Dr. Gary Moskovitz - Spine & Orthopedic Center

FOR OFFICE USE	
Date	Account#

TO BE COMPLETED BY THE PATIENT (PLEASE PRINT)

Name	Age	DOB	SSN#
Address			
City	State	Zip	
Phone# home ( )	work ( )	cell ( )	
Email Address			

Employment Information:
Occupation _____

Name of Employer _____

Address _____

Emergency Contact:
Name _____
Phone# _____
Relationship

Financial Information (party responsible for payment)

- ☐ Self (same as above)

☐ Spouse ☐ Parent ☐ Child ☐ Other	Name
	Phone
	Address
	City State Zip
	Age Date of Birth
	Employer Employer Address Ph # at work

Health Insurance Information

Insurance Company	
ID #	Group #

****DO YOU HAVE MEDICARE? YES NO INITIAL_____**

Patient Name _____

Please describe the condition you are being seen for.

Is your condition the result of an injury? ___Yes __ No

If **'Yes'** Complete the **injury** section below.

INJURY SECTION **Date of Injury:** **Day** **Month** **Year** **State**

- ❑ Motor Vehicle Accident
- ❑ Worker's Comp injury
- ❑ Slip and Fall
- ❑ Home
- ❑ Other

Describe what happened.

Have you had any of the following treatments for your current condition/ injury.

- ❑ Physical Therapy
- ❑ Chiropractic Treatments
- ❑ Massage Therapy
- ❑ Medications
- ❑ Trigger point Steroid Injections
- ❑ Epidural Steroid Injections

List all **Medications** you are taking

Allergies

- ❑ Penicillin
- ❑ Latex
- ❑ Sulfa
- ❑ Codeine
- ❑ Lidocaine
- ❑ Aspirin
- ❑ Erythromycin
- ❑ Others:
- ❑ None

Past Medical History

Do you have or have you ever had:

- ❑ Angina/heart disease
- ❑ Heart attack
- ❑ Stroke
- ❑ High Blood pressure
- ❑ Lung Problems
- ❑ Asthma Emphysema-Bronchitis
- ❑ Pneumonia
- ❑ Bleeding Disorder
- ❑ Blood Clots
- ❑ Phlebitis
- ❑ Liver problems
- ❑ Jaundice/ Hepatitis
- ❑ Kidney Problems
- ❑ Stomach Problems
- ❑ Ulcers
- ❑ Thyroid Problems
- ❑ Cancer
- ❑ Diabetes
- ❑ Alcohol or Drug abuse
- ❑ HIV / AIDS

Patient Name _____

Medical Conditions Under Current Treatment	**Anesthesia History** ❑ General Anesthesia ❑ Local ❑ Spinal Describe any Adverse Reactions
Past Surgical History List all operations you have had including dates	**Your Family Physician**
	Who is your current treating physician?

Do You Experience	**Social History**	**Family History**
❑ Chest pain / shortness of breath ❑ Unexplained weight loss ❑ Loss of appetite ❑ Frequent night sweats, fevers or chills	Married Single Divorced Widowed Who else lives in your household? Do you smoke? If Yes, how much. Do you drink? If Yes, how much.	Please list any serious illnesses that run in your family. Relative ❑ Cancer ❑ Heart Disease ❑ Stroke ❑ Diabetes ❑ Neurological/ Muscular disorder ❑ Other: _____
Height _____ Weight _____		

Do you have any metal in your body?	**Are You Claustrophobic?**
❑ Pacemaker ❑ Aneurysm Clips ❑ Heart Stents ❑ Other	❑ YES ❑ NO

Patient Signature _____

Date: _____

CONSENT OF DISCLOSURE
For the Usage and/or Disclosure of Protected Health Information

I hereby give consent to Spine & Orthopedic Center, P.A. and all health care providers furnishing care within Spine & Orthopedic Center, P.A.'s facilities, to use and disclose my protected health information for the purpose of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf by an authorized person, and delivered to the address at the bottom of this form. This notification of cancellation may be delivered in person or by mail, effective on the date received. Your cancellation will not be effective to the extent that we or other persons have acted in reliance upon this request.

You have the right to request restriction on the usage and disclosure of your protected health information for the purpose of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us. You may need to file and receive usage of your protected health information from any and all other health providers with access to your protected health information.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by calling 813 224-9222 or by mail request.

