PATIENT INFORMATION

Account#:_____

Today's Date: _____ Primary Care Physician _____ PCP Fax: _____

Patient's Name: _____
(Last) (First) (Middle Initial)

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____ Cell Phone:_____

Email Address: _____

Primary Language Spoken: English❑ Spanish ❑ Creole ❑ Other: _____

Do you need translation/communication assistance? Y❑ N❑ *Only Hearing impaired translator will be provided.*

Age: _____ Date of Birth: _____ Social Security Number: _____ Gender: Male ❑ Female ❑

Height: _____ Weight: _____ Marital Status: Single ❑ Married ❑ Other: _____

Race (**circle one**): Black or African American/ Asian/ American Indian or Alaskan Native/ White (this includes all Hispanic and Latino)/ Prefer Not to Participate

Ethnicity (**circle one**): Hispanic or Latino Non Hispanic or Latino Prefer Not to Participate

In Case of Emergency Notify: _____ Phone: _____

Current Employer: _____ Phone: _____

Employer's Address: _____

Area to be Treated: _____

Onset of Problem: _____

Detailed Description of Problem: _____

_____

_

Condition Related to Employment: Yes ❑ No ❑ If Yes, Please Complete the Following Information:

Date of Injury: _____ Employer at Time of Injury: _____

Address: _____ Phone: _____

Condition Related to Automobile Accident: Yes ❑ No ❑ If Yes, Please Complete the Following Information:

Date of Injury: _____ Insurance Name: _____

Address: _____

Policy #: _____ Claim #: _____

Phone: _____ Adjuster Name: _____

Are You Being Represented By An Attorney: Yes ❑ No ❑ If Yes, Please Complete the Following Information:

Attorney's Name: _____ Phone: _____

Address: _____

MEDICAL HISTORY QUESTIONNAIRE

Please check: ❑Initial Appointment ❑Follow-up Visit

Patient Name: _____ **Date:**_____

Family Physician:_____ **Account#:**_____

Allergies

❑No Change since last visit. ❑New info

Please list any medication allergies that you have.

Medications

❑No Change since last visit. ❑New info

Please list all medication you are taking?

❑Attach List

Social History

❑No Change since last visit. ❑New info

Do you smoke? ❑Yes ❑No

*If yes, how many per day?*_____

Do you drink alcohol? ❑Yes ❑No

*If yes, how many per week?*_____

Is it possible you may be pregnant?

❑Yes ❑No ❑N/A

Are you ❑Right Handed? or ❑Left Handed?

Medical History

❑No Change since last visit. ❑ New Info

Have you had any of the following Conditions?

Depression/Anxiety	❑Y	❑N
Diabetes	❑Y	❑N
Thyroid Disease	❑Y	❑N
High Cholesterol	❑Y	❑N
High Blood Pressure	❑Y	❑N
Lung Disease	❑Y	❑N
Heart Attack	❑Y	❑N
Rheumatic Fever	❑Y	❑N
Stroke	❑Y	❑N
Seizures/Epilepsy	❑Y	❑N
Asthma	❑Y	❑N
Emphysema	❑Y	❑N
Bronchitis	❑Y	❑N
Tuberculosis	❑Y	❑N
Liver Disease	❑Y	❑N
Pancreatitis	❑Y	❑N
Gout	❑Y	❑N
Osteoporosis	❑Y	❑N
Joint Replacement	❑Y	❑N
HIV Infection/AIDS	❑Y	❑N
Hepatitis	❑Y	❑N
Thrombosis	❑Y	❑N
Kidney Disease	❑Y	❑N
Cortisone treatment	❑Y	❑N
Glaucoma	❑Y	❑N
Pace maker	❑Y	❑N
Rheumatoid Arthritis	❑Y	❑N
Cancer	❑Y	❑N

If yes, Please list: _____

Other(list):

Review of Systems

❑No change since last visit ❑New Info

Do you have any of the following symptoms?

