Institute for Metabolic and Bariatric Surgery
1002 S. Old Dixie Highway· Suite 206 · Jupiter, FL 33458
Phone: 561-741-5695 · Fax: 561-741-5697

Health Information Form

I am interested in: ❑ **Gastric Bypass** ❑ **Sleeve Gastrectomy**

Name: Last, First, MI	Date of Birth:	Race:	Gender:	Marital Status M D S W
Address:	Home Phone	Email Address:		
City, State, Zip	Work Phone	Cell Phone		
Employer	Social Security No.			Age
Employer Address:	Occupation:	Primary Language		
City, State, Zip	May we leave messages on your answering machine? ❑ Yes ❑ No			
Religious Preference	Primary Care Physician			
Emergency Contact Relationship	Emergency Contact Number			
Pharmacy Name:	Pharmacy Address:			

Insurance Information: Pease provide a copy of your Health Insurance card and Driver's License. If you do not have Health Insurance or do not intend to use Health Insurance benefits for rendered services, please write "None".

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID number	Policy or ID Number
Group Number	Group Number
Subscriber's Name & Relationship to Pt.	Subscriber's Name & Relationship to Pt.

How did you hear about us? ___________________________________

I authorize the release of medical records necessary to process claims for health insurance benefits and request that payments be made directly to my physician for services rendered. A copy of this authorization is as valid as the original. I acknowledge that my submission of this form is no guarantee that I will be accepted as a patient. I also understand that you do not finance co-pays and deductibles, which must be paid in full when invoiced. I acknowledge receipt of the Notice of Privacy Practices and have read and understand it. I authorize the office to obtain or access medication history files.
COMMUNICATIONS REGARDING MY ACCOUNTS: Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

Signature: ____ **Date:** ____________

Patient Name:____

Height:	Weight:	BMI:
Weight Problems date to: Childhood Adolescence Young Adult Pregnancy Adulthood		
Waist Circumference	Hip Circumference	
Highest Weight in Past Five Years:	Lowest Weight in Past Five Years	

Dietary History

Approximate age when you first seriously dieted: ____________

Indicate all diets and diet programs you have used:

Jenny Craig	Nutri-System	Weight Watchers	Opti/Medi-Fast	Fen/Phen/Redux
Xenical	Meridia	Adipex	Tenuate	T.O.P.S
South Beach	OA	Acupuncture	Hypnosis	

Have you completed or are you currently enrolled in a six consecutive month physician supervised weight loss program, which includes behavioral, nutritional and exercise components? YES NO

Past Medical History: Are you now or have you ever been treated for any of the following? **Please add any not specifically noted.**

❑ Coronary Artery Disease	I25.83	❑ Aortic Valve Disease	I06.9
❑ Mitral Valve Disease	I34.9	❑ Heart Valve Replaced?	Z95.4
❑ Elevated Cholesterol/Triglycerides	E78.0	❑ High Blood Pressure	I10
❑ Type II Diabetes	El1.9	❑ Asthma	J45.909
❑ Shortness of Breath	R06.02	❑ Sleep Apnea Syndrome	G47.30
❑ Emphysema	J43.9	❑ Do you use home oxygen	❑ Y ❑ N
❑ COPD	J44.9	❑ Use of CPAP?	❑ Y ❑ N
❑ Heartburn	R12	❑ Low Back Pain	M54.9
❑ Hiatal Hernia	K44.9	❑ Chronic Fatigue Syndrome	R53.82
❑ Leak of Urine w/Cough / Sneeze	R39.81	❑ Anxiety Disorder	F41.1
❑ Low Thyroid Function	E03.9	❑ Depression	F33.9
❑ Fibromyalgia	M79.7	❑ Bipolar Disorder	F31.81
❑ Personal History of Breast Cancer	Z85.3	❑ Personal History Colon Cancer	Z85.038
❑ Hepatitis C	Z22.52	❑ Irritable Bowel Disease	F45.8
❑ Gout	M10.00	❑ Esophageal Reflux	K21.9
❑ Osteoarthritis	M15.0	❑ Gallstones	K80.20

Patient Name:____

Surgical History - Please list any and all operations you have had in your entire life, **including**

