor. Copayments, Coinsurance and Deductibles are due at the time of service. We only accept cash or Visa/Mastercard. **Checks are not allowed.** Should the account not be paid, the patient assumes all cost of collection, including, but not limited to court costs, interest and legal fees.

REGARDING INSURANCE

We will accept assignment of insurance benefits,however we do require a percentage of the bill to be paid at or before the time of service when applicable. The balance is your responsibility whether or not your insurance company pays. We cannot bill your insurance company unless you provide us with complete and accurate data. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will facilitate the claims process by filing for you. If you insurance company has not paid your account in full within 45 days you will be responsible for the balance. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medica insurance.
Exceptions to the above policy are restricted to the plans for which Dr. Shachner/Dr. Zaragoza/Dr Bassin/ Dr. Shintre or Dr. Pann are contracted providers (e.g.certain HMO's & PPO's.) You will be responsible for all required co-payments and deductibles at the time of service. You will also be responsible for payment for procedures not covered by the insurance company, or procedures performed for preexisting conditions if not covered by your policy. We will assist with obtaining authorizations for all procedures however preauthorization is not a guarantee of payment by your insurance company.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of normal office visits. Please help us serve you better by keeping scheduled appointments.

SURGERY

Once confirmed, surgery dates and times CANNOT be rescheduled for any reason except failure to be medically cleared. At the discretion of the surgeon a **$250.00** rescheduling fee will be applied.

Thank you for understanding our Financial Policy. Please let us know if you have questions for concerns. I have read the Financial Policy and understand and agree to this Financial Policy

_____ _____

Signature of Patient or Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF THE PRACTICE'S NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. You may refuse to sign this acknowledgement.

_____	_____	_____
Name (Print)	Signature	Date

The Practice Use Only

Date acknowledgement received: _____
Individual refused to sign: _____ [check if applicable]
An Emergency situation prevented the Practice from obtaining acknowledgement: ____[check]
Other reason acknowledgement was not obtained: _____
_____

Practice Employee Signature:_____ Print Name:_____
Date_____

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CONSENT TO TREAT

In the course of your treatment with South Florida Surgical Specialists, LLC, it may be necessary to contact you regarding your appointments, surgery or your medical condition. Please list family members or friends that you authorize us to speak with if we are unable to contact you. Without this authorization we are prohibited by law to answer any questions regarding your appointments, surgery or medical condition. This rule applies to spouses, children, parents and any other immediate family members

I, _____, hereby authorize the office of South Florida Surgical Specialists, LLC, Dr. Shachner, Dr. Zaragoza, Dr. Bassin, Dr Shintre and Dr. Melvin E. Pann, to contact

_____

_____

_____

or to leave a message at my home or office. There are / are not exceptions to the above.
Exceptions _____

This authorization will last indefinitely unless this office is notified in writing about any new changes.

Signature _____ Date _____

Witness _____