



Patient Registration Form

Patient Information

Patient Name (Last, First, M.I.): _____ **Birth Date:** ___/___/___

Social Security Number: _____ **Sex** (Circle One): Male / Female

Race (Circle One): Asian/African American/American Indian/Native Hawaiian/Pacific Islander/White

Ethnicity: Hispanic/Non-Hispanic **Preferred Language:** _____

Street Address: _____ **Apt/Unit Number:** _____

City: _____ **State:** _____ **ZIP Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Email Address:** _____

Referred By (Circle One): Insurance Plan / Hospital / Family Member / Friend / Yellow Pages / Doctor / Other

If referred by a doctor, please specify which doctor: _____

In case of an emergency, please contact: _____

Phone Number: _____ **Relationship to Patient:** _____

Previous Primary Care Physician: _____ **Phone Number:** _____

Preferred Pharmacy: _____ **Pharmacy Phone Number:** _____

Insurance Information

(Please give your Photo ID & insurance cards to the receptionist)

Insured's Name: _____ **Birth Date:** ___/___/___ **SSN:** _____

Address: _____ **Relationship to Patient:** _____

Primary Insurance: _____ **Policy Number:** _____

Group Number: _____

Secondary Insurance: _____ **Policy Number:** _____

Group Number: _____

The above information is true to the best of my knowledge.

Patient/Guardian Signature: _____ **Date:** ___/___/___



Health History

Medical History

Current Illness:

High Blood Pressure Yes No Number of Years: _____ Current Rx: _____
Diabetes Yes No Number of Years: _____ Current Rx: _____
High Cholesterol Yes No Number of Years: _____ Current Rx: _____
Asthma Yes No Number of Years: _____ Current Rx: _____
Cancer Yes No Number of Years: _____ Type: _____
Other Medical Condition (s) _____

Current Medications

Preventative History

Date of Last Physical Examination: _____ Last Eye Exam: _____

Last Mammogram: _____ Last Bone Density: _____ Last Pap Smear: _____

Prior Hospitalization(s)

Hospital _____ Date (Month/Year) ____/____/____ Reason _____

Hospital _____ Date (Month/Year) ____/____/____ Reason _____

Past Surgical History

Procedure _____ Date (Month/Year) ____/____/____ Reason _____

Procedure _____ Date (Month/Year) ____/____/____ Reason _____

Gynecological & Obstetrical History (Women Only)

Age at First Menstrual Cycle: _____ Last Menstrual Period ____/____/____

Number of Pregnancies:____ Vaginal Delivery:____ Cesarean Delivery:____ Miscarriage(s):____ Abortion(s):____



Health History (Cont.)

Allergies

Drug Allergies Yes No Which Drugs _____

Food Allergies Yes No Which Foods _____

Social History

Marital History: Single Married Separated Divorced Widowed

Occupation: _____ Retired Yes No

Religion: _____

Habits:

Cigarette Smoking: Currently Yes No Number of Cigarettes Per Day: _____

 Previously Yes No Number of Cigarettes Per Day: _____

 Total Number of Years Smoking: _____

Other Forms of Tobacco Use: Cigar: Y/N Pipe: Y/N Chewing Tobacco: Y/N

Recreational Drug Use: None Marijuana Crack/Cocaine

Alcohol: Currently Yes No Amount of Drinks Per Week: _____

 Previously Yes No Amount of Drinks Per Week: _____

 Total Number of Years Drinking: _____

Exercise: Regularly Occasionally Rarely Not at All

Sexual History

Sexually Active: Yes No Contraceptives: Condoms Birth Control Pills

History of Sexually Transmitted Disease: Yes No Which Sexually Transmitted Disease: _____

Family History

Family Member	Illness	Alive	Deceased
Mother			
Father			
Brother (s)			
Sister (s)			

Patient Name: _____ Date: ____/____/____



Consent for Treatment, Diagnostic and/or Therapeutic Procedures

Patient Name: _____ **Date of Birth:** _____

I hereby consent to and authorize a physician of the Amicus Medical Centers and any other health professional as designated to perform a physical examination and routine diagnostic procedures upon me.

I also consent to and authorize Amicus Medical Centers to prescribe a therapeutic regime which I shall follow.

Unless I explicitly refuse, I consent that the diagnostic procedure(s) ordered by the Amicus Medical Centers physician can be performed on me despite the risks involved and complications that might be involved which were explained to me at the time they were ordered.

