PATIENT REGISTRATION FORM

Patient Name: Social Security Number:

Date of Birth: Gender: Marital Status:

Race: Ethnicity: Language:

Address:
(Street, City, State, Zip)

Home Phone: Cell Phone:

E-mail Address: Employer:

RESPONSIBLE PARTY: (Complete only if different from patient)

Responsible Party Name: Social Security Number:

Date of Birth: Gender: Relation to Patient:

Address (if different from patient):
(Street, City, State, Zip)

Home Phone: Cell Phone:

E-mail Address: Employer:

WHO TO CALL IN CASE OF EMERGENCY:

Name:_____ Relationship: _____

Address:_____
(Street) (City/State/Zip)

Home Phone: (____)_____-_____ Work Phone: (____)_____-_____

Cell Phone: (____)_____-_____

PRIMARY INSURANCE INFORMATION

Plan Name: Relation to Patient:

Member I.D. Number: Group Number:

Policy Holder Name: Policy Holder SSN:

Policy Holder DOB: Policy Holder Gender:

Plan Address:
(Street, City, State, Zip)

SECONDARY INSURANCE INFORMATION

Plan Name: Relation to Patient:

Member I.D. Number: Group Number:

Policy Holder Name: Policy Holder SSN:

Policy Holder DOB: Policy Holder Gender:

Plan Address:
(Street, City, State, Zip)

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y____N____
IF YES, PLEASE NOTIFY THE RECEPTIONIST

ASSIGNMENT OF BENEFITS

I attest that the information I have provided to Family Tree Medical Group, PA is correct and true to the best of my knowledge. I hereby assign any medical and/or surgical benefits to Family Tree Medical Group, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I further authorize Family Tree Medical Group, PA to release all information to secure payment.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any physician, hospital, pharmacy, or medical care facility to provide all information regarding my medical or pharmaceutical history and treatment to Family Tree Medical Group, PA. I furthermore will allow my pharmacy to supply verification of benefits. I also authorize Family Tree Medical Group, PA to release my medical information to other physicians as needed to facilitate treatment.

Signature:_____Date: _____

AUTHORIZATION FOR APPOINTMENT REMINDERS

By signing below, you are authorizing us to send you text reminders for your upcoming appointments. Providing us with your cell phone number above, you agree to any fees or charges you may incur from your cell phone company. There will not be any reimbursement from Family Tree Medical Group if any charges apply.

Patient Name (Print): _____ Patient Signature: _____

Patient Authorization
Please read, initial and sign below.

(Initial)_____**Financial Policy**: I acknowledge that I received, reviewed, and agree to comply with the most recent version of the Family Tree Medical Group Policy as dated on August 1, 2018.

(Initial)_____**Financial Responsibility**: I understand that I am ultimately responsible for payment of my account. Payment is expected at the time of service. I understand I am responsible to pay my co-pay, co-insurance, or deductible according to my insurance contract at the time of service.

(Initial)_____**Insurance Coverage**: I understand that I am responsible to provide Family Tree Medical Group with my current insurance coverage information and insurance card at each and every visit. I will be responsible for paying any balances due as a result of not providing my most current insurance information. I understand that Family Tree Medical Group will not retroactively file claims due to my failure to provide current insurance information.

(Initial)_____**Assignment of Benefits**: I hereby authorize payment directly to Family Tree Medical Group, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to Family Tree Medical Group, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third party payor.

(Initial)_____**No Show Fee**: I acknowledge that I received, reviewed, and agree to comply with the Family Tree Medical Group No Show Policy and agree to pay any fees incurred from failure to comply.

(Initial)_____**Fee for Forms**: I understand that I received notice about the fee for all forms to be completed by Family Tree Medical Group and I agree to pay prior to receiving the completed form. (i.e. sports physicals, FMLA)

(Initial)_____**Privacy Policy**: I acknowledge that I received, reviewed, and agree to comply with the Family Tree Medical Group Privacy Policy.

