DATE _____

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH _____ /_____/_____

MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ LEGALLY SEPARATED ❑ DIVORCED ❑ WIDOWED

RACE ❑ CAUCASIAN ❑ BLACK ❑ NATIVE AMERICAN ❑ ASIAN ❑ HISPANIC ❑ _____

LANGUAGE ❑ ENGLISH ❑ SPANISH ❑ OTHER _____

(CHECK ONE) ❑ EMPLOYED ❑ RETIRED ❑ FULL TIME STUDENT ❑ SELF EMPLOYED ❑ UNEMPLOYED ❑ DISABLED ❑ PART TIME STUDENT

EMPLOYER _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____

WORK PHONE (_____) _____

CELL PHONE (_____) _____

PRIMARY CARE PHYSICIAN _____

HOW DID YOU HEAR OF US?
❑ PHYSICIAN ❑ WALK-IN ❑ FRIEND ❑ REFERRAL SERVICE
❑ YELLOW PAGES ❑ INSURANCE ❑ NEWSPAPER

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY _____

POLICY/SUBSCRIBER'S NAME _____ DATE OF BIRTH _____ RELATIONSHIP _____

GROUP # _____ EFFECTIVE DATE _____ MEMBER ID # _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

POLICY/SUBSCRIBER'S NAME _____ DATE OF BIRTH _____ RELATIONSHIP _____

GROUP # _____ EFFECTIVE DATE _____ MEMBER ID # _____

PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT _____

ADDRESS IF DIFFERENT THAN PATIENT

_____

_____

HOME PHONE (_____) _____

WORK/CELL PHONE (_____) _____

PARENT/LEGAL GUARDIAN NAME _____

ADDRESS IF DIFFERENT THAN PATIENT

_____

_____

HOME PHONE (_____) _____

WORK/CELL PHONE (_____) _____

PREFERRED PHARMACY

PHARMACY NAME _____ ADDRESS _____ PHONE _____

ALTERNATE ADDRESS

STREET _____ CITY _____ STATE _____ ZIP CODE _____

PHONE (_____) _____

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Name_____ Date_____

Age _____Marital Status _____

Primary Care Physician_____

Please describe the primary medical problem or symptom that you are being seen for today: _____

_____

Medicine or Latex Allergies (list medication and your reaction): _____

_____

Medications - Rx, Over-the-Counter and Supplements (include dosage & frequency)

1_____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Past Medical History (add year of beginning of problem)

_____Arthritis
_____Atrial fibrillation
_____Cancer
_____Congestive heart failure
_____Coronary artery disease
_____Diabetes mellitus
_____Glaucoma
_____High blood pressure
_____High cholesterol
_____Kidney disease
_____Liver disease
_____Lung disease/COPD
_____Migraine
_____Other illnesses (list below)
_____Other heart problems
_____Peripheral arterial blockage
_____Psychiatric illnesses
_____Stomach problems/ulcers
_____Stroke
_____Thyroid disease

Comments _____

_____

Past Surgical History (add year of procedure)

_____Appendix removal
_____Back/neck surgery
_____Brain surgery
_____Breast surgery
_____Carpal tunnel
_____Colon surgery
_____ Cosmetic surgery: type _____
_____ Gallbladder removal
_____ Gyn surgery: type _____
_____ Heart surgery: type_____
_____ Hip replacement
_____Knee replacement
_____Kidney surgery
_____Lung surgery
_____Vascular surgery
_____Other surgeries (list below)

Comments _____

_____

Social History

Occupation/Former Occupation _____ Marital Status _____

Do you currently smoke? _____No _____ Yes How much?_____Years? _____

Smoked in the past? _____No _____ Yes How much?_____Years? _____ Quit_____

Do you currently use alcohol? _____No _____ Yes How much?_____Years?

