



HEALTHCARE ASSOCIATES  
OF PALM BEACH

561- 877-1800 (Phone)  
561- 742-4480 (Dr Rogovin's Fax)  
866-950-0144 (Dr Doctor's Fax)  
7730 W. Boynton Beach Blvd. Suite 3  
Boynton Beach, FL 33437

## PATIENT REGISTRATION FORM

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

ZIP Code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: M or F Marital Status: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Patient place of employment: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Email: \_\_\_\_\_ Pharmacy: \_\_\_\_\_ phone number: \_\_\_\_\_

### **Medical Insurance Information:**

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Social Security #: \_\_\_\_\_

In case of emergency Notify \_\_\_\_\_

Number: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

### **Release**

I grant permission to view my perfection history from other sources.

I consent to report and receive immunization information from the state of Florida.

I consent to have my claims filed to my insurance carrier and I understand that any balance and or copays are my responsibility and are due at the time of the visit.

I am aware that there will be a \$10, \$25 or \$50 charge for ANY forms that our office must fill out or require Dr signature.

I understand that it is **my** responsibility to **notify the office if there is ever any change in my insurance** and or **mailing address and phone number. I am aware I may be billed if insurance is not updated.**



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## GENERAL CONSENT TO TREAT

By signing below, I or my authorized representative authorizes HAPB, physicians or practitioners and staff to conduct any diagnostic exams, tests, and procedures and to provide medication to assess; diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating physician to explain to me the reasons for any diagnostic exam, test, procedure, the available treatment options, and the common risks and anticipated burdens or benefits associated with these options as well as alternative courses of treatment.

---

Patient/Guardian signature

---

Date

## DIAGNOSTIC AND LAB RESULTS

In an effort to make sure that you receive your Lab/Imaging results in a timely manner **we will schedule a follow-up appointment to review your results. If, however, no appointment is made for a follow-up, please call us one week after your labs/diagnostic studies are performed.** We will get back with you as soon as possible. You may also check your Portal.

---

Patient Signature

---

Date



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## REVIEW OF SYSTEMS

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**PLEASE CIRCLE ANY CURRENT ACTIVE PROBLEMS AND GIVE A BRIEF EXPLANATION.**

### CONSTITUTIONAL

Fever  
Chills  
Feeling Poorly (Malaise)  
Loss of Appetite  
Anorexia  
Lethargy  
Unusual Change in Weight

### ENT

Earache  
Facial Pain  
Loss of Hearing  
Nose Bleeds (Epistaxis)  
Vertigo  
Nasal Discharge  
Sore Throat  
Ringing in the Ears (Tinnitus)  
Hoarseness

### EYES

Visual Disturbance  
Eye Pain  
Conjunctival Injection  
Discharge from the Eyes  
Eye Dryness  
Itching of the Eyes

### SKIN

Itching (Pruritus)  
Rash  
Purple/Red Spots (Purpura)  
Change in Skin Color

### CARDIOVASCULAR

Chest Pain  
Palpitations  
Awakening with Difficulty Breathing (PND)  
Leg Pain while Ambulating (Claudication)  
Lightheadedness  
Difficulty Breathing while Laying Down (Orthopnea)

### GASTROINTESTINAL

Abdominal Pain  
Heartburn  
Difficulty Swallowing (Dysphagia)  
Nausea/Vomiting  
Rectal Bleeding  
Change in Bowel Habits

### GENITOURINARY

Change in Urinary Frequency  
Incontinence  
Hesitancy  
Frequent Night Urination (Nocturia)  
Painful Urination (Dysuria)  
Weakness of the Urine Stream  
Blood in Urine

### ENDOCRINE

Excessive Urination (Polyuria)  
Excessive Thirst (Polydipsia)  
Temperature Intolerance  
Excessive Eating (Polyphagia)  
Thyroid Issues

### HEME/LYMPH

Unusual Bleeding  
Easy-Bleeding  
Night Sweats  
Unusual Infection  
Cancer (Type)

### MUSCULOSKELETAL

Joint Pain  
Muscle Aches  
Joint Swelling  
Joint Stiffness

### RESPIRATORY

Cough  
Sputum  
Hemoptysis (cough up blood)  
Shortness of Breath  
Wheezing

### NEUROLOGICAL

Seizure  
Muscle Weakness  
Headaches  
Change in coordination  
Dizziness

### PSYCHIATRIC

Anxiety  
Depression  
Insomnia

Explain any problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## HEALTH HISTORY