(Initial)_____ **E-Prescribing:** I voluntarily authorize Family Tree Medical Group to allow E-Prescribing for patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice; furthermore, I review pharmacy benefit information and medical dispense history as long as I am a patient at this office.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of all agreement with the above policies. A photocopy of this document is as valid as the original.

Patient Name: _____ DOB: _____ Date: _____

Patient Signature: _____

Medical History

Patient Name:	Date of Birth:	Age:	Today's Date:
	Birth Place:	Gender:	

Patient's Medical History: Has the patient ever had? (Circle all that apply)

Alcohol/Drug Abuse	Emphysema	High Blood Pressure	Psychiatric
Asthma	Epilepsy	High Cholesterol	Seasonal Allergies
Cancer	Heart Disease	Infectious Disease	Stomach Disorders
Colitis	Headaches	Kidney Disease	Thyroid Disease
Diabetes			

Immediate Family's Medical History: Blood relatives currently have or have ever had? (Circle all that apply)

Alcohol/Drug Abuse	Emphysema	High Blood Pressure	Psychiatric
Asthma	Epilepsy	High Cholesterol	Seasonal Allergies
Cancer	Heart Disease	Infectious Disease	Stomach Disorders
Colitis	Headaches	Kidney Disease	Thyroid Disease
Diabetes			

Family History:

	Age(s)	Living?	Age at Death	Cause of Death or Current Condition
Father	_____	Y / N	_____	_____
Mother	_____	Y / N	_____	_____
Brothers	_____	Y / N	_____	_____
Sisters	_____	Y / N	_____	_____
Child(ren)	_____	Y / N	_____	_____

List All Surgeries and Serious Illnesses:

Surgery/Serious Illness	Year	Hospital/Location
_____	_____	_____
_____	_____	_____

Medication/Food Allergies:

Medication	Reaction
_____	_____
_____	_____
_____	_____

Food	Reaction
_____	_____
_____	_____
_____	_____

Medications you are Currently Taking: (Including birth control, over the counter, and herbal medications).

Medication	Dose	Frequency

Dates of your last:

Blood test/Cholesterol Level: _____
Pap Smear: _____
Prostate Check: _____
Physical Exam: _____
Glaucoma Check: _____
Sigmoidoscopy/Stool Check: _____

EKG: _____
Chest X-ray: _____
Mammogram: _____
Tetanus Booster: _____
Pneumovax: _____
Skin Test for TB: _____

Social History:

Marital Status: _____ Occupation: _____ Spouse's Occupation: _____

Do you smoke? Y or N
If yes, age you started smoking: _____ Year you quit: _____ Packs per day: _____

Illicit drug use? ☐ Never ☐ Remote ☐ Recent ☐ Current

How much caffeine do you drink? (Average number of drinks per day)
None 1 2 3 4 ≥5

How much alcohol do you drink? (Average number of drinks per day)
None Rare (<1) Moderate (1-2) High (>2)

Do you exercise?
None Occasional Moderate Frequent

Seat Belt Use? Y or N Smoke Detector in Home? Y or N

Bike Helmet Use? Y or N Fire Extinguisher in Home? Y or N

Have you ever completed an Advance Directive or Living Will? Y or N

Have you requested your medical records from your previous Physician's office? Y or N
If not, please requests a release of records form at our front desk.

Thank you for taking the time to complete this form.

FAMILY TREE
MEDICAL GROUP, PA

NAME:_____ DATE:_____

Notice of Privacy Practices Acknowledgment Form
Consent To Use or Disclose Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice before signing this form. Your signature below acknowledges that you have received a copy of our Notice of Privacy Practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting any Family Tree Medical Group, PA staff. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bout by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations as described in our Notice. These disclosures may be by phone, mail, fax, or electronic transmission, Unless you indicate otherwise in writing (by completing the form: Request for Restrictions on Use and Disclosure of Protected Health information), if you allow a third party other than one of our practice's physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent Form you are consenting to the disclosure of you PHI to that third party. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. If you refuse to sign this consent or revoke this consent, Family Tree Medical Group, PA my refuse treatment or provide further treatment as of the time of the revocation, except to the extent that treatment is required by law.

