HEALTHCARE ASSOCIATES
OF PALM BEACH

561- 877-1800 (Phone)
561- 742-4480 (Dr Rogovin's Fax)
866-950-0144 (Dr Doctor's Fax)
7730 W. Boynton Beach Blvd. Suite 3
Boynton Beach, FL 33437

PATIENT REGISTRATION FORM

Last Name:_____ First Name: _____

Street Address: _____

_____

City: _____ State:_____

ZIP Code:_____ Date of Birth: _____

Gender: M or F Marital Status:_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Patient place of employment:_____

Race:_____ Ethnicity:_____ Preferred Language:_____

Email:_____ Pharmacy:_____ Pharmacy phone number:_____

Medical Insurance Information:

Primary Insurance:_____ ID#:_____

Secondary Insurance:_____

Social Security #:_____

In case of emergency Notify_____

Number:_____ Relation to patient:_____

Release

I grant permission to view my perfection history from other sources.

I consent to report and receive immunization information from the state of Florida.

I consent to have my claims filed to my insurance carrier and I understand that any balance and or copays are my reasonability and are due at the time of the visit.

I am aware that there will be a $25 - $50 charge for ANY forms that our office must fill out or require Dr signature.

I understand that it is my responsibility to **notify the office if there is ever any change in my insurance** and or **mailing address and phone number.**

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GENERAL CONSENT TO TREAT

By signing below, I or my authorized representative authorizes HAPB, physicians or practitioners and staff to conduct any diagnostic exams, tests, and procedures and to provide medication to assess; diagnose and treat my Illness or injuries. I understand that it is the responsibility of my individual treating physician to explain to me the reasons for any diagnostic exam, test, procedure, the available treatment options, and the common risks and anticipated burdens or benefits associated with these options as well as alternative courses of treatment.

_____ _____

Patient/Guardian signature Date

DIAGNOSTIC AND LAB RESULTS

In an effort to make sure that you receive your Lab/Imaging results in a timely manner we will schedule a follow-up appointment to review your results. If, however, no appointment is made for a follow-up, please call us one week after your labs/diagnostic studies are performed. We will get back with you as soon as possible.

_____

Patient Signature

_____

Date

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REVIEW OF SYSTEMS

Name:_____ Date:_____

Date of Birth:_____

PLEASE CIRCLE ANY CURRENT ACTIVE PROBLEMS AND GIVE A BRIEF EXPLANATION.

CONSTITUTIONAL
Fever
Chills
Feeling Poorly (Malaise)
Loss of Appetite
Anorexia
Lethargy
Unusual Change in Weight

ENT
Earache
Facial Pain
Loss of Hearing
Nose Bleeds (Epistaxis)
Vertigo
Nasal Discharge
Sore Throat
Ringing in the Ears (Tinnitus)
Hoarseness

EYES
Visual Disturbance
Eye Pain
Conjunctival Injection
Discharge from the Eyes
Eye Dryness
Itching of the Eyes

SKIN
Itching (Pruritus)
Rash
Purple/Red Spots (Purpura)
Change in Skin Color

CARDIOVASCULAR
Chest Pain
Palpitations
Awakening with Difficulty Breathing (PND)
Leg Pain while Ambulating (Claudication)
Lightheadedness
Difficulty Breathing while Laying Down (Orthopnea)

GASTROINTESTINAL
Abdominal Pain
Heartburn
Difficulty Swallowing (Dysphagia)
Nausea/Vomiting
Rectal Bleeding
Change in Bowel Habits

GENITOURINARY
Change in Urinary Frequency
Incontinence
Hesitancy
Frequent Night Urination (Nocturia)
Painful Urination (Dysuria)
Weakness of the Urine Stream
Blood in Urine

ENDOCRINE
Excessive Urination (Polyuria)
Excessive Thirst (Polydipsia)
Temperature Intolerance
Excessive Eating (Polyphagia)
Thyroid Issues

HEME/LYMPH
Unusual Bleeding
Easy-Bleeding
Night Sweats
Unusual Infection
Cancer (Type)

MUSCULOSKELETAL
Joint Pain
Muscle Aches
Joint Swelling
Joint Stiffness

RESPIRATORY
Cough
Sputum
Hemoptysis (cough up blood)
Shortness of Breath
Wheezing

