

PATIENT REGISTRATION FORM



Last Name: _____ First: _____ MI: ____ Suffix: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone: _____ Home Wk Cell Other Phone: _____ Home Wk Cell

Date of Birth: _____ Sex: Male Female Email: _____

Employer: _____ Marital Status: Single Married Divorced

Pharmacy: _____ Location: _____

Physician: _____

Student: Yes No If yes, Parent's Name: _____

Parent Address: _____

City: _____ State: _____ Zip Code: _____

Parent's Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Company: _____

Insurance: Subscriber Last: _____ First: _____ MI: ____ Suffix: ____

Relationship to Patient: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Claims Address: _____

Employer: _____ Phone Number: _____

Secondary No Secondary: _____

Insurance Company: _____

or Subscriber Last: _____ First: _____ MI: ____ Suffix: ____

Auto Relationship to Patient: _____ Date of Birth: _____

Insurance: Policy/Claim Number: _____ Group Number: _____

Claims Address: _____

Employer: _____ Phone Number: _____

Emergency Last Name: _____ First: _____ MI: ____ Suffix: _____

Contact: Address: _____

(Person not living City: _____ State: _____ Zip Code: _____

with you) Home Phone: _____ Work: _____ Cell: _____



FINANCIAL AGREEMENT

As your healthcare provider, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our policies.

PAYMENT FOR SERVICE IS DUE AT THE TIME OF SERVICE

- We accept all form of payment - Cash, Checks, Debit Cards, MasterCard, Visa, American Express and Discover. Returned checks are subject to a service charge of \$25.00 or 5% of the value of the check, whichever is greater and you will lose your privilege to write checks in our office.

INSURANCE PLANS

- It is the responsibility of the patient to select a physician who is participating with their insurance plan. Gainesville Family Physicians will only give contractual adjustments to patients who have insurance with which we participate.
- **MEDICARE PATIENTS:** Your deductible and 20% of the allowable charges are due at the time of service. Since we are a Medicare provider, we will file your Medicare claims. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare pays.
- **MEDICAID PATIENTS:** There is a \$2 copay for each visit, except for children and pregnant women.

CHILDREN OF DIVORCED PARENTS

- Payments are due at the time of service no matter who is responsible by order of the divorce decree.

CANCELATION, NO SHOW AND LATE APPOINTMENT POLICY

- In order to assure all patients receive the time and attention they deserve, we have established some guidelines for late arrives, not showing for appointments and late cancellation of appointments.
 - If you are 15 minutes late or more, the provider reserves the right to reschedule your appointment.
 - If you miss two or more consecutive appointments without notice, we reserve the right to discharge you from the practice.
 - Your appointment has been reserved for you. We reserve the right to charge you a \$30.00 fee if you do not show for your scheduled appointment or cancel/reschedule your appointment without a 24-hour notice. This fee is not payable by your insurance carrier and will be bill to you directly.

FINANCIAL AGREEMENT

- We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g. yearly physicals.)
- We emphasize that as your medical care provider, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE THE SERVICES ARE RENDERED.** On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that certain circumstances may arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account. Communication is key in these cases.
- If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including any attorney's fees, whether suit is filed or not.

I have read and understand the above Financial Policy.

Signature of Patient or Legal Guardian

Date

Print Patient's Name



PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Gainesville Family Physicians may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Gainesville Family Physicians' Notice of Privacy Practices for a more complete description of such users and disclosures.

Gainesville Family Physicians reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained at the office or by forwarding a written request to Gainesville Family Physicians at 6900 NW 9th Blvd, Gainesville FL 32605.

With my consent, Gainesville Family Physicians may call my home or other designated location for which I provided contact information, leave a message on voicemail/answering machine or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Gainesville Family Physicians may mail to my home or other designated location for which I provided contact information or any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential.

With my consent, Gainesville Family Physicians may email any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Gainesville Family Physicians, OA restrict how it uses or discloses my PHI. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

List any individuals to whom you have give consent to Gainesville Family Physicians to receive information on your behalf. No person other than yourself will be given information concerning your treatment, payment or healthcare operations unless you list them here. Those listed below may receive any information on your behalf.

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

By signing this form, I am consenting to Gainesville Family Physicians use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Gainesville Family Physicians may decline to provide treatment to me. I have read and understand the above agreement.

YES NO I hereby give consent to Gainesville Family Physicians to release information regarding my TPO to my spouse, _____ (*Spouse's Name*).

Signature of Patient or Legal Guardian

Print Name of Signature

Date

Print Patient's Name



LIFETIME AUTHORIZATION INSURANCE ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION

- I. RELEASE OF INFORMATION – I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Medicare or Blue Cross Blue Shield of Florida) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.
- II. PHYSICIAN INSURANCE ASSIGNMENT – I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.
- III. MEDICARE/MEDICAID – Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration, Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.
- IV. I permit a copy of these authorizations and assignments to be used in place of the original which is on file at the physician's office. This assignment will remain in effect until revoked by me in writing.

