Central Florida Family Practice

REGISTRATION FORM

(Please Print)

Today's Date:	PCP: Dr. Elba Masid, MD

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )

City:	State:	ZIP Code:	Occupation:

Employer:	Employer phone no.: ( )

How did you hear about this medical office?			

What pharmacy do you use?_____ Email Address_____

Location_____ Web Enabled? Yes or No

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance	☐ UHC	☐ Cigna	☐ Aetna	☐ Medicare	☐ Avmed

☐ BCBS	☐ Wellcare	☐ Citrus	☐ Care Plus	☐ Other:

Subscriber's name:	Policy Number:	Group Number	Birth date	Co-Insurance $	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Policy Number:	Group Number:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Central Florida Family Practice or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

Personal Health History **Name:**_____

Reason for visit:_____

Personal Health History: Do you have any current or past medical Problems? ☐ **Yes** ☐ **No**
If yes, Check ones that apply.

Past Medical History:	**Illness:** ☐ Diabetes ☐ Osteoarthritis ☐ High Cholesterol ☐ Hypertension ☐ Gout ☐ Seizure Disorder ☐ Heart Disease ☐ Epilepsy ☐ Kidney disease ☐ Asthma ☐ Bleeding disorder ☐ Thyroid disease ☐ Cancer ☐ Severe infections ☐ TB/Positive PPD ☐ Genetic defects ☐ Hepatitis C ☐ Liver disease ☐ Depression ☐ Gallbladder Disease ☐ Other_____

Past Surgical History:	Please list any major surgeries or procedures:

Current medication and dosage (include over - the-counter medications)	**Medications**	**Dosage / Frequency**

Allergies to medication and what happens when you take it?	**Medications**	**What Happens?**

Date of last Tetanus shot?_____ **Date of Last Period?**_____ **(Female Only)**

Your Family history: Has anyone in your immediate family suffered from any of the following:

Heart Attacks Strokes Diabetes No Relevant Family History
Cancer Type:_____ Asthma Hypertension

Social Habits: **Tobacco Use:** **Yes** **No** **Alcohol Use:** **Yes** **No**

Signature ________________________________ Date __________________________

Central Florida Family Practice

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **[Central Florida Family Practice]** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **[Central Florida Family Practice]** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **[Central Florida Family Practice]** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **[Lee Grant, 4513 Old Canoe Creek road, St. Cloud, FL 34769]**.

With this consent, **[I Central Florida Family Practice]** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **[Central Florida Family Practice]** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **[Central Florida Family Practice]** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **[Central Florida Family Practice]** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **[Central Florida Family Practice]** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **[Central Florida Family Practice]** may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable

Central Florida Family Practice

Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see and treat your child. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. **There is a charge of $15 for missed appointments.**
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (wellness) visit.

Initial: _____

Insurance Plans

Please understand

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2) If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit. (**HMO Plans**)
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example
    a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.
    b. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial: _____

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, we must approve referrals before they are issued.

Initial: _____

(over)

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) **Co-payments** are due at the time of service.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
6) If previous arrangements have *not* been made with our finance office, Any balance outstanding longer than 90 days will be forwarded to a collection agency.
7) For scheduled appointments, prior balances must be paid prior to the visit.
8) If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
9) We accept cash, Visa, Discover and MasterCard credit and debit.
10) A $35 fee will be charged for any checks returned for insufficient funds.

Initial: _____

Forms

1) There is no charge for a blue-and-yellow form given at the time of your child's visit. This is considered part of the visit. **However,** should you lose your forms, there will be a $5 charge ($5 for one form) to replace them.
2) Any additional school, camp, or sports forms are subject to a $5-per-form fee. Family and Medical Leave Act forms (FMLA) are $25. Payment is due when the forms are dropped off. We require 3-day turnaround time.

Initial: _____ Transfer of Records

1) If you transfer to another physician, we will provide a copy of your immunization record and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hours' notice.
2) A copy of your complete record is available for a $1-per-page fee up to 10, any additional pages are $0.25 each after 10 pages.
3) We do not charge if you request records to be sent by fax, you must sign a release of medical records form at the physicians office that you want your records to go to.

Initial: _____

Prescription Refills

1) For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

Initial: _____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____