PATIENT REGISTRATION
PLEASE PRINT AND COMPLETE ALL SECTIONS BELOW

Is your condition a result of an auto accident? Yes No   Work Injury: Yes No   Date of Injury: ___________

NEW OR UPDATED PATIENT PERSONAL INFORMATION

PERSONAL DATA ***(please print)***

Last Name: ______________________ Birth Date: ______________ Age: ________
First Name: ______________________ MI_____ Sex: M F   Marital Status: __________
Address: ______________________ Ht: ________ Wt: ________
City: ____________ State: ______ Zip: ______ Social Security: ______________________
Phone (Day): ____________ (Evening): __________ Driver's License: ______________________
Mailing Address: ______________________ Race: ___White ___Black ___ Hispanic ___Asian
City: ____________ State: ______ Zip: ______ ___ Pacific Islander ___ Other: __________

EMERGENCY CONTACT

Emergency Contact: ______________________ Relation: ______________________
Address: ______________________ City: ____________ State: ______ Zip: ______
Phone (Day): ____________ (Evening): __________

INSURANCE INFORMATION

__Medicare __Medicaid __HMO __PPO __POS __PPC

Primary Insurance: ______________________
Address: ______________________
City: ____________ State: ______ Zip: ______
Phone: ____________ Fax: ____________
Policy Holder: ___Myself ___Spouse ___Other:________
Name: ____________ Relation: ____________
SS# orID# of Policyholder: ______________________
Plan Name: ______________________
Policy#: ____________ Group#: ____________
Primary Care Physician: ______________________
Phone: ____________ Fax: ____________

Secondary: Insurance Name: ______________________
Address: ______________________
City: ____________ State: ______ Zip: ______
Policy#: ____________ Group#: ____________

Co-Pay # $________

Self Pay _Y__N__

___**Worker's Compensation** ___**Auto-accident Case**

Insurance Company: ______________________
Address: ______________________
City: ____________ State: ______ Zip: ______
Date of Injury: ____________
Employer at time of injury: ______________________
Address: ______________________
City: ____________ State: ______ Zip: ______
Phone: ____________ Fax: ____________
Claim#: ______________________
Claim Adjuster: ______________________
Phone: ____________ Fax: ____________
Case Manager: ______________________
Phone: ____________ Fax: ____________
Name of Attorney: ______________________
Contact Person: ______________________
Phone: ____________ Fax: ____________
Lawsuit Pending: ___Yes ___No
Auto-accident: Deductible $________ ___Met ___Not Met
LIEN: ___Yes ___No
LOP: ___Yes ___No

EMPLOYMENT INFORMATION

Employer: ______________________ Occupation: ______________________
Address: ______________________ Phone: ____________ Fax: ____________
City: ____________ State: ______ Zip: ______ Email: ______________________

Lifetime Authorization to Release Information & Assignment of Benefits (Financial Agreement)

I hereby authorize the release of any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Gericare Center, LLC (or named physicians) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to crossed over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

Date: ______________________   Patient Signature: ______________________

Guardian Signature: ______________________

HIPAA Compliance Information

H – Health I – Insurance P – Portability A – Accountability A – Act

Last Name:________________ First Name:____________________ DOB: _______

1) Please list any person/persons that are entitled to see your medical records or that we can inform about your medical condition and diagnosis.

Name:____________________

Phone: ____________________

Relation: __________________

Name:____________________

Phone:____________________

Relation:__________________

Name:____________________

Phone: ____________________

Relation: __________________

Name:____________________

Phone:____________________

Relation:__________________

2) Can confidential messages (i.e. Appointment Reminders) be left on your answering machine? YES NO **(Please note that a cell phone is not a secure and private line)**

3) If you have any of the following legal documents, we would appreciate it if you could bring us a copy for your medical chart.

