# MEDFLORIDA MEDICAL CENTERS
# NEW PATIENT PACKET

ENGLISH

## INSTRUCTIONS

1. PRINT THIS ENTIRE PACKET
2. Fill in all applicable fields. Print neatly and clearly and sign where indicated (SEE RED 'X')

SUBMIT OPTION 1: Scan and email the completed 8 pages to: medflrecords@mcmhealthcare.com
OR
SUBMIT OPTION 2: Fax the completed 8 pages to: 561-774-8576

**IMPORTANT NOTE: BE SURE TO SUBMIT THIS COMPLETED PACKET *PRIOR* TO YOUR APPOINTMENT.**

QUESTIONS?
Call us at 1-888-726-3017

MedFlorida Medical Centers

# NEW PATIENT INFORMATION

First Name _____ Last Name _____ Birthdate _____

Home Address_____City _____State ___ Zip_____

Social Security_____Cell Phone_____Home Phone _____

Email_____Drivers Lic#_____DL State_____

If seasonal resident, what is the ***secondary*** mailing address?

Address_____City _____State ___ Zip_____

**Relationship Status:** ☐Single ☐Married ☐Separated ☐Divorced ☐Domestic Spouse/Partner ☐Widowed ☐Other

Emergency Contact Name _____Phone_____Relationship_____

## INSURANCE

Ins Company _____ Group number _____ Policy or ID number _____

Currently on Medicare? ☐YES ☐NO

SECONDARY INSURANCE (if applicable)

Ins Company _____ Group number _____ Policy or ID number _____

## INSURED PERSON / PARTY

*If same person,check box ☐ and skip to next section. Complete section if insured is **different** than patient.*

First Name _____ Last Name _____ Birthdate _____

Address _____City _____State___ Zip_____

Social Security_____Cell Phone_____Home Phone _____

Email_____Drivers Lic#_____DL State_____

Relationship to Patient _____ Employer _____ Tel _____

## RESPONSIBLE PERSON / PARTY

*If same person,check box ☐ and skip to next section. Complete section if person is **different** than patient.*

First Name _____ Last Name _____ Birthdate _____

Address _____City _____State___ Zip_____

Social Security_____Cell Phone_____Home Phone _____

Email_____Drivers Lic#_____DL State_____

Relationship to Patient _____ Employer _____ Tel _____

MedFlorida Medical Centers

# NEW PATIENT INFORMATION

## PREVIOUS PRIMARY CARE DOCTOR / HEALTHCARE PROVIDERS

Primary Doctor Name _____Tel_____

Healthcare Company Name_____ Fax _____

Address _____City _____State___ Zip_____

Specialist Name _____ Specialty _____ Tel _____ Fax _____

Specialist Name _____ Specialty _____ Tel _____ Fax _____

Specialist Name _____ Specialty _____ Tel _____ Fax _____

## PHARMACY & PRESCRIPTION MEDICATIONS

Preferred Pharmacy_____ City/Location _____ Tel _____

Medication Name _____ Reason _____ Dosage _____ Frequency_____

Medication Name _____ Reason _____ Dosage _____ Frequency_____

Medication Name _____ Reason _____ Dosage _____ Frequency_____

Medication Name _____ Reason _____ Dosage _____ Frequency_____

Medication Name _____ Reason _____ Dosage _____ Frequency_____

**KNOWN ALLERGIES:**

_____

_____

_____

**SURGICAL HISTORY:**

_____

_____

_____

**PAST MEDICAL HISTORY:**

_____

_____

_____

_____

*The information provided is complete and accurate to the best of my knowledge.*

First Name _____ Last Name _____ Birthdate _____

Signature of Patient/Guardian X_____Date_____

MedFlorida Medical Centers

**NEW PATIENT INFORMATION**

# Financial Policy/Assignment of Benefits/Consent to Treatment

*This policy has been established to help us serve you better.*

It is necessary for us to make appointments to see our patients as efficiently as possible. No-shows and late cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late- cancellations delay the delivery of health care to other patients, some who are quite ill.

