Baptist Health Medical Group NORTH

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.)

Baptist Health Medical Group
NORTH

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

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

Purpose for Use of Disclosure of Protected Health Information

O Permanent Transfer
O Referral
O 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.

REDISCLOSURE: 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: _____

Baptist Health Medical Group
NORTH

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.

Baptist Health Medical Group

BAPTIST HEALTH SOUTH FLORIDA

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: _____