ב"ה

Amiel Levin MD
Internal Medicine - Geriatric Medicine

Patient Information

Name: _____ Date of Birth: _____

Social Security: _____-_____-_____ Gender: Male _____ Female _____

Permanent Address _____APT#___

City _____ State _____ Zip code _____

Florida Address (if different) _____APT#___

City _____ State _____ Zip code _____

Home Phone _____ Cell Phone _____

I allow the doctor to communicate with me via text messaging: Yes____ No___
I allow the doctor to leave voicemails regarding my health info on my cell: Yes___ No___

Email Address _____

Primary Doctor_____ Referring Doctor_____

Preferred Pharmacy _____

How did you find our practice? _____

Contact Information

In case of emergency contact _____ Phone #_____

Relation_____

Please Note: We prefer to communicate with only one family member. Would you like to assign someone in addition to yourself?

___Same As Above
___Primary Contact Name _____

Phone #_____ Relation to Patient_____

I allow the office to communicate with the above person regarding my medical care __Yes __No

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim.
I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Amiel Levin MD PA.

Signature _____ **Date** _____

Continue on following pages >

ב"ה

Amiel Levin MD
Internal Medicine Geriatric Medicine

Office Policies and HIPAA Disclosure

Thank you for choosing us as your health care provider. We are committed to your treatment. Please read and sign prior to treatment.

• Phone calls, text messages, or emails that require medical management (ex. new prescriptions, consultations etc.) will be charged at a rate of $45 in any month that service is given. Many insurance companies cover this charge. Co-pays and deductible may apply. Medicare patients with chronic conditions are covered under Chronic Care Management program. Co-pays and deductible may apply. We may call you once a month to keep track of any conditions you may have and bill according to Medicare guidelines. You can opt out by informing our staff.
Please note that it IS NOT the doctor's responsibility to call you with results. It is the patients responsibility to schedule a follow-up aapointment to discuss results.

• Missed appointments and same day cancellation will carry a charge of $25. Please avoid this fee by cancelling 24 hours in advance.

• There will be a late charge of $15 a month for any unpaid balance over 30 days.

• I assign directly to Amiel Levin MD PA all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The physician and associates may use my health care information and may disclose such information my insurance company/companies and their agents for the purpose of obtaining payments for services and determining insurance payments payable for related services.

• I acknowledge that payment is due at the time of treatment unless other arrangements are made. I accept full financial responsibility for all charges for all services provided to me or my parent(s). I understand that filing claims with my insurance company does not relieve me from my responsibility for the payment of all charges. I understand that if my account should be sent for collection for any reason, a 35% collection cost will be added to my account.

• Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates, unless contracted insurance rates apply.

This office complies with HIPAA regulations. A copy of this policy is obtainable for review. We may use or disclose your health information for certain purposes without your written authorization, including the following:

• Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.
• Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.
• Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Thank you for your understanding of our offices policies. Please let us know if you have any questions or concerns.
I have read the offices policies and I understand and agree to them:

_____ _____

Signature of Responsible Party Date

ב"ה

Name: _____ Date of Birth: _____

Past Medical History

Condition / Disease	Year Began	Condition / Disease	Year Began
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

If none, check here: ____

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

If none, check here: ____

Allergies or Intolerances

Medication / Food	Reaction	Medication / Food	Reaction

If none, check here: ____

Medications, Vitamins and Herbal Supplements

Medication	Strength	Number taken & frequency	Medication	Strength	Number taken & frequency
Example: Motrin	600 mg	1 - twice daily			

If none, check here: ____

Do you drink alcohol?	What type of alcohol?	Number of drinks per week?
Do you smoke?	If yes, how many packs per day?	
Are you a former smoker?	If yes, when did you quit? (Month/Year)	
How many packs did you smoke per day?	Number of Years smoked?	

ב"ה

Do you have any family history of illness?

Relative: _____ Illness: _____
Relative: _____ Illness: _____
Relative: _____ Illness: _____
Relative: _____ Illness: _____
If none, check here: ____

Review of Systems - Please mark or circle any items that are a problem for you:

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Difficulty sleeping	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	**None of the Above**

Other Doctors:

Name: _____ **Specialty:** _____

Phone: _____ **Date Last Seen:** _____

Name: _____ **Specialty:** _____

Phone: _____ **Date Last Seen:** _____

Name: _____ **Specialty:** _____

Phone: _____ **Date Last Seen:** _____

Name: _____ **Specialty:** _____

Phone: _____ **Date Last Seen:** _____

Name: _____ **Specialty:** _____

Phone: _____ **Date Last Seen:** _____

ב"ה

AUTHORIZATION FOR THE RELEASE OF INFORMATION

INFORMATION FROM THE MEDICAL RECORD OF:

Patient Name: _____ DOB: _____

SSN# _____ Phone# _____

RELEASE TO:

Name/ Facility: Amiel Levin MD

Address: 4302 Alton Rd STE 1010, Miami Beach, FL 33140

Phone: 305-531-6829 Fax: 305-531-4704 Alternate: 305-531-6829

RECORDS FROM:

Name/ Facility: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED:

O Doctor's Notes O Recent Labs O MRI/CT Reports O History & Physical

O EKG O Operative Report O Office Visits O Discharge Summary

O Abstract O Diagnostic Reports

O Other: _____

PURPOSE OF DISCLOSURE:

O Continued Medical Care O Personal Information O Insurance Company Request

O Other: _____

I hereby authorize _____ to release any or all clinical records, including, if applicable, records relating to the following conditions: Mental, Psychiatric, Alcohol, Drug Abuse, and AIDS or HIV results.

This authorization shall be in effect for 90 days following the date of signature. However, I understand that this authorization may be revoked any time by giving written notice to the facility. A photocopy of the authorization shall constitute a valid authorization.

The facility and its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorization herein.

Signature: _____ Date: _____