Cosmetic or Plastic Surgery: Please add any not specifically requested

OPERATION	YEAR(S)	OPERATION	YEAR(S)
Tonsillectomy / Adenoidectomy		Appendectomy	
Laparoscopic Gallbladder		Open Incision Gallbladder	
Total Abdominal Hysterectomy		Vaginal Hysterectomy	
Coronary Bypass (CABG)		Carotid Endarterectomy	
Colon / Large Intestine Surgery		Prostate Surgery	
Breast Biopsy ❑ R ❑ L ❑ Both		Mastectomy ❑ R ❑ L ❑ Both	
Breast Enlargement		Breast Reduction	
Liposuction		Tummy Tuck	
Hernia Repair		Spleen Removal	
Hip Replacement ❑ R ❑ L ❑ Both		Knee Replacement ❑R ❑L ❑Both	
Heart Valve Replacement		Coronary Artery Stenting	

Allergies: [ ]I have no known drug allergies · **OR** · [ ] I am allergic to the following DRUGS:

		Latex Allergy? ❑ Y ❑ N

Medications AND Supplements AND Over the Counter Drugs

Medication	Dose and Frequency

Jupiter Medical Specialists · Dr. Jefferson R. Vaughan · 1002 South Old Dixie Highway Ste 206 · Jupiter, FL 33458

Patient Name:____

Family Medical History: Which of the following diseases "**run in your family**".

Please add anything not listed.

Disease	Family Member	Disease	Family Member
Heart Disease		High Blood Pressure	
High Cholesterol		Obesity	
Diabetes		Lung Disease	
Stroke		Kidney Disease	
Breast Cancer		Colon Cancer	
Bleeding Problems		Prostate Cancer	
Other:		Other	

Social History

Occupation: __________________________________

Do you have any children? ❑ Yes ❑ No If so, how many? _______

Are you disabled? ❑ Yes ❑ No If so, why? ________________________

Who Lives at home with you? ❑ Alone ❑ Spouse ❑ Family ❑ Domestic Partner ❑ Roommate

Do you have any pets? ❑ Yes ❑ No If yes, what type? _____________________

Do you exercise? ❑ Yes ❑ No If so, what type and how often? _______________

Do you use any of the following?

Substance	Amount	How Often	How Many Years
Alcohol			
Tobacco			
Street Drugs / Type			
Caffeine			

Personal Physicians: If you would like for us to communicate your progress with your other physicians, **please provide their names.**

Specialty	Physician Name	Phone & Fax Number
Cardiologist		
Pulmonologist		
Mental Health		
Other		

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Patient Name:____

Review of Systems: Please check all symptoms that you frequently experience

1. General: ❑ Change in appetite ❑ Chills ❑ Fatigue ❑ Fever ❑ Weight gain ❑ Weight loss
2. Eyes: ❑ Diminished visual acuity ❑ Dry eye ❑ Eye pain ❑ Itching and redness
3. Ears/Nose/Throat: ❑ Ear pain ❑ Hoarseness ❑ Ringing in the ears ❑ Sinus trouble ❑ Sore throat
4. Endocrine: ❑ Excessive thirst ❑ Heat intolerance ❑ Frequent urination ❑ Thyroid problems
5. Respiratory: ❑ Blood in sputum ❑ Cough ❑ Shortness of breath ❑ Other: ________________
6. Breast: ❑ Breast lump ❑ Breast pain ❑ Breast swelling
7. Cardiovascular: ❑ Chest pain ❑ Palpitations ❑ Other: ____________________________________
8. Gastrointestinal: ❑ Bloating ❑ Cirrhosis ❑ Gallbladder problems ❑ Abdominal Pain ❑ Bowel changes ❑ Constipation ❑ Diarrhea ❑ Nausea ❑ Rectal bleeding ❑ Vomiting
9. Hematology / Lymphatic: ❑ Anemia ❑ Bleeding problems ❑ Groin mass ❑ Easy bruising ❑ Swollen glands
10. Genitourinary: ❑ Blood in urine ❑ Frequent urination ❑ Painful urination ❑ Genital problems
11. Musculoskeletal: ❑ Arthritis ❑ Back problems ❑ Muscle aches ❑ Painful joints
12. Skin: ❑ Cyst ❑ Dry skin ❑ Itching ❑ Masses ❑ Rash ❑ Skin cancer ❑ Skin oozing
13. Neurological: ❑ Confusion ❑ Dizziness ❑ Headache ❑ Memory loss ❑ Tingling/Numbness

