MIDLAND MEDICAL BROWARD, INC.

PATIENT INFORMATION SHEET

LAST NAME **FIRST** **MIDDLE INITIAL**

GENDER (as it appears on insurance) **PREFERRED LANGUAGE**

DATE OF BIRTH **SOCIAL SECURITY NUMBER**

ETHNICITY (check on): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

RACE (check one): ☐ White ☐ Black ☐ Native American

☐ Other (please specify):______________________________

CONTACT INFORMATION:

STREET ADDRESS **APT #**

CITY **STATE** **ZIP CODE**

☐ mobile ☐ home ☐ other

PRIMARY CONTACT PHONE

☐ mobile ☐ home ☐ other

SECONDARY CONTACT PHONE

EMAIL ADDRESS (to log into your Patient Portal and access doctor's notes and other health information)

EMERGENCY CONTACT INFORMATION:

NAME PHONE NUMBER RELATIONSHIP

DID ANYONE REFER YOU TO MIDLAND MEDICAL? ☐ yes ☐ no

NAME RELATIONSHIP

PREFERRED PHARMACY

For your convenience, we offer an on-site pharmacy with free delivery and a new patient gift certificate of $25

☐ Pride Pharmacy on-site (please transfer any existing prescriptions from my previous pharmacy listed below)
☐ Other (please fill out details below)

NAME LOCATION PHONE NUMBER

MIDLAND MEDICAL BROWARD, INC.

ASSIGNMENT OF INSURANCE AND RELEASE AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and is not a substitute for payment. Some carriers will pay fixed allowances for certain procedures, others will pay percentages of the charges. It is the patient's ultimate responsibility to pay any deductible, co-insurance, or any other balance not paid by your insurance carrier. If we are filing the claim for you, we allow 45 days from the billing date for the carrier to process the claim and make payment accordingly. If payment from your carrier is not received within this time frame, MIDLAND MEDICAL will inform you to pay your balance and seek reimbursement from your carrier. Billing insurance carriers is done as a courtesy to the patient and does not dismiss patient's responsibility for payment in full, unless other written arrangements have been made.

I certify that I have read and understand fully the provider's billing policy and agree to make payment in full, or satisfactory arrangement when asked to do so, as specified to do so, as specified above.

To the extent necessary to determine liability for the payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and other benefits, to include major medical benefits to which I am entitled, including Medicare, Private Insurance, etc. to MIDLAND MEDICAL.

This assignment will remain in effect until revoked by me in writing. A photocopy of this is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by my carrier. Should my account be referred to an attorney and/or collection agency, I shall be responsible for all applicable fees.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize release of any medical information (including HIV status and/or test results) necessary to process any and all medical claims. I also authorize payment to be made for said claims(s) to MIDLAND MEDICAL. I have read and understand and agree with all the information set forth in this document

____

Patient Signature

____

Patient Name Date

MIDLAND MEDICAL BROWARD, INC.

HIPAA WAIVER

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Midland Medical Broward will not release confidential health information nor discuss appointments, bills, medications or any other affairs pertaining to a patient to any unauthorized people either in person or by telephone, email or fax. This includes family members, spouses, and partners. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Also, information will not be given to an unauthorized person who may answer your telephone (either at home or at work). If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please complete the following:

I, ____, authorize the physicians and staff of Midland Medical Broward to release confidential medical information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify Midland Medical Broward if this authorization information changes.

Please check each box that applies

It is okay to leave confidential medical information for me on my:

- ☐ Home telephone (includes voicemail)
- ☐ Work Telephone (includes voicemail)
- ☐ Mobile telephone (includes voicemail)
- ☐ Home fax
- ☐ Work fax

It is okay to give confidential medical information to my:
(List specific names)

- ☐ Spouse/Partner ____
- ☐ Parent(s) ____
- ☐ Child(ren) ____
- ☐ Sibling(s) ____
- ☐ Other ____

I authorize this information to be disclosed in the following ways:

- ☐ Written/photocopy/paper
- ☐ Verbal
- ☐ Fax

Signature: ____

Date: ____

MIDLAND MEDICAL BROWARD, INC.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ____

Date of Birth: ____________________________

Name of previous Office or Healthcare Facility: __________________________________

Name of Doctor: __________________________________

Address: ____

____

Phone #: ____________________________

Fax #: ____________________________

FAX RECORDS TO: 954-565-0876

I hereby authorize Midland Medical Broward, Inc. to obtain the health information indicated below that is contained in my patient records to the recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and HIV/AIDS test results or diagnoses. I may revoke this authorization at any time, except where information has already been released, by completing Midland Medical Broward, Inc. Revocation of an Authorization Form. This authorization is valid for five years from the date of authorization written below. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. A photocopy or fax of this authorization is as valid as the original.

