

PATIENT REGISTRATION FORM (eCW)

(Please print)

PATIENT INFORMATION

Patient's Legal Name: (Last) (First) (MI)

Preferred Full Name (if different from above):

Address:

City, State, Zip:

Home Phone Number (landline): Cell: Work:

E-Mail Address: Date of Birth:

Gender Identity: Female Male Transgender Female to Male Transgender Male to Female Genderqueer Choose not to disclose Additional Gender category not listed

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Chose not to disclose Other not listed

Ethnicity: Hispanic or Latino Not Hispanic or Latino Choose not to disclose

Preferred Language: English Spanish ASL Japanese Mandarin Korean French Indian: Hindi, Tamil, Gujarati etc Swahili Russian Arabic Vietnamese Haitian Creole Bosnian/Croatian/Serbian/Serbo-Croatian Albanian Burmese Tagalog Farsi-Iranian/Persian Portuguese Cambodian Other not listed

Patient Social Security Number:

RESPONSIBLE PARTY INFORMATION (If not self) (Information used for patient balance statements)

Responsible party: Another patient Guarantor Self Check here if address and telephone information is same as patient

Responsible party name: (Last) (First) (MI)

Date of birth: MM/DD/YYYY Sex: Female Male

Responsible Party Social Security Number: Phone number:

Address:

City, State: ZIP:

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) (First)

Phone number: Do you have a living will? Yes No

Emergency contact relationship to patient: Guardian

Address:

City, State: ZIP:

Home phone: Work phone: Ext.

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: Date:

Printed name of patient or personal representative: Relationship to patient:

Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, BROWARD SURGICAL SPECIALISTS may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge BROWARD SURGICAL SPECIALISTS may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to BROWARD SURGICAL SPECIALISTS any insurance or other third-party benefits available for health care services provided to me. I understand BROWARD SURGICAL SPECIALISTS has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to BROWARD SURGICAL SPECIALISTS I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to BROWARD SURGICAL SPECIALISTS by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for BROWARD SURGICAL SPECIALISTS or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that BROWARD SURGICAL SPECIALISTS or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or BROWARD SURGICAL SPECIALISTS or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse
Parent
Legal Guardian

Guarantor
Healthcare Power of Attorney
Other (please specify) _____

BROWARD SURGICAL SPECIALISTS

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____

Date of Birth: _____

_____ (Patient/Representative initials) **Notice of Privacy Practices.**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **Release of Information.**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient/Representative Initials) **I consent** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient/Representative Initials) **I do not consent** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. I understand that once I have consented to receive communication via text or email, I still have the right to revoke that consent at any time.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

____ (Patient/Representative initials) **I consent to receive text messages** from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is _____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is _____.

OR

____ (Patient/ Representative Initials) I decline to receive communication via text.

____ (Patient/ Representative Initials) I decline to receive communication via email.

If you have previously consented to receive communication via text/email and wish to remove the consent

Revocation (I do not consent to use my cell or email any longer)

I hereby revoke my request for future communications via email and/or text.

___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text.

___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Patient/Parent/Guardian/Patient Representative Signature _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____

HCA PHYSICIAN SERVICES

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	Birth Date:	Social Security No. <i>(optional)</i> :
Patient's Address:	Requestor's Name/Phone Number (if patient is not the requestor):	
PHI Recipient Name:	Address/City/State/Zip	Phone Number: () _____ Fax Number: () _____
PHI Sender Name:	Address/City/State/Zip	Phone Number: () _____ Fax Number: () _____

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)

Date: _____ Event: _____

Purpose of Disclosure:

Is this request for psychotherapy notes?

Yes, then this is the only item you may request on this authorization.

No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
<input type="checkbox"/> All PHI in record		<input type="checkbox"/> Physician Orders		<input type="checkbox"/> Demographics	
<input type="checkbox"/> History and Physical		<input type="checkbox"/> Laboratory		<input type="checkbox"/> Rehabilitation	
<input type="checkbox"/> Consult Report		<input type="checkbox"/> Imaging/Radiology		Services	
<input type="checkbox"/> Operative Report		<input type="checkbox"/> Nursing Notes		<input type="checkbox"/> Special Test/Therapy	
<input type="checkbox"/> Progress Notes		<input type="checkbox"/> Medication Record		<input type="checkbox"/> Itemized Bill/Claims	
				<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Continued on next page

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

Original – Practice
Copy – Patient
Copy – Recipient

HIM.PRI.001, PS 70-190 Authorizations

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