PATIENT REGISTRATION & MEDICAL QUESTIONNAIRE

Patient's Name: _____Gender: _____DOB: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail: _____

Occupation & Employer or Date Retired:_____

Race: _____ Ethnicity: _____ Decline to Answer ☐

Spouse's Name:_____ Date of Birth:_____ Phone: _____

EMERGENCY: _____ Relation: _____ Phone: _____

Previous Primary Care Physician: _____

Address: _____ Phone: _____

ALLERGIES: (List all types, including medication, latex, foods, iodine, peanuts, eggs, shellfish, etc)

List all medications (including OTC), vitamins and supplements you are currently taking

CURRENT MEDICATIONS	DOSE	FREQUENCY

SURGERIES	YEAR	ANY COMPLICATIONS

Check all that you have completed in the time frame specified

☐	Chest X-Ray in the last 12 months	
☐	EKG in last 12 months	
☐	Colonoscopy in last 7 years – were any polyps found and removed?	Yes or No ☐
☐	Mammogram in the last 12 months (women only)	
☐	Pap Smear in the last 12 months (women only)	
☐	Eye Exam in the last 12 months	

TRILLIUM MEDICAL CENTER

Check all conditions that apply to you

GENERAL

- ☐ Frequent Fever
- ☐ Weight Loss
- ☐ Decreased Appetite
- ☐ Excessive Fatigue
- ☐ Weakness
- ☐ Weight gain

EYES

- ☐ Wear Glasses
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Discharge
- ☐ Blurry vision
- ☐ Floaters/Black spots
- ☐ Double vision
- ☐ Vision loss
- ☐ Pain with light

ENT

- ☐ Wear hearing aids
- ☐ Trouble Hearing
- ☐ Nose Bleeds
- ☐ Frequent Congestion
- ☐ Inability to smell
- ☐ Sinus
- ☐ Postnasal drip
- ☐ Sore throat / Lumps
- ☐ Mouth sores
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Change in dentition
- ☐ Ringing in ears

RESPIRATORY

- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Pain
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Bloody sputum
- ☐ Pleurisy
- ☐ Tuberculosis

GASTROINESTINAL

- ☐ Persistent nausea
- ☐ Vomiting Blood
- ☐ Heartburn
- ☐ Gallbladder problems
- ☐ Hernia
- ☐ Abdominal pain
- ☐ Ulcer / gastritis
- ☐ Change in bowel habits
- ☐ Liver disease
- ☐ Jaundice
- ☐ Diverticulitis
- ☐ IBS/Colitis
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Hepatitis

HEMATOLOGICAL

- ☐ Anemia
- ☐ Bleeding easily
- ☐ Blood clots
- ☐ Persistent swollen glands or lymph nodes
- ☐ Easy bruising

MUSCULOSKELETAL

- ☐ Back problems / Pain
- ☐ Muscle Stiffness / Cramps
- ☐ Joint Pain / Swelling
- ☐ Arthritis
- ☐ General Weakness
- ☐ Osteoporosis
- ☐ Restricted motion / Movement

INTEGUMENTARY

- ☐ Skin disease _____
- ☐ Rash
- ☐ Itching
- ☐ Dryness

NEUROLOGICAL

- ☐ Fainting/blackout spells
- ☐ Seizures
- ☐ Memory problems
- ☐ Trouble Concentrating
- ☐ Difficulty with speech
- ☐ Unsteady gait
- ☐ Headaches
- ☐ Stroke
- ☐ Numbness/tingling
- ☐ Tremors/hand shaking
- ☐ Eat Salty Foods/Add Salt to food
- ☐ Eat out Frequently

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HEAD

- ☐ Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Past Head Injury
- ☐ Fainting

CARDIOVASCULAR

- ☐ Chest pain/angina
- ☐ High blood pressure
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Chest pain
- ☐ Swelling hands/feet
- ☐ Leg pain while walking
- ☐ Pacemaker