Dates of Medical Records requested

From: __________________ To: ____________________

☐ All Records

☐ Specific Records (please complete Details)

Details: ____

____
Signature of patient or patient representative:

____ ______________
Print Name: Date:

MIDLAND MEDICAL-BROWARD, INC.

ATTENTION PATIENTS:

Under Florida Law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical claims for medical malpractice. Your doctor has decided not to carry medical malpractice insurance. This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against uninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.

I have read and fully understand this statement.

______________________________	______________________________	____________
Patient's signature	Patient's printed name	Date

ATENCIÓN PACIENTES:

Según las leyes de la Florida, se require generalmente que los medicos tengan seguro de mala práctica médica, o a lo contrario demostrar responsabilidad finaciera para cubrir posibles reclamaciones por mala práctica médica. Su doctor ha decidido no tener este seguro. Esto se permite por las leyes de la Florida sujetas a ciertas condiciones. Las leyes de la Florida imponen multas a los médicos no asegurados que no satisfagan juicios adversos derivados de reclamaciones de mala práctica médica. Este aviso ha sido provisto siguiendo las leyes de la Florida.

Yo he leído y entiendo perfectamente este aviso.

______________________________	______________________________	____________
Firma del paciente	Nombre del paciente en letra de molde	Fecha

ATANSYON TOUT PASYAN:

Selon lalwa Florid tout doktè sipoze genyen asirans malpratik medikal oswa montre responsabilite finansye ki pwouve yo ka peye yon reklamasyon pou malpratik medikal. Doktè isit la deside pa genyen asirans malpratik medikal. Lalwa Florid pèmèt sa a avèk kèk kondisyon. Lalwa Florid ap penalize doktè ki pa genyen asirans malpratik medikal e ki pa kapab satisfè yon reklamasyon malpratik. Nou founi notifikasyon sa a dapre lalwa Florid.

Mwen li ak byen komprann notifikasyon sa a.

______________________________	______________________________	____________
Siyati pasyan	Non pasyan	Dat

MIDLAND MEDICAL BROWARD, INC.

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMRATION. PLEASE REVIEW IT CAREFULLY

The Health insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the follo9wing purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute, de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatments alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain used and disclosures of protected health information including those related to family member, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. I f we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

By signature I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICE

Patient's signature: ______________________________________ Date: ____________________________________

MIDLAND MEDICAL BROWARD, INC.

AUTHORIZATION FOR TREATMENT AND HEALTHCARE INFORMATION CONSENT FORM

I authorize the physician, or the appointed staff, to administer treatment, anesthetics, or perform such operations as deemed necessary or advisable for the diagnosis and treatment of my healthcare. This includes blood draws for laboratory studies which may include HIV/AIDS diagnosis and treatment studies.

I understand as part of my healthcare, MIDLAND MEDICAL originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and health information for billing purposes.
- A means by which a third party payer can verify that services billed were actually provide.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have received the MIDLAND MEDICAL Notice of Privacy Practices, which provides a more complete description of information uses and disclosures. I have the right to review this notice prior to signing this consent. I understand the organization reserves the right to change their notice and practices at any time and I may request a copy of any revised notice by contacting MIDLAND MEDICAL.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment, or healthcare operations and that this organization is not required to agree to the restrictions requested. I understand I may revoke this consent by contacting MIDLAND MEDICAL's Privacy Officer and requesting a Revocation of Consent Form. I understand revoking my consent does not affect disclosures already made in reliance of my prior consent.

This consent is given freely with the understanding that nay and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as authorized by law. A photocopy or fax of this consent is valid as this original. This consent is valid for 10 years from the date of signing and may be revoked upon written request.

Patient's Printed Name | Date

Patient's Signature (or Personal Representative) | Patient's Date of Birth

Witness's Signature | Witness's Printed name

MIDLAND MEDICAL BROWARD, INC.

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Midland Medical Broward, Inc. as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies, which are as follows:

- The patient is ultimately responsible for the payment of his/her treatment and care.
- The patient is responsible for missed appointment charges as outlined in the fee schedule.
- The patient is responsible for charges associated with forms completion as outlined in the fee schedule
- The patient is responsible for any costs associated with collections of patient balances.
- Patient statements are mailed monthly. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement.
- The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency)

Patient Authorizations

- By my signature below, I hereby authorize assignment of financial benefits directly to Midland Medical Broward, Inc. and associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

____

Signature of Patient or Guardian

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible of charges and to submit claims to my insurance company at my discretion.

