

Ideal Family Practice

First Name:		Middle Name:	Last Name:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:		City, State, Zip:		E-mail Address: <i>(Required)</i>
Date of Birth: / /	Soc Sec #:	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed		
Home Phone:		Cell Phone:	Work Phone: (please include ext.)	
What is your <i>preferred</i> method of contact? <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> E-Mail <input type="checkbox"/> Mail				
Employer:	<input type="checkbox"/> Check here if Retired	Occupation:	Referred by or how did you hear about us:	
Emergency Contact:	Contact Phone:	Relationship to Patient: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Parent <input type="checkbox"/> Friend		
Race: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Other Race: <input type="checkbox"/> Unreported/Refused to Report				
Preferred Language:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unreported/Refused to Report		
Pharmacy:	Address:	Telephone #		
Name Financially Responsible Party: First Name: Last Name: MI:		Soc Sec #:	Date of Birth: / /	
Relationship of Financial Party to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____				
Address (if different from Patient):			Phone:	
Employed by:		Occupation:		
Business Address:		Business Phone:		
Insurance Company: Group #		Subscriber/Member #		
Additional Insurance				
<input type="checkbox"/> Check here if No additional Insurance and skip this section		Soc Sec #:	Date of Birth: / /	
Name Financially Responsible Party:		Relationship of Financial Party to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____		
Address: (if different from Patient):			Phone:	
Employed by:		Occupation:		
Business Address:		Business Phone:		
Insurance Company:		Contract #	Group #	Subscriber #
<i>By Initialing You Acknowledge and Agree to the Following Terms:</i>				
<p>_____ (<i>initial</i>) IFP will offer you access to your own personal PATIENT PORTAL where you can obtain your records and contact the office. The portal can be used to message your provider, request appointments or referrals, and to manage your prescriptions. The portal is not for urgent issues, messages sent through the portal will not be checked until the next business day. Please provide your email address for this function: _____ (<i>email</i>)</p> <p>_____ (<i>initial</i>) IFP is open Mon, Tues, Thurs, Fri: 8:00 am to 6:00 pm; wed 8:00 am to 12 noon. Same day appointments and are available with your provider; express care offers walk-in care for minor emergencies*. For emergencies please call 911 or go to the nearest ER. To reach the on-call provider after hours please call: 561-231-5200 and follow prompts. This service is available for urgent matters and is not for routine calls or prescription refills. *Please note hours of operation may change at discretion of IFP.</p>				

Ideal Family Practice

By Initialing You Acknowledge and Agree to the Following Terms:

_____ (initial) In order to keep your records accurate and avoid potentially harmful drug interactions, we may need to verify your medications through an external database or with your pharmacist. This allows IFP providers to know what medications other doctors have prescribed for you.

_____ (initial) I agree to arrive on time to my appointment (we recommend 15 minutes early); IFP requires 24-hour notice if I am unable to keep my appointment I understand that missed appointments with less than 24-hour notice may incur a fee of \$25. Missed appointments for lab may result in cancellation and rescheduling of the corresponding follow-up.

_____ (initial) Labs and diagnostic tests ordered prior to your visit or at your visit may require an additional follow-up appointment with your provider to discuss results. If you are unable to keep your scheduled appointment you will be required to reschedule to discuss your results. HIV testing and other sensitive labs will always require a follow-up with your provider.

_____ (initial) I hereby consent that I will not use any recording device of voice or image on the premise of IFP. This includes but is not limited to cameras, voice recorders, phones and Google glasses.

Advanced Directives:

Advanced Directives: A document called a Living Will advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare.

Do you have a living will? Yes No If yes – please provide a copy to IFP

Do you have a durable power of attorney? Yes No If yes – please provide a copy to IFP

Do you have a legal document designating anyone (other than your family/guardian) to make health decisions for you in the event you are incapacitated and cannot make them for yourself? Yes No

If Yes: Name: _____ Phone: _____ Are they aware of your choice Yes No

Would you like a copy of Advance Directive Information Yes No

Consent for Treatment

General Consent for Treatment: I hereby consent and authorize to the rendering of care and treatment, including but not limited to medical, surgical, diagnostic, administration of anesthesia or other treatments/procedures

(“Treatments”) considered necessary or advisable by employees and authorized agents of Ideal Family Practice (IFP).

Consent for Treatment of a Minor: I, _____ (print name of parent/guardian/authorized party) consent and authorize on behalf of _____ (print name of child/minor) to the rendering of care and treatment, in including but not limited to medical, surgical, diagnostic, administration of anesthesia or other treatments/procedures (Treatments) considered necessary or advisable by employees and authorized Agents of IFP.

General Acknowledgments: I understand that the practice medicine in is not an exact science. I understand the medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results for my examinations or Treatments. I understand and agree that I may be observed and/or receive care from medical, nursing and other health care students in training at IFP. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by IFP.

I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am Directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys’ fees incurred to collect any amount I may owe. I also hereby authorize Ideal Family Practice to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

Right to Refuse Treatments: I understand that I have the right to make informed decisions regarding all care and Treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any Treatments.

Signature of Patient/Responsible Party

Date

Print Name

Relationship to Patient

Ideal Family Practice

Agreement of Financial Responsibility

The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s), coinsurance or deductible(s) which are payable at time of service, and then bill you for any remaining amount determined to be your responsibility by your insurance company. Any balance you owe that remains unpaid 60 days after you were billed will be transferred to a collection agency for recovery.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of coverage and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In- Network rate.