Have you ever had or have you now: (please check the right of each item; if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Rheumatic fever			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation treatments			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Serious head injury			
Frequent or severe headache			
Dizziness or fainting spells			
ADD			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted disease			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Smoke 1+ pack cigarettes/week			
Regularly exercise			
Wear seat belt			
Other (specify)			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia			
Inherited blood disorder (Specify)			
Eye trouble besides need glasses			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Broken bone (specify)			
Kidney infection			
Bladder infection			



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## HEALTH HISTORY CONTINUED

### When was your last: Month/Year?

Fasting blood work? \_\_\_\_\_

PSA/ prostate check? \_\_\_\_\_

Stress test? \_\_\_\_\_

Colonoscopy? \_\_\_\_\_

Echocardiogram? \_\_\_\_\_

Bone Density test? \_\_\_\_\_

Mammogram? \_\_\_\_\_

Dilated Eye Exam? \_\_\_\_\_

Pap Smear? \_\_\_\_\_

Dermatology Visit? \_\_\_\_\_

Have you ever been hospitalized overnight? \_\_\_\_ Yes \_\_\_\_ No Which hospital \_\_\_\_\_?

Have you ever had surgery? If so, please list \_\_\_\_\_

Do you regularly visit any doctors beside your primary care physician?

Doctor: \_\_\_\_\_

Specialty: \_\_\_\_\_

Doctor: \_\_\_\_\_

Specialty: \_\_\_\_\_

Doctor: \_\_\_\_\_

Specialty: \_\_\_\_\_

Doctor: \_\_\_\_\_

Specialty: \_\_\_\_\_

Do you exercise? \_\_\_\_ Yes \_\_\_\_ No

Do you wear sunscreen? \_\_\_\_ Yes \_\_\_\_ No

Do you wear a seat belt? \_\_\_\_ Yes \_\_\_\_ No

### Females:

Have you ever been pregnant? NO \_\_\_\_ YES \_\_\_\_

How many times? \_\_\_\_\_

How many children have you given birth to? \_\_\_\_\_





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## SOCIAL HISTORY

Do you smoke?      Yes                  No                  I quit  
   \_\_\_\_\_                  \_\_\_\_\_                  \_\_\_\_\_

How many cigarettes a day do you or did you smoke? \_\_\_\_\_

Are you interested in quitting?    Yes    No

How many alcoholic beverages do you drink?

Per Day \_\_\_\_\_ Per Week \_\_\_\_\_ Per Month \_\_\_\_\_ I don't drink \_\_\_\_\_

Any recreational drug use now or in the past? \_\_\_\_\_

Are you?      Single                  Married                  Widowed                  Divorced                  Domestic partnership  
   \_\_\_\_\_                  \_\_\_\_\_                  \_\_\_\_\_                  \_\_\_\_\_                  \_\_\_\_\_

Have you ever had a sexually transmitted disease?      \_\_\_\_\_ Yes      \_\_\_\_\_ No

## FAMILY HISTORY

**MOTHER:** ALIVE \_\_\_\_\_ AGE \_\_\_\_\_ PRESENT ILLNESSES? \_\_\_\_\_

DECEASED? \_\_\_\_\_ if so age \_\_\_\_\_ CAUSE OF DEATH \_\_\_\_\_

**FATHER:** ALIVE: \_\_\_\_\_ AGE: \_\_\_\_\_ PRESENT ILLNESSES? \_\_\_\_\_

DECEASED? \_\_\_\_\_ AGE: \_\_\_\_\_ CAUSE OF DEATH? \_\_\_\_\_

**SIBLING:** ALIVE \_\_\_\_\_ AGE: \_\_\_\_\_ PRESENT ILLNESS? \_\_\_\_\_

DECEASED? \_\_\_\_\_ AGE: \_\_\_\_\_ CAUSE OF DEATH? \_\_\_\_\_

**SIBLING:** ALIVE: \_\_\_\_\_ AGE: \_\_\_\_\_ PRESENT ILLNESS? \_\_\_\_\_

DECEASED? \_\_\_\_\_ AGE: \_\_\_\_\_ CAUSE OF DEATH? \_\_\_\_\_



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## COMMUNICATION PREFERENCES

I agree that **HAPB** may communicate with me in writing to any address I have provided, may communicate with me orally or by text message to any telephone number I have provided and may communicate with me electronically to any email address I have provided. My preferred method of communication is (check one):

- Cellular phone  
 Home phone  
 Work phone

Medical Information and test results may be left in my answering machine/voice mail  
(Check one):  Yes  No

Medical Information and test results may be sent to me via text message to my cellular phone  
(Check one):  Yes  No

\*You may also access your health information via your personal Portal \* set up via your email address.

