PHYSICIANS GROUP
OF SOUTH FLORIDA, P.A.
Quality Personal Care

NEW PATIENT REGISTRATION FORM

_____ _____ _____/____/_____
Last Name First Name Middle Social Security Number

_____ Male / Female
Date of Birth **(Circle one)** ___Single ____Married ____Divorced ____Widowed ____Other

Race/ Ethnic Description

☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Native Hawaiian
☐ Asian Pacific American ☐ Pacific Islander ☐ Subcontinent Asian American
☐ American Indian or Alaskan Native ☐ Black non-Hispanic ☐ White non-Hispanic ☐ Other

PRIMARY LANGUAGE: _____ENGLISH _____SPANISH _____OTHER: _____

_____
Home Address Apt. # City State Zip

(____)_____(____)_____(____)_____
Cell Phone # Home Phone# Work Phone#

Where do you prefer to receive calls? ____Home ____Cell ____Work (Extension # _____)
Is it OK to leave a detailed message? Yes ☐ No ☐ Should we leave a name & number only? Yes ☐ No ☐

_____
E-mail address Employer Name Occupation

Patient Portal: Contact your physician via e-mail, request appointments, prescriptions and referrals, view your laboratory results and update your demographic information
Would you like to sign up for our office patient portal? Yes ☐ No ☐

_____(____)_____
Preferred Pharmacy Name & Address Pharmacy Phone #

In the event of an emergency, who should we contact?

_____ _____
Name of Contact #1 Relationship Name of Contact #2 Relationship

Can this person be contacted about your care, medical results and tests? Yes ☐ No ☐

Can this person be contacted about your care, medical results and tests? Yes ☐ No ☐

Work #: (____)_____Ext.____ Work#: (____)_____Ext.____

Cell #: (____)_____ Cell #: (____)_____

Home #:(____)_____ Home #:(____)_____

_____ _____
Patient's Signature Today's Date

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GENERAL CONSENT FORMCONSENT FOR TREATMENT

I, _____, hereby authorize Physicians Group of South Florida, P.A., the attending physician, or the physician designated by him/her, and other employees to examine and treat me. I also authorize such treatment and procedures as deemed necessary by the physician, including but not limited to, the taking of such x-rays, medications, blood samples, urine samples and other therapies as deemed necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment.

I hereby certify that I understand the above authorization.

Patient Signature Witness to Patient Signature

Other Person Authorized to Consent Relationship Date

NOTICE OF MEDICAL MALPRACTICE INSURANCE

Due to the current medical malpractice crisis your physician has decided not to carry medical malpractice insurance.

"Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida Law subject to certain conditions; Florida Law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law."

Acknowledged:

Patient Signature Patient Name (Please Print)

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Physicians Group of South Florida, P.A. and agree to assume responsibility for payment of charges that are not covered by my healthcare insurer. I understand that I am responsible for any amounts applied to the deductible, Co-Insurance and non-covered services under my insurance plan.

I hereby acknowledge that I have received a copy of the office Financial Policy.

Patient Name Patient Signature Date

Witness Name Witness Signature Date

PHYSICIANS GROUP OF SOUTH FLORIDA, P.A. - FINANCIAL POLICY

This Financial policy contains important information about financial responsibility for our professional services.

- Our practice participates with many health insurance companies. However, it is your responsibility to provide us with current insurance information and to confirm that our doctors are participating providers with your insurance plan at time of service. The burden of proof is your responsibility and not ours.
- You must present your current insurance card every time a service is rendered.
- If you are a member of an insurance plan with which we do not participate, our office will gladly file the claim on your behalf and payment in full is expected, at the time of services.
- It is also your responsibility to make payment at time of services for any **co-payment, deductible or co-insurance due.** Any services not covered by your insurance plan are your responsibility and payment in full must be made at time of services.
- If you make a decision not to involve your health insurance to pay for services and you cover the services entirely out of your pocket, be aware that, our office set up fees, may not be the same as the insurance allowable. You are turning down the right to use the insurance processing guidelines, therefore; you cannot expect us to file your medical claim at later time.

Payment may be with: Cash, Check, or Credit Cards

- Payment **in full** is expected at the time of service. Even though you have medical insurance coverage, you are ultimately responsible for payment of your account. Insurance arrangements are between you (the insured) and your insurance company.
- Our office makes **no** guarantee of benefits. Any quote of benefits provided by your insurance company is considered a general overview, and only a **guideline** until payment is finally received. All benefits are subject to review when the insurance company receives the actual claim form.
- Be aware that **If your insurance company has not paid your claim in full within 60 days, the balance of your account will be transfered to you**. It is your responsibility to make sure your insurance reimburses your physician for services rendered. After 60, days any unresolved balances may be placed with an outside collection agency and may also be subject to finance charges, attorney fees and collection agency fees. Once an account has been placed for collections, future appointments WILL NOT be made until you see or speak to a representative in our billing office. At that time, only Emergency care will be rendered. In the event of personal financial hardship, we are able to offer special financial arrangements.
- You are responsible for obtaining the necessary **referrals** prior to your visit.
- We reserve the right to charge interest in the amount of 8% as provided by state law. Or, at our option, we may charge a rebilling fee of $20.00 per bill.