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. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third payer within a reasonable period of time not to exceed 60 days.

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

Patient (or Responsible Party) Signature

Date

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following;

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Gainesville Family Physicians** may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS:

I authorize Gainesville Family Physicians to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Gainesville Family Physicians**.

I acknowledge that I have been given Gainesville Family Physicians Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

Patient Initial _____

I, the undersigned, authorize **Gainesville Family Physicians** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

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

Patient (or Responsible Party) Signature

Date

Patient Consent

Photographs, Videotapes and Audio Recordings

(Please Read and Sign)

I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's healthcare operations purposes (e.g. quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.

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


Patient (or Responsible Party) Signature


Date



Patient Name: _____ DOB: _____

List any **ALLERGIES** to drugs, latex, etc.:

List any **MEDICATIONS AND/OR HERBAL SUPPLEMENT OR VITAMINS** you take on a regular basis:

FAMILY HISTORY of any of the following:

	Father	Mother	Child	Sibling	Grandparent		Father	Mother	Child	Sibling	Grandparent
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Yes No Have you used recreational drugs recently? If yes, which ones? _____

Yes No Do you use tobacco? Which products? _____ How Much? _____

Yes No How much caffeine do you drink? _____

Yes No Do you drink alcohol? How Much? Liquor? _____ Beer? _____ Wine? _____

Yes No Do you exercise regularly? _____ If so, how often and duration _____

Occupation: _____ Marital Status: Married Single Divorced Widow

List any **HOSPITALIZATIONS or SURGERIES or SERIOUS ACCIDENTS:**

Date	Reason	Date	Reason

Have you ever been **DIAGNOSED** with any of the following? (Circle):

Abnormal Mammogram	Chronic Back Pain	Heart Murmur	Osteoporosis
Abnormal Pap	Chronic Constipation	Hemorrhoids	Post Polio Syndrome
Allergies or Hayfever	Chronic Diarrhea	Hernia	Pneumonia
Anemia	Depression	Herpes	Prostate, Cancer or Enlarged
Anxiety	Diabetes	Hepatitis	Psoriasis or Eczema
Arthritis/Rheumatism	Diverticulosis/Colitis	High Blood Pressure	Rheumatic Fever
Asthma	Erectile Dysfunction	HIV	Sexually Transmitted Disease
Chronic Back Pain	Epilepsy/Convulsions/Seizures	Hives	Stroke
COPD/Bronchitis	Fibromyalgia	Jaundice	Tuberculosis
Cancer	Gall Bladder Disease	Kidney Stones	Ulcers, Peptic
Cholesterol, Elevated	Heart Disease	Multiple Sclerosis	Varicose Veins/Phlebitis



Patient Name: _____ DOB: _____

Circle any **MEDICAL PROBLEMS** you have had or are currently experiencing:

- | | | |
|---------------------------|----------------------------|------------------------------------|
| Abdominal Pain/Cramping | Headache, Frequent | Persistent Nausea |
| Anxiety | Headaches, Severe | Severe Family Problems |
| Appetite Loss | Heartburn, Indigestion | Sexual Dysfunction |
| Black Tarry Stools | High Cholesterol | Shortness of Breath |
| Bowel Habit, Changes in | Kidney Stones | Sinus Problems |
| Burning with Urination | Leaking Urine Accidentally | Sore Throat |
| Changes in a Mole | Leg Pain with Walking | Swallowing Difficulty |
| Chest Pain | Loss of Consciousness | Swollen Ankles |
| Chronic Cough | Loss of Vision | Tremor/Hand Shaking |
| Chronic Pain in Joints | Marked Fatigability | Urethral Discharge |
| Depression | Marked Stressful Job | Urination, Decrease in flow |
| Difficulty Sleeping | Memory Loss | Urination, During night more twice |
| Difficulty Urinating | Moodiness, Excessive | Urination, Loss of control |
| Dizziness | Muscle Weakness | Urination, Painful |
| Early Morning Awakening | Nervousness | Urine, Blood in |
| Ears Ringing | Nose Bleeds | Vision, Failing |
| Easy Bleeding or Bruising | Numbness or Tingling | Vomiting Blood |
| Excessive menstrual pain | Pain or bleeding after sex | Vomiting, Nausea |
| Foot Pain, Cold Numbness | Palpitations | Weight Gain/Loss, Unexplained |
| Hair Loss, Unexplained | Persistent Constipation | Wheezing |
| Hay fever | Persistent Diarrhea | Other: _____ |

BRIEFLY DESCRIBE your present medical condition and elaborate on any medical problems you have circled above:
