All-Pro
ORTHOPEDICS AND SPORTS MEDICINE

Pembroke Pines
17779 SW 2nd St.
Pembroke Pines,
FL 33029

Hialeah
Palmetto Medical Arts Building
7100 W 20th Avenue, Suite 412
Hialeah, FL 33016

Wellington
1397 Medical Park Blvd. Suite 460
Wellington , FL 33414

Hollywood
210 S Federal Highway, Suite 302
Hollywood, FL 33020

info@allProOrthopedics.com 954.322.1110 954.322.1099

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Height: _____ Weight: _____

Race: ○ Caucasian ○ African ○ American ○ Hispanic ○ Asian ○ Other _____

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Other _____

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other _____

Preferred Pharmacy: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Chief Complaint

Dominant Hand: Right Left Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

Pain Numbness/Tingling Fracture Stiffness Other:_____

○ Shoulder	○ Right	○ Left	○ Pelvis	○ Right	○ Left	○ Neck
○ Upper Arm	○ Right	○ Left	○ Hip	○ Right	○ Left	○ Upper Back
○ Elbow	○ Right	○ Left	○ Thigh	○ Right	○ Left	○ Mid Back
○ Forearm	○ Right	○ Left	○ Knee	○ Right	○ Left	○ Low Back
○ Wrist	○ Right	○ Left	○ Lower Leg	○ Right	○ Left	○ Buttocks
○ Hand	○ Right	○ Left	○ Ankle	○ Right	○ Left	○ Tail Bone
○ Thumb	○ Right	○ Left	○ Foot	○ Right	○ Left	
○ Index	○ Right	○ Left	○ Great Toe	○ Right	○ Left	
○ Middle	○ Right	○ Left	○ 2nd Digit	○ Right	○ Left	
○ Third	○ Right	○ Left	○ 3rd Digit	○ Right	○ Left	
○ Little	○ Right	○ Left	○ 4th Digit	○ Right	○ Left	
			○ 5th Digit	○ Right	○ Left	

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: ○ Acute (sudden) ○ Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy)_____

2. Are you represented by an attorney? ○ Yes ○ No

Attorney Name:_____

Will there be any legal actions with respect to this problem? ○ Yes ○ No

3. Have you had a problem like this before? ○ Yes ○ No

Describe: _____

_____

4. Have you been seen in an ER? ○ Yes ○ No

Treating ER: (ex. St. Luke's Health) _____ Date: (mm/dd/yyyy) _____

 Patient Name: _____

History of Present Illness (continued)

5. Rate the pain (10 being the most pain):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6. Do the symptoms wake you from sleep?

○ Yes ○ No

7. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

8. What is the timing of the symptoms?

○ Constant ○ Intermittent (comes and goes)

9. Is the problem getting better or worse?

○ Getting better ○ Getting worse ○ Unchanged

10. What makes the symptoms worse?

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching Overhead

11. Are there any other symptoms associated with this problem?

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

Prior Testing / Treatment

Have you had any prior tests? ○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan

Have you had any prior treatment for this problem? ○ Yes ○ No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	○ Improved	○ Worsened	○ Unchanged	
Heat	○ Improved	○ Worsened	○ Unchanged	
Rest	○ Improved	○ Worsened	○ Unchanged	
NSAIDs	○ Improved	○ Worsened	○ Unchanged	_____
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	_____
Chiropractor	○ Improved	○ Worsened	○ Unchanged	_____
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	_____
HomeExerciseProgram	○ Improved	○ Worsened	○ Unchanged	_____
Surgery	○ Improved	○ Worsened	○ Unchanged	_____
Injections	○ Improved	○ Worsened	○ Unchanged	_____
Bracing	○ Improved	○ Worsened	○ Unchanged	_____
TENS unit	○ Improved	○ Worsened	○ Unchanged	_____

Other/Comments: _____

_____

_____

 Patient Name: _____

Select all previous hospitalizations/surgeries: ○ None

○ Aneurysm (Brain) Surgery	○ Hysterectomy
○ Aortic Bypass / Vascular Surgery	○ LAP Band / Gastric Bypass Surgery
○ Appendectomy	○ Lumpectomy
○ Cataract (Eye) Surgery	○ Mastectomy
○ Cholecystectomy (Gallbladder)	○ Malignancy/Cancer
○ Heart Surgery	○ Stents
○ Hernia Repair	

Orthopedic on side:	Right	Left
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
TotalShoulderReplacement	○	○
Spinal Surgery - Indicate Level: _____		

Other Surgery

_____

_____

_____

Other Orthopedic Surgery

_____

_____

_____

Medical Questions

Mark all that currently apply:

○ Metal in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you taking blood thinners? ○ Yes ○ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

○ None for all

					None	Comments
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool		○	_____
2) ENDO	○ Fever	○ Heat or Cold Intolerance	○ Night Sweats		○	_____
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	_____
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	_____
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	_____
6) CV	○ Chest Pain	○ Palpitations			○	_____
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath		○	_____
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems		○	_____
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps	○ Psoriasis	○	_____
10) NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness		○	_____
	○ Change in Bowel	○ Change in Bladder	○ Dizziness			
11) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder		○	_____
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	_____

 Patient Name: _____

Family History

Have any direct relatives had any of the following disorders? ○ None for all

Father	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Mother	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Sibling	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			

Social History

Do you use tobacco? ○ Daily ○ Occasionally ○ Former smoker ○ Never ○ Unknown

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled If no, what date did you last work? _____

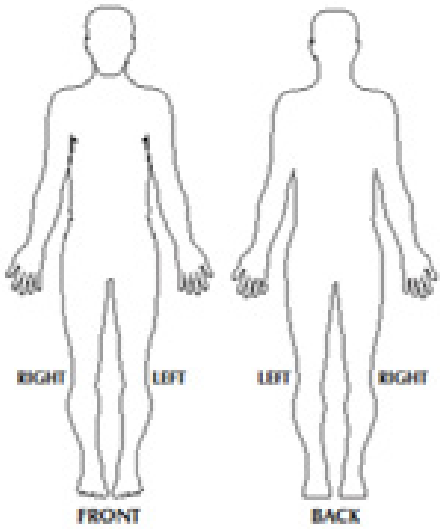
Please list work restrictions, if any: _____

Occupation: _____ Employer: _____ ○ Student

Pain Diagram

On the drawing below, mark an X where the pain is the worst.
Use the symbols below to show where you are having different kinds of pain:

Aching	^^^^
Numbness	====
Pins and Needles	oooo
Burning	xxxx
Stabbing Pain	////



 Patient Name: _____

Do you have any allergies? ○ Yes ○ No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	Reaction

Latex allergy? ○ Yes ○ No

Please list all medications you take on a regular basis: ○ None

Medication	Dosage and Frequency (e.g. 20 mg, once/day)

Do you have a personal history of any of the following? ○ None

○ Aneurysm Where: _____	○ Emphysema	○ Kidney Disease
○ Angina (Chest Pain)	○ Epilepsy	○ Kidney Stones
○ Arthritis Type: _____	○ Heart Attack	○ MRSA Infection
○ Asthma	○ Hepatitis Type: _____	○ Pacemaker
○ Bone or Joint Infections	○ HIV / AIDS	○ Phlebitis (Blood Clots)
○ Cancer Type: _____	○ High Cholesterol	○ Pulmonary Embolism
○ Chemotherapy / Radiation	○ Hypertension	○ Reaction to Anesthesia Type: _____
○ COPD	○ Hyperthyroidism	○ Seizures
○ Congestive Heart Failure	○ Hypothyroidism	○ Stomach Ulcers
○ Diabetes Type: _____ Last A1C: _____		○ Stroke / TIA
		○ Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

All-Pro
ORTHOPEDICS AND SPORTS MEDICINE

Pembroke Pines
17779 SW 2nd St.
Pembroke Pines,
FL 33029

Hialeah
Palmetto Medical Arts Building
7100 W 20th Avenue, Suite 412
Hialeah, FL 33016

Wellington
1397 Medical Park Blvd. Suite 460
Wellington , FL 33414

Hollywood
210 S Federal Highway, Suite 302
Hollywood, FL 33020

info@allProOrthopedics.com 954.322.1110 954.322.1099

Permanent ID: 9327

First Name		**Middle Inital**		**Last Name**		**Marital Status**	
Address					**Apt No.**		
City		**State**			**Zip Code**		
Home Phone:		**Cell Phone:**			**E-Mail:**		
DOB:		**Age**		**Sex**		**Social Security No:**		**Occupation**	
Language:		**Race:**			**Ethnicity:**		
Employer/School				**Business/Work Phone:**			
Pharmacy Name				**Pharmacy Phone:**			
If patient is minor: Parent/Guardian name:						**DOB:**	