A "No Show" is missing a scheduled appointment. A "Late Cancellation" is canceling an appointment without calling us to cancel 24 hours in advance of an office visit. We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

Payment for services is due at the time services are rendered. Methods of payment: Cash, American Express, MasterCard, Visa and Discover. (Returned check fee is $25.00).

We are happy to assist you in processing your insurance claim, however insurance coverage is a contract between you and your insurance company, and you are ultimately responsible for payment of your bill.

I understand that I may be billed for any out of pocket or reasonable collection fees if my account is not paid in a timely fashion. If it becomes necessary to pursue legal action to attempt to collect any outstanding balances, I agree that I am responsible for any and all attorney fees, court costs and any and all other costs deemed reasonable and customary and/or that may be allowed by the Court.

I hereby authorize and direct my insurance company to make payment to my physicians, providers and/or associates for services rendered and acknowledge that I am financially responsible for all non-covered services. I also authorize my provider to release to my insurance company any information necessary to process my claims. A photocopy of this assignment shall be considered as effective as the original.

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor's office of any changes in my medical status. I hereby authorize the healthcare staff to perform the necessary services I may need.*

I certify that I have read and understand the foregoing "Financial Policy/Assignment of Benefits/Consent to Treatment" and agree to all terms and conditions as stated above. I understand it is my sole responsibility to verify my medical coverage with the insurance company, HMO or PPO, Medicare / Medicaid, or other benefits programs and that I am ultimately responsible for payment in full of any outstanding balances. Note: *A charge of $25.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.*

First Name _____ Last Name _____ Birthdate _____

Signature of Patient/Guardian X_____Date_____

Acknowledgement of policyholder/responsible party (*if other than patient*):

First Name _____ Last Name _____ Date _____

MedFlorida Medical Centers

**NEW PATIENT INFORMATION**

## Authorization for Release of Information (ROI) – Primary Care Provider

I hereby give my permission for:

Tel: Fax:

to release a copy of the specific information/documents listed: All medical records

Drug Abuse Psychiatric/Psychological HIV/AIDS Alcohol Abuse

**MedFlorida Medical Centers**
**Attn: Medical Records**
**1950 W Hillsboro Blvd, Suite 201**
**Deerfield Beach, FL 33442**
**☎ Phone: (954) 363-9595 💻 Fax: (561) 774-8576**

___ (Initial Here) I hereby release the facility from any liability which may arise as a result of the use of the information contained in the records released.

***For the purpose(s) of Alcohol & Drug abuse clients only*** (*please check one*)**:**

This is a ☐ single disclosure **or** a ☐ continuing disclosure for 90 days.

Date on which consent is given (Today's Date) _____

Release Expiration Date _____

*(Consent is subject to revocation at any time)*

First Name _____ Last Name _____ Birthdate _____

Signature of Patient/Guardian X_____Date_____

*To Receiving Agency: Prohibition of Redisclosure! This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the patient provides specific written consent for the subsequent disclosure of this information.*

MedFlorida Medical Centers

**NEW PATIENT INFORMATION**

## Authorization for Release of Information (ROI) – Healthcare Provider

I hereby give my permission for:

to release a copy of the specific information/documents listed: All medical records

Drug Abuse  Psychiatric/Psychological  HIV/AIDS  Alcohol Abuse

**MedFlorida Medical Centers**
**Attn: Medical Records**
**1950 W Hillsboro Blvd, Suite 201**
**Deerfield Beach, FL 33442**
**☎ Phone: (954) 363-9595 💻 Fax: (561) 774-8576**

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First Name _____ Last Name _____ Birthdate _____

Signature of Patient/Guardian X_____Date_____

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MedFlorida Medical Centers

NEW PATIENT INFORMATION

# Communications Consent

Your physician(s) and other staff members will, at times, need to contact you. By filling out the Information below, we will be better able to serve you. Unless we have your written permission to do so, we will **not**:

- ✓ Leave messages with anyone except the patient or legal guardian.
- ✓ Leave medical information on an answering machine.
- ✓ Leave medical information on a voice mail, send emails, SMS/texts and/or fax.