PSYCHIATRIC

- ☐ Feeling Depressed
- ☐ Nervousness
- ☐ Disorientation
- ☐ Mood Change (High/Low)
- ☐ Feeling Stressed
- ☐ Feeling Hopeless

ENDOCRINE

- ☐ Excessive Sweating
- ☐ Thyroid Issues
- ☐ Fatigue
- ☐ Feeling Thirsty
- ☐ Frequent Urination
- ☐ Increased Appetite
- ☐ Goiter

GENITOURINARY

- ☐ Urinary tract infection
- ☐ Painful/burning urination
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Excessive urination volume
- ☐ Urine odor

Males Only

- ☐ Prostate Issues
- ☐ Discharge from Penis
- ☐ Curved or Bent Penis
- ☐ Erectile Issues
- ☐ Lack of sexual desire

Females Only

- ☐ Irregular menstrual cycle
- ☐ Menopause
- ☐ Breast Lumps
- ☐ Breast Pain
- ☐ Conduct self breast exams
- ☐ Vaginal Discharge
- ☐ Recent Pregnancy or Pregnant
- ☐ Vaginal Itching
- ☐ Pain during Intercourse
- ☐ Vaginal Dryness
- ☐ Lack of sexual desire

IMMUNOLOGIC

- ☐ Itchy or Watery Eyes
- ☐ Itchy or runny nose
- ☐ Frequent Sneezing
- ☐ Wheezing
- ☐ Congestion
- ☐ Hives

SOCIAL HISTORY

- ☐ Drink Coffee or Tea
- ☐ Drink Carbonated Beverages
- ☐ Drink Artificial Sweeten Beverage
- ☐ Drink Alcoholic Beverages
- ☐ Natural Fruit/Vegetable Juices

Which of the above do you consume more than 2 per day

- ☐ Coffee or Tea
- ☐ Carbonated Beverages
- ☐ Artificial Sweeten Beverage
- ☐ Alcohol, Beer, Wine
- ☐ Fruit/Vegetable Juices

- ☐ Smoke Cigarettes / Cigars
- ☐ ***Quit*** Smoking Cigarettes/Cigars

Quit When _____

- ☐ Exercise at least 30 minutes/week

Type: _____

- ☐ Have a Living Will
- ☐ Advance Directive

Other known Medical issues

_____

_____

_____

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Family History

MOTHER

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Seizures
- ☐ Allergies
- ☐ Meniere's Disease
- ☐ Stroke
- ☐ Asthma
- ☐ Migraines
- ☐ Alcoholism
- ☐ Cancer
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Osteoporosis
- ☐ Anemia
- ☐ Thyroid Problems
- ☐ High Blood Pressure
- ☐ Mental Illness
- ☐ High Cholesterol

FATHER

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Seizures
- ☐ Allergies
- ☐ Meniere's Disease
- ☐ Stroke
- ☐ Asthma
- ☐ Migraines
- ☐ Alcoholism
- ☐ Cancer
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Osteoporosis
- ☐ Anemia
- ☐ Thyroid Problems
- ☐ High Blood Pressure
- ☐ Mental Illness
- ☐ High Cholesterol

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

THE PATIENT: **Will be completed at first appointment – For review only.**

Name: _____ **DOB:** ___/___/_____

AUTHORIZATION: I authorize Trillium Medical Center to request health information that will be used in my continuity of care. This includes any sensitive medical information (STD, HIV/AIDS, alcohol or substance dependence/abuse, and mental health treatment). I understand that I have the right to request that any sensitive medical information is not disclosed by another provider.

