M. Christopher MacLaren, D.O., FAOAO
Board Certified, Diplomat and Fellow AOAO
Orthopaedic Surgery and Sports Medicine

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Board Certified Orthopaedics Surgeons
Fellow American Academy Orthopaedic Surgeons

813-855-8450 – Fax 813-926-6320

Patient: _____ DOB:_____

CONFIDENTIALITY
In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and / or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method that can assist with the care of the patient. I have read, understand and agree with the above.

Patient/GuardianSignature:_____Date:_____

INDIVIDUAL PATIENT AUTHORIZATION
Name the people and/or organization and their relationship to you that are authorized to use and/or disclose your personal health information.

Name:_____Relationship:_____Phone:_____

IRREVOCABLE MEDICAL LIEN
I hereby do authorize any and all parties, including any insurance company and my attorney (if applicable), to pay directly to Westchase Sports Medicine sums as may be due and owing for medical services rendered to me and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Westchase Sports Medicine. If applicable, I also authorize my attorney to **release any and all information** without limitation regarding any legal proceedings, judgments, or settlements that will aide in the recovery of Westchase Sports Medicine's unpaid sum.

I hereby further give an irrevocable lien to Westchase Sports Medicine against any proceeds of any settlement, judgment or verdict which may be paid to you, my attorney or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Westchase Sports Medicine for all medical bills incurred by me for services rendered in consideration of waiting for payment. I further understand that such payment is **not** contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have read, understand and agree with the above.

Patient / Guardian Signature: _____ _____Date: _____

MEDICAL RECORDS
Your records are kept in strict confidence as part of our permanent file. We will release copies only if we have your written permission. We prefer to mail copies of records, but we will give them to you in person to hand-carry if time is critical. **Please give us at least 48 hours notice prior to coming in and picking up records as it does take some time to get things together for you.** I have read, understand and agree with the above.

Patient / Guardian Signature: _____Date: _____

PRESCRIPTION REFILLS
Please don't wait until you run out of medicine to call for a refill. In fact, call at least two days ahead. In order to protect you, your doctor must review your medical file before renewing a prescription. Therefore please do not call for medications after hours or on weekends when records are unavailable. **It could take up to 48 hours after you call before your doctor can review your file and call in any prescription.** The files are reviewed and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. By law, doctors cannot order refills for certain narcotics over the phone. A written prescription is required in those cases. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____