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

NEW PATIENT REGISTRATION FORM

________________________ ________________________ ________/_____/_________
Last Name | First Name | Middle | Social Security Number

____
Date of Birth

Male / Female
(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
Can this person be contacted about your care, medical results and tests? Yes / No

Work #: (____) _________________Ext. _____

Cell #: (____)__________________________

Home #:(____)__________________________

____
Name of Contact #2 Relationship
Can this person be contacted about your care, medical results and tests? Yes / No

Work#: (____)___________________Ext. _____

Cell #: (____)__________________________

Home #:(____)__________________________

____________________________________ _______________
Patient's Signature | Today's Date

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INTERNAL MEDICINE
ALAN R. KUTNER, M.D.
IVAN M. JONAS, M.D.
JANE S. COHEN, M.D.
MARTIN DROST, M.D.
JASON L. RADICK, M.D.
LEILANY IRIZARRY-COLON, M.D.
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GASTROENTEROLOGY
& ENDOSCOPY
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ARIN H. NEWMAN, M.D.
DANIEL L. WOLFSON, M.D.

Confidential Communications Request

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave detailed telephone messages (i.e. lab results) when possible. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine or voice mail system.

However, it should be noted that our current Notice of Privacy Practices does allow us to call you with a courtesy reminder regarding any upcoming appointment(s).

Patient name:_______________________________________ DOB:________________

PLEASE SELECT ONE

I consent for detailed messages to be left on:

	My home answering machine:	Phone#
	My cell phone:	Phone#
	With my spouse/other:	Name:

______I do not consent for detailed messages to be left on any answering machine or voicemail; I prefer to be contacted personally at this number:__________________________.

This will remain in effect until you rescind it in writing.

This form must be signed by EITHER the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature of Patient:____________________________________ Date:_____________

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a Power of Attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative:________________________ Date:_____________

Personal Representative: _________________________________

Relationship to Patient:____________________________________

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?*

Patient Financial Responsibility Statement

Thank you for choosing Physicians Group of South Florida, PA (PGSF) as your healthcare provider. The medical services you pursue involve a financial responsibility on your part. This responsibility requires you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, please read and sign this form.

1. You will be required to follow all registration procedures, such as updating personal information, presenting your insurance card, and providing signatures. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be considered as a self-pay patient.
2. You are responsible for all payment obligations arising out of your treatment. You are responsible for deductibles, co-payments, co-insurance, and any other patient responsibility indicated by your insurance carrier and payment is due at the time of services.
3. You are responsible for knowing your insurance policy. If you are not familiar with your plan coverage, we suggest you contact your plan provider directly. The burden of proof is your responsibility.
4. If your insurance plan requires a referral authorization from a primary care physician, you are responsible for requesting this at your visit. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.
5. If your insurance plan does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary.
6. If you decide not to involve your plan to pay for services, be aware that Physicians Group of South Florida, PA will not file your medical claim.
7. If your account has a balance due, we expect payment within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will be in default and auto referred to a collection agency. For small balances, between $2.00 up to $50.00, we may stop sending billing statements any time after the initial statement, but you understand that the amount shall remain due and owing until paid in full and will be requested to be paid at the time of your next visit.

Additional Fees and Charges

- Returned checks $50 fee
- Fill out of any form $20 fee
- Tax itemized bill $10 fee
- E-visits $30 fee

____ ________________

Patient Signature Date

Acknowledgement

You authorize Physicians Group of South Florida, PA to release patient information acquired in the course of your examination and/or treatment; including but not limited to any and all medical records, notes, test results of any kind or other documents related to your treatment that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. PGSF does not accept responsibility for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans.

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the Physicians Group of South Florida, PA Patient Financial Responsibility Statement; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to PGSF for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan ______________________________________and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment, for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report. I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original. ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

____ ________________ ____________

Patient/Responsibility Party/Guardian Date of Birth Date

____ ____________

Witness Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

____ __________________

Signature of Patient Date

GENERAL CONSENT FORM CONSENT 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. Examination may include, but is not limited to, pelvic and rectal examinations. 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.

Please be aware that Physicians Group of South Florida, PA is committed to training the next generation of medical professionals, and as such, occasionally has medical or nursing students being supervised in the office, who will be designated as such.

I hereby certify that I understand the above authorization.

___________________________________	______________________________	________________
Patient Signature	Witness Name	Date

____

Other Person Authorized to Consent

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 Signature	Witness Name	Date

____

Other Person Authorized to Consent

NOTICE OF HIPAA/HITECH PRIVACY PRACTICE

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

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 Practice.

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 Signature	Witness Name	Date

____

Other Person Authorized to Consent

Medical Release Form

Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts practices from releasing any information without your written permission.

Your new Primary Care Physician would like to know your past medical history including information regarding past illnesses and conditions to best treat you.

To allow us to obtain a copy of your records from your previous doctor(s) or primary care physician, please complete and sign the attached records release form.

Please ask us if you need additional forms.

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MEDICAL RECORDS RELEASE FORM

Patient Name: ________________________________ Acct #: _____________ Date of Birth: _______/______/_______

Doctor's Name: ____ Phone #_________________________

Address: ____

City: ____ State: ___________________ Zip Code: ___________

I hereby authorize __________________________________ to release my medical records and/or Protected Health Information including those portions, if any, of my medical records pertaining to HIV testing diagnosis or treatment, Drug or Alcohol Abuse and treatment of Psychiatric treatment to:

PHYSICIAN'S GROUP OF SOUTH FLORIDA, P.A.

☐ **4300 Alton Rd Suite 810**
Miami Beach, Florida 33140
Tel: 305-674-5925 *Fax: 305-674-5927

☐ **1801 NE 123rd Street Suite 405**
North Miami, Florida 33181
Tel: (305)692-6100* Fax :(305)692-6101

This authorization is for the listed date(s) of treatment from ______________________to: ____________________

Please specify portion (s) of medical records requested: ____

By authorizing the release of the above mentioned records, I understand that medical records are confidential and cannot be disclosed without specific written consent of the person to whom they pertain, or as permitted by law. I also understand that, as regulated under the HIPPA guidelines, once records are released, the record custodian or its employees have no responsibility or liability that may arise regarding any aspect of this authorization.
Furthermore, I understand I may revoke this consent in writing at any time, except where disclosure has already been made or upon occurrence of the purpose for which this disclosure is authorized.
The authorization for Release of information (unless expressly revoked earlier) expires six (6) months from the date the release was signed by the patient or authorized agent.

I agree to accept responsibility for payment of the fee charged for the information requested. I understand the fees charged are allowable by Florida Law. The copying fee is waived only when photocopies are for the purpose of continuing medical care.

______________________________	____________________________	________________
Patient Signature	Patient's Printed Name	Date
______________________________	____________________________	________________
Witness Signature	Witness's Printed Name	Date