American Medical Group

DATE: _____

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

HOME ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ /_____ /_____ GENDER: _____ PHONE: _____

SSN: _____ - _____ - _____ MARITAL STATUS: _____

RACE: _____ HEIGHT: _____ WEIGHT: _____

EMAIL: _____

PRIMARY PHYSICIAN NAME: _____

REFERRING PHYSICIAN NAME: _____

REASON FOR TODAY'S VISIT: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ PHONE NUMBER: _____

RELATIONSHIP: _____

MAY WE SPEAK WITH/LEAVE A MESSAGE WITH ANOTHER PERSON REGARDING ANY APPOINTMENTS, MEDICATIONS, OR ISSUES? YES [ ] NO [ ]

IF YES, WHOM: _____ RELATIONSHIP: _____

**To add additional names, please see page 5 **

HEALTH INSURANCE COVERAGE

1) PRIMARY INSURANCE: _____

POLICY NUMBER: _____ PHONE NUMBER: _____

NAME OF POLICYHOLDER: _____ SPONSOR DOB: _____ /_____ /_____

2) SECONDARY INSURANCE: _____

POLICY NUMBER: _____ PHONE NUMBER: _____

NAME OF POLICYHOLDER: _____ SPONSOR DOB: _____ /_____ /_____

****PLEASE PROVIDE YOUR CARDS SO WE MAY SCAN THEM INTO OUR SYSTEM****

PATIENT NAME: _____ DATE: _____

BY **INITIALING AND SIGNING BELOW**, I AGREE TO ALL OF THE FOLLOWING:

AUTHORIZATION TO PAY PHYSICIAN, PATIENT FINANCIAL RESPONSIBILITY, ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA), AND MEDICAL RECORD REQUEST.

EMERALD COAST INFECTIOUS DISEASES DBA AMERICAN MEDICAL GROUP AND BAY FOOT & ANKLE CENTER

_____ **AUTHORIZATION TO PAY**: I AUTHORIZE PAYMENT OF BENEFITS TO EMERALD COAST INFECTIOUS DISEASES, AT AMERICAN MEDICAL GROUP FOR MEDICAL SERVICES RENDERED.

_____ **FINANCIAL RESPONSIBILITY**: I UNDERSTAND AND AGREE, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL OF THE INFORMATION ON THE BACK AND THE ATTACHMENTS AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ **HIPAA NOTICE**: I ACKNOWLEDGE THAT I HAVE READ A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES. I MAY REQUEST A COPY OF THIS NOTICE FOR MY RECORDS.

_____ **MEDICAL RECORDS REQUEST**: I ACKNOWLEDGE THAT I HAVE READ A COPY OF THIS OFFICE'S MEDICAL RECORDS REQUEST POLICY AND FLORIDA LAW COPY CHARGES. I MAY REQUEST A COPY OF THIS NOTICE FOR MY RECORDS.

_____ **WORKER'S COMPENSATION**: FOR THOSE THAT APPLY, I ACKNOWLEDGE THAT MY COMPANY MUST HAVE PROVIDED AUTHORIZATION TO EVALUATE AND TREAT PRIOR TO MY RECEIVING ANY SERVICES. IF THIS WAS NOT DONE, I WILL BE FINANCIALLY RESPONSIBLE FOR ALL SERVICES.

_____ _____

PATIENT SIGNATURE (PARENT IF MINOR) DATE

Financial arrangements to American Medical Group, hereinafter, ECID/AMG

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Mastercard, or Visa. We will be happy to help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a completed insurance form on each visit. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of the usual, customary, and reasonable allowances defined by most companies.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical providers, our relationship is with you, not your insurance company. While filing of medical claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Your co-payment responsibility

Can the doctor waive the co-payment? **NO!** It is against Florida Law. The routine waiver of patient balances, co-payments, and deductibles appears to violate a number of federal and state laws. *In Re: Petition for Declaratory Statement of Alan Altman, M.D.*, July 25, 1989, the Florida Board of Medicine stated that a medical doctor who waives copayments or forgives fees as a marketing technique to attract patients violates 3 Florida Statutes. First, the Board of Medicine held that where a physician performs as a service and submits a claim to the patient's insurance company for his "usual" or "customary" fee but forgives or waives the amount to be contributed by the patients as a copay for the service violates Section 458.331(1)(h), *Florida Statutes*, which prohibits a physician from filing a false report if the physician knows at the time that he renders billing that he does not intend to collect the full stated fee and if the practice of waiver or forgiveness of copayment is routinely or customarily done. Secondly, the routine waiver of a copayment constitutes a rebate to induce patronage of a patient in violation of Section 458.331. Finally, the routine wavier of a copayment as a marketing technique to attract patients constitutes the employment of a trick or scheme in the practice of medicine in violation of Section 458.331(1)(k), *Florida Statutes*.