Who may we thank for referring you to us?_____

Primary Care Physician_____ Phone:_____

Please list the name of a person to contact in case of an emergency other than a spouse or patient:

Name:_____ Relationship:_____ Phone:_____

Address:_____ Apt No._____ City_____ State_____ Zip_____

PRIMARY INSURANCE

Insurance Company:_____

ID#_____ Group #_____

Insured's Full Name:_____ Insured SS#_____ Insured DOB:_____

Relationship to Insured (Self, Spouse, Child, Other)_____

SECONDARY INSURANCE

Insurance Company:_____

ID#_____ Group #_____

Insured's Full Name:_____ Insured SS#_____ Insured DOB:_____

Relationship to Insured (Self, Spouse, Child, Other)_____

Date of Accident (if applicable):_____ Accident Type: MVA LOP Work Comp Other

Attorney Name:_____ Phone:_____

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN:_____ DATE:_____

All-Pro
ORTHOPEDICS AND SPORTS MEDICINE

Pembroke Pines
17779 SW 2nd St.
Pembroke Pines,
FL 33029

Hialeah
Palmetto Medical Arts Building
7100 W 20th Avenue, Suite 412
Hialeah, FL 33016

Wellington
1397 Medical Park Blvd. Suite 460
Wellington , FL 33414

Hollywood
210 S Federal Highway, Suite 302
Hollywood, FL 33020

info@allProOrthopedics.com 954.322.1110 954.322.1099

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND CONSENT TO USE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A. to use health information for treatment, payment, and health care operations purposes.

NOTICE OF PRIVACY PRACTICES: ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A. has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

AMENDMENTS: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: 17779 SW 2nd St, Pembroke Pines, FL 33029 Tel: 954-322-1110/ Fax: 954-322-1099

Acknowledgement and Consent

I have received the Notice of Privacy Practices for ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A.. They are authorized to use health information about (please print patient's name) _____for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____ _____

Signature of Patient **Date** **Account #**

Personal representative information (if applicable):

_____ _____

Name of Personal Representative Relationship to Patient

IDENTITY OF RECIPIENTS: Provide the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose covered information:

Permission to Leave Message: YES _____ NO _____

_____ Daytime Phone @ # _____

_____ On My Home Answering Machine Phone @ #_____

_____ On My Voicemail @ # _____

_____ With My Designated and Authorized Person(s) Named Below:

_____

All-Pro
ORTHOPEDICS AND SPORTS MEDICINE

Pembroke Pines
17779 SW 2nd St.
Pembroke Pines,
FL 33029

Hialeah
Palmetto Medical Arts Building
7100 W 20th Avenue, Suite 412
Hialeah, FL 33016

Wellington
1397 Medical Park Blvd. Suite 460
Wellington , FL 33414

Hollywood
210 S Federal Highway, Suite 302
Hollywood, FL 33020

info@allProOrthopedics.com 954.322.1110 954.322.1099

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS: _____

Do hereby IRREVOCABLY ASSIGN to the above named medical provider, any right or benefits under my policy of insurance with _____ ,for any service and/or charges provided by the above medical provider. Pursuant to this ASSIGNMENT OF BENEFITS, you are hereby directed to mail any and all checks directly and solely payable to the above named medical provider at the address listed on the HCFA-1500A form in box 33. As part of the ASSIGNMENT OF BENEFITS, I hereby instruct the insurance carrier that in the event the medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE PA is to be aside and not disbursed until the dispute is resolved.

IN WITNESS WHEREOF the undersigned has hereunto set his/her hand this _____ day of _____ , 20_____

_____ _____

Patient's Signature Patient's Name (please print)

All-Pro
ORTHOPEDICS AND SPORTS MEDICINE

Pembroke Pines
17779 SW 2nd St.
Pembroke Pines,
FL 33029

Hialeah
Palmetto Medical Arts Building
7100 W 20th Avenue, Suite 412
Hialeah, FL 33016

Wellington
1397 Medical Park Blvd. Suite 460
Wellington , FL 33414

Hollywood
210 S Federal Highway, Suite 302
Hollywood, FL 33020

info@allProOrthopedics.com 954.322.1110 954.322.1099

OUR CANCELLATION / NO-SHOW POLICY

DUE TO THE INCREASING NUMBER OF NO-SHOW AND SAME DAY CANCELLATIONS OF APPOINTMENTS, WE ARE INSTITTUING A NEW POLICY, EFFECTIVE IMMEDIATELY.