Psychiatric: ❑ Anxiety ❑ Depressed mood ❑ Eating disorder ❑ Suicidal thoughts

Patient Name (Print): ____ **Date:**__________________

Physician's Signature: ____ **Date:**__________________

ANNUAL QUESTIONNAIRE

Patient Name: ______________________________ Date: ____________________

1. Have you had a Pneumonia Vaccination? ❐ Yes ❐ No If yes, When: ____________________

2. Have you had a Flu Vaccination? ❐ Yes ❐ No If yes, When: ____________________

3. Do you have little interest or pleasure in doing things? ❐ Yes ❐ No

   If yes, check one: ❐ Several Days ❐ More than half the days ❐ Everyday

4. Are you feeling down, depressed or hopeless? ❐ Yes ❐ No

   If yes, check one: ❐ Several Days ❐ More than half the days ❐ Everyday

IF "NO" TO QUESTIONS 3 and 4, SKIP TO QUESTION #5

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several Days 1	More than Half the days 2	Everyday 3
Trouble falling or staying asleep or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television.				
Moving or speaking so slowly that other people could have noticed. Or the opposite? Being so fidgety or restless that you have been moving around a lot more than usual.				
Thoughts that you would be better off dead and/or of hurting yourself in some way.				

5. Have you fallen in the past year (If 65 or older please answer)? ❐ Yes ❐ No

   If yes, please complete:
   ❐ 1 fall with injury in the past year ❐ 2 or more falls with injury in the past year
   ❐ 1 fall without injury in the past year ❐ 2 or more falls without injury in the past year

Jupiter Medical Specialists, LLC
GENERAL SURGERY

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practices are available on the company's website and paper copies are out and available in the office and that I can take one of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

Patient: ________________________________ Date: ______________________

(print name)

Patient Signature:________________________

or

Patient's Representative: ___________________ Date: ______________________

Relationship to Patient: ____________________

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Jupiter Medical Specialists, LLC
GENERAL SURGERY

Jefferson Vaughan, MD

PATIENT REFERRAL FORM

Patient Name: ____ Date: ____________________

Which doctor will you be seeing? ____

Who referred you to our practice? ____

How did hear about us if other than doctor's office? (Please check off all that apply)

- ❒ Referral from a family member/friend (Name:____)
- ❒ Insurance Plan, Plan Directory Listing and/or Plan Website ______________________________
- ❒ Newspaper Ad (Which newspaper?) ____
- ❒ Yellow pages____
- ❒ Online ____
- ❒ Seminar or Lecture____
- ❒ Other (Please explain: ____

Dr. Jefferson R. Vaughan, MD, FACS
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1002 South Old Dixie Highway, Ste. 206, Jupiter, FL 33458
Office: 561-741-5695 Fax: 561-741-5697
www.BariatricFlorida.com

Bariatric Surgery Program Fee Policy Disclosure

The Bariatric Program is a collaboration of healthcare professionals assembled to provide a comprehensive surgical weight loss program. Achieving your weight loss goals will require life-long commitment and change in lifestyle. To give you the best opportunity for success, our program brings together a team of experts including a dedicated nurse, registered dietitian, licensed mental health counselor, exercise physiologist, and bariatric program coordinator. Our program is here to provide education, evaluation, and exceptional support before and after your bariatric surgery. Research has confirmed that this approach is essential to success. Regrettably, these particular services are not covered by your medical insurance.

These services include but are not limited to: Physician supervised weight-loss program, Registered Dietition, educational materials, monthly Support Groups and speakers, monthly newsletters, and insurance assistance.

