EMERALD COAST INFECTIOUS DISEASES MEDICAL GROUP, P.A.

PATIENT REGISTRATION: DATE: _____

PRIMARY PHYSICIAN NAME: _____

REFERRING PHYSICIAN NAME: _____

Height: _____ Weight: _____

PATIENT LAST: _____ FIRST: _____ MI: _____

HOME ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SEC: _____-____-_____ HOME PHONE: _____

DOB: _____ SEX: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

PHARMACY NAME: _____ PHONE NUMBER: _____

MARITAL STATUS: _____ RACE: _____

HOW WOULD YOU LIKE TO BE CONTACTED? [ ] CELL [ ] HOME
MAY WE LEAVE A VOICEMAIL MESSAGE? YES/NO

****

HEALTH INSURANCE COVERAGE:

1) PRIMARY INSURANCE COMPANY:_____

POLICY NUMBER: _____ PHONE NUMBER: _____

NAME POLICY UNDER: _____ SPONSOR DOB: _____

2) SECONDARY INSURANCE COMPANY: _____

POLICY NUMBER: _____ PHONE NUMBER: _____

NAME POLICY UNDER: _____ SPONSOR DOB: _____

****

PLEASE LIST ALL ALLERGIES AND REACTIONS. IF NONE, WRITE NONE:

Allergy	Reaction & when occurred

EMERALD COAST INFECTIOUS DISEASES MEDICAL GROUP, P.A.

OFFICE POLICIES: 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.

_____ **AUTHORIZATION TO PAY:** I AUTHORIZE PAYMENT OF BENEFITS TO DR. PATRICK ANASTASIO, AT EMERALD COAST INFECTIOUS DISEASES MEDICAL GROUP, P.A., 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 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 ECID's Medical Group, hereinafter, ECID

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 at 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 copayment responsibility

Can the doctor waive the copayment? **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 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 patient as a copay for the service violates Section 458.331(l)(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 Finally, the routine waiver 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(l)(k), *Florida Statutes*.

Policy for unpaid patient accounts

According to Florida law, ECID 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, ECID can refuse to see an established patient until the patient meets their financial obligation. To reinstate as a patient of ECID, 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, ECID 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.

EMERALD COAST INFECTIOUS DISEASE MEDICAL GROUP, P.A.

PATIENT NAME: _____

DATE OF BIRTH: _____ PHARMACY: _____

PLEASE LIST ALL MEDICATIONS, FREQUENCY, AND PHYSICIAN WHO PRESCIRBED 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 dosing	Directions	Prescriber	Date of prescribing

EMERALD COAST INFECTIOUS DISEASE MEDICAL GROUP, P.A.

PATIENT NAME: _____

DATE OF BIRTH: _____ CURRENT HEALTH STATUS: _____
SMOKING STATUS: _____

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	Y/N
Alzheimer's Disease	
Allergic Rhinitis (Hay Fever)	
Anemia	
Arthritis	
Asthma	
Birth Defects	
Bleeding Problem	
Cancer, if yes, where _____	
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, where _____	
Other: _____	

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

_____

_____

_____

List any hospitalizations:
Hospital Date Reason

_____

_____

_____

Are you currently using a home health agency? _____
If so, please list the agency name: _____

Emerald Coast Infectious Diseases Medical Group, P.A.

Financial Disclosure Notice to Patients

This is a notice informing you that Emerald Coast Infectious Diseases Medical Group, P.A. owns and operates Synergy Specialty Pharmacy for the convenience of our patients.

As an owner, he/she will receive enumeration for securing or soliciting patients for prescriptions you have filled at this entity or any items or services you may purchase or receive.

As a patient, you have the right to obtain these items or services from a pharmacy or provider of your choice. You will always have a choice in pharmacies and are in no way obligated to use our pharmacy.

As an alternative to Synergy Specialty Pharmacy, we have listed two pharmacies below as options for you to receive your prescriptions or services:

Recept Pharmacy
4011 Crescent Park Drive
Riverview, Fl. 33578
Toll Free: 888-664-6746

Digestive Care Pharmacy
3001 Coral Hills Drive, Suite 380A
Coral Springs, Fl. 33065
Toll Free: 800-314-3096

By signing below, you are acknowledging that you have received notice of the information provided above.

_____
Printed Name

_____ _____
Signature Date

Synergy Specialty Pharmacy Patient Disclosure
Emerald Coast Infectious Diseases Medical Group, P.A.

Consent to Discuss Treatment

Date: _____

I, _____,
give consent to Emerald Coast Infectious Diseases Medical Group, P.A. (ECID) physicians and/or staff to discuss my medical issues, treatment, and care with:

_____
Name

_____
Relationship

_____
Name

_____
Relationship

_____
Name

_____
Relationship

_____
Name

_____
Relationship

I understand ECID will not be violating any HIPPA (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

_____ _____
Witness Signature Date