Global Family Medicine and URGENT CARE CENTER

Gaston O Perez, MD

(843) 815-6468

WELCOME TO OUR OFFICE

NEW PATIENT REGISTRATION FORM

DATE: _____

Preferred Method of Contact: Call ☐ Text ☐ Email ☐

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Gender: _____ Social Security: _____

Mailing Address: _____ Appt #: _____

City: _____ ST: _____ Zip: _____

Primary Phone Number: _____ Home Phone: _____ Work Phone: _____

Cell Phone _____ Email / Portal _____ Marital Status: _____

Emergency Contact Information

Emergency Contact Name: _____ Phone Number: _____

Relationship to patient: _____

Employer Information:

Employer Name: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Occupation: _____

Insurance Information:

Primary: _____ Secondary: _____

Insurance Co: Name _____

Policy Holder Name _____

Policy Holder Date of Birth _____

Policy Holder SS # _____

Patient Relationship to Policy Holder: _____

PLEASE READ **Acknowledgement of Receipt of Notice of Practice Privacy**

All charges are due at time of service. If hospitalization is indicated, patient is responsible for furnishing insurance forms to the office prior to hospitalization.
All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office manager.

GLOBAL FAMILY MEDICINE, LLC reserves the right to modify the privacy practice outlined in the notice.
I have received a copy of the Notice of Privacy Practces **GLOBAL FAMILY MEDICINE, LLC**

_____ _____

Name of Patient (print) Date of Birth

_____ _____

Signature of Patient Today's Date

:

_____ _____

Signature of Patient Representative or Guardian Today's Date

Global Family Medicine and URGENT CARE CENTER

Notice of Privacy Practice

843-836-2273

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:
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of a laboratory test and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

HEALTH CARE ORGANIZATIONS: Your health information may be used as necessary to support the day-to-day activities and management of **GLOBAL FAMILY MEDICINE**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies to support government audits and inspection to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

PUBLIC HEALTH RECORDS: Your health information may be disclosed to public health agencies as required by law. For example we are required to report certain communicable diseases to the state's public health department.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information or its use for any other purpose than those listed above, require your specific written authorization. If you change your mind, after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorizations will not undo any use or disclosure of information that occured before you notified us of your decision to revoke your authorization.

INDIVIDUAL RIGHTS:

You have certain rights under the federal privacy standards, These include:
The right to request on the use and disclosure of your protected health information.
The right to receive confidential communications concerning your medical condition and treatment.
the right to inspect and copy our protected health information.
The right to amend or submit corrections to your protected health information.
The right to receive an accounting of how and when your protected health information has been disclosed.
The right to receive a printed copy of this notice.

ADDITIONAL USES OF INFORMATION:

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

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IMPORTANT OFFICE POLICIES

Global Family Medicine strives to offer each patient the best personalized care available. To make this possible, it is important to adhere to the guidelines listed below. Please read these carefully and initial each box. Please indicate your acceptance and agreement to follow these guidelines by signing the line at the bottom of this form.

INITIAL ☐

NO SHOWS ARE BAD!

We care about our patient's care and when you miss a scheduled appointment without any notice, it not only compromises your care, it also effects another patient who couldn't get in because we had the time reserved for your appointment. If you "No Show" for more than two appointments within one month, we will be unable to schedule you in the office again for a period of six months. "No Shows" will be billed a fee of $25 that must be paid before your next visit. Please be courteous and responsible!

INITIAL ☐

24 ADVANCE NOTICE FOR CANCELLATIONS

We ask that you give us 24-hour advance notice if cancelling any appointment. This gives us an opportunity to schedule and provide care for another patient. If 24-hour notice is not given, there will be a $25 cancellation fee that must be paid before your next visit.

INITIAL ☐

10 MINUTE LATE POLICY

We do our best to schedule and see our patients as quickly as possible. In order to keep patient flow moving smoothly, if you are more than 10 minutes late for an appointment, it will be necessary to either reschedule, or wait until is another opening. There are no guarantees that a same day opening will be available since opening due to cancellations are unpredictable. Consecutive late arrivals will result in a 6 month wait before future scheduling. Again, be courteous and responsible.