Policy for unpaid patient accounts

According to Florida law, American Medical Group can refuse to see an established patient until the patient pays his/her account balance. If the patient has an outstanding bill left unpaid after 3 months, with an account balance exceeding $500, American Medical Group can refuse to see an established patient until the patient meets their financial obligation. To reinstate as a patient of American Medical Group, the patient will have to pay for all services in advance. If the patient falls into arrears again, the patient will be dropped from the practice, American Medical Group will promise to see the patient for the next 30 days, on a cash basis, until the patient can find another physician or arrange a payment in full.

Medical records request/copies for medical records

Rule 64B8-10.003, Florida Administrative Code permits physicians to charge the requesting party for furnishing copies of medical records. The law states $1 per page for the first 25 pages of written material, 25 cents for each additional page, and the actual cost of reproducing non-written records, such as x-rays. The physician has 30 days to furnish the copies upon signing of the *Release of Medical Records*. However, if the records are those for a worker's compensation case, a physician may only charge up to 50 cents per page for the records and the direct cost for x-rays, microfilm, or other non-paper records. Rule 38F-7.601, Florida Administrative Code.

American Medical Group

MEDICATION AND ALLERGIES

PATIENT NAME: _____

DATE OF BIRTH: _____ /_____ /_____ PHARMACY: _____

LIST ALL ALLERGIES AND REACTIONS (IF NONE, WRITE NONE):

Allergy:	Reaction & date of occurrence:

LIST ALL MEDICATIONS, FREQUENCY, AND PHYSICIAN WHO PRESCRIBED THE MEDICATION (IF NONE, WRITE NONE) – IF YOU DO NOT KNOW YOUR LIST OR DID NOT BRING ONE, PLEASE STATE AS SUCH: _____

Medication Name and Dosage:	Frequency:	Prescriber:	Date Prescribed:

American Medical Group

MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: ____ /____ /_____

Complete all the fields as best as you can. This completed form helps provide the doctor with the most complete picture of your medical history.

Condition:	**Yes / No**
Alzheimer's Disease	
Allergic Rhinitis (Hay Fever)	
Anemia	
Arthritis	
Asthma	
Birth Defects	
Bleeding Problem	
Cancer, if yes, type & location _____	
Depression	
Diabetes Type 1, how controlled _____	
Diabetes Type 2, how controlled _____	
Heart Disease	
High Cholesterol	
High Blood Pressure	
Kidney Diseases	
Rheumatoid Arthritis	
Thyroid Disorders	
Tuberculosis	
Ulcer, if yes, location _____	
Other: _____	

SMOKING STATUS: [ ] Former [ ] Never [ ] Current smoker/ Packs per day _____

ALCOHOL USE: [ ] YES [ ] NO Drinks per day/week:_____

PREGNANT [ ] YES [ ] NO IF SO, HOW MANY WEEKS? _____ BREASTFEEDING [ ] YES [ ] NO

List any major diseases, surgeries, conditions, or illnesses not covered above:

_____

_____

List any hospitalizations:

Hospital: _____ Date: _____

Reason: _____

_____

American Medical Group

CONSENT TO DISCLOSE MEDICAL INFORMATION

Date: _____

[ ] I, _____, give consent to American Medical Group, P.A. (AMG) physicians and/or staff to disclose my protected health information with the following individuals:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

OR

[ ] I request that all of my protected health information be disclosed only to "me" and no one else other than my other healthcare providers.

May we leave a message on your answering machine about your medical care?
[ ] YES [ ] NO

I understand that by sharing this information, American Medical Group is not violating HIPAA (Health Information Portability and Privacy Act). I may revoke this at any time, in writing and presenting said letter to the office.

_____	_____
Patient Signature	Date