



PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Gender: M or F Date of Birth: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Place of Employment: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Email Address: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____ Relation to Patient: _____

MEDICAL INSURANCE INFORMATION:

Primary Insurance Name: _____ Member #: _____

Secondary Insurance Name: _____ Member #: _____

Social Security Number (last 4 digits only): _____

RELEASE:

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

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

I consent to have my claims filed with my insurance carriers, and I understand that any balance and/or copays are my responsibility and are due AT THE TIME OF VISIT.

I am aware that there will be a \$25 charge for any no-show/missed appointment without prior notice.

I understand that it is my responsibility to notify the office of any changes to my insurance coverage, mailing address, or phone number.

PATIENT INITIALS: _____ DATE: _____



GENERAL CONSENT TO TREAT:

By signing below, my authorized representative or I authorize Healthcare Associates of Palm Beach (HAPB), physicians, practitioners, and staff to conduct any diagnostic exams, tests, 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 or PA to explain to me the reasons for any diagnostic exam, test, or procedure; available treatment options; the common risks and anticipated burdens or benefits associated with these options, and alternative courses of treatment.

Patient / Guardian Signature

Date



REVIEW OF SYSTEMS:

Name: _____ Date of Birth: _____ Date: _____

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

GASTROINTESTINAL:

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

RESPIRATORY:

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

ENT:

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

GENITOURINARY:

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

NEUROLOGICAL:

Seizure
Muscle Weakness
Headaches
Change in Coordination
Dizziness

EYES:

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

ENDOCRINE:

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

PSYCHIATRIC:

Anxiety
Depression
Insomnia

SKIN:

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

HEME/LYMPH:

Unusual Bleeding
Easy Bleeding
Night Sweats
Unusual Infection
Cancer (list type below)

MUSCULOSKELETAL:

Joint Pain
Muscle Aches
Joint Swelling
Joint Stiffness

CARDIOVASCULAR:

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

Explain any problems: _____

HEALTH HISTORY

When was your last (give approximate date or N/A if it does not apply to you):

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

If you answered yes, what for? _____

Have you ever had surgery? If so, please list: _____

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

Doctor: _____ Specialty: _____

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? ____ Yes ____ No

How many times? _____ How many children have you given birth to? _____



HEALTHCARE ASSOCIATES
OF PALM BEACH

FAMILY HISTORY

MOTHER:

Alive: _____ Age: _____

Deceased? _____ If so, what age? _____ Cause of death? _____

FATHER:

Alive: _____ Age: _____

Deceased? _____ If so, what age? _____ Cause of death? _____

SIBLING:

Alive: _____ Age: _____

Deceased? _____ If so, what age? _____ Cause of death? _____

SIBLING:

Alive: _____ Age: _____

Deceased? _____ If so, what age? _____ Cause of death? _____

SIBLING:

Alive: _____ Age: _____

Deceased? _____ If so, what age? _____ Cause of death? _____



SOCIAL HISTORY

Do you smoke? _____ Yes _____ No

If yes, how many packs per day do you smoke? _____ How many years have you smoked? _____

If you quit smoking, how long ago? _____

If still smoking, are you interested in quitting? _____ Yes _____ No

How many alcoholic beverages do you drink?

_____ Per day _____ Per week _____ Per month _____ I do not drink

Do you, or have you used recreational drugs? _____ Yes _____ No

If yes, what? _____ When did you last use drugs? _____

Marital Status:

_____ Single _____ Married _____ Widowed _____ Divorced _____ Domestic Partnership

Have you ever had a sexually transmitted disease? _____ Yes _____ No

7730 W. Boynton Beach Blvd., Ste. 3, Boynton Beach, FL 33437

Phone: 561-877-1800 / Fax: 561-742-4480

hapbgroup.com



NOTICE OF PRIVACY PRACTICES

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), along with a brief overview of our Notice of Privacy. Our practice does comply with HIPAA regulations.

What is HIPAA, and how does the Privacy Rule affect you? The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave the federal government the authority to mandate how healthcare plans, providers, and clearinghouses store and transmit a patient's personal health information. The Privacy Rule was created to protect your rights as a patient of our practice, and we are required by law to comply with the regulation. Under the Privacy Rule, you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed, and allowed to act if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information? Any health information you provide to our practice, including your mailing address. Information that is created and retained by our practice or received from another healthcare provider that relates to your treatment, healthcare operations, payment, and /or that identifies you as an individual.

