BOCA GENERAL AND FAMILY MEDICINE, P.A.
PATIENT INFORMATION FORM

First Name: _____ M.I.:___Last Name: _____

Birthdate: _____ Sex: M_ F__Social Security Number: _____

Address: _____

City: _____ State: _____Zip_____

Northern/Secondary Address_____

Home Phone: _____ Work Phone: _____Ext: _____

Cell Phone: _____ Email Address: _____

Preferred Pharmacy Name/Address _____

_____**Phone**_____

INSURANCE INFORMATION FOR CLAIM FILING (choose one)

___ I have provided a copy of my insurance card. I understand that my co-pay is due at the time of my office visit.

___ I do not have insurance at this time. I understand that I will pay for my office visit.

NAME OF PERSON RESPONSIBLE FOR CHARGES OTHER THAN SELF (if applicable)

Name: _____ Relationship_____

Address:_____

City: _____ State: Zip_____

Home Phone: _____ Work Phone: _____ Ext: _____

***Emergency Contact:**

Name/Relationship:_____

_____**PHONE**_____

***List all persons in your household who, in your absence, may make requests on your behalf, and with whom we may speak to regarding your medical information.**

NAME: **RELATIONSHIP:**

BOCA GENERAL AND FAMILY MEDICINE, PA

Financial Policy / Consent for Treatment

I, (Patient/Parent/Guardian), acknowledge that all medical and other services incurred in my or my dependents care, rendered at Boca General& Family Medicine, PA (William L. Rowland, MD, Carlos Suero, PA. C)are my financial responsibility. All court costs, attorney's fees or other fees necessary to collect monies due will become my responsibility.

As a patient of Boca General & Family Medicine, PA (William L. Rowland, MD, Carlos Suero, PA- C), I consent to the provider's use and disclosure of protected health information about me in order to carry out treatment, payment and health care operations. I have been informed about the provider's Notice of Privacy Practices, and that such notice provides a more complete description of the uses and disclosures that the Provider may make concerning my protected health information. I understand that I have the right to review such notice before signing this consent. I also understand that, as described in the notice, the terms of that notice may change, and I may obtain a revised copy of the notice by contacting the provider in person or in writing. I further understand that I have the right to request that provider restricts how protected health information about me is used or disclosed for treatment, payment or health care operations. I recognize the provider is not required to agree to my request for a restriction, but if the provider does, it will be bound by such agreement. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

****

Patient Name:_____

BGFM has advised the above named patient that <u>OFFICE VIST/LAB WORK</u> is in my best medical judgement necessary for his/her care, but that insurance may not reimburse for any of the cost involved but by signing this ABN form the patient agrees to accept responsibility for the costs of this testing.

PATIENT
Signature_____Date_____

FOR OFFICE USE ONLY:

_____ Individual Refused to Sign

_____ Communication barriers prohibited obtaining acknowledgment

Boca General and Family Medicine PA
HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary Information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published, and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Signature: _____ Date:_____

PRACTICE GUIDELINES AND PATIENT FINANCIAL POLICIES

Prescriptions: It is our policy that you should be responsible to know when your medications must be refilled. To assist each patient we strongly recommend on EVERY visit that you bring all your medication bottles or a complete list of medications along with the # of remaining refills on each medication with you when you see your doctor or nurse practitioner. We will refill all your medications at this time to ensure that you have enough of EVERY medication until your next visit. Most controlled substances require an office visit monthly.

Labs and Diagnostic Tests: There will be a $15.00 charge for the convenience of collecting your specimens in the office (blood draw). You may request at any time to go to the lab for your bloodwork. Most insurances cover outside lab collection at no additional charge. All labs and diagnostic tests require a follow up visit with the provider to go over the results and insure continuity of care. No results will be given over the telephone unless directed by the physician on the day your test is ordered. It is your responsibility to make a follow up appointment to review the results with your physician.

Emergencies: Our providers will make every effort to receive your calls and respond promptly in an emergency. If you do not receive an immediate response you should call 911, receive paramedic intervention, and seek the nearest emergency room.

Appointments: Our office will schedule appointments as a common courtesy for patients and in consideration of your time. Appointments can also be scheduled online at bocageneral.com. Minors must be accompanied by a parent or guardian to be seen unless special arrangements have been made with the office. We require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation as a courtesy to other patients seeking services. A fee of $50.00 will be charged for non-cancelled and missed appointments. A pattern of non-cancelled/missed appointments may result in discharge from the practice.

Forms Fees: Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice: FMLA, immigration, disability, drivers' license, and school physical forms=$25.00. Additional fees may apply at the discretion of the practice and upon notification to you.

Medical Records: The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. The practice charges a fee for a copy of the records of $1.00 per page up to $25.00, then 0.25 cents per page after the first 25 pages. All outstanding account balance must be clear before BGFM can release medical record to the patient.

Insurance copayments, deductibles and coinsurance: Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, coinsurance, or non-covered services are to be paid at the time of your visit. If we question your insurance coverage, we will ask you to sign an "advanced beneficiary notice". You accept responsibility for all such expenses even if your insurance company is billed as a service to you.

Slow Insurance Response: You agree that if your insurance company takes more than 60 days to respond to your insurance claim, that we shall consider your services your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company.

Accident& Worker's Compensation: Although our office is happy to treat your medical conditions, if the cause is related to an auto or work-related accident you will be required to pay the full fees at the time of your visit.

Statement Policy: Our office sends patient statements each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance responds to the claim for services. Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees. A late fee may be charged for patient balances due that are more than 30 days old.

Collection and Bank fees: Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense, legal fees, and court costs. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of $35.

Patient Discharge: The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your practitioner.

I, (Patient/Parent/Guardian), have read and understand all the terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above.

Signature:_____ **Date:** _____