Our office charge additional fees for the following non-covered services:

- A $50 fee is charged for returned checks. We do not accept checks over $50
- An administration fee of **$20 per form** is charged for all forms: Disability, letters, FMLA, etc. This fee is due at time of request. Forms will **not** be completed without payment
- A $10 fee for any itemized bill print out that you need for your personal accounting
- A $50 one time set up fee to be able to have unlimited access to our patient portal
- A $30 fee for any E-visit, must have unlimited access to our patient portal. (Please ask for additional information).

This is to acknowledge that I have read / or received a copy of the Physicians Group of South Florida, PA Financial Policy.

Signature of Patient	Print Name	Date

PHYSICIANS GROUP
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NOTICE OF HIPAA/HITECH PRIVACY PRACTICES

This notice describes how your medical/protected health information may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY.

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP).

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request restrictions.
4. The right to request confidential communications.
5. The right to request alternative forms of communication.
6. The right to an Accounting of disclosures
7. The right to receive electronic copies of your health information
8. Out of Pocket Payments. If you paid out of pocket in full for a specific service, you have the right to ask that your PHI with respect to that item not to be disclosed to a health plan.
9. The right to get notice of a breach of Protected Health Information.
10. The right to a paper copy of the Notice of Privacy Practices

We want to assure you that your medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

"I hereby acknowledge that I have received a copy of the medical practice's NOTICE OF PRIVACY PRACTICES. I understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in any way"

_____ _____

Patient's / Representative's Printed Name Patient's / Representative's Signature

____Patient refused to sign. Patient was unable to sign because: _____

Today's Date: _____ _____

MEDICINE LIST

NAME:	
ALLERGIC TO: (Describe reaction)	
1)	
2)	
3)	
IMMUNIZATION RECORD (Date/Year of last dose taken)	
Flu Vaccine:	Pneumonia vaccine:
Tetanus:	Hepatitis Vaccine:

List all medicines you are currently taking. Include prescriptions (examples: pills, inhalers, creams, shots) and over-the-counter medications.

If you brought your own list, please provide a copy to us.

NAME OF MEDICATION	DOSE	DIRECTIONS *(How do you take it? When? How often?*

PHYSICIANS GROUP OF SOUTH FLORIDA, P.A.
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Past Medical History

Please review the following list. If you have any of these conditions check Yes or No and the approximate year of diagnosis. If you have other conditions not listed, please write them down in the space provided.

Condition / disease	Yes	No	Year	Condition / disease	Yes	No	Year
Alcoholism / Cirrhosis				Cataracts			
Anemia				Diabetes (high blood sugar)			
Arthritis				Gallbladder disease / stones			
Asthma / Emphysema				Glaucoma			
Bleeding / Blood Disorders / Clots				Crohn's disease / colitis			
Bone or spine				Heart disease			
Cancer (past)				Heart attack (MI)			
Leukemia				Hepatitis / Jaundice / Liver			
Lymphoma				High blood pressure			

Other Conditions: _

Please list all hospitalizations, and surgeries with the approximate date

Surgery	Date

Do you have anyone in your immediate family who has been diagnosed with Heart disease, Diabetes, Kidney disease, arthritis, Blood disorder, blood clots, or other condition?

List below the family member affected and what their condition was?

PHYSICIANS GROUP
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NOTICE OF PRIVACY PRACTICES
For
PROTECTED HEALTH INFORMATION
(HIPAA)

Effective Date: **April 20, 2016**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your care is created. Typically, this record contains medical information such as your symptoms, examination, test results, diagnoses, treatment and/or treatment plan and billing-related information. This information is considered Protected Health Information (PHI).

This Notice is intended to advise you about the ways we may use and disclose medical information about you. It also describes your rights and certain obligations with regard to your medical information and applies to all of the records of your care generated by your healthcare provider(s) for our organization.

Our Responsibilities

Our Organization is required to maintain the privacy of your health information and to provide you with a description of our legal duties and Privacy Practices regarding your health information that we collect and maintain.
We are required by law to abide by the terms of this Notice and notify you if changes are made. We reserve the right to make changes to the Notice and make the new provisions effective for all protected health information we maintain.
Copies of our Notice are available in our main reception area(s) and on our website.

