ADULT AND GERIATRIC CENTER OF SOUTH FLORIDA

PATIENT REGISTRATION FORM

Please be sure to fill out ALL FIELDS

Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Sex: Male _____ Female _____

Social Security #: Date of Birth:

Do you have a Living Will? Yes _____ No _____ (If Yes, please provide office with a copy)

Race: Caucasian _____ African _____ American _____ Asian _____ Hispanic _____ Pacific Islander _____ Other _____

Preferred Language: English _____ Spanish _____ Other _____

Email: _____

Pharmacy Name: _____ Pharmacy#: _____

Pharmacy Address: _____

Primary Physician Name: _____ PCP Phone #:. _____

Employment: Full-Time _____ Part-Time _____ Retired _____ Student _____

Employer name: _____

Employer Address: _____

Emergency contact First Name _____ Last Name _____

Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Relationship: _____

Patient Signature: _____ Date: _____

The above Information is true lo the best of my knowledge. I authorize my Insurance benefits be paid directly to the physician. I understand that i am financially responsible for any balance. I also authorize Adult and Geriatric Center of South Florida, or Insurance company to release any information required to process my calms. If Medicare is my only Insurance carrier, I understand that I am fully responsible for my coinsurance

Adult and Geriatric Center of South Florida

GENERAL CONSENT / PERMISSION FOR TREATMENT

Welcome to Adult and Geriatric Center of South Florida, LLC (hereinafter "Company").
Please read this document carefully. Feel free to ask questions or discuss this consent with your physician before signing.

_____ I, the undersigned, authorize the performance of such appropriately indicated examinations, testing, and other routine diagnostic procedures and treatments as my/the patient's physician consider to be necessary or appropriate for the purpose of diagnosis of my/the patient's condition. I understand that the nature of and the need for each procedure and treatment will be explained to me beforehand, and that I am free to refuse anyone or all procedures or treatments if I so choose.

_____ I consent to the diagnostic testing and/or disposal by Company of any blood, urine or other body fluids, stool specimens or tissues which are obtained in accordance with routine Company practice and governmental regulation. I further consent to the examination, study and retention of such specimens, and the use of the findings for medical purposes.

_____ I consent to the present and future prescription and/or administration of medicines or drugs by Company as may be deemed necessary by my/the patient's physician in the course of my/ the patient's diagnosis and treatment with the understanding that the nature of and the need for such medicines or drugs will be explained to me beforehand, and that I shall always be free to refuse each and all of them if I so choose.

_____ I understand that the explanation which will be given to me of the nature, intended purpose, and the reasonable foreseeable risks, consequences, complications, benefits and alternatives of the examination(s), procedure(s) or treatment(s) which may be performed or used in the course of diagnosis or treating my/the patient's condition will not be exhaustive and that other risks and complications may arise but the likelihood of their occurring is not reasonably foreseeable. I have been advised that if I desire a more detailed explanation prior to my consent such explanation will be given to me.

_____ I acknowledge that I have received no warranties or assurances with respect to any benefits which are hoped to be realized, or consequences which may result, from any of the examination(s), procedure(s) or treatment(s) which may be performed or used. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury and even death.

_____ I further acknowledge, I was not solicited or promised anything in exchange for receiving any service from the medical provider above; no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the service. I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service.

I certify that I have read this document in its entirety and that I fully understand it prior to my signing. I understand that I am to make any inquiries regarding any aspect of my/the patient's diagnosis or treatment which I do not understand. I represent to my/the patient's physician that I am eligible to give this consent.

Signature of Patient_____

Date_____

Signature of Legal Guardian_____

Relationship to Patient_____

Date_____

Phone: 954-799-6900 **Fax: 954-827-3803**

info@adultandgeriatriccenter.com **www.adultandgeriatriccenter.com**

ADULT AND GERIATRIC CENTER OF SOUTH FLORIDA

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 READ 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 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 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 promoted 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 Uses 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 an 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 you may request. If the 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

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us by writing to Adult and Geriatric Center of South Florida, LLC, PO BOX 970659, Coconut Creek FL 33097 or call Adult and Geriatric Center of South Florida, LLC at 954-799-6900. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

I have read, understood and agree with the HIPAA Privacy Notice

Patient Name: _____

Patient Signature: _____

Date: _____

ADULT AND GERIATRIC CENTER OF SOUTH FLORIDA

Mario Galdames, MD
Reinaldo Camargo, MD
Valerie Eyma-Heywood, MD
Dillobar Gelfond, MD
Lenette Blanco, APRN
Elianet Perez, APRN
Yaritza Pita, APRN
Martine Vedrine, APRN

PHONE CONTACT CONSENT AND AUTHORIZATION

I, _____ (Responsible Party Name), with respect to any services provided or that are planned to be provided to myself or, as an authorized legal representative, for the below listed individual, fully consent to and authorize _____ (Provider Full Name) ("Healthcare Provider") or any of its automated systems to contact me via phone (including to my cellular phone by way of phone call or text message) in relation to any services received from Healthcare Provider or any services planned to be received from Healthcare Provider (including any billing items or appointment reminders).

