CARINE FAMILY MEDICINE

1811 SHORE DRIVE SOUTH - SOUTH PASADENA - FLORIDA - 33707 - PHONE 727.391.4100 - FAX 727.398.2067

REGISTRATION

(PLEAST PRINT)

PATIENT INFORMATION

LAST:_____ FIRST:_____ Ml:_____ DATE OF BIRTH:____/_____/_____
SOCIAL SECURITY NO.:XXX-XX-_____ SEX: □ Male □ Female
ADDRESS:_____ MARITAL STATUS:_____
CITY:_____ EMPLOYMENT STATUS:_____
STATE:_____ ZIP:_____ OCCUPATION:_____
HOMEPHONE:_____-_____-_____ BUSINESS ADDRESS:_____-_____-_____
CELLPHONE:_____-_____-_____
WORK PHONE_____ EXT._____ EMAIL ADDRESS:_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? □ PATIENT □ GUARANTOR (Fill information below)

GUARANTOR:_____ is the guarantor the legal representative? □ Yes □ No
SOCIAL SECURITY NO. XXX-XX-_____
RELATIONSHIPS TO PATIENT:_____ DATE OF BIRTH:___/____/_____
ADDRESS _____
CITY/ STATE/ ZIP:_____
PRIMARY PHONE _____ EXT._____
EMAIL ADRESS:_____

PRIMARY INSURANCE **SECONDARY INSURANCE**

NAME: _____ NAME: _____
ADDRESS: _____ ADDRESS:_____
ID#:_____ ID#:_____
GROUP #:_____ GROUP #:_____
PERSON INSURED : □SELF □SPOUSE □PARENT PERSON INSURED: □SELF □SPOUSE □PARENT
INSURED NAME IF NOT PATIENT: _____ INSURED NAME IF NOT PATIENT_____
DATE OF BIRTH IF NOT PATIENT:_____/_____/_____ DATE OF BIRTH IF NOT PATIENT:___/_____/

IF NO MEDICAL INSURANCE, CHECK ONE: □ AUTO. □ WORKER'S COMP □SELF PAY

FOR AUTO AND WORKER'S COMP: NAME OF INSURANCE:_____
CLAIM ID NO._____
DATE OF INJURY/ACCIDENT:_____/_____/_____

Occupation:	□Retired □Unemployed □ LOA □ Disable
Employer:	Do you have children? □Yes □ No If yes, how many?
If employed, do you work night shift? □Yes □No	

Patient / Legal Representative Name: (Print Name)_____

Signature: _____ Date: _____

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Patient Name: _____

PATIENT INSURANCE NOTICE

YOUR INSURANCE COMPANY WILL PAY ONLY FOR THE SERVICES THAT IT DETERMINES TO BE REASONABLE AND CUSTOMARY ACCORDING TO THEIR OWN SURVEYS. IF YOUR INSURANCE COMPANY DETERMINES THAT A MEDICAL SERVICE IS NOT REASONABLE AND CUSTOMARY UNDER THEIR PARTICULAR PROGRAM STANDARDS, THEY WILL DENY THE CHARGES. PLEASE REVIEW YOUR TREATMENT PLAN WITH THE PHYSICIAN PRIOR TO THE SERVICES RENDERED. CARINE FAMILY MEDICINE INC DBA DOCTORS INN IS NOTIFYING YOU THAT YOU WILL BE RESPONSIBLE FOR ALL CHARGES THAT ARE DENIED BY YOUR INSURANCE COMPANY. YOU WILL BE EXPECTED TO PAY THE FULL BALANCE FOR THESE SERVICES. IF YOU ARE IN DOUBT REGARDING YOUR INSURANCE COVERAGE, PLEASE CONTACT YOUR CARRIER BEFORE YOU RECEIVE THE TREATMENT NECESSARY. WE WILL OF COURSE, HONOR ALL OF THE INSURANCE DISCOUNT AMOUNTS FOR COVERED CHARGES OF ALL OF THE PLANS THROUGH WHICH WE ARE A CONTRACTED PROVIDER. IF YOU HAVE ANY QUESTIONS, PLEASE SPEAK WITH OUR STAFF.

HIPPA

I HAVE READ THE NOTICE OF PRIVACY PRACTICES FOR CARINE FAMILY MEDICINE INC DBA DOCTORS INN AND HAVE BEEN PROVIDED SUFFICIENT OPPORTUNITY TO REVIEW THE DOCUMENT.

NOTICE OF PRIVACY ACT

I HAVE READ A COPY OF CARINE FAMILY MEDICINE NOTICE OF PRIVACY PRACTICE.

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDANT) HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO DR. EHREN CARINE ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSAR TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSION.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Ehren Carine D.O., Carine Family Medicine INC, and Doctors Inn for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any Information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim If "other health insurance" is indicated in Item 9 of the HCFA1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown In Medicare assigned case. The physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Communication:

We would like to offer you the ability to receive text message and email reminders for your appointments. We also send other health information out by SMS such as letting you know that your results are back, or that we need to get in touch with you. The SMS service should not be solely relied upon, as the responsibility of attending and cancelling appointments still rests with you, but we hope this will make things easier. Messages are generated by an NHS secure service; however they are transmitted over a public network to a personal phone. The practice will never transmit any information that would enable an individual patient to be identified, or specifically which tests they have had.

I CONSENT to the practice contacting me by text message or email provided above for the purpose of health information, result, visit reminders, billing, and appointment reminders. I will ensure that I keep the practice informed of my up to date mobile number at all times, or if the number is no longer in my possession.

Patient / Legal Representative Name: (Print Name) _____

Signature: _____ Date: _____

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OUR PRACTICE POLICY

INSURANCE COVERAGES:

Please be prepared to provide a copy of your insurance card at every visit. As a courtesy, we will bill your insurance carrier for you if proper paperwork is provided. Your insurance policy is a contract between YOU and the insurance company. The agreement is private, and we are not party to the contract. If services are not covered, we will have to bill you directly. We do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for the care provided. If an insurance carrier has not paid within 60 days of invoice billing, the amount will be your responsibility and will be payable in full by you. If you insurance carrier changes, you MUST notify us immediately. If new insurance information is not provided within 2 weeks of a visit, you will be financially responsible for the visit.
** All co-pay, deductible and balance are due at time of service. We offer an extended payment plan only to pre-approved patients. Patient must notify of any changes in insurance coverage prior to treatment, otherwise, patient will be responsible for any denied claims***

NONCOVERED SERVICES:

Please be aware that some services we provide may be non-covered services or are not considered necessary or reasonable under your policy but have been deemed medically in the best interest of your child by the physician. Any care not paid by your insurance will require full payment upon notice of claim denial. Periodic preventative health services may or may not be covered under you health care policy or may have annual limits. Any care not paid by insurance carrier will be your responsibility and payable in full by you.

MINOR PATIENTS:

The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card or payment by cash or check at time of service has been verified.

RETURNED CHECKS:

Any returned check will have a $30.00 processing fee applied to the account.

MEDICATION REFILLS:

Medication refills for ongoing medications will be provided without charge if within 3 months of a visit. We do require every chronic medication need be followed up with an office visit every 3 months. No medication refill will be given after hours. Please allow at least 2 business days to process refills.

FAILURE TO KEEP SCHEDULED APPOINTMENT:

If you are unable to keep your scheduled appointment, we ask that you please notify our office at least 24 hours prior to your appointment. Should you fail to provide a proper and reasonable notice, you will be charge $25.00 to $40.00 (depending on the type of appointment) for the time that was allotted to you. Credit card information might need to be provided to make any more appointment, no show fee will be applied if failure to keep your schedule appointment. Depending on the type of appointment, if you show up more than 5 minutes, you might be charged for a $25.00 late fee and ask to reschedule your appointment.

FORMS:

There will be a $50.00 charge for paperwork such as FMLA papers, homebound forms, etc. Payment will be collected at the time our office receives the paperwork. Please allow at least 3 business days for completion. Physical and vaccine forms will be available upon request at each well visit without additional charge. If you require additional copies (for camps, multiple schools, those on alternate vaccine schedules), there will be a $10.00 charge per form.

PATIENT DISMISSAL:

Any patient who threatens violence or physical assault will be dismissed immediately. We keep our right to dismiss patient for any of these following reasons:

- Persistent failure to keep scheduled appointments or adhere to agreed-upon treatment plans
- Repeated failure to pay reasonable medical bills
- Ongoing rude, disruptive, or unreasonably demanding behavior
- Habitual noncompliance
- Falsifying or providing misleading medical history
- Seductive behavior toward physician or staff
- Sentinel incident (eg, verbal threat, violence, criminal activity)

ACKNOWLEDGEMENT AND AUTHORIZATION:
I have read, understand, and agree to the above office policies. I will notify the office of any change to this information or permission.

Patient / Legal Representative Name: (Print Name) _____

Signature: _____ Date: _____

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Authorization to Disclose Confidential Information

Information to be disclosed by:

Person/ Facility:_____

Phone #: _____ Fax #: _____

Address:_____

Information may be disclosed to:

CARINE FAMILY MEDICINE

Address: 1811 SHORE DRIVE SOUTH, SOUTH PASADENA, FLORIDA 33707

Phone: 727.391.4100 Fax: 727.398.2067

Method of disclosure:

- ☐ Pick up at clinic/facility
- ☐ Fax #: _____
- ☐ Address: _____
- ☐ Email address: (please note that emailing may not be a secured method of communication): _____

Information to be disclosed:

- ☐ General Medical Record(s)
- ☐ Immunizations
- ☐ Progress Note(s)
- ☐ STD records
- ☐ Family Planning
- ☐ TB records
- ☐ Prenatal Records
- ☐ History and Physical Results
- ☐ Consultations
- ☐ Diagnostic test reports
- ☐ All records

I specifically authorize release of information relating to:

- ☐ HIV test results
- ☐ Substance abuse service provider client records
- ☐ Psychiatric, Psychological or Psychotherapeutic Notes
- ☐ Early Intervention
- ☐ WIC

Purpose of disclosure:

- ☐ Continue of Care
- ☐ Personal Use
- ☐ Other (specify)_____

Expiration Date: This authorization will expire 12 months from the date on which it was signed.

Redisclosure: I understand that once the above information is disclosed, I may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Conditioning: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sing this form.

Revocation: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid or Medicare.

Patient / Legal Representative Name:_____ (Print Name)

Signature: _____ Date: _____

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Signature: _____ Date: _____