**SOUTH BEACH MEDICAL ASSOCIATES**

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| **NEW PATIENT REGISTRATION** |

 **Date of Visit:** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ **Office Use Only** Account#:\_\_\_\_\_\_\_\_\_\_\_

**Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle Initial**\_\_\_\_\_ **First Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Social Security #:**\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**Gender:** ☐Male ☐Female **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed ☐Life Partner
**Race:** □ Caucasian□ African American □American Indian or Alaskan □Asian □ Other
**Ethnicity:** □ Hispanice □ Not Hispanice or Latino □ Other
**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your visit today work related: Please Circle (Yes/No)
Is your visit today for routine physicals: Please Circle (Yes/No)**
**Reason for Visit (Main Compaint):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who referred you to our practice?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION**

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| **Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**CITY:**\_\_\_\_\_\_\_\_**State:**\_\_\_**Zip Code:**\_\_\_\_\_\_\_\_\_\_ **Primary Contact phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Secondary Contact Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**E-Mail:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Preferred Method of Contact: ☐ E-Mail ☐ Mail ☐ Mobile ☐ PhoneMay we send you emails? (i.e., , appointment reminders, service offerings) Yes**\_\_  **NO**\_\_**May we send you texts reminders? Yes**\_\_\_  **NO**\_\_\_\_**May we leave voicemails at the above phone numbers? Yes**\_\_\_\_ **NO**\_\_\_\_ |

**EMERGENCY CONTACT INFORMATION**

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| **Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Phone#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Addess:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **INSURANCE INFORMATION** |

**PRIMARY INSURANCE INFORMATION**

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| **Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Todays’ Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Policyholder name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Policyholder DOB:**  \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ **Relationship to patient: ☐ Self ☐ Spouse ☐Child ☐ OtherInsurance Company:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Policy #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Group#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance Phone#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Claims Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SECONDARY INSURANCE INFORMATION**

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| **Insurance Company:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Policy #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Group#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Insurance Phone#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Claims Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I authorize the release of my medical information necessary for treatment or to process claims. I also authorize for the release of my medical records to any physician, hospital or ancillary care center participating in my care and treatment. Only medically necessary information will be released when requested. I understand that this information will be faxed or mailed to the party requesting the information.

I hereby assign all medical benefits to include major medical benefits to which I am entitled to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
This assignment will remain effect until revoked by me in writing. I further agree to be solely responsible for any balances that my insurance does not pay. I understand that I am responsible for any collection and/or legal fees incurred as a result of non-payment on my account.

If we **do** participate with your insurance plan, we will ask you to pay any co-payment, deductible or co-Insurance amount at the time of service and we will submit a claim to your insurance company.

If we **do not** participate with your insurance plan, we will ask you to pay in full at the time of service and as courtesy submit a claim to your insurance company.

If you **do not present any insurance cards we will presume you do not have any insurance coverage and payment in full will be due at the time of service.**

**A PHOTOCOPY OF THESE AUTHORIZATIONS ARE TO BE CONSIDERED LEGALLY VALID AS ARE THE ORIGINALS**.

 By my signature below, I affirm the above information.

**Patient’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| HEALTH HISTORY QUESTIONNAIRE |

**PATIENT INFORMATION**
Patient’s Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Chief Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
When Symptoms Started:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY (please check) ☐ NONE**

