CORAL SPRINGS
PRIMARY CARE

PATIENT INFORMATION

If not the patient, the individual completing this form is _____, the
☐ Parent ☐ Legal Guardian ☐ Legal Representative (each a "Personal Representative") of the patient.

Patient Name (the "Patient"): First Name:_____ Middle Initial: _____Last Name:_____

Date of Birth: ____(MM) ____(DD) _____(YYYY)

Address: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersexual ☐ Choose not to disclose

Current Gender Identity: ☐ Female ☐ Male ☐ Transgender: Male to Female ☐ Transgender: Female to Male
☐ Neither exclusive female or male ☐ Choose not to disclose ☐ Something else, please specify: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

Race: ☐ White ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ American Indian
☐ Other ☐ Declined to Specify

Preferred Language: ☐ English ☐ Spanish ☐ Creole ☐ Other_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Occupation: ☐ Full-Time Employee ☐ Part-Time Employee ☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Active Military

Employer Name: _____ Work Phone: _____-_____-_____

Emergency Contact: _____ Emergency Contact Phone: _____-_____-_____

Relationships to patient: _____

Consent to disclose medical information to Emergency Contact: ☐ Yes ☐ No

DISCLOSURE TO FRIENDS AND/OR FAMILY MEMBERS

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below.

Name	Relationship	Phone Number

Do you have a: ☐ Living will ☐ Advanced Directives ☐ DNR ☐ Power of Attorney ☐ None ☐ Refuse

Legal Guardian/Proxy or Caregiver: _____ Contact Phone: _____

Pharmacy Name: _____ **Pharmacy Phone Number**: _____-_____-_____

CORAL SPRINGS
PRIMARY CARE

INSURANCE INFORMATION

Primary Insurance: _____ Phone Number: _____

Insurance Address: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Responsible Party: ☐ Self ☐ Guarantor ☐ Check here if information is same as patient

Responsible Party Name (Last): _____ (First): _____ (MI): _____

Guarantor Date of Birth: ____(MM) ____(DD) _____(YYYY)

Address: _____ Primary Phone: _____

By signing below, I certify all information above is true and correct to the best of my knowledge.

Patient or Patient's Personal Representative: _____ **Date**: _____

FINANCIAL POLICY

____ (**Initials**) The doctors and the healthcare providers of this Physician Practice charge fees for the care provided to you. The fees may not be the same as the estimate given. This includes any deductibles and coinsurances. Copays are due at the time of service. You are also responsible for any deductibles and coinsurances on your insurance plan.

If your health insurance company does not pay the full amount of fees charged by the Physician Practice, you (the patient or responsible party) will pay the Physician Practice for the cost of care not paid by the health insurance company. This also applies for patients within their grace period.

If the insurance information provided to the Physician Practice is not correct, you may have to pay the fees associated with your care.

If you do not have health insurance, then you will have to pay the fees for the medical services rendered to you.

By signing below, you certify the facts you have given to the Physician Practice for payment under Title XVIII and XIX are correct.

____ (**Initials**) The Physician Practice can bill my health insurance company for my care. Payments will be made to the Physician Practice on my behalf.

Patient or Patient's Personal Representative: _____ **Date**: _____

CONSENT TO TREATMENT

____ (**Initials**) I am a patient of this Physician Practice. By signing below, I give my consent to be treated by this Physician Practice's providers.

____ (**Initials**) I understand treatment and services may include: lab tests, routine exams, screening tests (tests that can find an illness early, before a person shows signs of having the disease), diagnostic tests (tests that show if a person has a certain illness or health problem).

____ (**Initials**) I understand that no promises have been made to me about the results of any treatment or services.

____ (**Initials**) I understand that I have the right to refuse any treatment or procedure and have the right to discuss all medical treatments with my provider.

____ (**Initials**) I acknowledge that I have read and understood each of the above provisions appearing in this section. I have also had the opportunity to ask any questions, and by my signature, I consent and agree to such provisions individually and collectively. A copy may be used in lieu of the original.

____ (**Initials**) Consent for Treatment of Minor or Incapacitated Patient. As the Personal Representative of the minor or incapacitated patient, I hereby give consent for the Patient to receive medically necessary treatment and care, including emergency treatment, by this Physician Practice. We reserve the right to require proper identification of the Personal Representative prior to the provision of treatment and care to a minor or incapacitated patient.