By signing below, I understand that The Institute of Metabolic and Bariatric Surgery charges a **non-refundable** program fee of $**220.00**. If I have health insurance coverage for bariatric surgery, I understand that the program fee will not be credited towards any deductible or co-payment that I may owe. If I am a Self-Pay patient, I understand that if I continue with surgery the program fee will be credited towards the total amount of the procedure.

Patient Name (**please print**)____ Phone________________________

Patient Signature____ Date________________________

Envision
PHYSICIAN SERVICES

NOTICE OF PRIVACY PRACTICES
OF ENVISION HEALTHCARE CORPORATION

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.

Your health information is personal, and we are committed to protecting it. Your health information is also very important to our ability to provide you with quality care, and to comply with certain laws. This Notice applies to all records about care provided to you by Envision Healthcare's subsidiaries. (Your physician may have different policies and a different notice regarding your health information that is created in the physician's office.) Your information may be stored electronically and if so is subject to electronic disclosure.

I. We Are Legally Required to Safeguard Your Protected Health Information.

We are required by law to:

A. maintain the privacy of your health information, also known as "protected health information" or "PHI;"
B. notify you following a breach of unsecured PHI, under certain circumstances;
C. provide you with this Notice, and
D. comply with this Notice.

II. Future Changes to Our Practices and This Notice.

We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you previously. If a change in our practices is material, we will revise this Notice to reflect the change. You may obtain a copy of any revised Notice by contacting the Ethics & Compliance Department at 877-835-5267. We will also make any revised Notice available on our website at www.evhc.net.

III. How We May Use and Disclose Your Protected Health Information.

The law requires us to have your authorization for some uses and disclosures. In other circumstances, the law allows us to use or disclose PHI without your authorization. This section gives examples of each of these circumstances

Uses and Disclosures That Require Us to Give You the Opportunity to Object. Unless you object, we may provide relevant portions of your PHI **to a family member, friend or other person you indicate** is involved in your health care or in helping you get payment for your health care. We may use or disclose your PHI to notify your family or personal representative of your location or condition. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it later, after the emergency, and give you the opportunity to object to future disclosures to family and friends. Unless you object, we may also disclose your PHI to persons performing disaster relief activities.

A. Certain Uses and Disclosures Do Not Require Your Authorization The law allows us to disclose PHI without your authorization in the following circumstances:

(1) When Required by Law.
(2) For Public Health Activities.
(3) For Reports About Victims of Abuse, Neglect or Domestic Violence.
(4) To Health Oversight Agencies.
(5) For Lawsuits and Disputes.
(6) To Law Enforcement. We may release PHI if asked to do so by a law enforcement official, in the following circumstances: (a) in response to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) about a death we believe may be due to criminal conduct; (e) about criminal conduct at our facility; and (f) in emergency circumstances, to report a crime, its location or victims, or the identity, description or location of the person who committed the crime.
(7) To Coroners, Medical Examiners and Funeral Directors.
(8) To Organ Procurement Organizations.
(9) For Medical Research. We may disclose your PHI without your authorization to medical researchers who request it for approved medical research projects
(10) To Avert a Serious Threat to Health or Safety.
(11) For Specialized Government Functions.
(12) To Workers' Compensation or Similar Programs.

IV. Other Uses and Disclosures of Your Protected Health Information.

Other uses and disclosures of your PHI that are not covered by this Notice or the laws that apply to us will be made only with your written authorization. The law also requires your written authorization before we may use or disclose: (i) psychotherapy notes, other than for the purpose of carrying out our treatment, payment or health care operations purposes, (ii) any PHI for our marketing purposes or (iii) any PHI as part of a sale of PHI. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose your PHI for the purposes specified in the written authorization, except that

we are unable to retract any disclosures we have already made with your permission. In addition, we can use or disclose your PHI after you have revoked your authorization for actions we have already taken in reliance on your authorization. We are also required to retain certain records of the uses and disclosures made when the authorization was in effect.

V. Your Rights Related to Your Protected Health Information.

You have the following rights:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us to limit how we use and disclose your PHI. Any such request must be submitted in writing to our Privacy Officer. We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment. Notwithstanding the foregoing, we must agree to a restriction on the use or disclosure of your PHI if: (i) the disclosure is for our payment or health care operations purposes and is not otherwise required by law and (ii) you or another person acting on your behalf has paid for our services in full.

