PREFERRED PRIMARY CARE ASSOCIATES
3100 Coral Hills Dr., Suite 308, Coral Springs, FL 33065
954-636-2034 | Fax 954-636-3588 | www.preferredprimary.com

Welcome to PPCA / Bienvenido a PPCA

Please provide the following information / Complete esta información, por favor

NEW PATIENT INFORMATION / INFORMACION PACIENTE NUEVO(A)

PATIENT INFORMATION / INFORMACION DEL PACIENTE

First Name/Nombre	MI	Last Name/Apellido	Sex/Sexo (M/F)

Street Address/Dirección (Calle)	City/Ciudad, State/Estado, Zip Code/Código Postal

Home Phone/Teléfono ( )	Cell Phone/Teléfono Celular ( )	Email/Correo Electrónico

Birthdate (MM-DD-YYYY)/ Fecha de Nacimiento (Mes-Día-Año)	SSN/Número de Seguro Social	Race/Raza	Ethnicity/Origen Etnico

Marital Status/Estado Civil
☐ Married/Casado(a) ☐ Widowed/Viudo(a)
☐ Single/Soltero(a) ☐ Divorced/Divorciado(a) ☐ Separated/Separado(a)

Relation to Insured/Relación al Segurado
☐ Spouse/Esposos(a) ☐ Child/Hijo(a)
☐ Self/Usted ☐ Other/Otro(a)

Employment/Empleo
☐ Full-time/Jornada Completa ☐ Part-time/Media Jornada
☐ Retired/Retirado(a) ☐ None/Ninguno

Student/Estudiante
☐ Full-time/Jornada Completa ☐ Part-time/Media Jornada
☐ None/Ninguno

Employer or School Name/Nombre del Empleador o Escuela	Street Address/Dirección (Calle) and/or PO Box

Zip Code/Código Postal	City/Ciudad	State/Estado	Business Phone/Teléfono Business

FINANCIALLY RESPONSIBLE PARTY (If other than Patient) / RESPONSABLE ECONOMICO (Si no es Usted)

First Name/Nombre MI Last Name/Apellido	Home Phone/Teléfono

Street Address/Dirección (Calle) and/or PO Box	City/Ciudad, State/Estado, Zip Code/Código Postal

INSURANCE INFORMATION / INFORMACION DE SEGURO DE SALUD

Primary Insurance/Seguro Principal	Supplementary Insurance/Seguro adicional

Policy Holder's Name/Nombre del Titular	Date of Birth/Fecha de Nacimiento

Home Address (if different from the patient)/ Dirección (si es diferente a la del paciente)	Phone (if different from the patient)/ Teléfono (si es diferente a la del paciente)

By signing this form, I authorize the following/Al firmar este documento, autorizo lo siguiente:

(a) the release of any medical or other information necessary to process insurance claims/a enviar la información necesaria al seguro para procesar el pago
(b) payment of medical benefits directly to this practice for services rendered/el pago directo a esta oficina por los servicios realizados.

Signature/Firma _____ Date/Fecha _____

PREFERRED PRIMARY CARE ASSOCIATES
3100 Coral Hills Dr., Suite 308, Coral Springs, FL 33065
954-636-2034 | Fax 954-636-3588 | www.preferredprimary.com

HOW DID YOU HEAR ABOUT US?/CÓMO ESCUCHÓ O SUPO DE NOSOTROS? _____

IN CASE OF AN EMERGENCY,
WHOM SHOULD WE CONTACT?

EN CASO DE EMERGENCIA A
QUIEN PODEMOS LLAMAR?

Name/Nombre

Address/Dirección

City/Ciudad

State/Estado Zip Code/Código Postal

Daytime Phone/Teléfono (Dia)

Evening Phone/Teléfono (Noche)

Other Phone/Otro Teléfono

Relationship/Relación

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company.

IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR FEES FOR OFFICE VISITS BE PAID AT THE TIME OF EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, PPCA shall be entitled to reasonable attorney's fees and collection costs.