General			***Cardiovascular***		
Weight change	❑Y	❑N	Chest pain	❑Y	❑N
Fever	❑Y	❑N	Swelling Feet/leg	❑Y	❑N
Night Sweats	❑Y	❑N	Irregular heartbeat	❑Y	❑N
Fatigue	❑Y	❑N	Blood Clots	❑Y	❑N
Immune/Allergy			***Ear/Nose/Throat***		
Hives	❑Y	❑N	Ringing in the ears	❑Y	❑N
Rashes	❑Y	❑N	Loss of hearing	❑Y	❑N
Frequent infections	❑Y	❑N	Nose bleeds	❑Y	❑N
Swollen glands	❑Y	❑N	Trouble swallowing	❑Y	❑N
Musculoskeletal			***Urinary***		
Joint pain	❑Y	❑N	Incontinence	❑Y	❑N
Back or neck pain	❑Y	❑N	Painful urination	❑Y	❑N
Muscle weakness	❑Y	❑N	Blood in urine	❑Y	❑N
Muscle pain	❑Y	❑N	Burning	❑Y	❑N
Hematologic			***Endocrine***		
Anemia	❑Y	❑N	Excessive thirst	❑Y	❑N
Blood Clots	❑Y	❑N	Weight gain	❑Y	❑N
Bleed or bruise easily	❑Y	❑N	Excessive hunger	❑Y	❑N
Digestive			***Respiratory***		
Abdominal pain	❑Y	❑N	Shortness of breath	❑Y	❑N
Nausea or Vomiting	❑Y	❑N	Wheezing	❑Y	❑N
Bloody stools	❑Y	❑N	Cough	❑Y	❑N
Eyes			***Skin***		
Blurry vision	❑Y	❑N	Rashes	❑Y	❑N
Loss of vision	❑Y	❑N	Discoloration	❑Y	❑N
Itching	❑Y	❑N			
Neurological			**Other (list)**		
Dizziness	❑Y	❑N			
Numbness	❑Y	❑N			
Seizures	❑Y	❑N			
Stroke	❑Y	❑N			
Headaches	❑Y	❑N			

Surgical History

Please list any surgeries you have had. ❑No Change since last visit. ❑New Info

Procedure	Year

Patient/Gurantor: _____ **Date:**_____

Physician Signature:_____ **Date:**_____

Family History

❑No change since last visit ❑New Info

Has anyone in your family ever had:

Heart Disease	❑Y	❑N	If yes, who? _____
Lung Disease	❑Y	❑N	If yes, who? _____
Kidney Disease	❑Y	❑N	If yes, who? _____
Diabetes	❑Y	❑N	If yes, who? _____
Cancer	❑Y	❑N	If yes, who? _____

CONSENT FOR TREATMENT

I voluntarily consent to the Center for Bone and Joint Surgery and it's providers for the rendering of care, including treatment, injections, and administration of anesthesia and performance of diagnostic and/or surgical/corrective procedures. With any invasive procedure there is a risk of adverse reactions, including but not limited to allergic reactions, pain, scarring, infection and reactive synovitis.

MISSED APPOINTMENT NOTIFICATION

The United States Government and the Centers of Medicaid and Medicare Services have passed official instruction CRS613 allowing a charge for missed appointments. I understand that I may be charged a missed appointment fee of $25.00 if I do not cancel with a 24-hour notice.

EMERGENCY CARE/AFTER HOURS

Should you have an urgent problem when our office is closed, please call 561-798-6600 and remain on the line to leave your message with our answering service. In the event of a true emergency at any time of day, please call 911 or go directly to a hospital emergency room. The emergency room physician at the hospital will assess the problem and begin treatment as soon as your situation is evaluated. Our physician will be notified if needed.

Medication

The Center for Bone and Joint Surgery of the Palm Beaches makes it quick and easy for established patients to request Prescription and refills. Simply complete and submit our Prescription Request form on our Web site www.boneandjoint.org or call our office at (561) 798-6600, allow 3 business days. Please request your prescription during our office hours: Monday through Friday, 8 AM to 5 PM. No refills are issued during the evenings, weekends, or holidays. We ask that you anticipate your refill needs and order refills in advance to avoid an interruption in your medication therapy. Narcotics are not filled or refilled without **an appointment**

NARCOTIC MEDICATION

I understand I may be prescribed narcotic and sedative medication for treatment of my condition(s).

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibly that the medicine will not provide complete pain relief.