What is the Notice of Privacy Practice? Our official Notice of Privacy Practice is posted in our reception area and on our website, and it informs our patients about their rights regarding the protection of their Individually Identifiable Health Information and our obligations concerning the use and disclosure of such information. This notice applies to all records created, obtained, or retained by our practice. We may update our Notice of Privacy Practices at any time. The following categories describe the circumstances in which we may use and disclose your Individually Identifiable Health Information:

Treatment
Appointment Reminders
Health Care Operations
Health Care Operations

Treatment Options
Payment
Health-related benefits and services
Release of information to family/friends



The following categories describe unique situations in which we may disclose your individually Identifiable Health Information:

Public Health Risks, Health Oversight Committees, Lawsuits and Similar Activities, Deceased Patients' Organ and Tissue Donation, Serious Threats to Health or Safety, Military National Security, Inmates Worker's Compensation, Law Enforcement, Research

What are your rights concerning your Individually Identifiable Health Information?

You have rights regarding the Individually Identifiable Health Information that we maintain about you. The policies and procedures for the following circumstances are listed in our Notice of Privacy Practices:

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a paper copy of this notice
7. Right to file a complaint
8. Right to provide an authorization for other uses & disclosures

I have read the short notice on the previous page from HAPB Group and have been informed of how to obtain more information regarding the practice's Notice of Privacy.

Signature

Date

Print Name

Date



HIPAA PATIENT PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have read the notice of HEALTH CARE ASSOCIATES OF PALM BEACH'S Notice of Privacy Practices and HIPAA regulations on the previous page.

While completing my registration process, I hereby acknowledge:

I have read the information contained herein, and I can ask my healthcare staff for assistance in understanding my rights or to have these materials explained to me in more detail.

I understand the following:

- 1) These materials are to inform me of my privacy rights as a patient.
- 2) I understand that my personal "protected health information" (PHI) will be used and disclosed by my doctor 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 treatment, payment, and healthcare operations

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PATIENT SIGNATURE: _____ DATE: _____

PATIENT NAME (PRINT): _____ DATE: _____

RELATIONSHIP: _____ SELF OR OTHER: _____



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT /REPRESENTATIVE SIGNATURE: _____ DATE: _____

ADDRESS: _____

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

- 2 years 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) _____

RELEASE FROM:

PHYSICIAN NAME: _____

ADDRESS: _____

PHONE NUMBER/FAX NUMBER: _____

Please release my protected health information to the following physician:

**HEALTHCARE ASSOCIATES OF PALM BEACH, LLC
Mark Rogovin, D.O., F.A.A.F.P.
7730 W. Boynton Beach Blvd., Ste. 3 Boynton Beach, FL 33437
561-877-1800 Phone / 561-742-4480 Fax**

- Change of Insurance or Physicians
- Continuation of Care
- Referral
- Other

I understand that I must be provided with a signed copy of this authorization. I understand that written notification is necessary to cancel this authorization, and I may obtain information on how to withdraw it 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 federal privacy standards, the health information disclosed under this authorization may be redisclosed without my authorization. I understand that there may be a fee for copying of medical records.

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Phone: 561-877-1800 / Fax: 561-742-4480
hapbgroup.com**



PATIENT FINANCIAL RESPONSIBILITY

ASSIGNMENT OF BENEFITS:

I assign all insurance and Medicare benefits directly to Healthcare Associates of Palm Beach, LLC for services provided, and authorize the release of information needed to process claims.

COLLECTIONS AND COMMUNICATION:

If my account defaults and goes to collections, I agree to pay reasonable collection costs and any applicable interest. I agree that Healthcare Associates of Palm Beach may contact me by phone, text, or email using the information I provided.

SELF-PAY OPTION:

If I choose to "Self-pay" for services, I agree to pay in full prior to services being provided. I will remind the staff upon check-in for laboratory services that I will be billed as an uninsured patient to ensure that the correct lab company is used. The fees for self-pay patients are as follows:

- New Patient Visit - \$175
- Annual Well Visit - \$125
- Follow-up / Sick Visit - \$90
- Telehealth Visit - \$50
- Preoperative Visit - \$175 if non-cosmetic / \$275 if clearance is for a cosmetic procedure

**** NOTE**** - Our office uses Quest Diagnostics for all uninsured patients. You will receive a separate bill from Quest Diagnostics for lab services, billed at discounted, uninsured-patient pricing.

FINANCIAL AGREEMENT:

I agree to pay Healthcare Associates of Palm Beach for all services provided. If I have insurance, I authorize the office to bill my insurer and receive payment directly. I understand that I am responsible for any remaining balance, including deductibles, copays, coinsurance, or uncovered services. I understand that certain payments may be required at the time of or in advance of the services being charged for. I understand that I will be billed for any charges not paid by my insurance company. During my annual exam, if my provider identifies any risk factors or decides to treat a specific condition documented in my records, the related services may be billed in addition to my annual preventive care visit. This additional charge will be billed to my insurance company with my annual preventive visit. If my insurance company denies payment, then the balance may become my financial responsibility.

PATIENT /REPRESENTATIVE SIGNATURE: _____ **DATE:** _____