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| **☐Acid Reflux ☐Addiction ☐Alzheimer’s Disease ☐Amputation ☐Angina ☐Anxiety/Panic attack☐Arrhythmia ☐Atrial Fibrillation ☐Attention Deficit Disorder☐Asthma ☐Back/Neck Problems☐Bleeding Disorders ☐Blood Clot ☐Blood Transfusion ☐Blood Transfusion Reaction ☐Bowel disease ☐Bursitis ☐Cancer Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Past Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Cataract☐Cerebral Palsy ☐Chest Pain ☐Chronic Obstructive Pulmonary Disease (COPD) ☐Congenial Anomaly☐Congestive Heart Failure ☐Constipation ☐Coronary Artery Bypass Graft (CABG) ☐Coronary Artery Disease (CAD)☐Cohn’s Disease/Ulcerative Colitis☐Dawn Syndrome☐Defibrillator ☐Dementia ☐Depression ☐Diabetes ☐Dialysis ☐Diverticulosis ☐Edema☐Encephalitis** |
| **☐Endometriosis** |
| **☐Enlarged Prostate**  |
| **☐Gout** **☐Glaucoma** |
| **☐Headaches**  |
| **☐Heart Disease**  |
| **☐Hematuria**  |
| **☐Hepatitis**  |
| **☐Hernia**  |
| **☐High Blood Pressure**  |
| **☐History of VRE**  |
| **☐HIV/AIDS ☐IBS** |
| **☐Incontinence**  |
| **☐Kidney Disease**  |
| **☐Kidney Infections**  |
| **☐Kidney Stones**  |
| **☐Liver Disease**  |
| **☐Lupus**  |
| **☐Lyme Disease**  |
| **☐Lymphedema**  |
| **☐Mental Illness**  |
| **☐Migraines**  |
| **☐MRSA**  |
| **☐Myocardial Infarction (MI)**  |
| **☐Neck/back disorder**  |
| **☐Osteoarthritis**  |
| **☐Pacemaker**  |
| **☐Paralysis** |
| **☐Parkinson’s**  |
| **☐Peripheral Vascular Disease (PVD) ☐PDD (Autism-Rett)** |
| **☐Phlebitis**  |
| **☐Pneumonia**  |
| **☐Pressure Ulcer**  |
| **☐Prior Anesthesia Complications** **☐Rectal Bleeding** |
| **☐Rheumatoid Arthritis**  |
| **☐Shortness of Breath**  |
| **☐Sleep Apnea ☐Stoke/TIA** **☐STD****☐Stroke or CVA** |
| **☐Thyroid Disease** |
| **☐Tuberculosis**  |
| **☐Ulcers**  |
| **☐Urinary Frequency**  |
| **☐Urinary Tract Infection (UTI)**  |
| **☐Urinary Retention**  |
| **☐Valve Replacement**  |
| **☐Vertigo**  |
| **☐Weakness** |

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| **Others: (Not listed above)** |
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| **PLEASE LIST ALLERGIES TO MEDICATION ☐NONE**MEDICATION\_\_\_\_\_\_\_\_\_REACTION:\_\_\_\_\_\_\_\_\_\_\_ MEDICATION\_\_\_\_\_\_\_\_\_REACTION\_\_\_\_\_\_\_\_\_\_\_\_ MEDICATION\_\_\_\_\_\_\_\_\_REACTION:\_\_\_\_\_\_\_\_\_\_\_MEDICATION\_\_\_\_\_\_\_\_\_REACTION\_\_\_\_\_\_\_\_\_\_\_ |

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| **SURGICAL HISTORY** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **FAMILY HISTORY** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **SOCIAL HISTORY** |
| **Tobacco smoking status**  |
| **□ Current smoker □ Former smoker □ Never smoked**  |
| **☐Light-1-9cigs/day ☐Moderate-10-19-cigs/day ☐Heavy-20-39cigs/day ☐VeryHeavy-40+cigs/day Do you use: ☐Cigarettes ☐Chewing Tobacco**  |
| **Alcohol □ None ☐Occasional ☐Moderate ☐Heavy ☐Past Abuse** |
| **Drug Use □ None □ Yes List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Exercise □ None □ Yes How often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Caffeine □ None □ Yes How many drinks per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **PREVENTIVE and SCREENINGS** |
| **When were you last vaccinated for:**  |
|  **Tetanus \_\_\_\_\_\_\_\_\_\_\_\_\_ Influenza (flu) \_\_\_\_\_\_\_\_\_\_\_\_\_**  |
|  **Pneumonia \_\_\_\_\_\_\_\_\_\_ Shingles\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **For Females: Last Pap Smear? \_\_\_\_\_\_\_\_\_\_\_\_Mammogram? \_\_\_\_\_DEXA Scan\_Colonoscopy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **If you a smoker have you ever had chest CT scan or Abdominal Aortic Aneurysm screening? \_\_** |

**For Female Patients:**Are you currently pregnant? Date of last menstrual period:

Number of pregnancies: Live birth: Miscarriage:

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| MEDICATIONS |

|  |  |  |
| --- | --- | --- |
| No | Name | Dose and Frequency |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| 6 |  |  |
| 7 |  |  |
| 8 |  |  |
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| 10 |  |  |
| 11 |  |  |
| 12 |  |  |
| 13 |  |  |
| 14 |  |  |
| 15 |  |  |

If more please use space below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I confirm that the information provided is true and will be used as part of my treatment plan

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Todays’ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| NOTICE OF PRIVACY PRACTICES |

**ACKNOWLEDGEMENT OF RECEIPT OF**

**NOTICE OF PRIVACY PRACTICES**

**PERMISSION TO SHARE HEALTH INFORMATION**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Notice of Privacy Practices**

I acknowledge that I have received a copy of South Beach Medical Associates “Notice of Privacy Practices” and it has been clearly available at the front desk and online for review, and is available to me if I request a copy in the future.