I am consenting to the disclosure of my protected health information ("PHI") to the following individuals:

- **Name**_____**Relationship**_____
- **Name**_____**Relationship**_____
- **Name**_____**Relationship**_____
- **Name**_____**Relationship**_____

I have read and understand the information in this acknowledgment. I am the patient or am authorized to act on behalf of the patient to sign this document.
By signing below, I acknowledge and agree to the above conditions.

_____ _____
Signature of Patient Print Name of Patient
(OR AUTHORIZED REPRESENTATIVE) (OR AUTHORIZED REPRESENTATIVE)

* Please explain: Representative relationship to Patient and include a description of Representative authority to act on behalf of Patient

Privacy Practice
HIPAA Acknowledgment Form

Patient's Name:_____ D.O.B._____

I have received the Notice of Privacy Practices for the office of **Family Tree Medical Group, PA** and I have been afforded an opportunity to review it. I acknowledge that this law allows our office to share and disclose protected medical information regarding myself as a patient:

(1) Another physician, (such as a specialist our providers can refer me too), a hospital (where I may be admitted), pharmacy, or other provider of medical care, such as a therapist (PT, OT, Speech, etc), or DME company for medical equipment that I may require.

(2) Insurance companies (to process claims or obtain referrals).

(3) For the day to day internal operations of our office (evaluating employee performance, training, etc.)

I understand that in order for me to request a copy of patient medical records due to (moving, switching to another PCP, etc), I must complete a different release of information form, which may be provided by our office, or I may submit a letter which includes patient name, date of birth, reason for release, and the patients signature.

Patient/Responsible Party Signature:_____ Date: _____

FAMILY TREE MEDICAL GROUP, PA
1150 CYPRESS GLEN CIRCLE
KISSIMMEE, FL 34741
OFFICE (407) 483-3200 FAX (407) 483-3220

PATIENT I.D._____

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name:_____ Social Security # (last 4 digits): _____

Address:_____

Date of Birth: ____/____/____ Date of Service:_____ Phone #:_____

Identification Shown:_____ Mail □ Pick Up □

I hereby authorize **Family Tree Medical Group, PA** to use and **disclose to**: □ **or obtain from:** □ **or allow review:** □

_____ _____ Phone

Name of Facility or Person Fax

_____

Street Address City State Zip Code

the following information contained in my medical record regarding my hospitalization$_S$, care and treatment (please initial):

____ Complete Record ____ All Diagnostic Test Results ____ Pathology Report(s)

____ Abstract of Record ____ Consultation

____ Therapy Records ____ Radiology Only ____ Other (please specify)

____ Progress Note(s) ____ Lab Only _____

____ Operative Report

The purpose for the release of information at the request of the individual is:

□ Insurance □ Legal Action □Continued Treatment □ Personal Use □ Patient Communication (Behavioral Health)

□ Other (Please Specify) _____

This authorization will expire on the following date, event or condition: _____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

May **NOT** include information related to (please initial):

____ HIV/AIDS ____ Mental Health ____ Drug and/or Alcohol Abuse ____ Genetic Counseling/Testing Information

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that **Family Tree Medical Group, PA** may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.

_____ _____

Patient/Legal Representative or Parent/Legal Guardian Signature Date

Official Use Only: _____ Date:_____

□ Name of Person Releasing Information □ Name of Person Assisting with Review Number of pages copied _____

□ **I wish to revoke this authorization.** Signature: _____ Date: _____

INTERPRETER ONLY

(Please Print)

Name: _____ Agency: _____

Telephone:_____ Language: _____