NEUROLOGICAL
Seizure
Muscle Weakness
Headaches
Change in coordination
Dizziness

PSYCHIATRIC
Anxiety
Depression
Insomnia

Explain any problems:_____

_____

_____

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HEALTH HISTORY

Have you ever had or have you now: (please check the right of each item; if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Rheumatic fever			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation treatments			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Serious head injury			
Frequent or severe headache			
Dizziness or fainting spells			
ADD			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted disease			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Smoke 1+ pack cigarettes/week			
Regularly exercise			
Wear seat belt			
Other (specify)			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia			
Inherited blood disorder (Specify)			
Eye trouble besides need glasses			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Broken bone (specify)			
Kidney infection			
Bladder infection			

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HEALTH HISTORY CONTINUED

When was your last:

Fasting blood work?_____ PSA/ prostate check? _____

Stress test? _____ Colonoscopy? _____

Echocardiogram? _____ Bone Density test? _____

Mammogram? _____ Dilated Eye Exam? _____

Pap Smear? _____ Dermatology Visit? _____

Have you ever been hospitalized overnight?____Yes ____ No

Have you ever had surgery? If so, please list _____

_____

Do you regularly visit any doctors beside your primary care physician?

Doctor:_____ Specialty:_____

Doctor:_____ Specialty:_____

Doctor:_____ Specialty:_____

Doctor:_____ Specialty:_____

Do you exercise? _____Yes ____ No

Do you wear sunscreen? _____Yes ____ No

Do you wear a seat belt? _____Yes ____ No

Females:

Have you ever been pregnant? _Yes ____ No

How many times?_____

How many children have you given birth to? _____

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MEDICATION LOG

Please list any Allergies to medications: _____

_____

Please list all the medications you are currently taking both prescription and over the counter medication.

DATE	MEDICATION	DOSE GIVEN	FREQUENCY (i.e. 2x per day)	TIME	AM / PM

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FAMILY HISTORY

MOTHER

Alive: _____ Age _____ Present Illness? _____

Deceased If so what age?_____

Cause of death _____

FATHER

Alive: _____ Age _____ Present Illness? _____

Deceased If so what age?_____

Cause of death _____

SIBLING

Alive: _____ Age _____ Present Illness? _____

Deceased If so what age?_____

Cause of death _____

SIBLING

Alive: _____ Age _____ Present Illness? _____

Deceased If so what age?_____

Cause of death _____

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SOCIAL HISTORY

Do you smoke? _____Yes ___ No I quit _____

If so when?_____

How many cigarettes a day do you or did you smoke? _____

Are you interested in quitting? _____Yes ___ No

How many alcoholic beverages do you drink?

_____ Per Day _____ Per Week _____ Per Month____ I don't drink

Any recreational drug use now or in the past? _____

Are you?

_____Single _____Married _____Widowed _____Divorced _____Domestic partnership

Have you ever had a sexually transmitted disease? _____Yes ___ No

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HIPPA PATIENT PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge receipt of:

- HIPPA "PRIVACY NOTICE"

While completing my registration process I hereby acknowledge:

I have read the information contained and I can ask my healthcare staff if I need assistance in understanding my rights, or if I would like them to be explain these materials to me in more detail.

I understand the following:

1) That these materials are to inform me of my privacy rights as a patient
2) I have been given states that my personal "protected health information" (PHI) will be used and disclosed by my doctor or and his staff in the routine activities of treatment, payment and healthcare operations.
3) Before any other use or disclosure of my personal, protected health information is made. I will be asked for my written authorization.

I understand that I have the following rights:

- To CONFIDENTIAL COMMUNICATIONS
- To REQUEST RESTRICTIONS on Uses and Disclosures of my PHI.
- To REQUEST ACCESS to my personal protected health information
- To REQUEST AMENDMENTS to my personal protected health information
- To have an ACCOUNTING of any DISCLOSURES for purposes other than of treatment, payment and healthcare operations

I hereby authorize the following person(s) access to my health records:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

PATIENT SIGNATURE:_____ DATE:_____

PATIENT NAME:_____

RELATIONSHIP:_____SELF or OTHER:_____

THIS ACKNOWLEDGMENT EXPRIES SEVEN YEARS FROM THE DATE OF THE SIGNATURE ABOVE

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GENERAL CONSENT & ACKNOWLEDGEMENT FORM

