Howard J. Rudnick, M.D.
General Orthopaedics and Rehabilitation

4600 Linton Boulevard, Suite 250
Delray Beach, Florida 33445

844.744.4900 Tel
561.293.8318 Fax

RudnickMD.com

MEDICAL MALPRACTICE NOTICE

I ____ and/or my representatives agree not to bring a frivolous medical malpractice case or cause of action against Dr. Rudnick, or any legal entity providing care on his behalf. Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative(s) agree to use a(n) expert medical witness(es) who adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine who would typically have the background and experience to give an opinion on such a case. The expert(s) must be Certified by the American Board of Orthopedic Surgery, currently be in full-time active practice in the community, and be licensed to practice Medicine in Florida.

In consideration for this, Dr. Rudnick agrees to this same stipulation. I certify that I have read and fully understand the above information.

____
Patient or Legal Guardian Name (Print)

____ ____
Patient or Legal Guardian Signature: **Date**

MEDICARE/MEDICAID LIFETIME AUTHORIZATION AND PATIENT'S CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII AND/OR TITLE XIX 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 INTERMEDIARY CARRIERS; ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE/MEDICAID CLAIM. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY HEALTH INSURANCE DEDUCTIBLE AND COINSURANCE.

____
Patient or Legal Guardian Name (Print)

____ ____
Patient or Legal Guardian Signature: **Date**

ASSIGNMENT OF BENEFITS

Office Location: 4600 Linton Boulevard
Suite 250
Delray Beach, Florida 33445

I hereby assign all medical benefits, under my policy of insurance with _____________________________________ Insurance Company to which I am entitled, to above Provider of Service. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. This assignment is for the services rendered to the undersigned patient and covered by Personal Injury Protection coverage and medical payments coverage (where applicable.) The undersigned further agrees to pay any co-payments or deductible not covered by their insurance coverage. I hereby authorize said assignee to release all information necessary to secure the payment.

____
Patient or Legal Guardian Name (Print)

____ ____
Patient or Legal Guardian Signature: **Date**