Patient or Patient's Personal Representative: _____ **Date**: _____

PATIENT HIPAA ACKNOWLEDGEMENT & HEALTH INFORMATION EXCHANGE OPT-IN

___ (**Initials**) Notice of Privacy Practices. I acknowledge receipt of the Notice of Privacy Practices (www.mycspc.com) which describes my rights and this physician practice's duties with respect to my protected health information (my "PHI"), and specifies that this physician practice is permitted to use, disclose, receive and exchange my PHI for (i) treatment, payment and healthcare operations purposes; (ii) as I may authorize in writing; and (iii) as otherwise allowed pursuant to the regulations of the Health Insurance Portability & Accountability Act ("HIPAA") and relevant state laws (collectively, the "Permitted Uses"). I understand that I may contact the Privacy Officer (admin@mycspc.com) with any questions or complaints. To the extent permitted by law, I voluntarily consent to the use, disclosure, receipt and exchange of my PHI for the purposes described in the Notice of Privacy Practices.

___ (**Initials**) Health Information Exchange. I understand that this physician practice participates in one or more health information exchanges (HIEs). HIEs are designed to provide my healthcare providers with quick access to my medical records to make treatment more effective and efficient (https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/health-information-exchange). Through HIEs, the physician practice is able to share, request and/or

access health information from my electronic medical record(s) for Permitted Uses that may include but are not limited to my allergies, diagnoses, lab and imaging results, immunizations, medical history, medications, visit summaries and may also include sensitive information, such as HIV and sexually transmitted diseases, if applicable, with other healthcare providers involved with my treatment or care. This Physician Practice will follow state and federal laws, including HIPAA, when protecting the release of sensitive information. I expressly authorize this physician practice to share, request and/or access my health information through HIEs for Permitted Uses. I agree that if I do not want my health information electronically shared, requested and/or accessed through HIEs, I may opt-out at any time by completing an HIE Opt-Out form obtained from this location or the website (www.mycspc.com).

I understand that my participation in HIEs is voluntary and not a condition to receive treatment or care at this physician practice. My authorization to participate in the HIEs will continue until otherwise revoked by me and any subsequent revocation of authorization will not apply to my health information that has previously been shared, requested and/or accessed through HIEs for Permitted Uses.

Patient or Patient's Personal Representative: _____ **Date**: _____

CONSENT FOR COMMUNICATIONS

___ (Initials) By providing my phone number and email, I voluntarily and expressly authorize this Physician Practice (or third parties acting on behalf of Physician Practice, including Business Associates, and subject to patient confidentiality restrictions) to communicate with me at the number and email address that I provided above, using automated/autodialed phone calls, prerecorded messages, artificial voices, voicemail, automated SMS messages and email for information related to my treatment and care as well as marketing purposes for healthcare products and services recommended by the Physician Practice which may be beneficial to Physician Practice's patients. I understand that such communications may not be encrypted or secure. The physician practice will use appropriate safeguards to protect my PHI in accordance with HIPAA and relevant laws. Message and data rates may apply.

I acknowledge that I have the right to opt out of receiving future physician practice communications at any time by using the opt-out mechanism provided in the communication. I understand that I may revoke this consent for communications at any time, either by completing a new patient registration form or notifying physician practice in writing. I also understand that I am not required to sign this consent as a condition to receive treatment or services from this physician practice and that opting out of this physician practice's communications will not affect my treatment or the services available to me. I confirm that I own or control the phone number and email provided by me and agree to notify the physician practice in writing within thirty (30) days if I change my phone number or email address.

___ (Initials) I acknowledge and agree to receive communications concerning my treatment and care from the physician practice (or third parties acting on behalf of this physician practice, including Business Associates), which may occur more than once per day or three times per week and/or outside the hours of 9:00 AM to 5:00 PM (as necessary), in excess of the limitations under applicable law.

Patient or Patient's Personal Representative: _____ **Date**: _____

PHOTO IDENTIFICATION (if applicable)

For the benefit of its patients, the physician practice has implemented a process to use photographs of patients for identification and authentication purposes to enhance patient safety and security. I voluntarily and expressly authorize the physician practice to take a photograph of me (or the person for whom I am a Personal Representative) to be used for patient identification/authentication purposes during patient registration/check-in and throughout the duration of my visit. I understand that my photograph will only be used for this purpose, stored in my electronic medical record in accordance with HIPAA and relevant laws, and will not be shared with third parties without my consent except as required by applicable law. I understand that using my photograph for identification/authentication purposes is voluntary, and I have the right to revoke my authorization and opt-out of participating at any time by notifying the physician practice in writing. My refusal to participate will not affect my treatment or the services available to me at this physician practice. If I prefer not to be photographed, I will be asked to provide photographic identification at each visit.

Patient or Patient's Personal Representative: _____ **Date**: _____

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND ALL OF THE INFORMATION CONTAINED IN THIS DOCUMENT.