By submitting this patient information form, you are agreeing to the following:

- That payment of authorized benefits will be made on your behalf.
- That the benefits to which you are entitled, including Medicare, private insurance, and other health plans, will be payable to PPCA.
- That the assignment will remain in effect until revoked by you in writing. A photocopy of this assignment will be considered as valid as the original.
- That you are financially responsible for all charges, regardless of whether it is paid by your insurance.

THANK YOU FOR YOUR COOPERATION

Por favor recuerde que el seguro esta considerado un metodo de reembolso al paciente por pagos hechos al doctor y no es un substituto de pago. Algunas companias pagan cierta cantidad por ciertos procedimientos, y otros pagan un porciento del cargo. Es su responsabilidad pagar cualquier deducible, co-seguro, o cualquier otro balance que no es pagado por su compania de seguro.

PARA PODER CONTROLAR EL COSTO DE SU CUENTA, LE PEDIMOS QUE PAGUE SUS CARGOS EN EL MOMENTO DE SU VISITA.

Si esta cuenta es designada a un abogado para colección o demandas, PPCA tiene derecho a cobrar los cargos del abogado y costos de colección.

Entregando este formulario de paciente, usted acepta lo siguiente:

- Los pagos por beneficios autorizados seran hechos por usted.
- Que sus beneficios incluyendo los otorgados por Medicare, seguros privado, y otros planes medicos, seran pagados a PPCA.
- Que este documento permanecera en efecto hasta que usted lo cancele por escrito. Una fotocopia de esta cesión se considerará tan válida como la original.
- Que usted es el responsable económico de todos los costos, no importa si son pagados por su seguro.

GRACIAS POR SU COOPERACION

PREFERRED PRIMARY CARE ASSOCIATES
3100 Coral Hills Dr., Suite 308, Coral Springs, FL 33065
954-636-2034 | Fax 954-636-3588 | www.preferredprimary.com

Welcome to PPCA / Bienvenido a PPCA

Please provide the following information / Complete esta información, por favor

NEW PATIENT INFORMATION / INFORMACION PACIENTE NUEVO(A)

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer,
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date

Women Only:

# of Pregnancies	# of Miscarraiges	# of Abortions	# of Living

Last Pap Smear	Last Mammogram	Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details:

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

PREFERRED PRIMARY CARE ASSOCIATES
3100 Coral Hills Dr., Suite 308, Coral Springs, FL 33065
954-636-2034 | Fax 954-636-3588 | www.preferredprimary.com

THIS NOTICE DESCRIBES HOW PPCA MIGHT USE AND DISCLOSE INFORMATION ABOUT YOU AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. ***PLEASE REVIEW CAREFULLY.***

Introduction

At PPCA, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your individual rights as they relate to your protected health information.

Understanding Your Health Record/Information

Each time you visit PPCA, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your chart or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the health professionals who contribute to your care.
- Legal documents describing the care you received.
- Means by which you or a third-party payer can verify that services billed were provided.
- Tool in educating health professionals.
- Source of data for medical research.
- Source of information for public health officials charged with improving the health of this state and the nation.
- Source of data for our planning and marketing.
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of PPCA, the information belongs to you. You have the following rights:

- *Right to a Paper Copy of this Notice.* You may ask us to give you a copy of this notice at any time.
- *Right to Inspect and Copy.* You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.
- *Right to Amend.* You may request that we amend the medical information PPCA has about you if you feel it is incorrect or incomplete. You may request an amendment for as long as the information is kept by the practice. Requests to amend must be made in writing and submitted to PPCA's Privacy Office. You must provide a reason that supports your request, but PPCA has the right to deny your request for an amendment.
- *Right to an Accounting of Disclosures.* You may request an "accounting of disclosures." This is a list of the disclosures PPCA has made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer.
- *Right to Request Confidential Communications.* You may request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.
- *Right to Request Restrictions.* You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.
- *Right to Revoke Your Authorization.* You may revoke your authorization to use or disclose health information except to the extent that the action has already been taken.

PPCA's Responsibilities

PPCA will:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our policy and to make the new provisions effective for all protected health information we maintain. You are entitled to a paper copy of our privacy policy at any time at your request.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of your authorization.

