Ross Medical Group 8200 SW 117th AVE STE 100/200 MIAMI, FL 33183

REGISTRATION FORM REFERRED BY: _____

PATIENT INFORMATION

Patient's last name: First:			Middle:
Marital status (circle one): Single /Mar /Div /Sep / Wid	Driver's License #:	Birth date: / /	Sex: ( ) M ( ) F
Race/Ethnicity/Religion:		Primary Language:	
Street address:		Social Security no.:	
E-mail Address:	City:	State:	ZIP Code:
Home Phone #:	Work Phone #:	Cell Phone #:	
Occupation:	Employer:		
Preferred Pharmacy Name:	Pharmacy Phone #:	Pharmacy Fax #:	

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Primary Insurance Company:	Policy No:	Group No:	
Subscriber's name:	Birth date: / /	Subscriber's SS #:	
Patient's relationship to subscriber: ( ) Self ( ) Spouse ( ) Child ( ) Other			
Name of secondary insurance :	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

I hereby authorize Dr. Michael L. Ross, D.O., PA D/B/A Ross Medical Group to furnish information to all insurance carriers concerning my illness and treatment, and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

( ) I authorize Ross Medical Group to bill me electronically via email: _____

_____ _____

Patient/Guardian signature *Date*

Ross Medical Group 8200 SW 117th AVE STE 100/200 MIAMI, FL 33183

OUR POLICY REGARDING MEDICAL INSURANCE:

As a courtesy to our patients, we will be happy to complete and forward insurance forms relative to your medical treatment in our office, and we will do so without charge.

HOWEVER IN ORDER TO AVOID MISUNDERSTANDINGS, PLEASE READ CAREFULLY AND UNDERSTAND THE FOLLOWING POLICY OF THIS OFFICE IN REGARDS TO MEDICAL INSURANCE BENEFITS.

1. **Our professional treatment is rendered to you, not the insurance company:** therefore, you are directly responsible for the obligation of payment for treatment to us. If your insurance company requires a claim form with each visit you must bring in a form at the time of visit.

2. Due to the unethical practices of some insurance companies of stretching out payment beyond normal time, payments not received within 90 days from the insurance company; **must be paid by you**.

3. Our office reserves the right **not** to accept any insurance policy with a pre-existing clause or time limit for filing claims less than one year.

4. **If your account goes beyond the 90 days we reserve the right to charge 50% of the total amount owed once sent to collections.**

Please understand that the amount of benefits to be derived under your particular policy is a predetermined situation agreed upon between your employer and the insurance company. Therefore, if you have any questions in regards to dollar disbursement or what your plan will cover, you should refer these questions to **your employer.**

At the time of treatment, a form of payment for your consultation must be determined prior to you seeing the physician. **If we cannot verify your benefits or your insurance company denies your visit and you decide to pay for your services prior to resolving your insurance issues, be advised that most insurance companies will not reimburse you the full amount you pay at the time of the visit**. If you choose to pay for your visit, you will be considered a private patient without insurance for that visit. Your insurance benefits will not apply to this date of service nor will you be able to receive a claim form or itemized bill for insurance reimbursement. Please feel free to ask any questions you may have with regards to this policy.

I understand what I have read.

Patient/Guardian Signature: _____ Print Name: _____

Date: _____ Copy given to patient: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice at any time by contacting:

Contact Person: Dr. Michael L. Ross, D.O.
Address: 8200 SW 117TH AVE SUTIE 100 MIAMI, FL 33183
Telephone: (305)279-7677 Fax: (305)279-0977

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent**.**

SIGNATURE: I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations**.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRACTICES:
**** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT****

I, _____, have received a copy of this Notice of Privacy Practices.
Date: _____
Signature: _____

FOR OFFICE USE ONLY:
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
____ Refused to sign ____ Communication barriers prohibited signature ____ Emergency ____ Other

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Patient name**:** _____

Patient's Date of Birth: _____ Social Security_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____
Name *Address*

Phone: _____ Fax: _____

I hereby request a copy of the above patient's medical record:

MEDICAL RECORDS ARE TO BE RELEASED TO:

Ross Medical Group
8200 SW 117 Ave Suite 100/200 Miami, FL, 33186
Phone: 305-279-7677 Fax: 305-279-0977

INFORMATION REQUESTED (X):

( ) Office Consultation/Visit Report - Date of Service: _____

( ) Lab results - Date of Service: _____

( ) MRI, CT scan, and Ultrasound - Date of service: _____

( ) Colonoscopy Report - Date of Service: _____

( ) Pathology Result - Date of Service: _____

( ) Hospital Report - Date of Service: _____

( ) Other: _____ - Date of Service_____

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):

( ) Continued Medical Care ( ) Insurance Purposes

I UNDERSTAND THAT:

- This authorization will expire on: (insert date)_____
  (If left blank, the Authorization will be kept on file for future medical record requests).
- I have a right to revoke this authorization in writing at any time.
- My treatment cannot be conditioned on the signing of this authorization.
- The information released in response to this authorization will not be re-disclosed, except with a written authorization.
- I can receive a copy of this authorization form upon request

Patient Signature: _____ Date: _____

Witness: _____