Lampert MD
PLASTIC SURGERY

Plastic, Reconstructive, & Aesthetic Surgery
Diplomate, American Board of Plastic Surgery

Registration Information

Patient's Name: _____
Last **First** **MI**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Work #:** _____ **Cell #** _____

E-Mail Address: _____ **Driver License #:** _____

Social Security #: _____ **Date of Birth:** _____ **Age** _____

Marital Status: S M D W Sex: M F Primary Language Spoken: _____

Ethnicity: _____ **Race:** _____

Employer: _____ **Occupation:** _____

Emergency Contact: _____ **Phone:** _____

Who may we thank for your referral _____

Can we send you mailings and solicitations via e-mail? Yes___ No___

Purpose of your Visit _____

Insurance Information

Company Name: _____ **Policy #:** _____ **Group #** _____

Insured Name: _____ **Insured Date of Birth:** _____

I agree that should my insurance policy have a deductible, or not cover Dr. Lampert's fee for service, I will be responsible for the balance due in addition to interest compounded at 1.5% per month if not paid promptly.

I agree that should this account be referred to an agency or attorney for collection, that I will be responsible for all collection costs, attorney fees and court cost, and interest fees.

I certify the insurance information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____
Signature (Parent if Minor) ***Date***

MEDICAL INFORMATION

Primary Care Doctor_____**Phone#**_____

Height_____**Weight**_____

Regular Medications_____

Allergies_____

History of Surgeries_____

PERSONAL MEDICAL HISTORY:

High Blood Pressure_____ **Bleeding Or Clotting Problems**_____

Heart Trouble or Murmur_____**Alcohol or Drugs Dependency**_____

Asthma or lung Ailments_____**Diabetes**_____ **History of Anemia** _____

Epilepsy_____**Blindness or Glaucoma**_____

Hepatitis_____**Psychological Concerns**_____

Sexually Transmitted Disease_____**Date of Last Physical**_____

Date of Last Breast Exam_____**Do You Smoke**_____**How Much**_____

Do you have a history of sleep apena? [ ] Yes [ ] No

Do you use a CPAP Machine? [ ] Yes [ ] No

Have you seen a counselor, psychologist, psychiatrist, or other mental health professionals before?
[ ] Yes [ ] No

If yes, please explain any prior diagnosis and reason for visit:

_____

Are you actively receiving care from the mental health professional referred to above?
[ ] Yes [ ] No

Date of last appointment: _____

Lampert MD
PLASTIC SURGERY

Joshua Lampert, M.D., F.A.C.S
20200 West Dixie Highway, Unit G05
Aventura, FL 33180
Office: (305) 878-1920
Fax: (888) 672-7711

HIPAA AUTHORIZATION FORM

I, _____, hereby authorize the use or disclosure of my protected health information as described below:

1. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Dr. Joshua Lampert is authorized to disclose the following protected health information to

_____
Name or Organization

Relationship to Patient: _____

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:

☐ All healthcare information

☐ Other: _____

3. VALIDITY OF AUTHORIZATION FORM

This Authorization Form is valid beginning on _____.
MM/DD/YYY

4. ACKNOWLEDGEMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

MIAMI SURGERY, LLC

Lampert MD PLASTIC SURGERY

ASSIGNMENT OF BENEFITS

I irrevocably assign to Joshua Lampert, M.D., P.A., Miami Surgery, LLC, and each of its affiliates (collectively, "**Provider**") all of my rights and interests to any benefits or other recovery of any type whatsoever receivable by me or on my behalf that may be due and payable to me by any governmental payor, insurance company, health maintenance organization, managed care company, self-funded plan, plan sponsor, plan fiduciary, automobile liability, personal injury protection, medical payments, uninsured or underinsured motor vehicle benefits, settlements/judgments/verdicts, or any other third-party payor (collectively, "**Health Plan**") for healthcare goods and services I received from Provider.

I authorize direct payment to Provider of all such benefits or recovery from Health Plan, which payment shall be sent to:

20200 W. Dixie Hwy., Suite G05
Aventura, Florida 33180

I hereby authorize and designate Provider as my authorized representative to act on my behalf with respect to all matters related to the appeal of my claim for denials or reductions in payments, improper claims practices and administration, or any other misconduct by my Health Plan, including but not limited to, receiving all information, documentation, and/or notifications related to my claim(s).

I further authorize and fully assign to Provider the right to pursue all legal and equitable claims and causes of action including claims for attorneys' fees and costs that I may have against my Health Plan arising or related to any denials or reductions in payment, improper claims practices and administration, or other misconduct by my Health Plan for healthcare goods and services furnished by Provider. Moreover, I authorize Provider to initiate a complaint to the insurance commissioner or any other governmental agency for any reason on my behalf in my name or in Provider's name. Additionally, I authorize Provider as my agent and authorized representative to pursue any and all appeals, legal and equitable claims, and causes of action in Provider's name or in my name. In the event Provider is required to pursue any such appeals, claims, or causes of action, I agree to fully cooperate with Provider and their attorneys' and other professionals whom Provider hires to pursue such appeals, claims, or causes of action.

Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment, under Title XVIII or XIX of the Social Security Act, is correct and request that payment of authorized benefits are made to Provider on my behalf.

I agree to be financially responsible for charges not paid according to this assignment, to the extent permitted by applicable law. I also agree that any delay in paying the full amount of any and all amounts for which I am legally liable and any partial payments received by Provider towards my charges, shall not (a) constitute acceptance of any installment payment plan (unless expressly agreed to by Provider in writing), (b) constitute a waiver of the right to receive payment-in-full promptly upon demand, (c) constitute an "accord and satisfaction" of my charges, regardless of any such terms or restrictions indicated on, or included with, any payments, or (d) effect a settlement or resolve an existing dispute as to amounts due and owing by me to Provider. I further acknowledge that Provider does not accept reference-based pricing by Health Plans and, to the extent permitted by applicable law, Provider may elect to deny providing services to me or bill me directly for the balance of my bill, should it be determined that my Health Plan uses reference-based pricing to bill for non-network services.

I permit a copy of this authorization to be used in place of the original.

I, the undersigned, as the patient or patient representative, or, for a minor/incapacitated patient, as the legal guardian, hereby certify that I have read, and fully and completely understand this Assignment of Benefits and knowingly, freely, and voluntarily agree to be bound by its terms.

Signature Date

Print Name

Relationship to Patient

IMPORTANT NOTICE UNDER FLORIDA STATUTE LAW 458.320
PLEASE READ THIS IMPORTANT DOCUMENT AS THESE ARE YOUR RIGHTS UNDER FLORIDA STATUTE LAW 458.320

Dear Patient:

Under Florida law Statute (458.320 F.S.), physicians are generally required to carry medical malpractice insurance or demonstrate financial responsibility to cover potential claims for medical malpractice. I HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law under certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant of Florida law statute (459.320 F.S.).

This document MUST BE SIGNED AND WITNESSED before you initiate or continue under the care of Joshua A. Lampert, M.D.

Thank-you,

_____.
Joshua A. Lampert, M.D.

Note: No treatment can be provided by Joshua A. Lampert, M.D. unless this form has been read and signed. This form is provided to protect your rights under Florida Statute 458.320.

I, _____ ,have read this document
[PRINT FULL NAME HERE]

And acknowledge and understand its contents.

Signature_____ , Date _____.

Witness_____ , Date_____.

Copy received by patient _____.

COPY OF STATUTE PROVIDED ON REQUEST OR SIGNS CONCERNING THE FLORIDA STATUTE LAW 458.320 ARE POSTED IN OUR OFFICE

PATIENT PHOTO CONSENT
(HIPAA-compliant)

Permitted Users. I, the undersigned patient, consent to photographs, recordings and/or videos, by any medium in existence (hereinafter "photos") being taken of me during the below-identified procedure(s), which may be used by Dr. Lampert and/or any party or entity acting under his/ her license and authority, including but not limited to The American Society for Aesthetic Plastic Surgery (all such users hereinafter collectively referred to as "my Doctor"):

_____

_____

Permitted Uses. I consent to such photos and any associated quotes by me being edited and published by my Doctor in any print or electronic form, including but not limited to posts on websites and social media, for the purpose of informing my professional certifying board(s), the medical profession or the general public about medical procedures and my results, surgical or non-surgical, aesthetic or medically necessary, whether or not such settings are considered personal, educational, scientific or commercial.

I expect to be recognized from my photos or quotes.
I understand that my photos, once posted, will be licensed to and subject to each site's terms and conditions, and may be reposted by third parties, rendering retrieval or complete deletion unachievable.

Right to Revoke. I understand that I have the right to revoke this authorization in writing to my Doctor at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will exist for 50 years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my Doctor.

Redisclosure Possible. I understand that the information disclosed, or some portion thereof, may be protected by state and/or federal law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and I hereby waive such protections to the extent I may legally do so. I further understand that there is the po- tential for information disclosed under the terms of this authorization to be redisclosed by the recipient and no longer protected by HIPAA.

My Release. I release and discharge my Doctor and all parties acting under my Doctor's license and authority from all rights that I may have in the photos or quotes and from any claim that I may have relating to their use, including any claim for payment in connection with their distribution or publication.

My Approval and Consent. I certify that I have read this Authorization and Release and fully understand its terms. If I am the patient's parent, guardian or conservator, I have read this document and am authorized to consent on the patient's behalf.

_____ _____

Patient/Parent-Guardian-Conservator Signature Print Name & Date

_____ _____

Witness / My Doctor Signature Print Name & Date

Patient Name _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: The patient and JOSHUA LAMPERT M.D., 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 non financial losses hat 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 non financial 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: Sever-ability: 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 of the Agreement, the authority granted to the arbitrators and the limitations 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 the 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 Juris 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 the National Arbitration Forum Code of Procedure or such procedures as they may jointly decide. All arbitration hearings shall be conducted by video conference; 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 indicated 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, and the 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:** _____