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I agree to allow **HAPB** to contact the following family or friends as necessary to provide appointment reminders, to obtain payment and to receive information of my location and general condition. I understand that **HAPB** may contact these identified: individual is for these purposes unless I later instruct HAPB otherwise (check one):

Yes  No

If yes please provide the following – Name, Address, Phone number, Relationship

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**I HAVE READ, UNDERSTOOD AND FULLY AGREE TO each of the above statement and sign below as my free and voluntary act.**

Patient or Authorized Person Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_





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## **CONTROLLED SUBSTANCE PATIENT AGREEMENT FORM**

**Patient Name:** \_\_\_\_\_

I understand that prescription/controlled substances, now or in future, may cause addiction and is only one part of the treatment plan for my medical conditions.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

**I agree to the following:**

- **I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.**
- **Medication will not be called into pharmacy. It is my responsibility to keep track of my medication schedule.**
- **I will not increase my medicine until I speak with my doctor or nurse.**
- **My medicine may NOT be replaced if it is lost, stolen, or used up sooner than prescribed.**
- **Lost or stolen medication will NOT be refilled under any circumstance. It is my responsibility to protect and secure my medications. This includes keeping the medication out of reach of children.**
- **My doctor may request specialist evaluation of my treatment and I agree to keep appointments.**
- **I agree to give a blood or urine sample, if asked, to test for drug use.**
- **I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.**

- **The name of my pharmacy is:** # \_\_\_\_\_

### Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

### Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my doctor and I understand the above rules.

### Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working. I agree to provide primary care for you even if you are no longer getting controlled medicines from me.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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## **GENERAL CONSENT & ACKNOWLEDGEMENT FORM**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### **Consent for Treatment**

I consent to evaluation and treatment of the condition for which I, or my child or dependent, have come to ***Healthcare Associates of Palm Beach (HAPB)*** and authorize the physicians and other health care providers affiliated with HAPB to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by HAPB. I authorize HAPB to examine, use store and dispose of all tissue, fluids, or specimens removed from my body. I acknowledge and agree this consent will be applicable to all visits or episodes of evaluation and treatment at HAPB.

### **Responsibility for payment / Assignment of Benefits / Contact In consideration of the treatment provided at HAPB to me or my child or dependent,**

I agree to pay HAPB for such treatment. If private health insurance, Medicare, other governmental or other insurance programs cover the treatment, authorize HAPB to bill any such insurer for all charges incurred, in connection with the diagnosis, care, and treatment. My Insurance coverage may pay some amount of the bill, any balance will remain my personal responsibility, such as my deductible, co-payment, co-Insurance or charges not covered by my health insurance, Medicare, or any other programs for which I am eligible. I understand that certain payments may be required at the time of, or In advance of, service being charged. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them. I understand and acknowledge that:

- If I elect to pay for medical treatment in cash (self pay), payment is due in full before services are provided, I can request that my health Insurance, in any form, not be billed for that service or be notified that the service was provided.
- I am responsible for notification to my Insurance company to obtain authorization before service is rendered, and if I do not pre-certify for such services, my benefits may be reduced or lost, but I will still be responsible for paying HAPB for the services. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage.
- If I do not consent, or later revoke my consent, to the release of my information to any insurer that I have identified. I will be responsible to pay all list charges for the treatment and services received.



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I hereby assign to **HAPB** and the professionals involved in my care, all my rights and claims for reimbursement under any private health Insurance policy, Medicare, or any other programs that I identify for which benefits may be available to pay for the services provided to me, and authorize payment for such services to be made directly to **HAPB**.

I further agree to pay all cost of collections, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of emotion under the Constitution and the laws of the **State of Florida**.

I agree that in order for **HAPB** to service my account or to collect any amounts I may owe, **HAPB** or a vendor acting on its behalf, may contact me by telephone at any telephone number associated with my account, including cellular telephone numbers, which could result in charges to me.

I agree that **HAPB** or a vendor acting on its behalf may also contact me by sending text messages or e-mails, using any e-mail address I have provided. I acknowledge and agree that methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Further information concerning **HAPB** financial practices and expectations can be found in the Patient Billing Notice, which has been offered to me.

Patient Rights and Responsibilities: I understand that I have the right, and the responsibility, to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and presenting complaint, to **Healthcare Associates of Palm Beach**

General Conscript & Acknowledgement Form agree upon a treatment plan and follow that plan. I understand that my health care providers will treat me with respect, and I agree to do the same for them. Use and Disclosure of Health Information I understand that **HAPB** will use and disclose my health information for the purpose of treatment, payment, and healthcare operations. As permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me.

