Plantation Medical Clinic
100 NW 82nd Ave.
Suite 206
Plantation, Florida 33324

PATIENT DEMOGRAPHICS

Date: _____ Date of Birth: _____

Name: Last _____ First _____ Middle: _____ Female / Male

Home Address: _____Apt____ City _____ State_____ Zip _____

Home/Cell Number _____

Marital Status: Married Single Divorced Widowed

Occupation: _____
Employment Phone number _____ May we contact you at work if needed Y N

Email Address _____

INSURANCE INFORMATION

Primary Insurance Name _____ **Secondary** Insurance _____

Primary Policy # _____ Group# _____

Secondary Policy # _____ Group# _____

Are you the primary insured? YES / NO
If you are NOT, the policy holder please fill out **Insured's name** _____ **Date of Birth** _____

Relationship _____

MEDICAL INFORMATION

The last physician your care was under: Name _____ Phone _____
Last date you were evaluated: _____
Last Annual Wellness Exam: _____ **MEN** (only) Prostate exam _____
Last Lab Work: _____
Last Eye Exam: _____

WOMAN: Last Pap /GYN Exam: _____ Mammogram: _____
Physician's Name _____ Phone # _____
****Our office performs annual GYN and Pap exams please let us know if you will like us to preform your next annual exam.**

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List any current chronic medical conditions

1)_____
2)_____
3)_____
4)_____
5)_____

Past Surgical Procedures **Dates**

1) _____
2) _____
3) _____
4) _____
5) _____

Childhood Illnesses

_____
_____
_____

Vaccines

Flu _____
Pneumonia (over 50) _____
Shingles _____

MEDICATIONS **Allergies to Medications:** _____

List any medications that you currently take (including over the counter and vitamins)

	Name	**Strength**	**Directions**	**Prescribed By**
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____
5)	_____	_____	_____	_____
6)	_____	_____	_____	_____

Emergency Contact

Next of Kin (emergency contact) May **we contact this person if we cannot reach you** Y/ N
Name _____ Phone _____ Do you have a living will ___
Advanced Directive _____ DNR_____

Patients Name: _____ **Date of Birth** _____

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SOCIAL HISTORY

Do you drink alcohol? _____ If yes how much? _____ How often? _____

Do you currently smoke tobacco products? _____ how many packs per day _____

Are you interested in quitting? _____

Do you do some form of exercise daily? _____ How often? _____

What does your diet consist of? Balanced Vegetarian Diabetic Cardiac Low Carb Low Fat

Do you wear your seatbelt? _____

ROUTINE TASKS- Please indicate if you do or do not need help performing (circle)

1) Feeding yourself Yes No
2) Getting from a bed to a chair Yes No
3) Getting to the toilet Yes No
4) Getting dressed Yes No
5) Bathing or showering Yes No
6) Walking across the room (with cane or walker) _____ Walking up stairs _____ YES / NO
7) Taking Medications Yes No
8) Preparing meals Yes No
9) Managing money (bill pay) Yes No
10) House work (cleaning) Yes No
11) Shopping for food or personal items Yes No
12) Driving Yes No

If you answered yes to any of these questions who helps you?

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Patients Name _____ **Date of Birth** _____

HEALTH SCREENINGS

Depression Screening **Circle one**

1. Little or no interest / pleasure in doing things? Not at all Several days Nearly everyday
2. Feeling down, depressed or hopeless Not at all Several days Nearly everyday

Fall Risk – Please check the appropriate answer.

1) Are you afraid of falling No Yes
2) Have you fallen in the past year No Yes

If you answered yes, please explain:

Hearing

Difficulty hearing in a noisy, crowded room or at the movie theater _____
Difficulty understanding or feeling people are mumbling _____
Difficulty hearing over the telephone _____
Ringing in the ears _____
Pain in the ears constantly _____

FAMILY MEDICAL HISTORY

Relative	Living/ Deceased	Age	Medical Problem
Father			
Mother			
Brothers			
1			
2			
Sisters			

Plantation Medical Clinic

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient: _____

Address: _____

Date of Birth: _____

PLANTATION MEDICAL CLINIC AND DR. P. SIMEK are authorized to **furnish to /receive from** (Circle desired choice):

Recipients/Discloser: _____

For the purpose of: _____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

☐ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

☐ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

_____

_____

I release PLANTATION MEDICAL CLINIC AND DR. P. SIMEK, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from authorization. I may withdraw this authorization at any time by giving written notification to PLANTATION MEDICAL CLINIC, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on ___/___/___ *(Optional) if no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

_____ _____

Patient signature Date

_____ _____

Witness signature Date

100 NORTHWEST 82ND AVE, SUITE 206, PLANTATION, FLORIDA 33324

TEL: 954.424.7504, FAX: 954.424.7603

Plantation Medical Clinic
100 NW 82nd Ave.
Suite 206
Plantation, Florida 33324.