Alcohol use in the past? _____No _____ Yes How much?_____Years? _____ Quit_____

Recreational drug use? _____No _____ Yes How much?_____Years? _____ Quit_____

Family History	**Living**	**Age of death**	**Illness/Cause of Death**
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers-number____	_____	_____	_____
Sisters-number ____	_____	_____	_____
Children-number ____	_____	_____	_____

Patient Name_____

Date_____

Review of Systems
(check those that apply)

GENERAL
- ☐ Weight changed by more than five pounds
- ☐ Fatigued
- ☐ Fevers
- ☐ Problems with your medication
- ☐ Dizziness
- ☐ Faintness or passing out
- ☐ Weakness
- ☐ Tremor
- ☐ Numbness
- ☐ Nervousness or depression
- ☐ Headaches
- ☐ Difficulty with hot or cold temperatures
- ☐ Excessive thirst

EYES/EARS/NOSE/THROAT
- ☐ Problems with eyes or vision
- ☐ Problems with nose or smell
- ☐ Problems with sinuses
- ☐ Problems with throat or swallowing

GASTROINTESTINAL
- ☐ Loss of appetite
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty controlling bowels
- ☐ Nausea or vomiting
- ☐ Dark stool or blood in stool

RESPIRATORY
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Chest pain

CARDIOVASCULAR
- ☐ Swelling
- ☐ Palpitations
- ☐ Change in ability to exercise
- ☐ Discomfort of any kind in chest

GENITOURINARY
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Problems starting or controlling urine
- ☐ Decrease in strength of urinary stream
- ☐ Blood in urine

MUSCULOSKELETAL
- ☐ Painful or inflamed joints
- ☐ Stiff joints
- ☐ Leg pain with walking

INTEGUMENTARY
- ☐ Rash
- ☐ New mole or skin nodule
- ☐ Change in color or texture of skin or hair
- ☐ Bleeding in skin
- ☐ Bleeding from anywhere else

GYNECOLOGICAL
- ☐ Prolonged or excessive menstrual flow
- ☐ Change in timing of menstrual flow
- ☐ Problems with breasts
- ☐ Date of Last Menstrual Period _____
- ☐ Number of Pregnancies_____
  Full-Term_____
  Complications _____

Have you had the following preventative health measures?

- ☐ Colonoscopy or sigmoidoscopy
  Date:
- ☐ Stool for occult blood
  Date:
- ☐ PSA (prostate blood test)
  Date:
- ☐ Eye doctor examination
  Date:
- ☐ Bone density scan
  Date:
- ☐ Mammogram
  Date:
- ☐ Pap smear
  Date:
- ☐ Influenza vaccine
  Date:
- ☐ Pneumococcal vaccine
  Date:
- ☐ Tetanus–Diphtheria vaccine
  Date:
- ☐ Menigococcal vaccine
  Date:
- ☐ Varicella (Chicken Pox) vaccine
  Date:
- ☐ Hepatitis A vaccine
  Date:
- ☐ Hepatitis B vaccine
  Date:

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization

- For treatment, payment and health care operations
  - Example for treatment: Your physician refers you to a specialty doctor for continuing treatment. Your physician may send your medical records to the referring physician to help in the treatment plan for your condition.
  - Example for payment: A bill may be sent to a third party payer. The information on the bill may include information that identifies you, as well as your diagnosis, the procedures and supplies used.
  - Example for healthcare operations: Members of the medical staff, the Risk Manager, Quality Improvement Manager, or other quality improvement team member may use your health information to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare services that we provide. Another way we may use your health information is to conduct or arrange for a medical review, legal services or for an audit for compliance training.
- When a release is required by law, including judicial proceedings, health oversight regulatory agencies and law enforcement
- To medical examiners, coroners, funeral directors and research
- In an emergency situation or to avert a serious threat to health or safety
- To organ, tissue or other donation organizations if there is no indication in your record on how to harvest your organs
- Under certain circumstances, we may use and disclose limited medical information about you for research or quality improvement purposes within our organization. For example, clinicians may request our clinical research staff to review your medical information to see if you would be eligible for a study.
- To worker's compensation and other programs providing benefits for work-related injuries or illnesses

Any other use or disclosure of protected health information not listed above will be made only with the individual's written authorization. The individual has the right to revoke such authorization at any time.