Print Name of Patient: _____

Signature:_____ Date _____

If you are signing as the patient's representative:

Print Your Name:_____ Relationship _____

I; _____, direct my health care and medical services providers to disclose and release my protected Health Information to:

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

CANCELLATION

I hereby void the consent given above

Print Name of Patient _____

Signature of Patient _____ Date _____

If you are signing as the patient's representative

Print Your Name _____ Relationship _____

Address for cancellation:
Your cancellation will be effective upon receipt at the following address: 812 W. Dr. MLK Jr., Blvd, #201 Tampa, FL 33603

082218

PRIVATE CONTRACT BETWEEN PATIENT AND DR. GARY MOSKOVITZ/SPINE & ORTHOPEDIC CENTER, PA, FOR PAYMENT OF MEDICAL SERVICES

I, the patient, understand that I may be insured under a health insurance policy, personal injury protection policy, medical payments policy or the beneficiary of a governmental benefit provider, and that I may be a third party beneficiary under one or more insurance agreements, which may set forth a specified rate of reimbursement or code "fee schedule" for medical care at a rate less than the rates charged by Dr. Gary Moskovitz. It has been our experience many times, these "fee schedules" do not represent fair and customary charges for the services performed in this office and throughout our community. In order for Dr. Moskovitz/Spine & Orthopedic Center, PA, to continue to provide top level medical care, I understand, acknowledge and agree that Dr. Moskovitz/Spine & Orthopedic Center reserve the right to bill or not to bill any available health insurance, personal injury protection, or medical payment carrier or Governmental Benefit Provider. I further agree to release Dr. Moskovitz/Spine & Orthopedic Center from any and all contractual arrangements and/or fee schedules between myself and my insurance carrier/carriers. I further agree to pay the entire amount of medical charges involved by Dr. Moskovitz/Spine & Orthopedic Center for medical services rendered to me.

In case of an injury as a result of someone else's negligence, I agree and acknowledge that this private contract shall constitute an irrevocable right to collect against the proceeds of any settlement or verdict related to my injury claim. I authorized Dr. Gary Moskovitz to endorse any checks drafted in both of our names where such check is in payment for medical services rendered by Spine & Orthopedic Center, P.A., as a result of treatment that I have received and continue to receive for my injury. I forbid any insurance carrier, my attorney, or any other party from paying Dr. Moskovitz and/or Spine & Orthopedic Center, PA, any sums less than the full amount of my medical charges owed to Dr. Moskovitz and/or Spine & Orthopedic Center, PA, without prior written consent. I agree and direct my attorney to comply with the requirements of this private contract, Florida Law and Florida Bar Opinion, so that any and all amounts owed to Dr. Moskovitz and/or Spine & Orthopedic Center shall be paid in full prior to any disbursement to me, by my attorney as a result of any settlement and/or verdict returned in my case.

I hereby authorize Dr. Moskovitz and/or employees of The Spine & Orthopedic Center, PA, to furnish my attorney of record, if any, a full report of examinations, diagnostics, treatment, prognosis, and any other medical information provided to or documented by Dr. Gary Moskovitz/Spine & Orthopedic Center, PA, concerning my medical care for injury/accident, for which I may be treated. If I am not currently represented by an attorney, but retain an attorney on a future date, or change my current attorney of record, I will notify Dr. Moskovitz, M.D., and/or the representatives of Spine & Orthopedic Center of this decision in writing within two weeks of doing so.

I understand that I am fully and directly responsible to Dr. Moskovitz, M.D./Spine &Orthopedic Center, PA, for all bills for medical services rendered to me, and that I am receiving consideration from Dr. Moskovitz/Spine & Orthopedic Center, PA, as they are agreeing to render services to me and wait for payment. I understand and acknowledge that payment of any medical services is not dependent upon my receipt of any settlement, judgment, verdict or recovery of any kind. In the event that I eventually receive a recovery from any source due to my accident/injury which provides me with less than the full ability to pay for any and all outstanding medical expenses owed to Dr. Moskovitz/Spine & Orthopedic Center, PA, I fully understand that I will remain responsible to Dr. Moskovitz/Spine & Orthopedic Center, PA, for any outstanding balance not covered by the recovery of any kind from my claim. As a result, I acknowledge that Dr. Moskovitz has no financial interest in the outcome of my claim as I remain fully responsible for any balance left for my medical care and treatment.

