Patient Registration Form

Patient Information

Patient Name (Last, First, M.I.): _____ **Birth Date**: ____/____/___

Social Security Number: _____ **Sex** (Circle One): Male / Female

Race (Circle One): Asian/African American/American Indian/Native Hawaiian/Pacific Islander/White

Ethnicity: Hispanic/Non-Hispanic **Preferred Language**: _____

Street Address: _____ **Apt/Unit Number:** _____

City: _____ **State**: _____ **ZIP Code**: _____

Home Phone: _____ **Cell Phone**: _____ **Email Address**: _____

Referred By (Circle One)**:** Insurance Plan / Hospital / Family Member / Friend / Yellow Pages / Doctor / Other

If referred by a doctor, please specify which doctor:_____

In case of an emergency, please contact: _____

Phone Number: _____ **Relationship to Patient**: _____

Previous Primary Care Physician: _____ **Phone Number:** _____

Preferred Pharmacy: _____ **Pharmacy Phone Number**: _____

Insurance Information

(Please give your Photo ID & insurance cards to the receptionist)

Insured's Name: _____ **Birth Date**: ___/___/___ **SSN**: _____

Address: _____ **Relationship to Patient**: _____

Primary Insurance: _____ **Policy Number**: _____

Secondary Insurance: _____ **Policy Number**: _____

The above information is true to the best of my knowledge.

Patient/Guardian Signature: _____ **Date**: ____/____/_____

Patient Name: _____ **DOB:** _____**Date:** _____

Please answer the following questions:

Reason for the visit: ( ) Physical ( ) Vaccine Update ( ) Other Symptoms:_____

Are your child's vaccinations up to date: ( ) Yes ( ) No *(Please provide any records to Front Desk).*

Is your child taking any medications: ( ) Yes ( ) No

Current Medication(s): _____

What is the child's current living situation? ( ) Lives with both Parents ( ) Lives with one Parent ( ) Lives with Relatives ( ) Lives with Adopted Family ( ) Lives in Group Home

Birth History

( ) **I do not know the birth history**

Place of Birth (Hospital Name): _____

Was baby discharged from the hospital with mother? ( )Yes ( ) No If no, please explain: _____

Type of Delivery: ( )Vaginal ( ) Cesarean **If cesarean, why?** _____

Was the baby born: ( ) Term ( ) Early ( ) Late **If early, how many weeks gestation?** _____

Did your baby have any complications right after birth? ( ) Yes ( ) No Explain_____

Did mother have any illnesses or problems during pregnancy? ( )Yes ( ) No Explain_____

During pregnancy, did mother:

Smoke: ( )Yes ( ) No Drink Alcohol: ( )Yes ( ) No Use drugs or take medication(s): ( )Yes ( ) No

Which drug/medication(s): _____ **When:**_____

Initial Feeding: ( ) Breast Milk ( ) Formula ( ) Both If formula feeding, what type of formula? _____

Developmental Milestones:

What age child rolled over: _____ What age child sat up: _____ What age child stood up? _____

What age child walked alone: _____ What age child talked *(mama, dada, etc.)*: _____

What age child stop wearing diapers: _____ What age child started writing letters? _____

What is your child's current school grade: _____ **School Name**: _____

For girls: At what age was her first period: _____ When was her last period: _____

Has your child ever been hospitalized? No ( ) Yes ( ) Explain: _____

Has your child ever had surgery? No ( ) Yes ( ) Explain: _____

Is your child currently suffering or had suffered from any illness? No ( ) Yes ( ) Explain:_____

Is your child allergic to any medication or food products? No ( ) Yes ( ) Explain: _____

_____

Patient Name: _____ DOB: _____Date: _____

Past Medical History

Does your child have, or has he/she ever had any of the following *(Please check all that apply.)***:**

	Chicken Pox/Measles/Mumps/Rubella		Frequent Ear Infections
	Problems with ears/hearing		Nasal/Environmental Allergies
	Problems with eyes/vision		Asthma/Wheezing
	Bronchitis/Bronchiolitis/Pneumonia		Heart Problems/Heart Murmur
	Seizures/Convulsions/Epilepsy		Anemia/Sickle Cell/Bleeding Disorder
	Frequent Headaches		Frequent Abdominal Pain/ Severe Constipation
	Diabetes/Elevated or Low Blood Sugar		Bladder/Kidney Infection
	Eczema/Other Chronic or Recurrent Skin Condition		Thyroid/Endocrine Conditions
	Bed-wetting (After Age 5)		Use of Drugs or Alcohol
	Immune Diseases ***(HIV or Aids)***		Cancer Type:_____

Any other significant medical problem: _____

Biological Family Medical History

Has any of your family members had any of the following *(Please check all that apply.)***:**

