Patient Registration Form

Name (First): _____ (MI):_____ (Last):_____
Address: _____ Apt# _____
City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____-_____ Cell Phone: (____)_____-_____
***Email (required):** _____
Birthdate: ___ / ____ / _____ Sex: □F □M Marital Status: □S □ M □D □W
Social Security #: _____
Occupation: _____ Employer: _____
City / State: _____ WorkPhone: (____)_____-_____

Insurance Information (We require a copy of your insurance card)

Company:_____ Member ID#: _____
Insured's Name:_____
If Spouse is Primary:
Spouse Name: _____ Date of Birth: _____

Pharmacy Information

Pharmacy Name: _____ Pharmacy Number: (____)_____-_____
Pharmacy Fax: (_____)_____-_____

How did you find out about us? Circle one please

□ Groupon Sun Sentinal/Miami Herald Website TV (station)_____ Referral from a Physician □

Zoc Doc Family/ Friend □ Aventura Magazine □ Other _____

Physician that Referred You: _____ Specialty: _____
(If other than referring Physician):

Emergency Contact

Name: _____ Phone:_____
Relation to patient: _____

I authorize Boriken Medical Group to execute any documents necessary, and release to my health insurance carrier or other organizations as required. Any pertinent medical information about myself as may be required to process for claims of reimbursement of fees charged to me for medical treatment Boriken Medical Group. The above information is true to the best of my knowledge.
I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance.
I also authorize Boriken Medical Group or insurance company to release any information required to process my claims.

Signature _____ Date: _____

Patient's Name_____ D.O.B _____

Women Only *(Please check box if yes)*

Are you pregnant or considering a pregnancy sometime in the future? □
Are you breast feeding? □
Are your legs more painful associated with menstruation? □
Have you been diagnosed with Pelvic Congestion Syndrome? □
Number of pregnancies? _____ Number of deliveries? _____ Ages of children? _____

Patient Name: _____ D.O.B: _____

CONSENT FOR MEDICAL CARE

Please Read This Form Carefully and Completely Before Signing It

I, _____, understand that I have a condition that requires medical treatment.

I authorize Boriken Medical Group to determine what kind of medical examination including but not limited to physical, pelvic examination (vagina, cervix, uterus, fallopian tubes, ovaries, rectum), or external pelvic tissue or organs (testicules, penis) using any combination of modalities, which include, but need not to be limited to, the health care providers gloved hands or instrumentation and diagnostic procedures (tests) must be done in order to learn more about my condition. These may include electrocardiograms, ultrasounds, blood tests, blood pressure, or other routine tests. I understand that if my doctor advises a more complex test, or one which has special risk, that it will be explained to me. Further, I authorize the personnel of Medical Group to assist in giving, or to give the tests which my doctor will order.

I also authorize my doctor to determine what kind of treatment is to be given, and to perform such procedures as he/she may deem necessary, in his/her professional judgment, to preserve my health. Additionally, I authorize the personnel of Boriken Medical Group to assist in giving the treatment which my doctor will order. I fully understand that medical tests or treatments may involve certain unavoidable risks.

If part of my treatment is very complex or carries special risks, it will be explained to me.

I understand that it is not practical to list every aspect of medical care, nor every procedure or treatment which I might receive. However, I acknowledge that my doctor is available to answer my questions I might have. I understand that the practice of medicine and surgery are not exact sciences, and acknowledge that no guarantee or assurance has been made to me as a result of treatments or examination.

I certify that I have read this form, and had it explained to me, and certify that I fully understand its contents.

Patient Signature: _____ Date:_____

For Patients Unable to Sign

Signature of Legal Representative: _____ Date: _____

HIPAA

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Effective April 9, 2003

Due to new federal and state mandates, please note the following important information.

Boriken Medical Group is committed to maintaining and protecting the confidentiality of our patients' personal and confidential information. We are required by federal and state law to protect the privacy of our patients' health and personal information. Therefore, we have instituted the following changes to ensure compliance with these laws.

We are no longer permitted to leave detailed messages on answering machine or with family members. We must speak directly with the patient.

Print Patient Name:_____ Patient Signature:_____

Date:_____

Notice of Privacy Practice Acknowledgement
Boriken Medical Group

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____
Patient Name or Legal Guardian (print) Date

_____
Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

Boriken Medical Group, LLC
12600 Pembroke rd, st 208, Miramar, Fl, 33027
Phone 954-620-0026 Fax 954-620-0047

Financial Responsibility Agreement

THE UNDERSIGNED agrees, whether he/she signs as parent, spouse, guarantor, guardian, or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, I authorize attorney to obtain my credit report: and the undersigned shall pay reasonable attorney's fees and collection expenses.

Please be aware by signing this form you are agreeing that office has made you aware of Cancellation Fee of $35.00 For same day appointment cancellation and no show.

Patient's Signature: _____

Print Name: _____

Social Security Number: _____

Date: _____

E-mail Consent & Acknowledgment Form

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine

across state lines.

e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.

b. Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.

d. Put the patient's name in the body of the e-mail.

e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).

f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.

g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

HOLD HARMLESS

Boriken Medical Group, LLC
12600 Pembroke rd, st 208, Miramar, Fl, 33027
Phone 954-620-0026 Fax 954-620-0047

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (Print) : _____

Patient Signature : _____ Date : _____

Patient Email: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I – Authorization

I,_____ DOB: _____ give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section III of this document.

Section II - Health Information

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information:
- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Disclose Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other: _____

_____

_____

Section III – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

Name of Person authorized and Relationship to me: _____

And/Or

Name: _____

Organization: _____

Address: _____

Phone: _____

Fax: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them

Section IV – Signature

_____ _____
Print Patient Name Date

_____
Signature

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form: _____

_____

_____