

JAIN HAND SURGERY CENTER (ACCIDENT FORM)

Patient Name _____ Date _____

What was the date and appx time of the accident
_____?

What was the exact location of the accident
_____?

What was involved in the accident (such as car, house, door, trailer hitch, wet floor, etc?)

Description of the accident: _____

Name, address and phone number of liable party: _____

I verify that I believe the above account of my accident to be true to the best of my knowledge

Signature _____

Date _____

JAIN HAND SURG CENTER (CONSENT FOR TREATMENT OF A MINOR)

I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child

In the event of a medical situation occurring during my absence when the physician(s) or staff are unable to contact me. This authorization extends to both physician(s) and nursing personnel involved in the treatment of my child or child for which I am the legal guardian. I release the physician and any individual designated by the physician, as well as the health care facility in which such is provided, from liability while performing indicated procedures for my minor child.

Signature of parent or legal guardian _____

Date _____

Witness _____

Date _____

Acknowledgment of Receipt of Privacy Notice for Jain Hand Surgery Center

We are required by law to provide you with a copy of our Notice of Privacy Practices, to ensure that our records are accurate, please sign this form as acknowledge that you have been provided with a copy of our Notice.

Signature of Patient (or legal Representative)

Date

Signature of Employee, Title of Employee

Date

Authorization and Release

I, _____ (Name of patient) hereby give authorization to Jain Hand Surgery Center for the release of information concerning the status of my health care, such as results of laboratory test, etc, and to discuss my plan of treatment with:

Name of Individual

Relationship of Individual

In consideration, I release the Practice of Jain Hand Surgery Center, Its subsidiaries and affiliates, as well as its agents and employees, from and do hereby waive any and all claims that I may now or hereafter have for damages of any kind resulting from the release of information to the individual designated above.

Patient Signature

Witness Signature/Date

Living Will Notice

The state of Florida has passed a law requiring physicians to document that their patients understand the term "Living Will". A living Will allows a competent adult to set directions for their medical care should a terminal medical condition develop. The law also allows a patient to designate another person to make these decisions for them should the patient become unable to do so. Please check the appropriate box, then sign and date at the bottom

- I have a Living Will and will provide this office with a copy for my medical records
- I DO Not have a Living Will, but understand what it is and what it is for.
- I would like to be provided with additional information about the Living Will and will request it from the nurse or doctor