

**Patient information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Preferred Name \_\_\_\_\_ Assigned Sex at Birth: Male \_\_\_\_\_ Female \_\_\_\_\_

Gender Identity (if different from assigned): \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Marital Status \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ State: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Preferred phone number: \_\_\_\_\_ Email address: \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ How did you hear about us?

Preferred Pharmacy Name Address Phone \_\_\_\_\_

**Seasonal Patients**

Out of town address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ State: \_\_\_\_\_

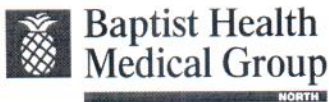
Who is your usual primary care physician?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

When do you come to South Florida? \_\_\_\_\_ Leave? \_\_\_\_\_

Do you have a living will or DNR form: \_\_\_\_\_ If yes, need a copy on file. (If not, we encourage you to do so; ask us for five wishes.)



AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize that my Medical Records be released from or to (circle one)

Physician Name/Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

I hereby authorize that my Medical Records be released to or from (circle one) Fax:

Physician Name/Clinic:

Address:

Information Requested

- For dates of service: From: \_\_\_\_\_ Through: \_\_\_\_\_
- Physician notes
- Lab results
- X-ray reports
- Complete record
- Other: \_\_\_\_\_

Purpose for Use of Disclosure of Protected Health Information

- Permanent Transfer
- Referral
- Other: \_\_\_\_\_

*Note: fee may be assessed for records requested for personal use*

Patient Information

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN #: \_\_\_\_\_

SENSITIVE INFORMATION: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

REDISCLASURE: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

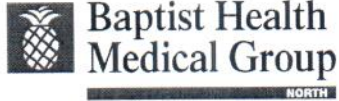
RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time; I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

OTHER RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: *(If I do not specify an expiration date, event, or condition, this authorization will expire in twelve (12) months.)*

Signature of Patient or legal representative: \_\_\_\_\_

If signed by legal representative, relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_



### PATIENT CONTACT

**Contact Information\***

The following people, other than duly designated guardian or conservator, are authorized to discuss my medical condition or billing information:

1. \_\_\_\_\_  
Name Relationship Phone Number

2. \_\_\_\_\_  
Name Relationship Phone Number

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Phone number: \_\_\_\_\_

**\*Please Note:** This contact information will remain in effect unless change is received from you in writing.



## CONSENT FOR TREATMENT

I hereby give consent for performance of medical treatment. I consent to examination, diagnosis and general medical care and treatment (including but not limited to physical examinations, administration of medications, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, and other screening tests and minor procedures). In addition, I agree to abide by facility regulations designed to enhance the care and safety of patients.

Initials: \_\_\_\_\_

Minor: \_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_

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

## FINANCIAL POLICIES

I agree to pay for the charges for medical services rendered. I understand that my health insurance may not pay the full amount of the fees charged; I agree to pay for those charges which are not paid by my health insurance. If I have **not** given this facility the correct health insurance information; I may have to pay the fees for my care. If I do not carry health insurance, then I agree to pay the facility for charges, unless other arrangements are made.

I authorize payment of Medicare, Medicaid or other insurance benefits otherwise payable to me for the services provided that are deemed necessary by me or my child's physician(s), directly to this facility and its affiliates, attending and consulting physicians and allied health professionals. Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVII and XIX of the Social Security Act is correct, and request that these payments of authorized benefits be made directly to this facility and its affiliates, attending and consulting physicians and allied health professionals on my behalf.

Initials: \_\_\_\_\_

## RECORD RELEASE AUTHORIZATION

I hereby consent to the release of information to other doctors, staff and healthcare providers who treat me. I also authorize the release of health information to insurance companies or any payer source, for billing purposes. I further give my permission to allow agencies hospital, physicians, insurance companies, adjuster, healthcare providers to review my clinical records, including those representatives from State, Federal and regulatory agencies. I hereby consent to my data being used for research purposes; however I will not be individually identified in any way.

Initials: \_\_\_\_\_

## PATIENT ACKNOWLEDGEMENT

May we leave a message in your voicemail or on your answering machine:  Yes  No

By signing below I also agree that:

The facts given to this facility are correct. I have read and understand all the facts stated above.

I have had the opportunity to ask questions about this information; all my questions have been answered.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian Print: \_\_\_\_\_ Relationship: \_\_\_\_\_

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