____

Signature of Patient or Guardian

MIDLAND MEDICAL BROWARD, INC.

FEE SCHEDULE

Simple forms:

$5.00

FMLA and Disability forms

$15.00

Medical Records:

$1.00 per page for the first 25 pages
$0.25 for each additional page

No Show Fee for Missed Appointments:

$60.00

Maximum lab fee for insurance covered patients:

$15

Cancellations made at the time of a scheduled appointment or after a scheduled appointment will be considered as a missed appointment to which the aforementioned fee will be applied. A patient is permitted 3 missed appointments within a 12 month period, after which the patient will be considered for discharge from the practice.

Medical records cannot be mailed, faxed, or emailed to patients. There is no charge for medical records being sent to another healthcare provider or healthcare facility.

Self paying patients will be notified of the cash price prior to their lab draw. ***PAYMENT MUST BE RECEIVED IN ADVANCE.***

A copayment/coinsurance is an expense that the provider is expected to collect at time of visit. Providers should collect copayments/coinsurance amounts as defined by the member's contract. Participating providers are contractually prohibited from waiving a copayment/coinsurance which is considered an unacceptable billing practice for providers.

PATIENT SIGNATURE DATE

Agreement for Prescribing Controlled Substances

Patient Name: _______________________________________ Date of Birth: _________________

Prescribing a controlled substance is a matter Midland Medical takes very seriously. We have put a policy and protocol in place to protect your health as the patient. This is an agreement between you, the patient, and Midland Medical Center.

Controlled substances will only be written if ALL of the following are true:

A. Pain Management referral has been given and Pain Management office visit completed. Plan of care from Pain Management received, in patient chart and kept current (updated by a Pain Management visit, every six months)
B. Pain Management *Plan of Care* has, and continues to be, followed
C. Passed urine drug and toxicity screen at *each* refill
D. No controlled substances have been filled from outside doctors (via E-FORCSE)
E. The control is due to refill based on date dispensed (via E-FORCSE) and max daily dosage
F. This form is signed

I am aware that if at any time I misuse my medication, fail a drug screen, fail a randomized pill count or obtain any narcotics from another provider; I will not be prescribed the pain medications and may be discharged from Midland Medical Center.

I am aware that if I lose, misplace, or have my prescription or medications stolen, no early prescription replacement will be given.

I am expected to keep scheduled appointments. I am aware I will be charged $60 for any missed appointments, and a total of three missed appointments in any calendar year may result in me being discharged from Midland Medical Center.

The choice (brand or generic) of drug and dose will be determined by the Pain Management doctor. Midland providers will not change the drug or increase the dose. If that specific medication is not covered on your insurance formulary or you cannot purchase the VDszb;m’aln’zm z,bzsdf;lxreason, you should address this with your Pain Management doctor.

My Midland Medical Provider has reviewed the above with me, and I agree to comply with all rules and regulations of control medication prescribing with Midland Medical Center.

Patient Signature: ____ Date: ______________

Provider Signature: ____ Date: ______________

MIDLAND MEDICAL NEW PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*:	**DOB:**	**Gender:**
Previous/Referring doctor:	**Date of last physical exam:**	
Reason for Visit:		

PERSONAL HEALTH HISTORY

Medical Problems (Diagnosed)	Surgeries/Procedures	Hospitalizations (other than surgeries)

If you need extra space, check this box and continue on back ☐

List *ALL* of the medications you take, including vitamins and supplements

Name the Drug	Dose	How often	Reason for taking

If you need extra space, check this box and continue on back ☐

Allergies to medications: If you are not allergic to any medications, check this box ☐

Name the Drug	Reaction You Had

Vaccinations

Vaccine	Date received (if known)
Influenza	
Tetanus	
Pneumonia	
zoster	
Hepatitis A	
Hepatitis B	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Section	Question		
Alcohol	Do you drink alcohol? ☐ Yes ☐ No (skip to next section, Tobacco.)		
	If yes, how often do you drink? _____ per ☐week ☐ month		
	How much do you drink when you drink? ☐ 1-2 drinks ☐ 3-4 drinks ☐ 4-5 drinks ☐ more than five drinks		
	Are you concerned about the amount you drink?	☐ Yes	☐ No
	Do you ever drive after drinking?	☐ Yes	☐ No
	Have you had any accidents/falls or fights due to your drinking?	☐ Yes	☐ No
Tobacco	Do you use tobacco? ☐ Yes ☐ I used to. (Skip to Former tobacco question) ☐ No (skip to next section.)		
	If you are currently using tobacco:		
	☐ Cigarettes –____ packs/day	☐ Vape—amount/day:_______	☐ Other—type and amount/day
	Interest level in quitting: ☐ Very interested and motivated ☐ Very interested ☐ Interested ☐ Not Interested		
	Former tobacco users, how long did you use tobacco and when did you quit?	# of years:	Year quit:
Sex	Do you have sex with men, women or both?		
	Relationship status: ☐ relationship, monogamous ☐ relationship , typically monogamous ☐ Relationship , open ☐ single		
	Have you had sexual activity within the last 12 months? ☐ Yes ☐ No (If no, skip to next section-Exercise.)		
	Do you experience pain with sexual activity? ☐ Yes ☐ No		
	Approximate number of partners in past 12 months: ☐ 1 (skip to next section-Exercise) ☐ 2-4 ☐ 5-10 drinks ☐ more than 10		