THE POLICY IS AS FOLLOWS:

1. Cancelled appointments within 24 hours of appointment time -$25.00 fee.

2. No show for appointment time -$50.00 fee.

3. Surgery cancellation within five days of schedule surgery time -$750.00 fee.

4. Any forms or letters will charge accordingly.

OUR STAFF APPRECIATES YOUR UNDERSTANDING

THANK YOU,

I have read and agree to the above policy.

Patient's Signature	Patient Print	Date

All-Pro
ORTHOPEDICS AND SPORTS MEDICINE

Pembroke Pines
17779 SW 2nd St.
Pembroke Pines,
FL 33029

Hialeah
Palmetto Medical Arts Building
7100 W 20th Avenue, Suite 412
Hialeah, FL 33016

Wellington
1397 Medical Park Blvd. Suite 460
Wellington , FL 33414

Hollywood
210 S Federal Highway, Suite 302
Hollywood, FL 33020

info@allProOrthopedics.com 954.322.1110 954.322.1099

Patient: _____ Date of Birth: ____/____/____

Insurance Carrier: _____ Member ID: _____

Service Date: ____/____/____

By signing below, I acknowledge and agree to have following procedure(s). I am aware that if my insurance does not pay, I will be financially responsible for payment of service(s) rendered as follows:

- ○ L3960: Arc 2.0 Shoulder Brace
- ○ L1832: Crossover Knee Sleeve
- ○ L3660: Clinic Shoulder Immobilizer
- ○ L4361: J Walker Boot
- ○ L3908: Universal Wrist Splint
- ○ L3807: Universal Wrist Thumb Spica
- ○ L3760: T-Chek
- ○ L1832: G3 Cool Knee Range Motion
- ○ L1902: Wraptor Ankle
- ○ L0627: Horizon 627 Back Braces Short
- ○ L0637: Horizon 637 Back Braces Long
- ○ L1843/L2397: OA Single Upright Knee Brace
- ○ L1843: Functional ACL Low Contact
- ○ L1833/:L2810: Hinged Knee Brace. Post Op Knee
- ○ L1810: Patella Stabilizer
- ○ L0648: Warrior Spine 648
- ○ L0650: Warrior Spine 650

Patient Signature: _____

Witness: _____

Date: ____/____/____

*** Medicare patients.: Please be aware that you will be responsible for the 20% co-insurance amount applied by Medicare upon adjudication of your claim. ***

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: The patient and All-Pro Orthopedics And Sports Medicine, P.A., the undersigned Medical Care Provider ("MCP") - which includes any affiliated physicians, employees, any related medical group, professional association, or any other entity or individual which has provided medical services in conjunction with the MCP — agree to submit any dispute whatsoever to binding arbitration including without limitation any claim for malpractice, personal injury, battery, breach of express or implied contract, loss of consortium, wrongful death or any payment or any other disputes relating in any way to past, present or future medical care. Any dispute will go to binding arbitration.

Article 2: All Claims Must be Arbitrated: The patient, and/or his or her spouse, born or unborn children, parents, heirs, or anyone launching any legal or equitable action (hereinafter "the Patient") and the MCP agree that any complaint of any type which in any way. relates to medical services shall, without exception, be submitted to binding arbitration. The governing law shall be the Federal Arbitration Act, state law notwithstanding. It is the express intention of the parties that any and all claims or complaints of any kind shall be submitted to and resolved by binding arbitration, which will be the exclusive and sole remedy. It is the specific and irrevocable intention of the parties to submit any question concerning this Agreement's arbitrability to the arbitrators only and to no other person or entity. For all issues regarding the validity of this - Agreement in court, the prevailing party shall be entitled to attorney's fees and to costs as determined by the court.

The MCP and any affiliated medical service provider that chooses to join in this Agreement agree to be equally bound just as the Patient is bound to binding arbitration in the event of any dispute. Such disputes can be brought by the MCP against the Patient, including terms of payment, services rendered, physical or emotional abuse, and other disputes. The Patient understands that any and all medical care provided is sufficient consideration, and the Patient will be fully and legally bound by this Agreement. Both parties to this Agreement are giving up their constitutional right to have any dispute decided in a court of law before a jury. All parties understand that they are giving up their right to have any dispute decided by a judge or jury through the court system. Resorting to the legal system by action at law or in equity will only be permissible if necessary to enforce any decisions reached through arbitration. The parties agree that any dispute about any provisions of this Agreement will be decided through arbitration.