- I realize it is my responsibility to keep others and myself from harm. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.
- I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
- I consent to urine and blood screens. Because these drugs have potential for abuse or diversion, strict accountability is necessary. Urine or serum toxicology screens will be requested and your cooperation is required. Presence of unauthorized substances may prompt discontinuance of narcotic medication.
- I will not abuse my narcotic medication by taking more than the prescribed dosage, combining the medication with illegal controlled substances, prescribed or non-prescribed or excessive amounts of sedatives, including alcohol, as this may result in profound sedation and death.
- I may decline narcotic medication and associated toxicology screens. I may choose to use non-narcotic pain medication such as NSAIDS or Acetaminophen,

INSURANCE INFORMATION

Primary insurance Name: _____Id #_____

Insured's Name: _____Relationship to patient _____

Insured's SSN:_____ Date of Birth: _____

Secondary Insurance Name:_____Id#_____

Insured's Name: _____Relationship to patient _____

Insured's SSN:_____ Date of Birth: _____

I authorize the Center for Bone & Joint Surgery of the Palm Beaches, P.A. to release any information acquired in the course of my examination or treatment to my insurance company. I hereby authorize payment directly to the Center for Bone & Joint Surgery of the Palm Beaches, P.A. of the medical benefits, if any, otherwise payable to me for this service, not to exceed the usual and customary fees. I recognize and accept responsibility for any balance or fee not covered. All information is complete to the best of my knowledge.

_____ _____

Patient or Guardian Signature Date

PRIVACY RELEASE, MEDICAL RELEASE AND FINANCIAL AUTHORIZATION

PATIENT CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

A. I understand that as part of my health care, The Center for Bone and Joint Surgery of the Palm Beaches originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:
   - o A basis for planning my care treatment
   - o A means of communication among the many health professionals who contribute to my care
   - o A source of information for applying my diagnosis and surgical information to my bill
   - o A means by which a third party payer can verify that services billed were actually provided
   - o A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

B. I understand and have been provided with a NOTICE OF PRIVACY POLICIES that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:
   - o The right to review the notice prior to signing this consent
   - o The right to object to the use of my health information for directory purposes
   - o The right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment or healthcare operations

C. I understand that The Center for Bone and Joint Surgery of the Palm Beaches is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal regulations.

D. I further understand that The Center for Bone and Joint Surgery of the Palm Beaches reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of federal regulations. Should The Center for Bone and Joint Surgery of the Palm Beaches change their notice, they will send a copy of any revised notice to the address I've provided (whether US postal mail or email).

E. I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

F. I understand that as part of this organizations treatment, payment or healthcare operations, it may become necessary to disclosure my protected health information to another entity and I consent to such disclosure for the above permitted uses, including disclosures via facsimile.

G. I understand that The Center for Bone and Joint Surgery of the Palm Beaches may charge me or the interested third party a fee for the copies as set forth on the fee schedule at Medical Records Department from The Center for Bone and Joint Surgery of the Palm Beaches. I also understand that I may be required to pay the fee in full before I can obtain the copy.

HOW TO REVOKE YOUR AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective The Center for Bone and Joint Surgery of the Palm Beaches must receive the revocation in writing. The letter should be mailed to the following address via Certified US Mail: 10131 Forest Hill Blvd. Ste. 230, Wellington, FL 33414-6109

The revocation letter must include:

- o The patient's name, address, and telephone number
- o The effective date of this authorization and the recipients of the protected health information
- o The patients desire to revoke this authorization, date of the revocation and patients signature

All revocations must be sent to the attention of the Privacy Officer. This authorization shall expire five (5) days after received by the Privacy Officer. After this date, The Center for Bone and Joint Surgery of the Palm Beaches can no longer use or disclose the patients protected health information without first obtaining a new authorization form.

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Notice of Privacy Policies for The Center for Bone and Joint Surgery of the Palm Beaches.

Privacy Notice effective September 23rd, 2013.

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS AND/OR AUTHORIZATION TO PAY.