If this Consent and Authorization applies to someone for whom you are a legal representative, please print their name below, if not please indicate so by populating the blank with N/A.

_____
Patient/Guardian Name

_____
Patient/Guardian Signature

_____
Date

ADULT AND GERIATRIC CENTER OF SOUTH FLORIDA

THIRD PARTY CONSENT AGREEMENT FORM

I hereby consent and authorize Adult and Geriatric Center of South Florida and all Providers in the practice for evaluation and treatment related to Primary and Geriatric care. In giving consent, I do not waive my right to a second opinion.

I also give consent for the facility to release demographic and insurance information to Adult and Geriatric Center of South Florida. Furthermore, I give consent for Adult and Geriatric Center of South Florida and all Providers in the practice to bill the resident's insurance for medical care rendered.

I certify that I have read and fully understand the contents of this agreement. I also certify that I have full legal authority to consent to this care.

_____	_____
Signature of Responsible Party	Facility Name/Room No.
_____	_____
Print Name	Print Resident's Name
_____	_____
Date	Primary Insurance ID
_____	_____
Phone # of Responsible Party	Secondary Insurance ID

ADULT AND GERIATRIC CENTER OF SOUTH FLORIDA

OFFICE POLICY

PLEASE READ CAREFULLY AND INITIAL NEXT TO THE LINE AND SIGN ON THE BOTTOM THAT YOU UNDERSTAND AND ACCEPT TO ADHERE TO OUR POLICIES.

_____ Payments, co-payments, and deductible amounts are due at the time of service unless special arrangements have been made. The billing department will gladly file insurance claims on my behalf; however payment cannot be guaranteed. I understand that the billing department will make every effort and several attempts to obtain payments and/or clarify if my insurance company misquoted my benefits, my benefits changed, or any other reason that the insurance company denies my claim. I will be responsible for any unpaid balances not covered by my insurance company. I will also be responsible for a $25 charge for any checks returned for insufficient funds.

_____ I am also acknowledging my understanding that since my appointment time has been set aside exclusively for me, that I am responsible for notifying my practitioner 24 hours in advance to avoid a $25 cancellation fee. I am aware that my insurance company will not pay for missed appointments.

_____ As your primary care office we understand the need for referrals. We also understand how frustrating the referral process can be and will try our best to make it as smooth and easy as possible. In order to speed the process, we ask that you as the patient and the insured member look on your provider list booklet for the specialist in your network you would like to see. Once you have chosen your in-network specialist provide us with name and contact information and we will provide you with the referral. We ask for your help to speed the process.

_____ If you would like to obtain a copy of your medical records there will be a charge of $.25 cents per page. Please allow 3 to 5 business days.

_____ For all FMLA papers, Disability Claim Documents, and any other documents needed to be filled out and signed by the doctors, there will be a $25 fee. Please allow 5 to 7 business day.

I have read, initiated, and understood the above statements to the best of my knowledge.

_____	_____	_____
Signature	Print Name	Date

ADULT AND GERIATRIC CENTER OF SOUTH FLORIDA

FINANCIAL POLICY

Thank you for choosing us as your health care providers. The health care industry is rapidly evolving and with the constant changes in insurance policies and the growing costs of maintaining quality health care services, we have implemented the following financial policy which we ask that you read, accept and acknowledge.

REGARDING INSURANCES:

- We must have a copy of your current insurance card. Therefore it is the responsibility of the patient to make sure you offer your insurance card to the Receptionist for copying if your insurance has changed since your last visit.
- If you have an HMO plan with which we have a contract, a proper referral from your Primary Care Physician is necessary for you to be seen. This referral must contain the diagnosis, number of visits allows, and the expiration date of the referral.
- It is the patient's responsibility to keep track of the number of remaining referrals and expiration date. You may call our office at any time to verify this information prior to your visit. If you are seen without a valid referral, you will be responsible for the bill.
- For HMO patients, if we are seeing you as Primary Care Physicians, it is your responsibility to make sure that your insurance has our Provider listed as your Primary Care Physician and that the visit is covered.
- If you have a co-pay on your card, you will be responsible for the payment of that co-pay on the day of your appointment.
- All co-pays are collected at the Reception Window upon registering.
- If you have a PPO plan with which we have a contract, you will be responsible for the co-pay if listed on your card. If you have not met your deductible, or if you have a co-insurance that remains after the insurance company has paid their portion, you will be responsible for this balance and payment will be expected.
- It is the patients responsibility to make sure we are in network with your insurance.
- For your convenience we are able to schedule 2 tests on the same day of vour visit, However if your insurance requires a co-pay for each test, you are responsible for payment of both the co-pays.
- You will be responsible for payment of services if your insurance has lapsed in coverage, or is not in effect at the time of service.