The parties hereby bind anyone whose claims may arise out of or relate to treatment or services provided by the MCP at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" means both the mother and the mother's expected child or children. The parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action if they have been involved in any way in the care of the Patient. This may include claims of the Patient against other physicians,

nurses or medical professionals, or a hospital or other facility. Additionally, this Agreement is intended to resolve all claims for vicarious liability of the MCP.

Article 3: Recovery: The signers agree that the maximum total amount of all noneconomic and economic damages combined shall never exceed $250,000.00, applied on a per case basis, regardless of the number of claimants seeking compensation, and regardless of the number of physicians, professional associations, employees or entities named as defendants. The Patient agrees to waive any and all rights to any higher award. This limitation applies regardless of whether another healthcare provider, such as a physician, a hospital or other facility or employees of such a physician, hospital or facility are named as defendants in the binding arbitration or in any other proceedings. "Noneconomic damages" means nonfinancial losses that would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other nonfinancial losses to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act. The arbitrators may choose to award damages in excess of $250,000.00 only when extreme hardship is demonstrated: As consideration for the limitation on any waivers, the MCP will pay' up to and only the first $2,500.00 of attorney fees for the Patient.

The parties agree that if any punitive damages are awarded, they may not exceed three times any compensatory award. Same as required by Medicare/Medicaid, the parties agree that any awards in excess of $10,000.00 shall be paid in equal annual payments over ten (10) years without being reduced to present value. The arbitrators may reduce the time period in cases of extreme hardship. They will also consider any other collateral sources of compensation (e.g., workers compensation, life insurance, disability, charitable, and governmental benefits, and other monies paid to the injured patient or any other party) which shall diminish any awards for noneconomic and/or economic damages. The MCP shall be entitled to an off-set for any monies received by the Patient for claims against any other health care provider, if such claims arise out of or relate in any way to the claims of the Patient against the MCP. The parties agree to the complete disclosure of all collateral sources of compensation. Failure to promptly disclose any additional sources on request is agreed to be grounds for immediate and total dismissal of any claim.

Article 4: Statute of Limitations: In no case shall the statute of limitations exceed twelve (12) months from the date any alleged injury or problem could or should have been discovered regardless of the age of the Patient. The arbitrators and their empowerment under the FAA shall determine any question concerning the application of this provision. If this provision is held to be invalid it is replaced by the statute of limitations set forth in F.S. §766.

Article 5: Severability: If any specific term or provision of this Agreement is determined by a court of competent jurisdiction to be illegal, invalid, or otherwise unenforceable, the entire remainder of this Agreement shall be construed to be in full force and effect, and all other provisions will still apply. The Parties agree in general that any provisions so challenged will be brought to the arbitrators to decide upon, and not to a judge or jury.

Article 6: Merger Clause: This Agreement represents the entire agreement made between the MCP and the Patient. It supersedes any other agreements between the Patient and the MCP. Except as expressly set forth herein, there are no other representations, promises, understandings, or agreements of any kind between the parties. The Patient signing this Agreement acknowledges that he or she has not relied in any way upon any oral or written statements made to them besides what is contained within this Agreement. All parties acknowledge and understand that this Agreement cannot be changed, altered or modified in any way except by an instrument in writing, signed by all parties.

Article 7: Pronouns and Headings: The singular shall be held to include the plural, the plural held to include the singular, and the use of any gender shall be held to include every gender. All headings, titles, subtitles, or captions are inserted for convenience only, and are to be ignored in any construction of the provisions hereof.

Article 8: Procedures and Applicable Law: The parties agree to try to resolve all issues within nine (9) months of any complaint. This Agreement, its substantive provisions, the scope ..pfAh_e,Agreernent, the authority granted to the arbitrators.. and the.,linaitations contained in this Agreement, are to be governed by, and interpreted pursuant to the Federal Arbitration Act, any conflicting state law notwithstanding. To the extent not inconsistent with the FAA, it shall also be governed by provisions of the Revised Uniform Arbitration Act as adopted in the principal state where the MCP practices. The parties `agree that any dispute between them shall be determined by a panel of three arbitrators. Each party shall select one arbitrator from a list of qualified legal/medical experts provided by the MCP. All arbitrators will hold either Medical Degrees or both Medical and Ards Doctor Degrees. The two arbitrators selected shall then select a third arbitrator from the same list. Each party may remove the other's chosen arbitrator only once. The three arbitrators shall resolve any and all disputes between the parties pursuant to the National Arbitration Forum Code of Procedure or such procedures as they may jointly decide.