Special Cases:

- **Appointment Reminders:** We may contact you by paper, phone or leave a message to remind you of an upcoming appointment or that your due for a preventative service, or request that you call the office
- **Treatment Alternatives:** We may use or disclose your medical information to tell you about or recommend treatment options or alternatives

Effective May 1, 2013

- **Health Related Benefits and Services:** We may use your medical information to contact you and offer other health-related services or medical education that may be of interest to you

Your Rights: You have the following rights concerning your protected health information (PHI):

- Request restricted access to all or part of your information. We are not required to grant all of your requests.
- Request restricted access not to share treatment information with your insurance if you paid the health care organization in full.
- To receive correspondence of confidential information by alternate means or location (Example: records to be mailed to a work address instead of the home address).
- To inspect or receive copies of your protected health information. *A processing fee for copies may apply*.
- To request changes to be made to your protected health information.
- To receive an accounting of the disclosures by us of your protected health information in the six years prior to your request.
- To get updates or reissue of this notice, at your request
- The individual will submit all requests in writing to the health care organization

Healthcare Organization: This organization is required to:

- Maintain the privacy of your protected health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of the notice currently in effect
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means
- Notify you of a breach involving your unsecured protected health information (PHI)

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide you the revised notice.

We will not use or disclose your protected health information without your authorization, except as described in this notice.

To File a Complaint or Contact a Company Representative: If you have questions or feel that your privacy rights have been violated, you can contact the Compliance Manager or the Office for Civil Rights. The law forbids us from taking retaliatory action against you if you complain.

Company Representative: Compliance Manager
Address: 943 South Beneva Road, Suite 306, Sarasota, Fl 34232
Phone: 941-955-1108

The Office for Civil Rights (OCR)
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, Ga 30303-8909
Phone: (800) 368-1019
TDD: (800) 537-7697
Fax: (404) 562-7881

Effective May 1, 2013

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Acknowledgement of Notice of Privacy Practices Receipt

I, _____, (patient name) acknowledge that I have received the Notice of Privacy Practices that provides a more complete description on how my information will be used and/or disclosed.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature or Legal Representative Date

For Office Use Only

Documentation of Good Faith Efforts

The patient presented for his/her appointment on this date and was provided with a copy of Intercoastal Medical Group's Privacy Notice. A good faith effort was made to obtain a written acknowledgement of receipt of the notice. However, an acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Due to a medical emergency
- ☐ Unable to communicate with the patient
- ☐ Other (describe below):

_____

_____

_____ _____
Employee Name (Please Print) completing form Date

_____
Employee Signature

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CONSENT FOR COMMUNICATION AND/OR DISCLOSURE
CONSENTIMIENTO PARA LA COMUNICACIÓN Y DIVULGACIÓN

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Intercoastal Medical Group. I understand that this HIPAA consent applies to ALL providers of Intercoastal Medical Group. It is my responsibility to notify Intercoastal Medical Group of any changes.

Vea las siguientes alternativas o limitaciones relativas a la comunicación con su proveedor de atención médica o empleado Intercoastal Médicos del Grupo. Entiendo que este consentimiento HIPAA se aplica a todos los proveedores Intercoastal Médicos del Grupo. Es mi responsabilidad de notificar al grupo de Intercoastal de cualquier cambio.

Please Print (Last Name/*Apellido*) (First Name/*Primer Nombre*) (M.I.) (DOB/*Fecha de Nacimiento*)

1st Phone Preference/*preferencia teléfono*: _____
Cell/*Celular* ☐ Home/*Casa* ☐ Work/ *Trabajo* ☐

2nd Phone Preference/*preferencia teléfono*: _____
Cell/*Celular* ☐ Home/*Casa* ☐ Work/ *Trabajo* ☐

Do we have permission to leave the following information on voicemail?*¿Tenemos permiso para dejar la siguiente información en el correo de voz?*
____Billing/*Cobro* ____ Medical/*Información Médica*

Would you like to use the Patient Portal as your preferred method of communication? ___Y___N
¿Prefiere usted usar el sistema portal del paciente en la computadora cómo su método preferido de comunicación?