A. Known by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint The Center for Bone and Joint Surgery of the Palm Beaches and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said The Center for Bone and Joint Surgery of the Palm Beaches which checks, drafts or money orders are made payable for services which have been made by The Center for Bone and Joint Surgery of the Palm Beaches at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

B. Furthermore, the undersigned allows The Center for Bone and Joint Surgery of the Palm Beaches or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

C. The undersigned by these presents does give and grant the said The Center for Bone and Joint Surgery of the Palm Beaches as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other documents.

MEDICAL RELEASE

A. A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me to release true copies of same to The Center for Bone and Joint Surgery of the Palm Beaches or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

B. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney do or cause to be done by virtue of these present.

C. I hereby authorize my insurance carrier (s) to pay directly to: Center for Bone and Joint Surgery of the Palm Beaches, 10131 Forest Hill Blvd. Ste. 230, Wellington, FL 33414-6109

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services, I hereby IRREVOCABLY ASSIGN to The Center for Bone and Joint Surgery of the Palm Beaches any rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by The Center for Bone and Joint Surgery of the Palm Beaches.

I fully understand and accept the terms of this authorization. IN WITNESS WHEREOF the undersigned have hereunto set their hands:

_____

Patient or Guardian Signature

Date: _____

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, understand that *The Center for Bone and Joint Surgery of the Palm Beaches* is authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner of *The Center for Bone and Joint Surgery of the Palm Beaches* or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this information, it may be subject re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (Please check all that apply):

☐ **The Patient's Entire Medical Record:** This requires an explanation why the entire medical record may be disclosed.

☐ **The Patient's Demographic Information:**

☐ Name ☐ Address ☐ Telephone ☐ Date of Birth

☐ **Medical / Billing Data:**

☐ Appointment(s) Date and Time ☐ Medication(s) ☐ Lab and Test Results

☐ Billing / Statement Information

☐ **Attorney authorized by this form that may use and disclose the patient's protected health information**:

Attorney's Name: _____

Address: _____

Telephone: _____ Fax Number: _____

☐ **Other Recipient:** _____

_____

☐ **Name(s) of person(s) authorized by this form to which the patient's protected health information will be disclosed:**

_____

_____

☐ **Check only if applicable.** This authorization permits *The Center for Bone and Joint Surgery of the Palm Beaches* to send the protected health information ONLY to this address and/or fax number:

_____

_____

Center for Bone and Joint Surgery of the Palm Beaches, P.A. shall send information ONLY as authorized above. Any disclosure of the patient's protected health information to another person or entity not mentioned above will require a separate authorization.

_____ _____

Patient or Guardian Signature Date

FINANCIAL AGREEMENT

I. In consideration of the services to be rendered to me, **I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF THE *CENTER FOR BONE AND JOINT SURGERY OF THE PALM BEACHES* IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF *THE CENTER FOR BONE AND JOINT SURGERY OF THE PALM BEACHES.*** Should the account be referred to an attorney or licensed collections agency for collections, I shall pay reasonable attorney's fees and collections expenses. All delinquent accounts (those not paid within sixty (60) days from the date of service) shall bear interest at the legal rate. In the event the account is referred to a licensed collections agency or an attorney, I shall pay 25% collections fees and reasonable attorney's fees on the balanced owed.

II. I hereby authorize direct payment to *The Center for Bone and Joint Surgery of the Palm Beaches* of any insurance benefits otherwise payable to me for the services rendered at a rate not to exceed *The Center for Bone and Joint Surgery of the Palm Beaches* regular charges. It is agreed that payment to *The Center for Bone and Joint Surgery of the Palm Beaches,* pursuant of this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this agreement.

I understand that *The Center for Bone and Joint Surgery of the Palm Beaches* shall have the right at any time to refuse to provide medical care or treatment to me. I certify that I am a patient or am dully authorized by the patient as the patient's general agent to execute this document and accept its terms.

III. I understand that, as a courtesy, *The Center for Bone and Joint Surgery of the Palm Beaches* will file my primary insurance. If after sixty (60) days from the date of service and/or surgery insurance has not paid, the total balance will be considered due and payable.

THIS REFERS TO MEDICARE PATIENTS ONLY:

IV. Regarding **MEDICARE ASSIGNMENT**: This means *The Center for Bone and Joint Surgery of the Palm Beaches* will accept payment in full for what MEDICARE allows not what MEDICARE pays. It is the patient's responsibility for the 20% of the MEDICARE allowable for which MEDICARE does not pay. I fully understand that I agree to be responsible for this 20%.