Permission to Verbally Discuss Protected Health Information with Family and Friends – Information Sheet

We have established a process that allows you to tell us who we may talk with about your health care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

How can I give others permission to get verbal information about me?
Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

Does this mean that you will not speak to anyone I haven't specifically named on the form?
No. If permitted by law, HealthPartners Family of Care may speak to other individuals involved in your care (or payment for that care).

How is the information on the form used?
Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?
- If an individual want to share information with spouse or significant other
- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping a patient with health issues
- If a college student wants information shared with a parent• If an adult child calls to find out his/her parent's appointment time

What if I change my mind?
You can change or revoke (stop) this process at any time by writing to us at the address shown below. Forms are available at your clinic, or you can obtain a new form at www.healthpartners.com.

What happens if I don't complete this form?
We will continue to protect your private health information as required by law.

Can the person I designate also get copies of my medical records?
No, they can only receive verbal information. To get copies of medical records, complete a separate Authorization form available by contacting your primary clinic/facility at the phone number listed below, or at www.healthpartners.com.

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Permission to Verbally Discuss Protected Health Information with Family and Friends

—Completion of this form is optional—

Patient name	Date of birth	Medical record number, if known	
Patient street address	City	State	ZIP
Home phone	Work phone		

I give permission for the Plantation Medical Clinic to VERBALLY share the information I have checked with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. ***(check all boxes that apply)*** **This form does not authorize releasing copies of my records.**

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
  - ☐ Substance use disorder
  - ☐ Developmental disability
- ☐ Lab/test results (☐ Check here to include HIV results)
- ☐ Billing and payment information Other (describe):
- ☐ _____

Plantation Medical Clinic has my permission to discuss the above information with the following family, friends and other people. This information is directly relevant to their involvement in my health care (or payment for that care).

1 Name _____
Street address _____
City, State, Zip _____
Home phone _____ Work phone _____

2 Name _____
Street address _____
City, State, Zip _____
Home phone _____ Work phone _____

I understand that in certain situations the Plantation Medical Clinic may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where Plantation Medical Clinic has already made disclosures in reliance upon this request. I understand this permission remains in effect until the time I revoke it in writing.

Signature of Patient/Authorized Representative X **Date**

If other than patient, state relationship and authority to sign _____

_____

Plantation Medical Clinic

Thank you for choosing **Plantation Medical Clinic**. as your healthcare provider. The medical services you seek imply a **Financial Responsibility** on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form.

If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or by receiving medical services from Plantation Medical Clinic you agree:

Co-payments and Deductibles

1. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are **responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility** indicated by your insurance carrier or our FINANCIAL POLICIES, which are not otherwise covered by supplemental insurance.

_____ Sign and Date _____

Managed Care and Commercial Plans

2. Managed Care (HMO, PPO, etc.). All managed **care co-payment amounts are due at the time of service.** If your insurance plan requires a referral authorization from a primary care physician, you are responsible for presenting this at your initial visit. If you request an office visit without a referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. 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. Please note all referrals and authorizations **require 3-5 business days to process**.

_____ Sign and Date _____

Knowing Your Health Plan

3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services Plantation Medication Clinic , and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Plantation Medical Clinic are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Plantation Medical Clinic ; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

_____ Sign and Date _____

Plantation Medical Clinic

Registration and Insurance cards

4. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. 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 treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be re-scheduled by Plantation Medical Clinic.

_____ Sign and Date _____

Authorization and Assignment of Benefits

5. We may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign to Plantation Medical Clinic , for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your 1 | Page dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you.

You authorize Plantation Medical Clinic and associated physicians, staff, and hospitals 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, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on my account) 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. Plantation Medical Clinic does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

_____ Sign and Date _____

Authorization to Contact

7. You authorize Plantation Medical Clinic personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. Plantation Medical Clinic, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection. You authorize Plantation Medical Clinic to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contact.

_____ Sign and Date _____

Plantation Medical Clinic

Payments and additional charges

8. We accept payment by **check, cash, money order, debit cards or credit cards (Visa, MasterCard or Discover). a. Payment by Check.** If payment is made by check and it is returned or declined for any reason, your account will be charged a **surcharge of $50.00** or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution. When you pay by check you also authorize Plantation Medical Clinic, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limits (plus any applicable sales tax). **Patients may incur and are responsible for the payment of additional charges at the discretion of Plantation Medical Clinic** including but not limited to charges for a

   1. **Missed appointment** without 24 hours' advance notice $35.00 NO SHOW FEE
   2. Charges for **extensive phone consultations** and/or after-hours phone calls requiring treatment, or prescriptions
   3. Charges for **copying and distribution of patient medical records**; (v) charges for extensive forms preparation or completion.