✓	**Illness/Condition**	**Family Member/Comment**
	Hypertension (Before Age 50)	
	High Cholesterol (Before Age 50)	
	Heart Disease (Before Age 50)	
	Diabetes (Before Age 50)	
	Cancer Type:_____	
	Nasal/Environmental Allergies	
	Tuberculosis	
	Liver Disease	
	Mental Disorders/Retardation	
	Deafness	
	Asthma	
	Anemia/Sickle Cell/Bleeding Disorder	
	Seizures/Convulsions/Epilepsy	
	Immune Diseases ***(HIV or AIDS)***	
	Bed-wetting (After Age 10)	
	Use of Drugs or Alcohol	

Any other significant medical problem: _____

Consent for Treatment, Diagnostic and/or Therapeutic Procedures

Patient Name: _____ Date of Birth: _____

I hereby consent to and authorize a physician of the Amicus Medical Centers and any other health professional as designated to perform a physical examination and routine diagnostic procedures upon me. Additionally, I hereby authorize Amicus Medical Centers to use telemedicine in the course of my diagnosis and treatment.

I also consent to and authorize Amicus Medical Centers to prescribe a therapeutic regime which I shall follow.

Unless I explicitly refuse, I consent that the diagnostic procedure(s) ordered by the Amicus Medical Centers physician can be performed on me despite the risks involved and complications that might be involved which were explained to me at the time they were ordered.

Signed: _____

Patient or Authorized Patient Representative

Printed Name: _____

Date/Time: _____

Witness: _____

Authorization to Bill Health Insurance/Assignment of Benefits

I _____ (print name) do hereby give full permission and authorize **Amicus Medical Centers – Corporate Billing Center**, to bill _____ (name of insurance company) for services rendered by **Amicus Medical Centers**. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Amicus Medical Centers, LLC – Corporate Billing Center

1300 Concord Terrace

Suite 210

Sunrise, FL 33323

By signing this document, I also agree to the following statements below:

I understand that I am responsible for understanding information about my health insurance policy and providing such information to **Amicus Medical Centers**, for correct billing. I am also responsible to notify **Amicus Medical Centers** in the case of change of my health insurance status – inclusive benefits and any information I receive relating to care I have or will receive in this office.

I understand that **Amicus Medical Centers** will be providing services and billing my health insurance for those services at various times during the course of my care at this office. I understand that ultimately, I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at **Amicus Medical Centers** during my care. I also understand that my insurance company and related policy plan may offer benefits for services provided at A**micus Medical Centers**, but that such benefits do not necessarily guarantee payment for those services.

I understand that the policy of **Amicus Medical Centers** requires payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. If my account is not paid within 90 days of the date of service and no other financial arrangements have been made, I will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting my account. I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand that it is my responsibility to alert **Amicus Medical Centers** of any change in my medical status or insurance coverage.

The undersigned does agree to observe and abide by all of the statements made above.

_____ _____

Patient's Signature **Date**

_____ _____

Patient's Printed Name **Date**

E-Prescribing PBM Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- Formulary and benefit transactions-- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions--Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that **Amicus Medical Centers** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purpose.

Signed: _____

Print Patient's Name: _____

Patient's Date of Birth: _____

If signed by Representative,
State name of Representative: _____

Relationship to Patient: _____

Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received **Amicus Medical Centers' Notice of Privacy Practices** which provides a complete description of information, uses and disclosures**.** I acknowledge that I had an opportunity to review and ask questions concerning **Amicus Medical Centers' Notice of Privacy Practices** prior to signing this consent.

HIPAA Patient Information Consent

The following person(s) are allowed to receive and discuss my protected health information and/or pick up medications/prescriptions, results, reports and/or my billing information from **Amicus Medical Centers** on my behalf.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Patient or Patient's Representative

Signed: _____

Print Patient's Name: _____

Patient's Date of Birth: _____

If signed by Representative,
State name of Representative: _____

Relationship to Patient: _____

Date: _____

Consent for NonParent/Guardian

I _____, hereby give permission for the person(s) mentioned below to accompany my child(ren) for their initial examinations and/or any subsequent visits with Amicus Medical Centers. I authorize them to see all necessary medical records and make healthcare decisions of a routine nature, including treatment plans, medications and vaccinations administration. I authorize Amicus Medical Centers to discuss medical information about my child(ren) with the authorized person(s).

Additionally, I give the authorized person(s) the authority to make more serious or urgent health care decisions in the even that I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

This consent shall be effective from date of signature until revoked by myself.