~Lifetime Authorization~

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related MEDICARE claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to MEDICARE for payment to me.

_____ _____

Patient or Guardian Signature Date

MEDICAL REPORTS AND DOCTOR'S LIEN

FOR USE ON LEGAL CASES ONLY

Patients Name: _____ SSN: _____

Acct. No._____ D/A: _____

Dear _____:

I do hereby authorize *The Center for Bone and Joint Surgery of the Palm Beaches ("CBJ")* to furnish you, my attorney, with copies of all medical records relating to treatment received by me from doctors, physician assistants, nurses or any other clinical member employed by *"CBJ"* in regard to the accident in which I was involved.

I further authorize and direct you, my attorney, to pay directly to *"CBJ"* such sums as may be due and owing for medical services rendered to me both by reason of this accident and by reason of any other bills, including interest on the unpaid balances of my account, that are due *"CBJ"* and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect *"CBJ"*. In addition, I hereby give a lien on my case to *"CBJ"* against all proceeds from any settlement, judgment or verdict which may be paid to my attorney and/or I as a result of the injuries and damages claimed in connection with my case. Expect that, as the sole and only exception to a lien on the proceeds of my case are the fees and costs due my attorney as a result of any settlement, judgment or verdict obtained by my attorney.

I fully understand that I am directly responsible to *"CBJ"* for all medical bills submitted for services rendered to me and that this agreement is made solely for *"CBJ"* additional protection and in consideration of *"CBJ"* awaiting payments on its medical bills until a settlement, judgment, verdict or a dismissal of my case is obtained. I further understand that such payment is not contingent on any settlement, judgment or verdict from which I may eventually recover funds to pay *"CBJ"* bills for services rendered to me. Furthermore, I hereby agree and consent to *"CBJ"* entitlement to intervene in any action, suit or claim which may be filed by me or my attorney for this injuries treated by *"CBJ"*. In addition, I hereby acknowledge that the covenants and agreements made herein do not pertain to any health or managed care contracts between my health care insurer and *"CBJ"* to which I may be a direct or third party beneficiary.

In the event suit is initiated for collection of medical bills due to *"CBJ"* in accordance with this agreement, I agree to pay, in addition to the medical bills, all expenses necessitated by the collection of said medical bills including but not limited to reasonable attorney's fees and costs incurred by *"CBJ"*.

Signature of Patient/Guardian: _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from my settlement, judgment or verdict, excluding attorney's fees and cost due me, as may be necessary to adequately protect *"CBJ"* as above stated.

Signature of Attorney: _____ Date: _____

Please return copy to the Center for Bone and Joint Surgery of the Palm Beaches and you may keep one for your records.

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy. Any alterations to this document will be deemed as null and invalid.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of
(Print Name)

this Office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

DISCRIMINATION IS AGAINST THE LAW

The Center for Bone & Joint Surgery of the Palm Beaches, PA ("CBJ") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CBJ does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CBJ provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters;
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

CBJ provides free language services to people whose primary language is not English, such as Information written in other languages

If you need these services, contact CBJ's Compliance Officer.

If you believe that CBJ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- CBJ Compliance Officer: Eduardo Pantoja
- Mailing Address: 10131 Forest Hill Blvd, Suite 230, Wellington, FL 33414
- Telephone number: (561) 633-4161
- Fax: (561) 633-4361
- Email: civil.rights@boneandjoint.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, CBJ Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (561) 633-4161.	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (561) 633-4161. (Spanish)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (561) 633-4161. (French Creole)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (561) 633-4161. (Vietnamese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (561) 633-4161. (Portuguese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (561) 633-4161。(Chinese)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (561) 633-4161. (French)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (561) 633-4161. (Tagalog)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (561) 633-4161. (Russian)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (561) 633-4161. (Arabic)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (561) 633-4161. (Italian)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (561) 633-4161. (German)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (561) 633-4161 (TTY: (561) 633-4161)번으로 전화해 주십시오. (Korean)	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (561) 633-4161. (Polish)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (561) 633-4161. (Gujarati)	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (561) 633-4161. (Thai)