**Medical Information Release Form**

**(HIPAA Release Form)**

**Release of Information**

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information to my insurance as listed previously.

This information may be also released to:

[ ] Spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Child(ren)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Information is not to be released to anyone.

[ ] *I UNDERSTAND THAT THIS RELEASE WILL REMAIN IN EFFECT UNTIL OTHERWISE STATED BY ME IN WRITING.*

**By my signature below, I affirm the above information.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

DO YOU HAVE ANADVANCE DDIRECTIVE? \_\_\_\_YES \_\_\_\_NO

DO YOU POA? If yes, who is? NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| PATIENT POLICIES |

The physicians and staff of South Beach Medical Associates (SBM) are pleased to welcome you to our facility. We hope that your visit will be a pleasant experience. SBM firmly believes that a good physician/patient relationship is based upon mutual understanding and open communication. The patient policies listed below have been developed to address any questions regarding a patient’s visit and account. If you have any questions or do not understand any of these policies, please feel free to contact our office at (772) 252-5265.

**REGISTRATION**Please note that SBM practices requires patient forms for check-in process. You may complete them prior to your visit or upon arrival to complete all necessary information as indicated below. Upon your initial visit to SBM, we will collect your billing and demographic information during the registration process. This information will include address, telephone number, social security number, date of birth, insurance information, employer information, emergency contact information, and other similar information. It is important that this information is kept up-to-date. Accordingly, at each subsequent visit, you will be asked to verify this information when you arrive for your appointment. In the event that any of the information has changed, you will be asked to update the information before seeing your physician.

**MISSED APPOINTMENTS**Please give at least a 24 hour notice (one business day) if you will not be able to keep your appointment. If you are a new patient, failure to show up for your initial appointment may result in the inability to reschedule. Repeated failure to provide an appropriate notice or accumulating three no shows in a 12-month rolling period may result in dismissal from SBM practices.

**DISMISSAL**SBM views the provider-patient relationship as critically important to our ability to provide appropriate and safe care. If we are unable to create or maintain this relationship with you we may need to discontinue the relationship. Reasons that may deem this necessary include consistent no shows, noncompliance, or failure to adhere to our patient policies.

**FMLA & DISABILITY FORMS**If you require FMLA paperwork or disability forms to be completed, there will be a $10-$25 fee for each request and it may take up to 10 days for completion. Payment is required prior to processing and can be made via credit, cash or check.

**MEDICAL RECORD REQUESTS**Upon receipt of a valid medical record release, your records will be released to you or the selected physician or facility of your choice. Please allow up to 10 business days for completion.

**MEDICATION REQUESTS**Medication requests or refills will be processed within 2 business days and must be requested and filled within business hours Monday through Friday 8:30am-4:30pm. We recommend contacting your pharmacy or using the Patient Portal to submit requests for medications. Calls made to the office for any prescriptions after-hours or over the weekend will need to be called into the office during regular business hours or they can be requested electronically via the Patient Portal to be processed within the next 2 business days. The on-call physicians will not have access to patient medication information. If you are prescribed opioids, you will be required to sign a controlled substance agreement annually.

**PAYMENT FOR SERVICES**Payment for services provided is ultimately your responsibility. For your convenience, we accept cash, personal checks, Health Savings Accounts (HSA), Visa, MasterCard, AmEX and Discover. Our patient portal provides an easy and secure way to pay your bill. If you have a balance and are unable to pay it in full we can set you up on a payment plan.

**HEALTH INSURANCE**If you will be using health insurance to settle your account, you will be asked to present your current insurance card at each visit. If your insurance has out of pocket expenses (co-pays and deductibles), we will collect that amount at each visit. We will file an initial claim based upon the information that you have provided to us. Under state law, your insurance company has 45 days in which to process and pay the claim, request more information, or deny the claim and notify us of the decision. If they have not notified us within 90 days of the date of service, it will be assumed that your insurance coverage is no longer in effect and the unpaid balance will be your responsibility.