All arbitratioh hearings shall be conducted by video conf6tence; the 'MCP will provide equipment and pay all costs of video conference bridging' and that of the arbitrators. The parties shall adopt rules of evidence such as the arbitrators may see fit. The MCP shall pay the full costs of the arbitration, but shall not be responsible for paying any fees or costs charged to the Patient by their attorney save the first $2,500.00 as incli-dated above. Reasonable discovery will be permitted by both sides. The parties agree that the arbitrators are to render a written decision with reasons stated for the decision. This agreeMent is to be construed to follow F.S. §766 and provides patient with all rights necessary under F.S. §766 and the Florida Medical Malpractice Act. With the exceptions of a right to a trial by jury and the statute of limitations, if there is a conflict between this Agreement and either F.S. §766 or the Florida Medical Malpractice Act then F.S. §766 or the Florida Medical Malpractice Act will prevail.

Article 9: Right of Counsel and Rescission: The Patient understands that this Agreement is a legal document, and the Patient has the right to consult with an attorney before signing if desired. Your MCP encourages you to consult an attorney prior to signing or during a fifteen (15) day rescission period. You may rescind this Agreement for fifteen (15) days after signing it;

you agree that it will be in full force and effect until the date received at the MCP's office. To rescind it, return a copy to the MCP by certified mail-return receipt only with "CANCELED" written on the first page, and signed by you underneath that word. The Agreement will then be rescinded for all future care, but you agree it will be valid for any and all care provided by the MCP to the Patient for the entire period of all medical services up to the rescission.

Article 10: Authority to Sign: The Patient represents that he or she does have the authority to sign and execute this document on his/her own behalf (if signed by the Patient), or on behalf of the Patient (if signed by a person other than the Patient.)

Article 11: No Undue Influence: The individual signing this Agreement hereby acknowledges that he or she has not been pressured, induced, coerced, or intimidated in any way into signing this agreement, and has signed it of his or her own free will and accord and not under duress of any kind. The parties agree that they have been given every opportunity to ask questions and received answers concerning the specifics and intent of their Agreement.

Article 12: Frivolous Legal Actions: The Patient agrees that under no circumstances will a frivolous action or claim be brought againSt the MCP,. 6ridthe MCP agrees to not bring any frivolous action or claim against the Patient. If two or more Arbitrators rule that any action or claim brought against either party if frivolous in nature, the prevailing party shall be entitled to economic and noneconomic damages, including loss of wages or other compensation, damage to reputation, full attorney's fees and punitive damages.

Article 13: Mediation: At the MCP's sole expense, upon any compliant or alleged injury, the parties agree to promptly mediate in good faith with a qualified mediator prior to any arbitration hearing. A qualified professional mediator with medico-legal background shall be mutually agreed upon.

NOTICE: BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY OR TRIAL BY A JUDGE.

I hereby agree that all provisions of this Agreement are in full effect, and no word, sentence, paragraph or provision may be crossed out, excised or removed.

PATIENT SIGNATURE X	(DATE)
(Or Patient Representative)	(Indicate relationship if signing for patient)

OFFICE SIGNATURE X	(DATE)

All-Pro
ORTHOPEDICS AND SPORTS MEDICINE

Pembroke Pines
17779 SW 2nd St.
Pembroke Pines,
FL 33029

Hialeah
Palmetto Medical Arts Building
7100 W 20th Avenue, Suite 412
Hialeah, FL 33016

Wellington
1397 Medical Park Blvd. Suite 460
Wellington , FL 33414

Hollywood
210 S Federal Highway, Suite 302
Hollywood, FL 33020

info@allProOrthopedics.com 954.322.1110 954.322.1099

Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Person Requesting records and relationship: _____

Home Phone: _____ Daytime Phone: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of medical records or a summary or narrative of my protected health information, to the person (s) or entity below.

HIV/ AIDS: I DO___ DO NOT___ consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the result of my medical records. Initial: _____ Date: _____

Limitation's on the information you may release subject to this Release Form are as follows:

_____

_____

Release my protected health information to the following person(s) / entity:

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

I do ___ do NOT ___ give permission for these records to be faxed to the above entity.

The reasons or purposes for this release of information are as follows:

_____

_____

_____ _____

Patient Signature [or parent, guardian or legal representative] Date