*Please read below and carefully consider whom you want to have access to your medical information.*

I give MedFlorida Medical Centers my permission to leave phone messages, send emails and text messages or fax anything regarding my medical care and test results, as well as any changes in location, hours of operation, appointments and/or marketing information, on the following answering systems and/or devices. I fully understand that this consent will remain in effect until I revoke it in writing.

*IMPORTANT: Initial each item and fill in each space to confirm "YES" you grant consent:*

_____ INITIALS: My cell phone/voice mail _____

_____ INITIALS: My home phone answering machine/voice mail _____

_____ INITIALS: My office/work voice mail _____

_____ INITIALS: My personal fax _____

_____ INITIALS: My email: _____

All my medical care information may be discussed with the following individuals:

Contact Name _____Phone_____Relationship_____

Contact Name _____Phone_____Relationship_____

Contact Name _____Phone_____Relationship_____

Contact Name _____Phone_____Relationship_____

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First Name _____ Last Name _____ Birthdate _____

Signature of Patient/Guardian X_____Date_____

MedFlorida Medical Centers

NEW PATIENT INFORMATION

## Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to (CHECK ALL):

☐ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

☐ Obtain payment from third-party payers.

☐ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by MedFlorida Medical Centers of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review in office or online at www.medflorida.com, such Notice of Privacy Practices prior to signing this consent. I understand that MedFlorida Medical Centers has the right to change the Notice of Privacy Practices from time to time and that I may contact this office at any time by phone or in person to obtain a current copy of the Notice of Privacy Practices at: 1950 W Hillsboro Blvd, Deerfield Beach, FL 33442

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

First Name _____ Last Name _____ Birthdate _____

Signature of Patient/Guardian X_____Date_____

MedFlorida Medical Centers

NEW PATIENT INFORMATION

# REFERRALS POLICY

Referrals are required by most health insurance companies to ensure that patients are seeing the correct providers for the correct problems. Failure to obtain the necessary referral before seeing a specialist can result in coverage not being applied to a visit or service, and costs being passed on directly to the patient. The purpose of the referral process is to provide prompt and proper care as defined by the PCP at the appropriate facilities/providers within the Insurance Company network.

Be aware, if your insurance is an “HMO plan type”, you cannot visit a specialist or obtain an imaging test or procedure without having an INSURANCE AUTHORIZATION given by your plan. We as PCP office review your referral policies and will determine if the service is “medically necessary” and process a referral/authorization accordingly.

The determination of whether a covered benefit or service is Medically Necessary requires compliance with the requirements established in Florida Administrative Code, Chapter 59G - 1.010.

To be Medically Necessary or a Medical Necessity, a Covered Benefit shall meet the following conditions:

- ✓ Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- ✓ Be individualized, specific, and consistent with symptoms or confirm diagnosis of the illness or injury under treatment, and not more than the patient’s needs.
- ✓ Be consistent with generally accepted professional medical standards as determined by the program, and not be experimental or Investigational.
- ✓ Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
- ✓ Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the Provider.

***DO NOT MAKE APPOINTMENTS WITH SPECIALISTS OR IMAGING FACILITIES UNTIL A REFERRAL OR AUTHORIZATION HAS BEEN FURNISHED BY INSURANCE (this may take up to 2 weeks from when this information is submitted)**

****IF YOU ARE A NEW PATIENT**** PLEASE CALL US AT 1-888-726-3018 AT LEAST 5 DAYS IN ADVANCE TO NOTIFY US ABOUT ANY PENDING APPOINTMENTS AS WE NEED TO GATHER ALL YOUR PRIOR MEDICAL RECORDS TO BE ABLE TO PROCESS ANY REFERRAL(S).

First Name _____ Last Name _____ Birthdate _____

Signature of Patient/Guardian X_____Date_____