Activity	How often you use condoms with activity	Activity	How often you use condoms with activity	Activity	How often you use condoms with activity
☐ perform oral		☐ insertive vaginal		☐ insertive anal	
☐ receptive oral		☐ receptive vaginal		☐ receptive anal	

Section	Question		
	Have you ever been diagnosed with a sexually transmitted infection, such as syphilis, gonorrhea or chlamydia? (if no, skip to next section)		
	If so, what were you diagnosed with and approximately when?		
Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for at least 30 min.)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for at least 30 minutes)		
Occupation	What kind of work do you do?		
Diet	Are you dieting?	☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No
Drugs	Do you currently use drugs recreationally?	☐ Yes	☐ No
	If yes, which drugs do you use and how often do you use them?		
	Do you feel like drug use is a problem for you?	☐ Yes	☐ No
Personal Safety	Physical and/or emotional abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

OTHER PROBLEMS

Check if you are having any symptoms in the following areas to a significant degree and briefly explain.

	Yes	No		Yes	No		Yes	No
Fatigue	☐	☐	Blurred vision	☐	☐	Acute (new) joint pain	☐	☐
Fevers/Sweats/Chills	☐	☐	Double vision	☐	☐	Muscle aches	☐	☐
Significant weight gain	☐	☐	Change in vision	☐	☐	Weakness of arms or legs	☐	☐
Unintentional weight loss	☐	☐	Ringing in ears	☐	☐	Fainting or nearly fainting	☐	☐
Rashes	☐	☐	Changes in hearing	☐	☐	Memory loss	☐	☐
Bleeding from gums or nose	☐	☐	Ear pain	☐	☐	Headache	☐	☐
itching	☐	☐	Difficulty or pain with swallowing	☐	☐	Pins and needles of hands or feet	☐	☐
bruising	☐	☐	Sore throat	☐	☐	Increased urination	☐	☐
rashes	☐	☐	Post nasal drip	☐	☐	Difficulty urinating	☐	☐
Dizziness	☐	☐	Nasal congestion	☐	☐	Urinating at night	☐	☐
Difficulty breathing	☐	☐	heartburn	☐	☐	Depression	☐	☐
Wheezing	☐	☐	Cramping	☐	☐	Sadness	☐	☐
Cough	☐	☐	Nausea or vomiting	☐	☐	Anxiety	☐	☐
Chest pain	☐	☐	Constipation	☐	☐	Panic attacks	☐	☐
palpitations	☐	☐	Diarrhea (more than 3 times/day)	☐	☐	Insomnia	☐	☐
Swelling of feet or legs	☐	☐	Rectal pain	☐	☐	Difficulty concentrating	☐	☐

If yes to any of the above, briefly describe:

MIDLAND MEDICAL BROWARD, INC.

Our Promise of Privacy and Consent to Patient Records

Our office is fully committed to compliance with HIPAA guidelines by:

1. Providing appropriate ***security*** for our patient records.
2. Protecting the ***privacy*** of our patients' medical information.
3. Providing our patients with proper ***access*** to their medical records
4. Appropriately maintaining our patient information and bill processes in compliance with national ***standards***.

If you ever have any questions or concerns about your services or charges, we encourage you to call and ask for our Compliance Officer.

Summary of the HIPAA Rule

1. It sets boundaries on the use and release of health records.
2. It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
3. It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patients' privacy rights
4. It strikes a balance when public responsibility requires disclosure of some forms of data – for example, to protect public health.
5. For patients – it means being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.
6. It enables patients to find out how their information may be used and what disclosures of their information have been made.
7. It generally limits release of information to the minimum reasonable need for the purpose of the disclosure.
8. It gives patients the right to examine and obtain a copy of their own health records and request corrections.

Our goal in reviewing and updating our privacy standards center on these components of the final rule. In all that we do in connection with patient records, we should keep in mind the above principles.