Signed: _____

Patient or Authorized Patient Representative

Printed Name: _____

Date/Time: _____

Witness: _____



Authorization to Bill Health Insurance/Assignment of Benefits

I _____ (print name) do hereby give full permission and authorize **Amicus Medical Centers – Corporate Billing Center**, to bill _____ (name of insurance company) for services rendered by **Amicus Medical Centers**. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Amicus Medical Centers, LLC – Corporate Billing Center

1300 Concord Terrace

Suite 210

Sunrise, FL 33323

By signing this document, I also agree to the following statements below:

I understand that I am responsible for understanding information about my health insurance policy and providing such information to **Amicus Medical Centers**, for correct billing. I am also responsible to notify **Amicus Medical Centers** in the case of change of my health insurance status – inclusive benefits and any information I receive relating to care I have or will receive in this office.

I understand that **Amicus Medical Centers** will be providing services and billing my health insurance for those services at various times during the course of my care at this office. I understand that ultimately, I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at **Amicus Medical Centers** during my care. I also understand that my insurance company and related policy plan may offer benefits for services provided at **Amicus Medical Centers**, but that such benefits do not necessarily guarantee payment for those services.

I understand that the policy of **Amicus Medical Centers** requires payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. If my account is not paid within 90 days of the date of service and no other financial arrangements have been made, I will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting my account. I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand that it is my responsibility to alert **Amicus Medical Centers** of any change in my medical status or insurance coverage.

The undersigned does agree to observe and abide by all of the statements made above.

Patient's Signature

Date

Patient's Printed Name

Date



E-Prescribing PBM Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- Formulary and benefit transactions-- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions--Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that **Amicus Medical Centers** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purpose.

Signed: _____

Print Patient's Name: _____

Patient's Date of Birth: _____

**If signed by Representative,
State name of Representative:** _____

Relationship to Patient: _____

Date: _____



Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received **Amicus Medical Centers' Notice of Privacy Practices** which provides a complete description of information, uses and disclosures. I acknowledge that I had an opportunity to review and ask questions concerning **Amicus Medical Centers' Notice of Privacy Practices** prior to signing this consent.

HIPAA Patient Information Consent

The following person(s) are allowed to receive and discuss my protected health information and/or pick up medications/prescriptions, results, reports and/or my billing information from **Amicus Medical Centers** on my behalf.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Patient or Patient's Representative

Signed: _____

Print Patient's Name: _____

Patient's Date of Birth: _____

If signed by Representative,
State name of Representative: _____

Relationship to Patient: _____

Date: _____



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name (print): _____ **Date of Birth:** _____

Person(s) or facility authorized to use / disclose the information: _____

Address: _____

Phone: _____ Fax: _____

Please disclose the exact information to be disclosed, including dates of service: OR the specific records marked below:

Date(s) of Service: _____

- All Medical Records
- History & Physical
- Pathology Reports
- Progress Notes
- Procedure Notes
- EKG
- Labs
- Radiology
- Other _____

This information is to be released to:

- Amicus Medical Centers of Pembroke Pines
- Amicus Medical Centers of Pompano
- Amicus Medical Centers of West Palm Beach
- Amicus Medical Centers of East Boynton
- Amicus Medical Centers of West Boynton
- Amicus Medical Centers of Boca Raton
- Amicus Medical Centers of Plantation
- Amicus Medical Centers of Deerfield Beach

Address: _____

Phone: _____ Fax: _____

Acknowledge the following statements:

- a) I understand that I may withdraw this Authorization at any time by sending a written request to Amicus Medical Centers. Such cancellation will not have any effect on any action taken by Amicus Medical Centers before the cancellation.
- b) This authorization will expire six (6) months from the date of signature, or when revoked or on the following date: _____.
- c) I understand that this information may include information relating to:
 - 1) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection
 - 2) Mental or behavioral health or psychiatric care.
 - 3) Treatment of drug or alcohol abuse.
- d) I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.
- e) I understand that records in electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of Amicus Medical Centers, its release of information vendor or the person making the request. By requesting records in this format, the Requestor is knowingly and voluntarily assuming this risk and all consequences, losses and damages that might result.
- f) If Amicus Medical Centers has requested this Authorization, I understand that Amicus Medical Centers will give me a copy of this Authorization form after I sign it.
- g) I understand that Amicus Medical Centers may not condition treatment, payment, enrollment or eligibility of benefits on the completion of this Authorization.
- h) This information will be used / disclosed for the following purpose(s): _____

I hereby release Amicus Medical Centers from any liability which may arise as a result of the use of the information contained in the records released.

Name of Patient/Guardian: _____ Birthdate: _____

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____