- Do you have a Living Will? YES NO
- Do you have a designated Health Care Surrogate? YES NO
- Do you have an appointed Durable Power of Attorney for health care decisions? YES NO

______________________________________ ____________________

Signature Date

PATIENT'S PERSONAL HISTORY & HEALTH ASSESSMENT

DATE___/____/__

LAST NAME:________________________ FIRST NAME____________________ SOC SEC #________________

D.O.B.______________ SEX:__________

DATE OF LAST PHYSICAL EXAM:________________________ PHYSICIAN:______________________

MEDICAL EQUIPMENT:

Check if you use a Cane?_____ Oxygen?___ Catheter?_____ Walker?_____ Wheelchair?_____ Nebulizer?______

Check if you use Glasses?_ Hearing Aid?________

SOCIAL HISTORY:

Alcohol________ Smoking_____ Drugs_______ Other____________________________

RELIGION: ________________

IMMUNIZATIONS: (Please indicate the last year that the vaccine was given for each)

Pneumococcal__________ Rubella______ Tetanus______ Influenza_____ Diptheria_____ Other____________

FAMILY HISTORY:

	Alive	Dead	Age at Death	Cause of Death	List Illnesses
Mother:	☐	☐			
Father:	☐	☐			
Brother:	☐	☐			
Sister:	☐	☐			

Check if you have/had any of the following illnesses. If unsure, leave blank.

	Yes	No		Yes	No		Yes	No
Alcohol Overuse	☐	☐	Frequent Kidney/Bladder Infections	☐	☐	Nervous Breakdown	☐	☐
Allergies (other than medications)	☐	☐	Frequent Lung Infections	☐	☐	Radiation Treatments	☐	☐
Anemia (low blood count)	☐	☐	Gallbladder Disease	☐	☐	Rheumatic Fever	☐	☐
Arthritis	☐	☐	Goiter	☐	☐	Sexually Transmitted Diseases	☐	☐
Asthma	☐	☐	Gout	☐	☐	Sickle Cell Anemia	☐	☐
Bleeding Tendency	☐	☐	Hay Fever	☐	☐	Stomach Ulcers	☐	☐
Cancer	☐	☐	Heart Attack	☐	☐	Stroke	☐	☐
Chicken Pox	☐	☐	Hepatitis	☐	☐	Suicide Attempt	☐	☐
Colitis	☐	☐	High Blood Pressure	☐	☐	Thyroid	☐	☐
Congenital Heart Disease	☐	☐	Intestinal Polyps	☐	☐	Tuberculosis	☐	☐
Depression	☐	☐	Jaundice	☐	☐	Whooping Cough	☐	☐
Diabetes	☐	☐	Leukemia	☐	☐	Other (please specify)	☐	☐
Dialysis	☐	☐	Measles	☐	☐	____________	☐	☐
Emphysema	☐	☐	Migraine	☐	☐	____________	☐	☐
Epilepsy/Seizures	☐	☐	Mumps	☐	☐	____________	☐	☐

Please indicate to our staff if you have any trouble filling out these forms

Patient Medication and Prior History Information

PLEASE COMPLETE THE FOLLOWING if you have not done so in the past 6 months.... Thank you.

Name: ________________________, ____________________
Last Name **First Name**

Are you **allergic** to any medications? Yes ☐ No ☐ If yes please list them below:

____

____

Operations: (Name & Year)

Hospitalizations: (Reason & Year)

Current medications -include strength if known (PLEASE INCLUDE OVER THE COUNTER MEDICATION)

Please Print Below

If you do not know the name of the medication please list the class of medication or reason why you take them

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ____, have received/reviewed a copy of the Gericare Center, LLC Notice of Privacy Practices.

____ __________________
Signature of Patient/Legal Representative **Date**

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

GERICARE CENTER LLC DOCTOR'S OFFICES FINANCIAL POLICY STATEMENT

We are committed to providing the highest level of medical care to our patients. To ensure that our patients fully understand our billing process, we ask that you read and sign this financial policy statement.

INSURANCE PARTICIPATION:
We have submitted applications for participation to all major insurance companies and already participate with some of them. However, it is the patient's responsibility to ensure that the physician he/she is seeing is listed with the insurance company as a participating provider. Any patient treated by a non-participating physician will be responsible for any deductibles, co-insurance, uncovered services, etc.. Imposed by their insurance company. From time to time we may ask you to assist us in obtaining payment from your insurance company on claims that have remained unpaid for an extended period of time.