Patient's Name(s): _____ **DOB:** _____

_____ **DOB:** _____

_____ **DOB:** _____

Person(s) Authorized to Accompany Minor/DOB	**Relationship to Minor**
_____	_____
_____	_____
_____	_____

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____ Contact Number of Parent/Guardian _____

*Authorized person(s) must provide photo identification at the time of the minors visit.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____/_____
Last **First** **Middle Initials** **Maiden**

Address: _____
Street **City** **State** **Zip Code**

Birth Date: ____/____/____ **Telephone:** _____

I, _____ **authorize** _____
Patient/Personal Representative Name **Facility Name** **Address** **City** **State** **Zip**

_____ _____
Phone **Fax**

to release my health information indicated below to the following party: (Initial One)

— MYSELF
— FACILITY/OTHER _____
Name **Address** **City** **State** **Zip**

_____ _____
Phone **Fax**

— I will pick up copies of my records, please provide my records in_____ Paper Form

— Mail copies of my records to the individual listed above via US mail. Please provide my records in_____ Paper Form

For the purpose of: _____

I authorize release of information covering treatment dates of: _____
The type and amount of information to be disclosed is as follows**: (include dates where appropriate):**

Please **initial appropriate** classification of information when applicable:

___ **Drug & Alcohol Treatment Information and/or records**
___ **Mental Health Information and/or records**
___ **HIV/AIDS Information and/or records**
___ **Genetic Information and/or records**

❒ Entire Medical Record, excluding: _____
❒ History and Physical
❒ Consultations
❒ Discharge Summary
❒ Problem List
❒ Operative Report
❒ Pathology Report
❒ Radiology Reports: *(date)* from_____*(date)* to_____
❒ Laboratory Reports *(date)* from_____*(date)* to_____
❒ Physician Progress Notes
❒ Other, describe: _____

❒ I understand that, under Florida Law, the classification of records checked above relating to treatment rendered to me are privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to persons and agencies other than those designated by me, or my personal representative or otherwise provided in Florida law.

❒ I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Department and/or provide an expiration date to the Health Information Department. **Expiration Date**___/_____/_____

❒ I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and the facilities of Amicus Medical Center will not base my treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524 (with a reasonable charge).

❒ I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Amicus Medical Center.

❒ I understand that Amicus Medical Center will release only the minimum amount of information necessary to fulfill a request.

Unless otherwise revoked, this authorization will expire twelve months from the date of the signature listed below.

Name of Patient/Guardian: _____ Birthdate:___/_____/_____

Signature of Patient: _____ Date:___/_____/_____

Signature of Witness: _____ Date:___/_____/_____

You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

You have the right to receive an accounting of the disclosures of your medical information made by our practice during the last six years (or following April 14, 2003), except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.

You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.

You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact our Privacy Officer at the address and phone number on the back of this brochure.

If you would like further information regarding your rights, or regarding the uses and disclosures of your medical information you may contact our practice administrator at the address and phone number on the back of this brochure.

Revision of Notice of Privacy Practices

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at our office and will make paper copies of the revised Notice of Privacy Practices available upon request.

Dr. Alexandra Silva-Plazas

Pediatrician

Amicus Medical Center

of Pompano Beach

135 S. Pompano Parkway

Pompano Beach, FL 33069

(954) 974-8901

AMICUS OUR PATIENTS... OUR FRIENDS JUST FOR Kids

NOTICE OF PRIVACY PRACTICES

Your privacy is important to us. We know that it is important to you, and we value the confidence that you have in AMICUS MEDICAL CENTERS. We want to ensure that you understand the information we gather about you, how we use it, and the steps we take to safeguard it. In this policy, "we" and "our" refers to AMICUS MEDICAL GROUP. This policy applies to all the services we provide. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your health information. If you cease to be a patient of AMICUS MEDICAL CENTERS information in this policy, as amended occasionally, will continue to apply.

TO OUR PATIENTS

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Our practice is required by law to abide by the terms of this Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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.

Our office is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice, you may call the office and request that a revised copy be sent to you in the mail or by asking for one at the time of your next appointment.

How We May Use and Disclose your Medical Information.

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and in order to support the business activities of the practice, including, but not limited to, use by administrative personnel reviewing the quality of the care you receive, employee review activities, training of medical students, licensing, contacting or arranging for other business activities..

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders

We may contact you to provide appointment reminders.

Treatment Information

We may contact you with information about treatment alternatives or other health-related benefits and services

Disclosure to Department of Health and Human Services

We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Family and Friends

Unless you object, we may disclose your medical information to family members, other relatives or close personal friends when the medical information is directly relevant to that person(s) involvement with your care.

Notification

Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.

Disaster Relief

We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

Health Oversight Activities

We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect

We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Legal Proceedings

We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement

We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

Coroners, Medical Examiners and Funeral Directors

We may disclose your medical information to a coroner, medical examiner or a funeral director.

Organ Donation

If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Research

We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.

Public Safety

We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Worker's Compensation.

We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.

Business Associates

We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

Authorizations

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact our Privacy Officer at the address and phone number on the back of this brochure.

Your Rights Regarding Your Medical Information

You have the following rights with respect to your medical information:

You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.

You have the right to receive communications from us in a confidential manner.

Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records