



Formerly known as Meli
Orthopedic Centers of Excellence

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www.orthopedixmd.com

Meet Our Providers

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Minn Saing, MD
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Richard Zavoyiski, MD
Mirylsa Colón-Martínez, M.D

Specialties

Pediatric Orthopedics	Hand & Upper Extremity
Sports Medicine	Neck & Spine
Non-Surgical Treatments	Scoliosis
Foot & Ankle	Total Joint Replacements
Fractures & Trauma	Work-Related Injuries

WELCOME TO ORTHOPEDIX MD CENTERS OF EXCELLENCE

We welcome you to our practice and look forward to providing you with the best possible care. The information below will help to make the process smoother.

1. If you have insurance and you have a copay and/or deductible, payment is expected at the time of your visit (this is a contractual agreement with your insurance company).
2. **This office works by appointments; however, due the nature of our practice, we sometime experience delays. Please be patient as we give every patient the same careful attention.**
3. Please make cancellation at least 24 hours before your scheduled appointment.
4. Please advise the office BEFORE your next appointment if you change insurance companies, or we may have to reschedule you (some insurances companies require preauthorization/referral prior to your visit)
5. **If your insurance requires an authorization/referral it is your responsibility to ensure it is in our office prior your appointment.**
6. Advise the office of immediately of any change in address or telephone number.
7. Please advise the front desk if you have changed your primary care physician (PCP).
8. The doctors do not discuss any financial matters. If you need special arrangements to be made, please speak with our Billing Department directly at (954) 580-4084.

WE LOOK FORWARD TO MAKING YOUR EXPERIENCE WITH US A PLEASANT ONE

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

ORTHOPEDEX MD CENTERS OF EXCELLENCE is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

Treatment

We may disclose your medical or health information to other healthcare professionals, coaches, and immediate family members to include spouse, parents, adult, children, guardians, and insurance companies for the purpose of treatment, payment, or healthcare operations.

Example: "On occasions, it may be necessary to seek consultation regarding your condition from the other healthcare providers associated with ORTHOPEDIX MD CENTERS OF EXCELLENCE."

Payment

We may disclose your medical or health information to your insurance provider for the purpose of payment or healthcare operations.

Example: "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to ORTHOPEDIX MD CENTERS OF EXCELLENCE, for health care services rendered. If you pay for your health care services personally, we will provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation

We may disclose your medical or health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your medical or health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or in the event of your death.

Public Health

As required by law, we may disclose your medical or health information to public health authorities, for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your medical or health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your medical or health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or in missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Person

We may disclose your medical or health information to coroners or medical examiners.

Research

We may disclose your medical or health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your medical or health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public. In addition, we may disclose your medical or health information for military, national security, prisoner, and government benefits purposes.

Marketing

We may contact you for marketing purposes, or fund raising purposes as described below.

Example:

“It is our practice to participate in charitable events to raise awareness, foot donations, gifts, money, etc. During these times we may send you a letter, postcard, invitation, or call your home to invite you to participate in the charitable activity. It is not our policy to disclose any personal health information about your condition for the purpose of ORTHOPEDIX MD CENTERS OF EXCELLENCE sponsored fund raising events.”

Calls at home

As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we will leave you a reminder message on your answering machine. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Health Information Rights

- You have the right to request restrictions on certain uses and disclosures on your health information. However, please be advised that ORTHOPEDIX MD CENTERS OF EXCELLENCE is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication of delivery. (based upon patient’s request)
- You have the right to inspect and/or copy your health information.
- You have the right to request that ORTHOPEDIX MD CENTERS OF EXCELLENCE amend your protected health information. However, please be advised that ORTHOPEDIX MD CENTERS OF EXCELLENCE is not required to amend your protected health information. In case you request to amend your protected health information is denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by ORTHOPEDIX MD CENTERS OF EXCELLENCE.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon your request.

CHANGE OR OWNERSHIP

Please be aware that in the event that ORTHOPEDIX MD CENTERS OF EXCELLENCE is sold or merged with another organization, your health information/records will become the property of the new owner.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

ORTHOPEDIX MD CENTERS OF EXCELLENCE reserves the right to amend this Notice of Privacy Practices at any time in the future, and make the new provisions effective for all information that it maintains and until such amendment is made, ORTHOPEDIX MD CENTERS OF EXCELLENCE is required by law to comply with this notice.

WELCOME TO ORTHOPEDIX MD CENTERS OF EXCELLENCE

TODAY'S DATE _____

PATIENT NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ MALE FEMALE

LOCAL ADDRESS _____ APT _____

CITY _____ STATE _____ ZIP CODE _____

PERMANENT ADDRESS _____ APT _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

