Key West Orthopedics, P.A.
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Key West, Florida 33040
TAX ID #65-0610560

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I _____ understand that as part of my health care, Key West Orthopedics, P.A., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or 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, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge receiving a copy of Key West Orthopedics, P.A., Notice of Privacy Practices with the effective date of April 14, 2003.

_____ _____
Patient's Signature Date

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.

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Please answer the following questions to help us protect your privacy:

1) May we leave a detailed message on your answering machine? YES/NO
Telephone#_____

2) May we leave a message at your place of employment? YES/NO
Telephone#_____

If the answers to the above questions are NO, please let us know how you wish to be notified by our office:_____

3) May we release information to anyone other than you? YES/NO (i.e. spouse, child, friend)
If the answer is YES, please list each person:

Name:_____Relationship:_____

Name:_____Relationship:_____

FOR OFFICE USE ONLY: [ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.