I understand and acknowledge that **HAPB** may record medical and other information related to my treatment in paper, electronic, photographic, video and other formats and that such information will be used in the course of my treatment, for payment purposes and to support healthcare operations. I give **HAPB**, its employees and agents consent to exchange information with other health care professionals and providers (for example physicians, consultants, hospitals, nursing home, home health agencies, and pharmacies) about my prior and current health conditions to facilitate treatment, or to facilitate discharge planning.

As applicable I specifically consent to the release by **HAPB** of any, and all information, test results and records regarding my treatment for drug or substance abuse, alcoholism, mental health, HIV or AIDS to:

- 1) My treating physicians and independent professionals and other health care professionals and providers, and,
- 2) Any private health insurance plan, Medicare, other governmental insurance programs or other third-party payer that I identify to obtain payment for the treatment and services provided to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## **HIPPA PATIENT PRIVACY NOTICE ACKNOWLEDGMENT**

I acknowledge receipt of:

- HIPPA "PRIVACY NOTICE"

**While completing my registration process I hereby acknowledge:**

I have read the information contained and I can ask my healthcare staff if I need assistance in understanding my rights, or if I would like them to be explain these materials to me in more detail.

**I understand the following:**

- 1) That these materials are to inform me of my privacy rights as a patient
- 2) I have been given states that my personal "protected health information" (PHI) will be used and disclosed by my doctor or and his staff in the routine activities of treatment, payment and healthcare operations.
- 3) Before any other use or disclosure of my personal, protected health information is made. I will be asked for my written authorization.

**I understand that I have the following rights:**

- To CONFIDENTIAL COMMUNICATIONS
- To REQUEST RESTRICTIONS on Uses and Disclosures of my PHI.
- To REQUEST ACCESS to my personal protected health information
- To REQUEST AMENDMENTS to my personal protected health information
- To have an ACCOUNTING of any DISCLOSURES for purposes other than of treatment, payment and healthcare operations

I hereby authorize the following person(s) access to my health records:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ SELF or OTHER: \_\_\_\_\_

**THIS ACKNOWLEDGMENT EXPRIES SEVEN YEARS FROM THE DATE OF THE SIGNATURE ABOVE**



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**AUTHORIZATION FOR RELEASE OF MEDICAL RECORD**

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**CITY/STATE/ZIP** \_\_\_\_\_

The information you may release subject to this signed release form is as follows:

- 2 year from the last date seen
- History and Physical, Progress Notes
- Care Plan, Lab Records, Radiology Reports
- Pathology Records, Treatment Records, Medication Records
- Other Records (Please Specify): \_\_\_\_\_

**Requesting from , Physician Name:** \_\_\_\_\_

**Address**

**PHONE:**

Release my protected health information to the following physician person facility or entity and/or those directly associating in my medical care to:

**HEALTHCARE ASSOCIATES OF PALM BEACH**  
**Mark Rogovin, DO | Trudell Doctor, MD**  
**7730 Boynton Beach Blvd Suite 3**  
**Boynton Beach, FL 33437**  
**Dr Rogovin's Fax: 561-742-4480**  
**Dr Doctor's Fax: 866-950-0144**

- Change of Insurance or Physicians.
- Continuation of Care
- Referral
- Other: \_\_\_\_\_

I understand that I must be provided with a sign copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how withdraw my authorization by contacting the office above. I understand that HAPB will not be able to release my records to someone without a signed consent. By signing this form, I do expressly and voluntarily consent to the disclosure of the information checked above. I understand that if the persons listed above are not mandated by the federal privacy standards the health information disclosed because of this authorization may be redisclosed without by obtaining my authorization. I understand that there may be a fee for copying of medical records.

Patient/Representative Signature \_\_\_\_\_

Date: \_\_\_\_\_

**CONSENT FOR MY HEALTHCARE PROVIDER TO VIEW MY HEALTH INFORMATION IN THE CARE QUALITY & COMMONWELL HEALTH INFORMATION EXCHANGE**



Healthcare Provider(s): Healthcare Associates of Palm Beach, LLC. This consent form allows you to permit the above-named healthcare provider(s) ("Provider") to view and access your health information through a computerized system called a Health Information Exchange (HIE).

The HIE's collect health information from the places where you receive medical treatment and makes it available electronically to the Provider listed above. Your health information in the HIE's is used by the Provider for your medical treatment and to coordinate your medical care with other healthcare providers.