PATIENT RESPONSIBILITY:
Without exception, it is the responsibility of the patient to pay his/her co-payment and any unpaid portion of the deductible at the time of service. Any additional co-payments, deductibles and/or co-insurance will be billed to the patient as indicated by your insurance carrier on their Explanation of Benefits (EOB). Your insurance company will mail you an EOB outlining the services rendered and the portion of the bill which is your responsibility. All patients without insurance must pay in full at the time services are rendered.

DENIED CLAIMS:
Our billing agent will not become involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefit issues, eligibility issues, pre-existing conditions or any other matter, which causes the claim to be denied. Should your claim be denied for any of these reasons or any other reasons not listed here, the claim will become the responsibility of the patient and payment will be expected immediately.

LABORATORY CHARGES:
Please note that the services provided to you may require outside lab work. We will forward your laboratory tests to a participating lab company whenever possible. You must contact the lab company directly should you receive any bills from them.

PAYMENT OPTIONS:
For your convenience we offer a variety of payment options. We accept all major Credit Cards, Personal Checks, Cashier/Bank Checks and of course CASH. All returned checks will be assessed a $30.00 returned check fee in addition to the original charge.

REFUNDS:
All refunds will be processed within 6-8 weeks after the overpayment is discovered on the patient's account or at the time the refund is requested. Patients who have insurance but made a partial payment or made payment in full will not be refunded until payment in full is received from their insurance company. Refunds for payments made with a credit card will be credited back to the credit card used, for all others a check will be issued within 6-8 weeks.

REFERRALS:
All of our patients requiring the services of outside specialists will be given a referral depending on their health plan. Please note that no referrals will be given without first being treated by one of our physicians as required by your health plan.

RELEASE OF ASSIGNMENT:
"I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, Blue Cross Blue Shield, Avmed , Aetna, Wellcare, Freedom, Optimum, Simply, GHI, Humana, TRICOR, Staywell, Beech Street, PHCS, Multiplan, United Healthcare, Oxford plans and commercial insurance to Gericare Center LLC Doctors Office. I understand that I am financially responsible for all the charges whether or not covered by the insurance I provide for the visits with Gericare Center LLC. I hereby authorize said assigned to release any information necessary to secure payment on my behalf."

Responsible Party Signature: DATE:

Patient Name: DOB:

Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients, You may request a copy of the full text of this law from your health care provide or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his individual dignity, and with protection of his need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he does not speak English.

A patient has the right to know what rules and regulations apply to his conduct.

A patient has the right to be given by his health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that shall deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his rights, as stated in Florida, through the grievance procedure of the health care provider or health care facility which served him and to the appropriate state licensing agency.

A patient is responsible for providing to his health care provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses. hospitalizations, medications, and other matters relating to his health.

A patient is responsible for reporting unexpected changes in his condition to his health care provider.

A patient is responsible for reporting to his health care provider whether he comprehends a contemplated course of action and what is expected of him.

A patient is responsible for following the treatment plan recommended by his health care provider.

A patient is responsible for keeping appointment and, when he is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his actions if he refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Patient Signature: ______________________________

Date: ____________________

Authorization to Obtain / Release Medical Records

Patient Name ____________________________

Address ____________________________

City/State/Zip ____________________________

DOB ____________ SSN ____________________

I hereby authorize Gericare Center, LLC to **Obtain / Release** my protected health information **From / To:**

____

____

____

____

This request shall include: ____________________

1. All Medical Records
2. Lab Work/Diagnostic/Office Notes

I hereby authorize the use or disclosure of my individually identifiable health information for continuation of care. I understand that this authorization is voluntary. I understand that this shall be valid for a period of (1) year and may be revoked at any time upon written notice, except when the information has been received per this agreement. I further understand that the confidentiality of this information may be protected by the Federal. Regulations prohibiting any further disclosure of this information without specific written authorization of the undersigned.

Patient Signature ____________________________

Date ____________________________

7539 Spring Hill Drive
Spring Hill, Fl 34606
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