FACILITIES / PHYSICIANS:

*Florida **SB 1606/HB 1083** has standardized the **response time** for practitioners to provide requested medical records to **no more than 14 days from the receipt of a request**. Should no records exist or you are unable to provide in the required time frame, please advise.*

1. _____
Physician or Facility Name, PCP or Type of Specialty, City & State, Phone Number if available

2. _____
Physician or Facility Name, PCP or Type of Specialty, City & State, Phone Number if available

DISCLOSURE:

[ ] Most recent Progress Note or Last 3 Encounter Notes [ ] Complete Medication List (Current)

[ ] Last 2 Lab Results/Reports (past 1 Year) [ ] Pathology Results (past 2 Years)

[ ] Imaging / Radiologist Reports (past 1 Year) [ ] Other _____

ACKNOWLEDGMENT OF RIGHTS:

Right to Revoke: I understand that I may revoke this authorization at any time by delivering a written revocation to the releasing facility, except to the extent that action has already been taken.
Voluntary Sign-off: I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
Redisclosure: I understand that once this information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations (HIPAA).
Expiration: This authorization will automatically expire **one year** from the date of signature.
Statutory Fee:
Continuity of Care (No Fee): In accordance with **Florida Statute § 395.3025**, patients whose records are requested for the purpose of **continuing to receive medical care** are not required to pay a fee. As a professional courtesy, digital transfer of records to another medical facility for continuity of care is provided **free of charge**.
Personal or Non-Medical Requests (Fees Apply): If records are requested for personal use or non-medical purposes (legal or insurance), I understand that I (or the receiver) will be charged a fee as permitted by **Florida Statute § 456.057** and **Florida Administrative Code Rule 64B8-10.003**.
Current Florida allowed fees: $1.00 per page for the first 25 pages and $0.25 per page thereafter.

Signature of Patient (or Representative):_____

Relationship (if Representative): ☐ Spouse ☐ Guardian ☐ Other: _____ **Copy of POA Provided**: Yes / No

Print Name:_____ **Date Signed:** _____

PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE

Patient Name:_____ **Date of Birth:** _____

At the present time,_____is my insurance carrier. I will inform Trillium Medical Center PLLC **(TMC)** of any changes with the above insurance carrier.

As a courtesy, TMC has agreed to file a claim for services rendered with my insurance carrier. I am responsible and required to pay TMC on the date of service for the following:

1. Any co-payment as set by my insurance carrier
2. Any policy deductible or if coverage is terminated
3. Any amount my insurance carrier deems patient responsibility
4. Any amount considered non-covered by my insurance plan

Should TMC not receive payment from my insurance carrier after 45 days from date of service, I may be requested to pay my balance in full and be reimbursed for any payment be received at a later date. I understand that I am responsible for making sure that all charges are paid, and any disagreement or dispute whether covered by insurance or not, will be my responsibility to resolve.

If I am self-pay patient or have a deductible that must be met prior to any insurance payments, I understand that payment is required at the time services are rendered. TMC accepts Cash, VISA, MasterCard, Discover, American Express and Apple & Google Pay.

I understand that any balance is owed after insurance has processed and identified as Patient Responsibility, I am responsible to pay the balance within 30 days of insurance notification or TMC statement received. I may be subject to a **"Late Fee"** of $10.00 per month or 1% interest per month (whichever is less) if my account balance is not paid within 30 days of notification.

Any requests for "Special Forms" that are requested to be completed and signed are not part of the services rendered. The fee for these services will vary based on the complexity and expected time required. In most cases it will vary from $25 to $100 and must be paid at the time of the request.

I understand that any missed appointments, including same date cancellations, are subject to our **No Show Policy**. If a fee is assessed, payment must be made prior to my next appointment.

Should any balance not be paid as required, I agree that I am responsible for all collection costs, including legal fees and court costs should my account have to be referred to an attorney or collection agency.

I HAVE READ THE ABOVE INFORMATION AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY TRILLIUM MEDICAL CENTER.