REGARDING MEDICARE PATIENTS:

- Patients are responsible for meeting their annual deductible each year.
- Once the deductible has been met, patients without secondary insurance will be required to pay their 20% portion at the time of their visit.
- If you have secondary/supplementary insurance it is the responsibility of the patient to provide the Receptionist with a copy of the card.
- We will file with secondary/supplementary carriers. However, in the event that the secondary insurance does not pay, patients will be billed for the balance.

NON PARTICIPATING INSURANCES AND SELF-PAY PATIENTS:

- If you have presented us with a health insurance card with which we do not participate, you will be expected to pay 100% of our billed amount at the time the services are rendered. We do offer discounts to patients who are paying cash.
- Once payment is made by you, the claim will be submitted to your health insurance carrier on your behalf. Any reimbursement due for out of network benefits should be sent directly to you. If your insurance company mails the payment to our office, a refund check will be sent to you in the amount paid by the insurance company.

PARTIAL PAYMENTS/PAYMENT PLANS.

- Partial payments will only be accepted if prior arrangements have been made.
- If you wish to proceed with any necessary testing and would like to set up n payment plan, just ask to st someone in Billing and this will be arranged for you.
- Once a payment plan is arranged payments must be made consistently or the balance will be considered delinquent, and may then be subject to finance charges or eventually turned over to our collection agency regardless of having made any payment arrangements. If there has not been any attempt to make payment your account will be turned over to our collection agency and you will be charged a 22% collection fee.

DELINQUENT ACCOUNTS:

- Delinquent accounts will be subject to monthly billing charges until the account is settled in full.

CANCELLATION POLICY:

- Going forward we require 24 hour notice for all cancelled appointments or your account will be charged $25.00.
- Please be aware that this charge is your responsibility and is not covered by your insurance
- In addition there will be a $25.00 charge for all

no-shows.

DIAGNOSTIC TESTING: (FOR ALL PATIENTS)

Please be aware that following your office visit the doctor may order blood work or other diagnostic testing that may not be deemed "medical necessary" by either Medicare or your insurance carrier. It is possible that your insurance carrier has made its own determination as to what tests they deem to be "medically necessary". Therefore there may be charges not covered by your carrier. In such an event, these charges will become the responsibility of the patient.

MANAGED CARE PLANS: (PATIENTS WITH MANAGED CARE PLANS)

In order for your visit and/or testing to be covered by your insurance, you may be required to provide this office with a valid referral issued by your primary care physician. If the referral we have for you on file has expired, or you do not bring a referral with you as needed, you will have two options, to reschedule your appointment, or pay upfront for all services provided to you today.

INSURANCE AUTHORIZATION AND ASSIGNMENT: (FOR ALL PATIENTS)

I request payment of Medicare and/or participating managed care products be made payable to CCG of South Florida, LLC on my behalf for any services provided to me by this Practice. I authorize the release of any information about me to Medicare and/or other participating managed care products and its agents that may be needed to determine these benefits.

FINANCIAL RESPONSIBILITY FOR PAYMENT

I am aware that due to any of the reasons listed below; it may be possible that my insurance carrier will deny payment for services rendered to me today. In that event, I understand that I will be financially responsible for those charges.

- I do not have my insurance card with me I do not have a valid referral for this visit
- This office does not participate with my insurance carrier
- I do not have health insurance and will pay for my visit today.

Thank you for your understanding of our financing policy. Please let us know if you have any questions or concerns and you will be referred to the appropriate individual. I have read the above Financial Policy and understand and agree with its terms,

_____	_____	_____
Signature	Print Name	Date

ADULT AND GERIATRIC CENTER OF SOUTH FLORIDA

This Office has a policy to keep patient information confidential. You may designate below if you want someone other than yourself to have access to your private health information.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Patient Name: _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Adult and Geriatric Center of South Florida, LLC.

Patient Signature: _____ Date: _____

RELEASE OF INFORMATION TO PERSONS OTHER THAN MYSELF

I allow the people listed below to receive medical information about my condition at any time:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____