_____ Sign and Date_____

Financial Responsibility

9. Statement is signed by another person, on your account, then that co-signature remains in effect until cancelled in writing. Cancellation in writing shall become effective the date after receipt, and shall apply only to those services and charges thereafter incurred. By signing as Financial Responsibility Party, you hereby guarantee the full and prompt payment to Plantation Medical Clinic of all indebtedness of Patient to Plantation Medical Clinic, whether now existing or hereafter created (the "Indebtedness"); and you further agree to pay all expenses, legal or otherwise, incurred by Plantation Medical Clinic in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said Indebtedness shall be fully paid. There shall be no obligation on the part of Plantation Medical Clinic at any time to first exhaust its remedies against Patient, any other party, or any other rights before enforcing the obligations of Financial Responsibility Party.

_____ Sign and Date _____

Acknowledgement

Acknowledgement By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the Plantation Medical Clinic **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 Plantation Medical Clinic for the below Patient's care and treatment, including copayments 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.

_____Sign and Date _____

Plantation Medical Clinic

Please be advised our office is a participating physician office of the Hedis Quality Measure control programs with your insurance company.

There are yearly exams that are required by your insurance company to be completed yearly.

In order for us to be in good standing with your insurance company it is expected of you to comply.

Here is a list of requirements

1. Mammograms (yearly)
2. Annual Wellness Exam (yearly)
3. Eye Exams normal and Diabetic retinal exam (yearly)
4. Podiatry Diabetic Exam (yearly)
5. HBA1c Blood sugar – if you are not a diabetic (yearly)
   if you are pre-diabetic or diabetic every 3 months
6. Cholesterol check (LDL) (yearly) unless elevated
7. Blood Pressure Check
8. Medication Review
9. BMI (yearly)
10. Flu Shot
11. Bone Mineral Density (for osteoporosis) yearly
12. Colorectal Screen (FOBT Cards) yearly
13. Colonoscopy every 10 years
14. Pap exams every 3 years if negative

By signing this form, you are willing to comply with all these requirements.

Patient Name: _____

Patients Signature: _____

DATE: _____

PATIENT:_____
DOB:_____

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

I hereby authorize and request that payment of benefits by my primary insurance company _____, and my secondary (if applicable)_____ be made directly to **PLANTATION MEDICAL CLINIC PA.** for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of my bill. I further understand that I may be responsible for all charges NOT covered by insurance.

- In addition, I authorize **PLANTATION MEDICAL CLINIC PA.** to disclose any and all written information from the above named insurance company and/or its designated representatives, at the determination of my primary care office. Such disclosure shall be for reimbursement purposes for those services received.
- I hereby release **PLANTATION MEDICAL CLINIC PA.**, its officers, agents, employees and any clinic staff at this office, from all liability that may arise as a result of disclosure of information to the above named insurance company or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge the following:

1) I am aware and understand that this organization will not be used unless the above named insurance company or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
2) I agree to participate and assist **PLANTATION MEDICAL CLINIC PA.** or its designated representatives with any appeal process necessary to collect payments for services rendered.
3) Im aware and have been advised of the provisions of Federal and State statutes, rules and regulations, and provide for my right to confidentiality of said records.
4) I understand this assignment and authorization MAY be subject to change at anytime, except to the extent that action has been taken in reliance thereof. In any event, this authorization MAY expire once reimbursement for services rendered is complete.

5) **PLANTATION MEDICAL CLINIC PA.** is acting in filing for insurance benefits assigned to _____(initial) **PLANTATION MEDICAL CLINIC PA.** can assume NO responsibility for guaranteeing payment of ANY charges from ANY insurance company.
6) I understand that a firm contracted by **PLANTATION MEDICAL CLINIC PA.** for billing and collection purposes may bill and collect accordingly.
7) **PLANTATION MEDICAL CLINIC PA.** is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes all medical records, plan of benefits or any insurance plans documents.
8) Should an overpayment take place (in office), a credit will be placed on the account and distributed for use upon future appointments.
9) **PLANTATION MEDICAL CLINIC PA.** shall be entitled to the full amount of its charges without offset.
10) ***I understand the terms and conditions and acknowledge receipt of a completed and signed copy of this release form.***

PATIENT SIGNATURE: _____

DATE:_____

STAFF SIGNATURE:_____ **DATE:**_____