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) _____

Mental History

Mental Illness:

Bipolar Disorder	Yes ☐ No ☐	Number of Years: _____	Current Rx: _____	
ADD/ADHD	Yes ☐ No ☐	Number of Years: _____	Current Rx: _____	
Anxiety	Yes ☐ No ☐	Number of Years: _____	Current Rx: _____	
Depression	Yes ☐ No ☐	Number of Years: _____	Current Rx: _____	

Other Medical Condition (s) _____

Current Medications

_____

_____

Preventative History

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

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

Last Colonoscopy/Egd:_____

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): _____

Patient Name: _____ Date: _____/_____/_____

Health History (Cont.)

Allergies

Drug Allergies ☐ Yes ☐ No Which: _____

Other Allergies ☐ Yes ☐ No Which: _____

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. Additionally, I hereby authorize Amicus Medical Centers to use telemedicine in the course of my diagnosis and treatment.

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

Center 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 A**micus 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 INFORMATION

Patient Name: _____/_____
Last **First** **Middle Initials** **Maiden**

Address: _____
Street **City** **State** **Zip Code**

Birth Date: ____/____/____ **Telephone:** _____

I, _____ **authorize** _____
Patient/Personal Representative Name **Facility Name** **Address** **City** **State** **Zip**

_____ _____
Phone **Fax**

to release my health information indicated below to the following party: (Initial One)

— MYSELF
— FACILITY/OTHER _____
Name **Address** **City** **State** **Zip**

_____ _____
Phone **Fax**

— I will pick up copies of my records, please provide my records in_____ Paper Form

— Mail copies of my records to the individual listed above via US mail. Please provide my records in_____ Paper Form

For the purpose of: _____

I authorize release of information covering treatment dates of: _____
The type and amount of information to be disclosed is as follows**: (include dates where appropriate):**

Please **initial appropriate** classification of information when applicable:

___ **Drug & Alcohol Treatment Information and/or records**
___ **Mental Health Information and/or records**
___ **HIV/AIDS Information and/or records**
___ **Genetic Information and/or records**

❒ Entire Medical Record, excluding: _____
❒ History and Physical
❒ Consultations
❒ Discharge Summary
❒ Problem List
❒ Operative Report
❒ Pathology Report
❒ Radiology Reports: *(date)* from_____*(date)* to_____
❒ Laboratory Reports *(date)* from_____*(date)* to_____
❒ Physician Progress Notes
❒ Other, describe: _____

❒ I understand that, under Florida Law, the classification of records checked above relating to treatment rendered to me are privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to persons and agencies other than those designated by me, or my personal representative or otherwise provided in Florida law.

❒ I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Department and/or provide an expiration date to the Health Information Department. **Expiration Date**___/_____/_____

❒ I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and the facilities of Amicus Medical Center will not base my treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524 (with a reasonable charge).

❒ I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Amicus Medical Center.

❒ I understand that Amicus Medical Center will release only the minimum amount of information necessary to fulfill a request.

Unless otherwise revoked, this authorization will expire twelve months from the date of the signature listed below.

Name of Patient/Guardian: _____Birthdate:___/_____/_____

Signature of Patient: _____Date:___/_____/_____

Signature of Witness: _____ Date:___/_____/_____