For More Information or to Report a Problem

If you have questions, would you like additional information, or believe your privacy rights have been violated, you can contact: Preferred Primary Care Associates, Attn: Privacy Officer, 3100 Coral Hills Dr., Suite 308, Coral Springs, FL 33065, 954-636-2034.

We May Use Your Health Information in the following situations:

Treatment: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist in your treatment if you are referred to another provided or if you choose to leave the care of a PPCA physician.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Regular healthcare operations: Members of your healthcare team, which include physicians, medical assistants, and administrative personnel employed by PPCA, as well as other healthcare and insurance personnel, may use your health information to provide your healthcare. Health information may be transmitted to these individuals in a variety of ways, including mail, telephone, fax, and electronic mail.

Business associates: There are some services provided in our organization through contacts with business associates. An example is certain tests performed by outside laboratories. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care. We also may use that information to contact you as a reminder of an appointment in our office or another healthcare facility.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, friend or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

By signing below, I acknowledge that I have received a copy of the Privacy Policy of Preferred Primary Care Associates (PPCA), and that I authorize PPCA to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations, as described in the Privacy Policy.

_____

Signature of Patient of Authorized Representative

_____

Print Name of Patient or Authorized Representative. Print Relationship to Patient, if applicable.

_____

Date

PREFERRED PRIMARY CARE ASSOCIATES
3100 Coral Hills Dr., Suite 308, Coral Springs, FL 33065
954-636-2034 | Fax 954-636-3588 | www.preferredprimary.com

OFFICE POLICIES

New Patients: If you are a new patient to our practice you can download and complete New Patient Paperwork prior to appointment. We welcome new patients for consultations. You may contact us directly or through a referring physician. Please arrive approximately 20 minutes early to allow for parking, timely arrival and additional paperwork signatures. Please bring a list of all medicines you are presently taking (include all herbal and over the counter medications), photo ID and your health insurance card(s) and method of payment for co-pays/deductibles.

Referrals: If a referral has been made to another physician and you do not hear from that physician's office within 2-3 days, please contact our office so that we can assist you in getting your appointment scheduled.

Laboratory Testing: When the doctor orders blood work, please have it done no less than 1 week prior to your next appointment so that your lab results can be discussed with you when you come in.

After hours: Brining your concerns to our attention during office hours will ensure the problems is dealt with sooner and a prompt follow-up is scheduled. For urgent matters, you should go to the Emergency Department for any medical emergencies.

Change of information: If you have any changes on your name, address, phone number or insurance, please notify us as soon as possible. We do not want such changes to affect your medical care.

Payment policies: Your co-pay or deductible must be paid at the time of service. Our office files your insurance as a courtesy, please review and understand your insurance policy. Your insurance policy is a contract between you and your insurance company. It is not a contract between you and our Doctors. Should your insurance carrier withhold payment or partial payment of your claim for any reason, we will be glad to assist you in obtaining an explanation from them. However, we cannot guarantee payment of your claim. Also, we cannot be responsible for negotiating fees or claims with insurance companies or any other entity. Patients are responsible for payment of medical care within a reasonable time, regardless of the status of the claim. If your insurance plan is out of network: we will have to collect full payment at time of service. After service we will send a claim to insurance and insurance will notify you how much of what you paid will be covered or not. Patient balances are expected to be paid in full. We do not have payment plans for outstanding balances. Partial balances payments through the mail will not be accepted. If you have any questions or are not prepared to pay for your appointment, please notify one of our staff prior to your appointment. If you are unable to pay for residual balances from previous dates of services, you may be asked to reschedule your appointment. There is a $50.00 fee for missed appointments (unless a 24-hour notice is given) or more than 15 minute late arrival. There is a $25.00 for printing medical records (first 100 pages then additional 30 cents/per page). There is a placement fee of thirty dollars ($30.00) in addition to the balance subject to collection.

By my signature below I acknowledge that I agree with Payment Policies.

Patient Signature:

_____ Date: _____/_____/_____