Continued

RE: Contract

I further agree to refrain from submitting bills for medical services provided to me by Dr. Moskovitz/Spine & Orthopedic Center, PA, to my health insurer, personal injury protection, medical payment carrier and/or governmental benefit provider resulting from my injury/accident, or have them submitted by anyone on my behalf. In the event that the bills for medical services are submitted by me or any other person on my behalf to any carrier set out above, and payment is made to Dr. Moskovitz/Spine & Orthopedic Center, PA, I understand and I agree that I will remain responsible for any balance which is not paid by any of these sources. Application of any "fee schedule" by a health insurance, personal injury protection, medical payments carrier or governmental benefit provider will not apply to the balance of my medical charges. I understand and agree that I will remain responsible for either any balance remaining or the entire amount of medical charges rendered by Dr. Moskovitz/Spine & Orthopedic Center, PA, if they are required by or elect to return any payment to any insurance carriers.

I further agree that in the event of this private contract and/or the underlying debt for medical charges covered hereby are litigated, the prevailing party shall be entitled to recover their reasonable attorney fees and litigation costs connected therewith.

This private contract shall also act as a lien for all outstanding medical charges, with all rights and benefits that accompany such a lien under the laws of the State of Florida being given to Dr. Moskovitz/Spine & Orthopedic Center, P.A.

I hereby acknowledge and understand the content of this private contract, and agree that, before signing below, I have had an opportunity to ask any and all questions I may have concerning the terms of this agreement. I accept the terms of this document in its entirety. By signing below, and returning the document to Dr. Moskovitz and/or representatives of Spine & Orthopedic Center, PA, I am agreeing to be bound by the contents of same. I acknowledge by signing below that I have been advised that if this is a personal injury case, that should my attorney wish not to cooperate in protecting the doctor's interest set forth in this private contract, Dr. Moskovitz and/or representatives of Spine & Orthopedic Center retain the right to refuse to await payment and claim the entire balance of my medical charges due and owing at that time.

This agreement supercedes any other agreements, and this agreement encompasses the entirety of any agreement between Dr. Moskovitz/Spine & Orthopedic Center, PA, in reference to payment of medical services. If any portion of this private contract is deemed to be unenforceable as a matter of law, any and all other portions of the contract will remain in full force and effect.

_____
DATE

_____
PATIENT (PRINT NAME)

_____
PATIENT SIGNATURE

DR. GARY MOSKOVITZ
Spine & Orthopedic Center

812 W. Dr. MLK Jr. Blvd., Suite 201
Tampa, FL 33603
Phone 813-224-9222 Fax 813-224-9224

NOTICE OF INITIATION OF TREATMENT

DATE: _____

PHYSICIAN: Dr. Gary Moskovitz

PATIENT NAME: _____

INSURED: _____

DATE OF LOSS: _____

INSURANCE COMPANY: _____

CLAIM NUMBER: _____

POLICY NUMBER: _____

To Whom It May Concern:

Please be advised that I have been consulted by and have been rendering medical treatment to the above referenced patient, with the patients first date of treatment occurring on _____ .

In accordance with F.S. 627.76 (5) (B), I will be timely submitting the bills.

_____ _____
Authorized Representative Patient Signature

The patient also authorizes you, as the insurance company, to release any and all insurance information pertaining to the motor vehicle accident on the above date.

_____
Patient Signature

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

Private Contract for Medicare Patients
With Gary G. Moskovitz, M.D.

The Patient also known as the beneficiary, and his or her legal representative acknowledges that they are entering into a private contract for medical surgical care with Dr. Gary G. Moskovitz, M.D.

Gary G. Moskovitz, M.D. has met and maintains the criteria as an "opt out" physician under Medicare Section 1802 (3) (B) of the Social Security Act. The "opt out" period began at 12:01 am January 1, 2022 until 12:01 am December 31, 2023.

The patient also known as the beneficiary, and his or her legal representative agrees to the following:

Patient/ Beneficiary or his or her legal representative accepts full responsibility for payment of Dr. Moskovitz's charge for all services furnished by Dr. Moskovitz.

Patient/Beneficiary or his or her legal representative understands that the Medicare limits do not apply to what Dr. Moskovitz may charge for items or services furnished by Dr. Moskovitz.

Patient/Beneficiary or his or her legal representative agree not to submit a claim to Medicare or ask Dr. Moskovitz or his office staff to submit a claim to Medicare.

Patient/Beneficiary or his or her legal representative understands that Medicare payment will not be made for any items or services furnished by Dr. Moskovitz that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

Patient/Beneficiary or his or her legal representative enters into a contract with the knowledge that he or she has a right to obtain Medicare-covered items and services from physicians who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians who have not opted out.

Patient/Beneficiary or his or her legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to make payment for items and services not paid for by Medicare.

Patient/Beneficiary or Legal Representative _____

Physician _____

Effective Date _____

12/09/2021