INITIAL ☐

PAYMENT DUE AT TIME OF SERVICE:

We accept personal checks, cash, and credit cards. We cannot hold checks.

MISSED VISIT FEE:

If you fail to attend a scheduled procedure or appointment without notice, the following fee will be charged and is the responsibility of the patient:

LAB: $25
PHYSICIAN: $25
UTRASOUND: $60
NUCLEAR STRESS TEST: $160

INITIAL ☐

IMPORTANT NOTICE FROM THE FEDERAL GOVERNMENT

"It is unlawful to routinely avoid paying your copay, deductible, or coinsurance payment... even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical careas outlined in your insurance plan even if your doctor allows it. Both parties may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP"s"Take What Insurance Pays. Failure to comply places you in violation of Federal Insurance Fraud Laws, State Insurance Fraud Laws, Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1999 [section 231(h) of HIPAA]. Exceptional cases do not apply,. P{lease see contact info for more information. Office of Inspector General, Department of Health and Human Services, Contact by phone:201-619-1343, by fax 202-260-8512, by email: paffairs@oig.hhs.gov by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room5541 Cohen Building, 333 Independence Ave,, SW, Washington, DC 20201, Joel Schaer, Office of Counsel to the Inspector General , 202-619-0089

Patient Name (print): _____ Date of Birth _____

Patient Signature: _____ Today's Date: _____

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PAYMENT POLICIES

Thank you for choosing Global Family Medicine as your primary care provider. We are committed to providing you with quality, affordable health care. Most of our patients have questions regarding patient and insurance responsibility for services rendered and we are providing you a copy of our payment policy for your convenience. Please read and ask us about any questions you may have. Once you have read and understood this policy please sign at the bottom of this form. A copy will be provided to you upon request.

INSURANCE: We participate in most insurance plans including Medicare. If you are not insured by a plan that we are in contract with, payment in full is expected at each visit. If you are insured ba a plan we are under contract with , but DO NOT have an up-to-date insurance card, payment in full will be required until we are able to verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company if you have any questions regarding coverage.

CO-PAYMENTS AND DEDUCTIBLES: All co-payments and deductibles must be paid at the time of your visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductible payments is considered a fraud. Please help us uphold the law by paying co-payments or deductibles at each visit.

NON-COVERED SERVICES: Please be aware that some, perhaps all of the services you receive may not be considered reasonable byr Medicare o other insurers. You must pay these services in full at the time of your visit.

PROOF OF INSURANCE: All patients mus complete our information form before seeing the doctor. We must obtain a copy of your driver's license or photo ID with current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

CLAIM SUBMISSIONS: We will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits is a contract between you and your insurance provider, we are not a part of that contract.

COVERAGE CHANGES: If your insurance company changes, please notify us before your next visit so that we may make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you directly.

NON-PAYMENTS: If your account is 90 days past due, you will receive a letter stating you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if your balance remains unpaid, it may be referred to a collection agency and you may be discharged from our practice. If this is to occur you will be notified by regular or certified mail that you have 30 days to find alternative medical care and our physician will only be able to see you on an emergency basis during that 30 day period.

MISSED APPOINTMENTS: Our policy is to charge for missed appointments and appointments cancelled without 24-Hour notice. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your scheduled appointments.

Our practice is committed to providing the best treatment available to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment pokicy. Please let us know if you any questions or concerns.

I have read and understand the payment policy and and agree to abide by its guidlines.

Signature of patient or responsible party

Date

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PATIENT MEDICAL HISTORY

Please fill this information out as completely and accurately as you can.

Today's Date: _____ Date of Last Physician Exam: _____

Last Name _____ First Name: _____ Middle _____

Chief Complaint:
What is the main reason for your visit today? (Describe your problem in detail)

List Past Surgeries: Month / Year

List any Medications you take:

List Past Illnesses:

List any alergies you may have (food, medicine, ect.)

List any Family Medical History: (Heart disease, cancer, ect.