If you give your consent, the Provider will be able to view all of your health information in the HIE's for this episode of care.

You can give Consent or deny Consent. Your Provider cannot tell you that you must give Consent in order to receive medical treatment. You may stop the Provider from viewing your health information through the HIE's at any time.

Please read the information on page 2 before making your decision.

**Your Consent choices (initial only one):**

\_\_\_\_\_ I GIVE CONSENT for Healthcare Associates of Palm Beach, LLC to access ALL of my health information through the Health Information Exchanges listed on page 3 for the purpose of providing me with health care services, including emergency care.

\_\_\_\_\_ I DENY CONSENT for the Provider named above to access my health information through the Health Information Exchanges listed on page 3 for any purpose, even in a medical emergency, unless the law specifically permits it without my consent.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

The patient is an unemancipated minor or is unable to complete this Consent form due to a medical emergency, unconsciousness, incompetency, etc.; therefore, the above consent decision was made on behalf of the patient by:

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Relationship to Patient

**PLEASE READ these details about the Camden HIE and your consent:**

**1. How your health information will be used:** Your health information will be used by your Provider to:

- Provide you with medical treatment and related services
- Coordinate your medical care with other healthcare providers
- Improve the quality of medical care you receive

2.  
**3. What types of information about you are included:** Your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications you have taken. This includes information created before and after the date of this Consent Form. Sensitive health conditions may also be included, such as:

- Alcohol or drug use problems
- Birth control, abortion, family planning
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

3. **Where health information about you comes from:** Health information about you comes from places that have provided you with medical care. These include: hospitals, physicians, pharmacies, laboratories, the Medicaid program, nursing care services, emergency medical services, and other health organizations that provide information to the HIE's.

4. **Who may access information about you, if you give Consent:** Only authorized people that work for the Provider may access information about you through the HIE's. These include, but are not limited to:

- Doctors and other medical and non-medical staff directly involved in your medical care
- Doctors and other medical and non-medical staff on call or covering for your doctor and directly involved in your medical care

5. **Penalties for improper use or access of your health information:** There are penalties for wrongful access to or use of your health information through the HIE's. If at any time you suspect that someone who should not have seen or gotten access to your health information has done so, contact the Provider listed on this form (561-877-1800) immediately.

6. **Re-disclosure of information:** Health information about you may be re-disclosed by the Provider to others only to the extent permitted by state and federal laws and regulations. The healthcare providers who access this information through the HIE's must comply with these regulations.

7. **Effective period:** This Consent Form will remain in effect until you notify our office to discontinue your enrollment in the HIE's.

8. **Withdrawing your consent:** You may withdraw your consent at any time by signing a new Consent Form. Providers that have accessed your health information through these HIE's while your consent was in effect may copy or include your health information in their own medical records. If you decide to withdraw your consent, those providers are not required to return or remove your health information from their records.

9. **Copy of Consent Form:** You are entitled to get a copy of this Consent Form after you sign it.

**Healthcare Associates of Palm Beach, LLC is currently a member of the following Health Information Exchanges:**

- ✓ Care quality
- ✓ Commonwell

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# Healthcare Associates of Palm Beach, LLC

## Patient Financial Responsibility Form

Thank you for choosing Healthcare Associates of Palm Beach as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for His/Her treatment and care. We are pleased to assist you by submitting visit billing to Our contracted insurers. However, **the patient is required to provide us with the current and updated insurance information**, and **will be** responsible for any charges incurred if the information provided is not correct or updated at time of visit. Patients are responsible for copays, coinsurance, deductibles, and other procedures or treatments not covered by their insurance plan. These charges may include (but are not limited to): Charge for returned checks, Charge for missed appointments without 12 hours advance notice, Charge for extensive phone consultations, procedures/diagnosis not covered by your insurance plan. Charges for the copying and distribution of patient medical records per **Florida Statutes 395.3025**. Charges for forms completion, Any costs associated with collection of patient balances.

For your convenience, we accept cash, check, and most major credit cards at our office.

By my signature below, I hereby authorize assignment of financial benefits directly to Healthcare Associates of Palm Beach, LLC for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

By my signature below, I authorize Healthcare Associates of Palm Beach, LLC to communicate by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form.

\_\_\_\_\_ **Signature of Patient or Guardian Waiver of**

**Patient Authorizations** **DATE:** \_\_\_\_\_

**I do not wish** to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and I will submit claims to insurance at my discretion

**Patient signature:** \_\_\_\_\_

**Signature of Patient or Guardian Date** \_\_\_\_\_.