I give my permission to share the following information with the person(s) listed below. *Yo doy mi permiso para compartir la información siguiente con la persona o personas que se nombran a continuación.*

Name/*Nombre*: _____ Relationship/*Relación*: _____
Appointment/*Cita* **Y or N** Billing/*Cobro* **Y or N** Medical/*Información Médica* **Y or N**

Name/*Nombre*:_____Relationship/*Relación*_____
Appointment/*Cita* **Y or N** Billing/*Cobro* **Y or N** Medical/*Información Médica* **Y or N**

Name/*Nombre*: _____ Relationship/*Relación*_____
Appointment/*Cita* **Y or N** Billing/*Cobro* **Y or N** Medical/*Información Médica* **Y or N**

Please note that if a person is not listed on this form Intercoastal Medical Group will not share information with him/her. *Por favor, tenga en cuenta que si una persona no aparece en este formulario Intercostal Medical Group no compartirá información con él/ella.*

_____
Signature of Patient/ *Firma del Paciente or Guardian* Date/*Fecha*

_____
Witness Signature/*Firma del Testigo* Date/*Fecha*

PLEASE READ AND UNDERSTAND THIS INFORMATION

Our Policy Regarding Patient Financial Responsibility 08/20/10

Managed Care Plans. Intercoastal Medical Group files insurance claims for managed care groups with which we participate. We accept payment for covered services from these insurance plans in accordance with our contract. Our patients are responsible for applicable co-insurance and deductible amounts. Our patients are also responsible for any and all payments for services that are not covered by insurance. The patient is responsible for payment of amounts they owe at the time of the visit.

Medicare. Intercoastal Medical Group files insurance claims for Medicare on assignment. We accept Medicare allowable amounts as payment and the patient is responsible for charges applied to their deductible, any co-insurance and non-covered charges.

Other Insurance. If the patient's insurance is with a company with which we do not participate, the patient is responsible for payment of their bill at the time of service. We will, however, file non-assigned claims to these insurance companies as a courtesy for our patients, unless the insurance is a Medicare Advantage Replacement Plan. Unfortunately, we are unable to file claims with Medicare Advantage plans if we are not participating providers.

Self Pay. All services are required to be paid in full at time of service.

Cancellations. Intercoastal Medical Group asks that you notify your physician's office if you are unable to keep your appointment. This courtesy will allow us to schedule another patient who needs to see the physician. Patients who consistently fail to show for their appointments and/or fail to notify us may be asked to find another physician outside of Intercoastal Medical Group.

Summary. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within the policies and guidelines of our patient's insurance plan. **It is, however, the responsibility of the patient to know and understand those policies and guidelines. It is also the responsibility of the patient to seek medical care only with physicians participating with their plan.**

I understand that I am responsible for the payment of this account, and hereby assume and guarantee payment of all expenses incurred during my office visit. In the event a credit (refund) balance appears on this account, I hereby irrevocably authorize the office to transfer and apply such credit on any outstanding account with IMG incurred by myself, or my dependents. Should legal action be required to secure payment of this account, I agree to pay a reasonable collection expense, all court costs and a reasonable attorney's fee incurred thereby.

I have read and understand the office policy stated above and agree to accept the responsibility described.

_____ _____

Patient/Responsible Party Date

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment under the insurance program be either made to myself or to the provider on any service furnished to me. I authorize the above named provider to release any information needed for this claim. I further permit a copy of this authorization to be used in place of the original and I authorize the use of a telefax or photocopy of the information. This signature will act as a lifetime authorization for Medicare.

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me, including hospitalization and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV, to release to the Social Security Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am financially responsible for all charges whether or not paid by said insurance.

_____ _____

Patient/Responsible Party Date