Do you smoke or use tobacco products? Yes / No

If yes, how often?

Do you use caffinated products ? Yes / No

If yes, How often?

Do you exercise regularly? Yes / No

If yes, how often?

Do you drink alcohol? Yes / No

If yes, hoiw often?

Have you ever had a blood transfusion? Yes / No

If yes, please esxplain:

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REVIEW OF SYSTEMS

Do you now have any problems related to the following systems
Circle Yes or No

Please explain "Yes" answers in the space to the right

Gastrointestinal

Abdominal Pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Heartburn	Y	N
Burping	Y	N
Blood in stool	Y	N

Other_____

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Sweating	Y	N
Weight Loss	Y	N
Weakness	Y	N

Other_____

Eyes

Blurred Vision	Y	N
Double Vision	Y	N

Other_____

Ear / Nose / Throat

Ear Pain	Y	N
Hard of hearing	Y	N
Sore throat	Y	N
Runny Nose	Y	N

Other_____

Neurological

Tumors	Y	N
Dizzy spells	Y	N
Memory problems	Y	N
Frequent headaches	Y	N

Other_____

Endocrine

Excessive Thirst	Y	N
Fatigue	Y	N

Other_____

Female Genitourinary

Frequent urination	Y	N
urgent urination	Y	N
{ain on urination	Y	N
Vaginal discharge	Y	N
Urine discharge	Y	N
Lower abdominal pain	Y	N
Blood in urine	Y	N
Painful menstruation	Y	N

Other_____

Cardiovascular

Chest Pain	Y	N
Shortness of Breath	Y	N
Varicose Veins	Y	N
Swelling of extremeties	Y	N

Other_____

Skin

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Change in fingernails	Y	N
Hair loss	Y	N

Other_____

Musculoskeletal

Joint pain	Y	N
Back pain	Y	N
Neck pain	Y	N

Other_____

Hematologic / Lymphatic

Swollen glands	Y	N
Easy bruising	Y	N

Other_____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Sputum	Y	N

Other_____

Allergic / Immunologic

Seasonal allergies	Y	N
Sneezing	Y	N
Watery, itchy eyes	Y	N

Other_____

Male Genitourinary

Pain in the testicles	Y	N
Penile discharge	Y	N
Night time urination	Y	N
Dribbling urination	Y	N
Difficulty starting urine	Y	N
Blood in urine	Y	N

Other_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Global Family Medicine to release the following information from the health records of:

TO BE RELEASED TO:

Patient Name:_____ SSN:_____ DOB:_____

Name:_____ Relationship:_____ DOB:_____

Name:_____ Relationship:_____ DOB:_____

☐

INFORMATION TO BE RELEASED: (check all that apply)

☐ **Entire Record** ☐ **Lab Results** ☐ **Nursing Notes** ☐ **Demographics**

☐ **ER Notes** ☐ **Radiological Results** ☐ **Physician Orders** ☐ **Medical Records**

FOR THE PURPOSE OF:

☐ **Dictated Reports (H&P, Discharge, Summary, OP Notes, Consults, Test Results, ect.**

☐ Anything on behalf of the patient
☐ Creating / changing / cancelling appointments
  ☐ view or correct demographic information to include signing on my behalf
  ☐ receive documents containing my PHI on my behalf with an authorization for release of information signed by me

☐ Picking up prescriptions and medications on my behalf

☐ Speaking to Global Family Medicine staff regarding my PHI including but not limited tobilling and insurance.

Other_____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of Global Family Medicine and/or Global Urgent Care. at the adress listed above or in a manner described in the Notice of Privacy Rights I also understand that if information has been released by relying upon this authorization that revocation will not be valid.

I PLACE NO LIMITATION HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCOLOGICAL ILLNESS. MENTAL ILLNESS OR RETARDATION AND ACQIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The physician's office listed above may not condition treatment, payment, on signing of this authorization unless allowed by law.

I understand that this Release of Information will expire within one year from the date listed below"

Patient Signature:_____ Date:_____

Patient's Guardian Signature: _____ Date:_____

Relationship to Patient:_____