Copay $ _____

Atlantic Health
MEDICAL ASSOCIATES

New Patient Registration Form

General Information (please print)

Name: _____ DOB: _____ Sex: __M __F

Social security #: _____Ethnicity: Hispanic___ Not Hispanic ___ Decline___

Marital status: ___Never Married ___Married ___Domestic Partner ___Divorced ___Separated ___Widowed

Race: ___Caucasian ___Asian ___African American ___Hispanic ___Multi-Racial ___Other ___Decline

Primary Address:_____ Apartment #:_____ City:_____ State: ____ Zip:_____

Home Ph: _____Work Ph: _____ Cell Ph: _____ Authorize Text? ___Y ___N

E-mail: _____ Authorize E-mail? ___Y ___N

Employment status: ___Employed ___Unemployed ___Retired ___Full-time Student ___Part-time Student

Employer: _____ Occupation: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Emergency Contact Relationship:_____

Pharmacy Information (please print)

Pharmacy Name: _____ Pharmacy Address:_____

Pharmacy City:_____ Pharmacy State: ____ Pharmacy Zip:_____ Pharmacy Ph:_____

Patient Phone Message Consent (please print)

It is our policy to notify you to confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voice mail/machine YES _____ NO _____ (initial yes or no)
- Leave a detailed message with individual answering the phone YES _____ NO _____ (initial yes or no)

Sharing of Medical Information (please print)

I give the physician and office staff of ATLANTIC HEALTH MEDICAL ASSOCIATES permission to discuss my medical condition with the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Primary Insurance (please print)

Insurance name _____ Member ID #_____

Group ID# _____ Social Sec # _____ DOB _____

Subscriber's name _____ Relationship to insured _____

Secondary Insurance (please print)

Insurance name _____ Member ID #_____

Group ID# _____ Social Sec # _____ DOB _____

Subscriber's name _____ Relationship to insured _____

Patient Authorization and Acknowledgment for ePRESCRIBE ALL PATIENTS

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of ATLANTIC HEALTH MEDICAL ASSOCIATES to enroll me in the ePrescribe Program.

Initials

Patient Authorization and Acknowledgment for PHARMACY BENEFITS ALL PATIENTS

I authorize the physician and/or staff of ATLANTIC HEALTH MEDICAL ASSOCIATES to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third party pharmacy payors for treatment purposes.

Initials

Patient Authorization and Acknowledgment for MEDICARE

I authorize the physician and/or staff of ATLANTIC HEALTH MEDICAL ASSOCIATES to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Initials

Patient Authorization and Acknowledgment for PPO, POS, EPO, OAP, HMO, and SELF PAY PATIENTS

I authorize the physician and/or staff of ATLANTIC HEALTH MEDICAL ASSOCIATES to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to ATLANTIC HEALTH MEDICAL ASSOCIATES the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company. If I am a self pay patient, I understand that I am financially responsible for all services including but not limited to laboratory test, blood work and urine analysis. Furthermore, All patients understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and ATLANTIC HEALTH MEDICAL ASSOCIATES to photograph me for medically related documentation purposes.

Initials

Patient No Show/Cancellation Policy Acknowledgment for ALL PATIENTS

I understand that ATLANTIC HEALTH MEDICAL ASSOCIATES will charge a $25.00 fee for no shows or failure to cancel appointments within 24 hours of your scheduled appointment time. After hour cancellations can be left in our general voice mailbox. This includes cancellations on weekends and/or holidays.

Initials

Patient Lab Results Acknowledgment for ALL PATIENTS

I understand that ATLANTIC HEALTH MEDICAL ASSOCIATES will not discuss lab results over the telephone. In the event of urgent result(s), a provider will contact you to schedule an immediate office visit. Please allow 4-5 business days after your lab work is performed for your results to be received in our office. You must schedule a follow-up appointment to discuss your labs results with your physician.

Initials

Patient Portal and Medical Records Acknowledgment for ALL PATIENTS

I understand that ATLANTIC HEALTH MEDICAL ASSOCIATES offers a complimentary online patient portal to safely and securely access your patient records at your leisure. Portal access information will be provided upon checkout. All patients are strongly encouraged to register on the online portal. I understand that ATLANTIC HEALTH MEDICAL ASSOCIATES will only provide patient records externally with a signed medical release by the patient and in observance of Rule 64B8-10.003, Florida Administrative Code. Records request made by attorneys, other primary care physicians, and/or specialist may be subject to a fee. Patients reserve the right to access their records on the portal and provide to a third party of their choice.

Initials

Special Accommodations and Acknowledgment for DISABLED PATIENTS

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify ATLANTIC HEALTH MEDICAL ASSOCIATES of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by ATLANTIC HEALTH MEDICAL ASSOCIATES is the patient's responsibilities.

Initials

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES for ALL PATIENTS

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish. ***I acknowledge that I have received a copy of the ATLANTIC HEALTH MEDICAL ASSOCIATES Notice of Privacy Practices.***

Initials