B. The Right to Choose How We Communicate With You. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail, or never by telephone). We must agree to your request as long as it would not be disruptive to our operations to do so. You must make any such request in writing, addressed to our Privacy Officer.

C. The Right to See and Copy Your PHI. Except for limited circumstances, you may look at and copy your PHI if you ask in writing to do so. Any such request must be addressed to our Patient Billing Service Center, which will respond to your request within 10 days (or 30 days if the extra time is needed). In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If we keep your information in an electronic format, you may request that we provide it to you in that format and we will do so if it would be feasible.

D. The Right to Correct or Update Your PHI. If you believe that the PHI we have about you is incomplete or incorrect, you may ask us to amend it. Any such request must be made in writing and must be addressed to our Patient Billing Service Center, and must tell us why you think the amendment is appropriate. We will not process your request if it is not in writing or does not tell us why you think the amendment is appropriate. We will act on your request within 30 days or less if state law requires (or 60 days if the extra time is needed), and will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will ask you who else you would like us to notify of the amendment.

We may deny your request if you ask us to amend information that:

(1) was not created by us, unless the person who created the information is no longer available to make the amendment;
(2) is not part of the PHI we keep about you;
(3) is not part of the PHI that you would be allowed to see or copy; or
(4) is determined by us to be accurate and complete.

If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement or complaint, or to request inclusion of your original amendment request in your PHI.

E. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI going back six years from the date of your request. The list will not include disclosures we have made for our treatment, payment and health care operations purposes, those made directly to you or your family or friends or through our facility directory, or for disaster relief purposes. Neither will the list include disclosures we have made for national security purposes or to law enforcement personnel.

Your request for a list of disclosures must be made in writing and be addressed to the Billing Center address that is listed on your invoice. We will respond to your request within 30 days, or less if state law requires (or 60 days if the extra time is needed). The list we provide will include disclosures made within the last six years unless you specify a shorter period. The first list you request within a 12-month period will be free. You will be charged our costs for providing any additional lists within the 12-month period.

F. The Right to Get a Paper Copy of This Notice. Even if you have agreed to receive the Notice by e-mail, you have the right to request a paper copy as well. You may obtain a paper copy of this Notice by contacting the Ethics & Compliance Department at 877-835-5267. The Notice is also available on-line at www.evhc.net.

VI. Complaints.

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the federal Department of Health and Human Services. To file a compliant with the DHHS put your complaint in writing and address it to the U S Department of Health & Human Services, 200 Independence Ave. S.W., Washington DC, 20201. Or call them at 877-696-6775. To file a complaint with us, put your complaint in writing and address it to our Envision Healthcare Corporation HIPAA Privacy Officer at Envision Healthcare Corporation 1A Burton Hills Blvd, Nashville, TN 37215. You may also contact our Privacy Officer at 877-835-5267 to file a complaint, or if you have questions or comments about our privacy practices. We will not retaliate against you for filing a complaint.

Jupiter Medical Center
Jupiter, Florida 33458

CONSENT FOR TREATMENT - GENERAL

CONSENT TO TREATMENT: The undersigned, as the patient, or as the guardian or representative of the patient, consents to such laboratory, diagnostic and treatment procedures/examinations, including a pelvic or rectal exam, considered reasonably necessary for the care and treatment of my condition during my admission for outpatient or inpatient care as rendered to the patient under the instructions of a licensed physician or other health care practitioner.

AGREEMENT TO PAY CHARGES: I hereby assign to the health care entity my right to payment for healthcare services and supplies I receive from the health care entity. I direct anyone paying or receiving money for services or supplies I receive, to pay the money to Jupiter Medical Center or their affiliates. I understand that the health care services I receive may not be covered or paid for, or may only be partially covered or paid for, by my healthcare insurance company or any other third party payer. In the event that the billed charges for the healthcare services I receive are not covered or paid for on my behalf, or are only partially covered or paid, I understand and agree that I am responsible for the payment of the billed charges, or the remaining balance of billed charges for an such service or, if the health care entity has a contractual payment arrangement with my insurance company or third party payer, I will be responsible for the payment of any co-payments, deductibles, and co-insurance for covered services and billed charges for any non-covered services. Any phone number I have provided may be used for the purpose of collecting payments in connection with any services provided by any Jupiter Medical Center provider or affiliate.

