REGISTRATION SLIP

DATE_____ PRIMARY LANGUAGE SPOKEN_____

RACE_____ ETHNICITY:_____

SOCIAL SECURITY #_____ DRIVERS LI #_____

PATIENTS FIRST NAME_____MIDDLE INITIAL_____

LAST NAME_____

PERMENANT
STREET ADDRESS_____APT_____

CITY_____STATE_____ZIP_____

HOME PHONE(_____)_____ WORK PHONE (_____)_____

CELL PHONE(_____)_____

TEMPORARY STREET ADDRESS_____APT_____

CITY_____STATE_____ZIP_____

LOCAL PHONE_____

OCCUPATION_____ BUSINESS NAME_____

BUSINESS ADDRESS_____

DATE OF BIRTH_____MARITAL STATUS_____ SEX_____

SPOUSES NAME_____SPOUSES WORK #_____

SPOUSES WORK ADDRESS_____

GUARANTOR (IF OTHER THAN PATIENT OR PATIENT IS A MINOR)

GUARANTOR FIRST NAME_____LAST NAME_____

STREET ADDRESS_____APT_____

CITY_____STATE_____ZIP_____

RELATIONSHIP TO PATIENT_____

IN CASE OF EMERGENCY PLEASE NOTIFY

FIRST NAME_____LAST NAME_____

ADDRESS_____PHONE# (_____)_____

_____RELATIONSHIP TO PATIENT_____

EMAIL ADDRESS_____

Pharmacy address and phone_____

_____

_____

INSURANCE INFORMATION

MEDICARE#_____

PRIMARY INSURANCE_____
ADDRESS_____

ID OR POLICY #_____ GROUP#_____

SUBSCRIBER_____DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE_____
ADDRESS_____

ID OR POLICY #_____GROUP#_____

SUBSCRIBER_____DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____

PLEASE CHECK WHICH APPLY:

_____ I HAVE A LIVING WILL
_____I HAVE A HEALTH CARE SURROGATE FORM
_____I WOULD LIKE TO BE PROVIDED WITH A LIVING WILL
_____I WOULD LIKE TO BE PROVIDED WITH A HEALTH CARE SURROGATE FORM

PLEASE PROVIDE THE OFFICE WITH COPIES OF THESE IMPORTANT DOCUMENTS .

MEDICARE B AUTHORIZATION SIGNATURE

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS,OR TO THE BILLING AGENT OF THIS PHISICIAN OR SUPPLIER ANY INFORMATION NEEDED FOR THIS RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND THAT THIS IS A LIFETIME SIGNATURE AUTHORIZATION

DATE_____PATIENT SIGNATURE_____

MEDICARE DEDUCTIBLES AND CO INSURANCE

I UNDERSTAND THAT I WILL RECEIVE ONE COURTESY STATEMENT FOR THESE RELATED EXPENSES. IF ACCOUNT IS STILL PAST DUE -**THERE WILL BE A $10.00 MONTHLY BILLING FEE ADDED TO EACH MONTH THE ACCOUNT REMAINS OUTSTANDING. THIS AMOUNT IS TO COVER THE COST ASSOCIATED WITH MAILING THE STATEMENT TO ME.**

PATIENT
SIGNATURE_____DATE_____

INSURANCE AUTHORIZATION SIGNATURE ON FILE

I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS
I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE CARRIERS
I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL IF ANY INSURANCE INFORMATION HAS BEEN FALSIFIED, OR IF I HAVE PROVIDED INCORRECT INSURANCE INFORMATION
I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE CARRIER.
I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR
I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORGINAL
I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT TO INTERNAL MEDICINE SPECIALTY ASSOCIATES PA FOR ANY AND ALL SERVICES RENDERED.

DATE_____PATIENT SIGNATURE_____

I UNDERSTAND THAT COPAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED AND THAT IF THE COPAYMENT IS NOT PAID AT THAT TIME , I WILL BE BILLED FOR THE COPAYMENT PLUS A $10.00 A MONTH BILLING FEE.

THIS INCLUDES NOT HAVING A CURRENT INSURANCE CARD THAT SHOWS MY CURRENT COPAYMENT AND I MUST BE BILLED FOR ANY ADDITIONAL COPAYMENT AMOUNT.

PATIENTS
SIGNATURE_____DATE_____

Internal Medicine Specialty Associates

NOTICE OF PRIVACY PRACTICES

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

As a patient you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to request confidential communications
5. The right to a report of disclosures of your information
6. The right to a paper copy of this notice

We want to assure you that your Medical/Protected health information is secure with us. This notice contains information about how we will insure that your information remains private.

1. Written requests for your Medical/Protected information must be accompanied with a written authorization signed by you or legal representative
2. It is our policy to disclose your Medical/Protected information to immediate family members living in your household. We will follow this policy unless you have provided in writing a list of immediate family members you wish to exclude.
3. Please complete attached list of family members and others not living in your household that you would like us to disclose your Medical/protected information
4. **Under the law we have the right to refuse to treat you should you choose to refuse to disclose your Medical/Protected Information**

If you have any questions regarding this notice the name and phone number of our contact person is provided below:

Effective Date of this Notice:_____

Contact Person: Michele Rodgers 954 981 7070

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed. I also understand that the Practice will offer me updates to this NOTICE OF PRIVACY PRACTICES upon request should it be amended, modified or changed in any way.

_____

Please print patient name or representative

_____Date_____

Patient or Representative signature

( ) Patient refused to sign ( ) Patient unable to sign because _____

_____Date_____

Signature of Office Representative

Internal Medicine Specialty Associates

Authorization to Release Medical Information

Date:_____

I, _____ give permission to the office to discuss my health information and my conditions with the following individuals. I understand that at any time I may change this information by completing another form to update or to notify the office in writing if I choose to discontinue a person from my list.

Person:	**Relat:**	**number:**

_____

Patient Signature

Witness:

_____