Fee for Service

_____ (*initials*) I agree to pay my account at the time service is rendered or will make financial arrangements satisfactory to IFP for payment. If my account is sent to collections, I agree to pay collection expenses, court fees and reasonable attorney fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefit of any type under any policy of insurance insuring the patient, or any party liable to the patient, is hereby assigned to IFP. If Co-payments and/or deductibles are designated by my insurance company or health plan; I agree to pay them to IFP. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Non-Covered Services:

_____ (*initials*) I understand that IFP contracts with health care plans which specifically state services which are "covered" by the health care plan. Accordingly, the undersigned accepts full financial responsibility for all services, which are determined by the health care service plans not to be covered. I agree to cooperate with IFP to obtain necessary health care service authorizations. I understand that not all services provided are considered medically covered services by my health plan and payment will be due at the time of service.

Credit Card Policies for Co-pays, Deductibles, Co-Insurance, and Other Balances:

_____ (*initials*) I understand I am responsible for payment of services at the time they are rendered and for any unpaid balances in the event of third party or insurance claims. An updated and current insurance and credit card will be requested of me each time at check in. If I have an outstanding balance after the insurance claim has been processed, my credit card will be charged for the outstanding amount. I will receive a confirmation of the charge along with a billing statement explaining the reason for my remaining balance. I understand that this in no way will compromise my ability to dispute a charge or question my insurance company's determination of payment. I understand that failure to pay any outstanding balances may result in additional fees or may be sent to collections.

MEDICARE PATIENTS ONLY:

_____ (*initials*) IFP accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to IFP. If I receive payment, then I am responsible to provide payment and EOB to IFP upon receiving such payment.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient /Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient

Ideal Family Practice
Phone: 561-231-5200, Fax: 561-231-5201
13475 Southern Blvd. Suite 100
Loxahatchee, FL 33470

Authorization to Release Medical Records

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ Date of Birth: _____

Address: _____ Last 4 of SS#: _____

City: _____ State: _____ Zip: _____ Phone: _____

Initial each section below:

_____ 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 request to the Medical Records Department.

_____ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign and the facility of Ideal Family Practice will not base treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect a copy of the information to be disclosed, as provided in 45 CFR 164.524 (with 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 no longer protected by federal confidentiality laws or Ideal.

I Authorize (print name of party releasing the records): _____ to release my health information to Ideal Family Practice for the purpose of my healthcare and treatment.

Information to be Disclosed (please check all that apply):

_____ All Records _____ Imaging _____ Lab _____ EKG _____ Other: _____

Purpose for Disclosure: _____ Continuation of Care _____ Other _____

Unless otherwise revoked, this authorization will expire 36 months from the date of the signature listed below.

Patient/Patient's Representative: _____ Date: _____

The contents of this facsimile belong to Ideal Family Practice and may be privileged, confidential or otherwise protected from disclosure and is intended for the named addressee only. If received by anyone other than the named addressee, please contact the sender at the address above or call 561.231-5200 to notify of error. Under no circumstance should this material be shared, retained or copied by anyone other than the named addressee.

Ideal Family Practice
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM (HIPAA OMNIBUS RULE)

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

Please **print** patient name

Please **sign** your name

Legal Representative if signing for minor/other

Description of Authority

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

Cell Phone Confirmation Home Phone Confirmation Work Phone Confirmation
 Text Message to my Cell Phone Email Confirmation **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

Cell Phone Confirmation Home Phone Confirmation Work Phone Confirmation
 Text Message to my Cell Phone Email Confirmation **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS** or **NEW HEALTH INFO** on behalf of this Healthcare Facility via:

Cell Phone Confirmation Home Phone Confirmation Work Phone Confirmation
 Text Message to my Cell Phone Email Confirmation **Any of the Above**

By signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only: As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:
 It was emergency treatment I could not communicate with the patient The patient refused to sign The patient was unable to sign because
Other (please describe) _____

Signature of Privacy Officer: _____ Date _____

Assignment of Benefits Form

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Ideal Family Practice ("Health Care Provider") and any of its duly authorized agents and employees as and to be the undersigned's tur and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and Ideal Family Practice which checks, drafts or money orders are made payable for services which have been rendered by Ideal Family Practice at the request of or with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment incudes, but is not limited to, all rights to collect benefits directly from my insurance company ("Insurer") for services that I have received and all rights to proceed against my insurance company in any action including legal suit of for any reason by insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the Health Care Provider as my assignee.

The undersigned by these presents does give and grant Ideal Family Practice as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other document.

At any time after Insurer fails to render the applicable payment within thirty (30) days upon receipt of Health Care Provider's medical bills for any date of service, this agreement may be revoked. Health Care Provider's said revocation will be effective on the thirty-first (31st) day after Insurer has received Health Care Provider's medical bill(s) that Insurer has denied, withdrawn, reduced, or failed to pay in accordance with Florida Statute 627.736. Said revocation shall include any and all dates of service subsequent to the thirty-first (31st) day after Insurer has received Health Care Provider's medical bill(s) that Insurer has denied, withdrawn, reduced, or failed to pay in accordance with Florida Statue 627.736.

A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do and cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I hereby authorize my contracted insurance company, previously identified, to pay and to mail directly to Ideal Family Practice the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to Ideal Family Practice any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any services and charges provided by Ideal Family Practice.

Patient's Signature: _____ Patient's Name: _____ Date: _____