How We May Use and Disclose Medical Information About You.

The following describes examples of the way we may use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other healthcare professionals such as physicians, nurses, technicians, clinical laboratories, imaging centers, medical students, or other personnel who are involved in your care.

We may communicate your information using various methods, orally, written, facsimile, and electronic communications. We may contact you to remind you of your appointment by telephone or reminder card unless requested otherwise.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. Examples may include contacting your insurance company for referrals, verification, or preapproval of covered services.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessments, employee review activities, licensing, legal advice, accounting support, information systems support, and conducting or arranging for other business activities such as lab or radiology interfaces within the EHR, and through a Health Information Exchange (HIE) program. We may use or disclose, as needed, your health information within a medical group to support your care.

We may also provide other healthcare professionals who contribute to your care with copies of various reports and information to assist him/her and ensure that they have appropriate information regarding your condition/treatment plan and diagnosis.

Business Associates, BA: Provide services for our organization through written contracts and/or service agreements. Examples of these services include billing, collection, and software support. We may disclose your health information to a BA so they can perform the services we have asked them to do such as billing your third-party payer for services rendered. The BA is

also required by law to protect and safeguard your health information which is clearly defined through our Business Associate Agreement and written contracts/service agreements.

Breach Notification: In the event that there has been a breach of unsecured protected health information (PHI) identified on behalf of our organization or a BA you will be notified within 60 days of the breach. In addition to your individual notification we may be required to meet further reporting requirements set forth by state and federal agencies.

Uses and Disclosures That May Be Made *With* Your Consent, Authorization or Opportunity to Object: We will not use and disclose information without your written authorization, except as described in this Notice or as required by applicable laws. Written authorization is required for, most uses and disclosures of psychotherapy notes; PHI for marketing purposes unless we speak with you and disclosures that constitute a sale of PHI. If you provide an authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your authorization.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate with you via newsletters, mailings or other means regarding treatment options and information on health-related benefits or services; to remind you that you have an appointment; or other community based initiatives or activities to include limited marketing or fundraising initiatives in which our facility is participating. You have the right to opt out at any time if you are not interested in receiving these communications, please contact our Privacy Officer.
Marketing and Fundraising initiatives, if applicable are limited and may require a separate authorization.

Uses and Disclosures That May Be Made *Without* Your Authorization or Opportunity to Object: We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to the following types of entities, including but not limited to:
- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

If you are not present, able to agree or object to the use or disclosure (such as in an emergency situation), then your healthcare provider may, using professional judgment will determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

State-Specific Requirements: Many states have reporting requirements which may include population-based activities relating to improving health or reducing health care costs, cancer registries, birth defect registries and others.

Your Health Information Rights
Although your health record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy: You and/or your personal representative have the right to inspect, review and receive a copy of your medical information. Electronic copies are available and may include various electronic means such as a patient portal or other reasonable accommodations requested. We may deny your request to inspect and copy in limited circumstances to include release of psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If you are denied access to medical information, you may request that the denial be reviewed.

Requests to copy and/or a review must be submitted in writing to our practice. There will be a fee charged for all applicable copying and producing copy of portable media (CD, USB) up to the maximum amount as prescribed by governing law.

Amend: If you feel that the medical information we have is incomplete or incorrect, you may ask us to amend the information by submitting a request in writing.
We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of your medical information; the list will not include disclosures to carry out treatment, payment and healthcare operations. OUR PRACTICE will provide the first accounting to you in any 12-month period without charge, upon receipt of your written request. The cost for subsequent requests for an accounting within the 12-month period will be up to the maximum amount prescribed by governing law.

Request Restrictions: You have the right to request a restriction or limitation of your medical information we use or disclose about you for treatment, payment or health care operations.
Restrictions from your health plan (insurance company): You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket.

Other Restrictions, Limiting Information: You also have the right to request and limit any medical information we disclose about you to someone who may be involved in your care or the payment of your care, such as a family member or friend. We ask that you submit these requests in writing.
We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternate phone number or address. We ask that you submit these requests in writing.

To exercise any of your rights, please submit your request in writing to the practice's privacy officer indicated below.

For More Information or to Report a Problem
If you have questions and would like additional information please contact the Privacy Officer. If you believe that your (or someone else's) privacy rights may have been violated, you may file a complaint with the Privacy Officer at the contact number below or with the Secretary of Health and Human Services. All complaints must be submitted in writing within 180 days of when you knew that the act or omission occurred and there will be no retaliation for filing a complaint.

Privacy Officer: **Jane S. Cohen, COO**
Address: 1801 NE 123rd Street #405
City / State / Zip: North Miami, FL 33181
Telephone Number: 305-674-5925
Fax Number: 305-674-5927