PATIENT INFORMATION DISCLOSURE FOR TREATMENT, OPERATIONS AND PAYMENT: The undersigned, as the patient or as the guardian or authorized representative of the patient, authorizes JMC to release any and all information regarding the hospital services and supplies, for the purpose of treatment, operations or payment to any payer or other entity or person deemed necessary by JMC. This includes authorization to release information pertaining to psychiatric and/or psychological care (but not psychotherapy notes), alcohol and/or substance abuse and serologic test results including HIV. JMC may also obtain prescription history from the patient's insurance company and healthcare providers for the purpose of treatment.

MEDICARE AND MEDICAID BENEFITS: I certify that the information given by me in applying for payment under Medicare is correct (including the answers given by me in response to the questions of the Medicare Secondary Payer (MSP) questionnaire), I request payment of authorized Medical benefits on my behalf for services furnished to me by or in Jupiter Medical Center, including physician services, I authorize any holder of medical and other information about me to release to Medicare and its agents my information needed to determine these benefits or benefits for related services.

RELEASE OF LIABILITY AND RESPONSIBILITY FOR PERSONAL VALUABLES: I understand that I am responsible for all articles and personal property (money, documents, radios, jewelry, dentures, eyeglasses, hearing aids, etc.) and/or clothing which I retain in my possession (on my person or in my room) and for any other articles and/or clothing which may be brought to me while I am a patient in JMC. I hereby release JMC, physician(s) and team members from any claim for loss, damage to or complete destruction of such property, which is not deposited with the hospital for safekeeping in the hospital safe.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that a copy of the " Notice of Privacy Practices" has been made available to me.

INDEPENDENT CONTRACTORS: I acknowledge that some physicians and other providers operating and practicing in this hospital are not agents or employees of the hospital. These include but are not limited to the following groups: Emergency Physicians, Anesthesiologists, Pathologists, Radiologists, Staff and/or Contract Providers. Physicians and other providers bill separately for their services and may or may not accept my insurance.

STUDENT HEALTH CARE PROVIDERS: I understand healthcare may be provided to me in the form of services rendered by a student health care provider such as a student nurse, respiratory therapist, and pharmacy intern or radiology technology student participating in my care. I understand that by signing this form I am consenting to the supervised care rendered by such health care providers.

DIAGNOSTIC PHOTOGRAPHY AUTHORIZATION: I authorize radiographic films, x-rays, mammograms and other diagnostic films including still, movie or television photography to be taken of me during my hospital stay and consent to the use of such films for medical, scientific or educational purposes.

Jupiter Medical Center
Jupiter, Florida 33458

CONSENT FOR TREATMENT - GENERAL

WORKERS COMPENSATION: According to Florida Statute section 440.105(7): "Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in **s.817,234.**"

TOBACCO FREE ENVIRONMENT: I understand that Jupiter Medical Center is a tobacco-free environment and that I may not use tobacco products including cigarettes, cigars, pipes, herbal tobacco products, and chewing tobacco on the hospital campus or at any facility owned, leased or operated by Jupiter Medical Center. I understand the use of electronic cigarettes or vapor is not recognized by Jupiter Medical Center as a nicotine replacement therapy and their use is also prohibited.

ADVANCE DIRECTIVE QUESTIONS:

1. Do you have an Advance Directive? ☐ yes ☐ no ☐ Unable to respond
2. If yes, is it on file? ☐ yes ☐ no. If no, copy requested? ☐ yes ☐ no
3. If no Advance Directive, copy given? ☐ yes ☐ declined

ACKNOWLEDGEMENT
The undersigned certifies that he/she has read and understood the foregoing and agrees to its terms:

Signature of Patient or Legally Authorized Representative	Date/Time	Printed Name of Patient
Relationship to Patient if signing on Patient's Behalf	Date/Time	Reason Patient Unable to Sign
Witness	Date/Time	