WOULD YOU LIKE OUR MONTHLY NEWSLETTER? NO YES

EMPLOYER'S NAME _____

REASON FOR YOUR VISIT TODAY? _____

PREFERRED PHARMACY _____ PHONE NO. _____

IS THIS DUE TO AN ACCIDENT? NO YES IF YES, DATE OF ACCIDENT _____

IF YES, IS THIS A **WORK** OR **AUTO** ACCIDENT? WORK AUTO OTHER _____

PRIMARY INSURANCE _____ I.D. # _____

SECONDARY INSURANCE _____ I.D. # _____

RESPONSIBLE PARTY _____ DATE OF BIRTH _____

SOCIAL SECURITY # OF RESPONSIBLE PARTY _____

RELATIONSHIP TO RESPONSIBLE PARTY _____

REFERRED BY _____

YOUR MEDICAL DOCTOR _____ PHONE NO. _____

IN CASE OF EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE NO. _____

PATIENT MEDICAL INFORMATION

PLEASE LIST ANY / ALL MEDICAL PROBLEMS _____

OPERATIONS AND DATES _____

PLEASE LIST ANY/ALL MEDICATIONS _____

ALLERGIES TO ANY MEDICATIONS _____

DO YOU SMOKE? NO YES, HOW MUCH? _____

DO YOU DRINK? NO YES, HOW MUCH? _____

HEIGHT _____ WEIGHT _____

AVERAGE BLOOD PRESSURE READING
SYSTOLIC (TOP NUMBER) _____ DIASTOLIC (BOTTOM NUMBER) _____

IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS, PLEASE CHECK ALL THAT APPLY

- | | | |
|---------------------------|---------------------------|-------------------------------|
| _____ DIABETES | _____ KIDNEY DISEASE | _____ HIGH CHOLESTEROL |
| _____ HIGH BLOOD PRESSURE | _____ ARTHRIS | _____ STOMACH PROBLEMS |
| _____ STROKE | _____ INTESTINAL PROBLEMS | _____ ASTHMA |
| _____ HEART DISEASE | _____ GOUT | _____ PHLEBITIS (BLOOD CLOTS) |
| _____ THYROID PROBLEMS | _____ HEPATITIS | _____ ULCERS |
| _____ HIATAL HERNIA | _____ CANCER | _____ H.I.V |

DO YOU HAVE A FAMILY HISTORY FOR ANY OF THE ABOVE MENTIONED CONDITIONS? NO

YES IF YES, PLEASE EXPLAIN:

ARE THERE ANY OTHER MEDICAL PROBLEMS THAT WE SHOULD BE AWARE OF? _____

WOMEN ONLY: ARE YOU PREGNANT? NO YES

PLEASE READ AND SIGN BELOW

In the event insurance is filed for surgery or other services rendered to me, I hereby authorize this office to release information to my insurance company and assign benefits directly to ORTHOPEDIX MD CENTERS OF EXCELLENCE.

1. MEDICAL RECORDS RELEASE

I authorize the release of any/all medical information necessary to process a claim or any related claims for my physician or to my attorney.

2. HMO AND MEDICARE PATIENTS – NON COVERED BENEFITS

I have been notified by my physician/supplier that Medicare/HMO is likely to deny payment for certain items (i.e. soft goods, outside x-ray review, etc.). If Medicare/HMO denies payment, I agree to be personally and fully responsible for payment.

3. SIGNATURE ON FILE/LIFETIME AUTHORIZATION

The signature below is required by ALL Medicare patients.

I request that payment of authorized Medical benefits be made to my physician/supplier for services rendered and any information needed to determine these benefits for any related services.

SIGNATURE: _____ **DATE:** _____

PAYMENT POLICY: PLEASE BE AWARE THAT PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

ACKNOWLEDGMENT OF RECEIPT

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF NOTICE OF PRIVACY PRACTICES BY ORTHOPEDIX MD CENTERS OF EXCELLENCE.

NAME: _____
PLEASE PRINT YOUR NAME

SIGNATURE: _____ **DATE:** _____

With my signature I agree that ORTHOPEDIX MD CENTERS OF EXCELLENCE and its collections department/agency may contact me at any of the phone numbers I have provided to discuss all balances pertaining to my account. MOCE also has permission to contact me via email if any or all of my phone number have been changed or disconnected.

FOR OFFICE USE ONLY

DATE ACKNOWLEDGEMENT WAS RECEIVED: _____

OR

REASON ACKNOWLEDGEMENT WAS NOT OBTAINED: _____

STAFF NAME: _____ DATE: _____ OFFICE LOCATION: _____ (EAST/WEST)

CANCELLATION POLICY

Our cancellation policy states that any scheduled appointment (either an office visit or procedure) must be cancelled with a 24 hour advanced notice, during normal operation hours (Monday through Friday; 8:30 am – 4:30 pm). Cancellations with less than 24 hour notice of scheduled appointment is noted as an **“untimely cancellation”**, and any missed appointment is labeled as a **“no show”**.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to seemingly “full” appointment book.

Please be informed that it is the policy of ORTHOPEDIX MD CENTERS OF EXCELLENCE centers of Excellence to monitor and manage appointment “no shows”.

Patients who fail to arrive for a scheduled appointment, without a 24 hour advanced notice, will be considered a “no show”.

Patients who consistently fail to arrive for more than (1) scheduled appointment are considered a CHRONIC “no show”.

“No show” appointments will incur the following fee: Follow up appointment \$30.00

Please note that this fee will not be covered by your insurance company. ***You MUST pay this fee in full*** before a future appointment can be made. Chronic “no show” patients are subject to dismissal from the practice.

By signing below, I have reviewed the above, fully understand and agree with the terms provided herein.

NAME: _____
PLEASE PRINT YOUR NAME

SIGNATURE: _____ **DATE:** _____