_____ _____

Patient Signature **Date**

No Show Policy

(Includes same day cancelations & arrivals over 15 minutes late)

We understand that unforeseen circumstances can lead to missed appointments, same-day cancellations and late arrivals. To help mitigate this, we utilize an automated reminder system using text notifications and emails. **If a schedule change is needed, you can respond directly to these reminder messages to let us know.**

When timely notifications of schedule changes are received, we greatly appreciate your communication and consideration. Often, with timely notification, we can fill an open time slot with another patient seeking an earlier appointment or consultation with the doctor. However, **when we don't receive notification, it creates an unfortunate gap in the schedule, indirectly affecting other patients who may need an appointment.**

To increase awareness on the importance of timely communication, we have implemented this simple policy that most service businesses have: **If an appointment is not canceled or rescheduled at least 24 hours prior to your scheduled appointment time, or should you arrive more than 15 minutes late for your appointment, a fee may be charged.**

We all know that doctors sometimes run over on appointments as they provide the time and care that all patients deserve. While we strive to stay on schedule, late arrivals impact all patients after your scheduled time. Therefore, in consideration for other patients, **we can only hold your appointment for 15 minutes beyond the scheduled time.** After that, if necessary, your appointment may need to be canceled or rescheduled. **It may be possible to be seen at a slightly later time if another patient arrived early and was able to be seen earlier.**

Related Fees with this Policy

- First Occurrence - ***No Fee, reminder only, Credit Card put on file***
- Second Occurrence - ***$25 fee will be charged to your credit card***
- Third or more occurrences - ***$50 fee will be charged to your credit card***

Patient Name (Print)	Signature	Date
		___/___/___

Telehealth Informed Consent

What is Telehealth? Telehealth allows you meet your healthcare provider remotely (Voice or Video) using a phone, computer, or tablet. You don't need to travel; you just need an internet connection. For more information visit https://trilliummedicalcenter.com/telehealth

Benefits

- Reduces exposure to infectious diseases.
- Medical consults wherever you are, saving travel time and reducing work & childcare disruptions
- Typically provides quicker physician access, shortening appointment wait times
- May eliminate need for an Urgent Care visit

Risks

- Information may be insufficient for a proper medical decision, still requiring an office visit
- Lack of actual or incomplete records could cause errors in decisions
- The experience will feel different from in-person visits and primarily what you share
- Diagnosis may be limited without a physical exam and ask you follow up if symptoms persist
- While rare, technical issues may disrupt the session
- Today most networks and devices are secure, but the patient is responsible for what they use

Privacy

- Telehealth's are NEVER recorded; notes are kept in secure medical records, the same as office visits
- Patients are responsible for being in a private place to avoid being overheard
- Our video technology is HIPAA compliant, but a very small risk of privacy breach exists

Choice

- Use of Telehealth is a patient OPTIONAL. You will be asked each time if you consent.

Cost

- Your insurance sets the rates and in most cases insurance co-pays or deductibles apply
- If both telehealth and office visits are needed, insurance treats each as separate visits

Consent

- Signing means you understand how a telehealth is different, but you're not required to use it

_____

Please print your name here

_____

Signature *Date*

NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on May 22, 2018, and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes, and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Office. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other people you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013, immunization records for students may be released without authorization (if the PHI disclosed is limited to proof of immunization). If an individual is deceased, you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $0.29 for each page and the staff time charged will be $35 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan, if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities. Including the disclosure of your PHI in the event of transfer, merger, or sale of the existing practice to a new provider.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes.

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ 0.29 for each page and the staff time charged will be $35 per hour including the time required to copy your health information (or $ 0.54 per page, whichever is less). If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision, we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US: Trillium Medical Center, PLLC
Telephone: 561-736-0881 **Fax:** 561-736-0887 **Email:** office@Trillium-Medical.com
Physical Address: 10301 Hagen Ranch Road, Suite C-180, Boynton Beach FL 33437

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with our Notice of HIPPA Privacy Practices, which states how we may use and/or disclose your protected health information. By signing this form, you acknowledge receipt of this Notice of HIPPA Privacy Practices.

I acknowledge that I read this Notice of HIPPA Privacy Practices (3 pages), and I made a personal copy or requested a copy from Trillium Medical Center after signing.

_____
Please print your name here

_____ _____
Signature *Date*

We cannot discuss your protected health information with anyone other than yourself unless you authorize us to do so.

Please list below the name(s) and phone numbers of individual(s) that you authorize our office to discuss your Personal Health Information and care.

You must notify our office in writing of any additions or deletions to this list.

_____ _____

_____ _____