**CARD ON FILE
SBM** has a card on file policy, which is a convenient method of payment in which we securely store your Health Savings Account (HSA), credit or debit card on file for services that your insurance doesn’t cover. Please refer to the hand-out for more information on the process and terms for this agreement.

**RETURNED CHECKS**The fee for a returned check is $30.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

**WORKERS COMPENSATION CLAIMS**Our physician provide services under workers compensation plans. You will need to provide us with the case number as well as the address to which the claims are to be filed.

**SELF-PAY PLAN**If you are self-pay, you will be expected to pay for services rendered. You will be required to pay a $100 deposit on the day of service for any office visits. There may be additional charges for testing and other services rendered subsequent to your visit. You will be billed for these items. Payment must be made in full prior to the services being rendered.

**PAST DUE ACCOUNTS**Past due accounts cost both time and money; therefore, patients with delinquent accounts will be required to make payment at the time of service. If you are unable to make mutually agreeable payment arrangements, we will be glad to reschedule your appointment. Those accounts failing to honor agreed upon payment terms will be sent to a collections agency and collection fees may apply. If your account is sent to a collection agency, patients and/or their immediate family members may be dismissed from SBM practices for financial reasons. If this is occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care.

**TREATMENT FOR MINORS**While Florida law considers anyone under age 18 to have the consent of a parent or guardian before receiving medical treatment, there are exceptions for emancipated minors and “mature minors” (over age 15 and who can show a health care provider that they have enough maturity and understanding to make medical care and treatment decisions). In addition, there are certain statutory exceptions whereby a minor who understands the risks and benefits of proposed care can consent to: emergency healthcare, limited outpatient mental health care, alcohol and drug abuse treatment, testing for STI/HIV/AIDS, and some family planning services. A separate consent form will be signed by the minor at every visit for these exceptions.

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| **ANNUAL CONSENT FORM FOR TREATMENT OF MINOR CHILD (under age 18)** |

**Permission to Treat**

The State of Florida has enacted a new law that imposes additional obligations on health care providers when obtaining consent to treat a minor child. This form seeks to comply with our obligations under this new law, including obtaining a written consent to prescribe, where medically indicated, medicinal drugs needed by the minor child identified below. The new law also states that written consent must be obtained from a parent who has legal custody of the minor child or is the legal guardian of the minor child.

By signing below, I represent that I am either a parent with legal custody or the legal guardian of the minor child named below.

I give SOUTH BEACH MEDICAL ASSOCIATES facility, physicians, other medical professionals, and employees consent to provide, solicit and arrange for health care services, and prescribe medicinal drugs when necessary, to the minor child named below.

I/we have been informed that medical care and treatment of my/our child at well exams and other times deemed necessary, typically include, as determined by the health care practitioner, a full physical examination including an external genital examination. Florida Statutes Section 456.51 (Consent for Pelvic Examinations) requires written consent by the patient or the patient’s legal representative before a health care practitioner may perform any type of pelvic examination on a patient including an external genital exam. This Permission to Treat expresses my/our consent that an external genital exam may be performed on my/our child/children as part of their medical care and treatment.

THIS CONSENT FORM HAS BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED.

Name of Minor First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth of Minor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name of Parent/Legal Guardian First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Assignment of Benefits Form |

**Financial Responsibility:**

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

**Assignment of Benefits:**

I hereby assign all medical and surgical benefits, to include major medical benefits which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to South Beach Medical Associates for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by

insurance.

**Authorization to Release Information:**

I hereby authorize South Beach Medical associates to:

1. Release any information necessary to insurance carriers regarding my illness and treatments.

2. Process insurance claims generated in the course of examination and treatment.

3. Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing.

I have requested medical services from South Beach Medical Associates on behalf of myself and/or

my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable at the date that services are rendered and agree

to pay all such charges incurred in full immediately upon presentation of the appropriate

statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Consent for Evaluation and Treatment Consent |

 **CONSENT FOR PURPOSES OF TREATMENT, AND HEALTHCARE OPERATIONS**

**TO THE PATIENT:**

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

 I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employee Job Title:\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_