Patient Name:_____

DOB:_____

Consent for Treatment

I consent to evaluation and treatment of the condition for which I, or my child or dependent, have come to ***Healthcare Associates of Palm Beach*** **(HAPB)** and authorize the physicians and other health care providers affiliated with CPC to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is nm an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by HAPB. I authorize HAPB to examine, use store and dispose of all tissue, fluids, or specimens removed from my body I acknowledge and agree this consent will be applicable to all visits or episodes of evaluation and treatment at HAPB

Responsibility for payment / Assignment of Benefits / Contact In consideration of the treatment provided at CPC to me or my child or dependent,

I agree to pay HAPB for such treatment. If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover the treatment, authorize HAPB to bill any such insurer for all charges incurred, in connection with the diagnosis, care, and treatment. My Insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, co-Insurance or charges not covered by my health insurance, Medicare, Medicaid or any other programs for which I am eligible. I understand that certain payments may be required at the time of, or In advance of, service being charged. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them. I understand and acknowledge that:

- If I elect to pay for medical treatment in cash, in full before services are provided, I can request that my health Insurance, in any form, not be billed for that service or be notified that the service was provided.

- I am responsible for notification to my Insurance company to obtain authorization before service is rendered, and if I do not pre-certify for such services, my benefits may be reduced or lost, but I will still be responsible for paying HAPB for the services. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage.

- If I do not consent, or later revoke my consent, to the release of my information to any insurer that I have identified. I will be responsible to pay all list charges for the treatment and services received.

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I hereby assign to **HAPB** and the professionals involved in my care, all my rights and claims for reimbursement under any private health Insurance policy, Medicare, Medicaid or any other programs that I identify for which benefits may be available to pay for the services provided to me, and authorize payment for such services to be made directly to **HAPB.**

I further agree to pay all cost of collections, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of emotion under the Constitution and the laws of the **State of Florida.**

I agree that in order for **HAPB** to service my account or to collect any amounts I may owe, **HAPB** or a vendor acting on its behalf, may contact me by telephone at any telephone number associated with my account, including cellular telephone numbers, which could result in charges to me.

I agree that **HAPB** or a vendor acting on its behalf may also contact me by sending text messages or e-mails, using any e-mail address I have provided. I acknowledge and agree that methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Further information concerning **HAPB** financial practices and expectations can be found in the Patient Billing Notice, which has been offered to me.

Patient Rights and Responsibilities: I understand that I have the right, and the responsibility, to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and presenting complaint, to **Healthcare Associates of Palm Beach**

General Conscript& Acknowledgement Form agree upon a treatment plan and follow that plan. I understand that my health care providers will treat me with respect, and I agree to do the same for them. Use and Disclosure of Hearth Information I understand that **HAPB** will use and disclose my health information for the purpose of treatment, payment, and healthcare operations. As permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me.

I understand and acknowledge that **HAPB** may record medical and other information related to my treatment in paper, electronic, photographic, video and other formats and that such information will be used in the course of my treatment, for payment purposes and to support healthcare operations. I give **HAPB**, its employees and agents consent to exchange information with other health care professionals and providers (for example physicians, consultants, hospitals, nursing home, home health agencies, and pharmacies) about my prior and current health conditions to facilitate treatment, or to facilitate discharge planning.

As applicable I specifically consent to the release by **HAPB** of any, and all information, test results and records regarding my treatment for drug or substance abuse, alcoholism, mental health, HIV or AIDS to:

1) My treating physicians and independent professionals and other health care professionals and providers, and,
2) Any private health insurance plan, Medicare, Medicaid, other governmental insurance programs or other third-party payer that I identify to obtain payment for the treatment and services provided to me.

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COMMUNICATION PREFERENCES

I agree that **HAPB** may communicate with me in writing to any address I have provided, may communicate with me orally or by text message to any telephone number I have provided and may communicate with me electronically to any email address I have provided. My preferred method of communication is (check one):

- ☐ **Cellular phone**
- ☐ **Home phone**
- ☐ **Work phone**

Medical Information and test results may be left in my answering machine/voice mail
(Check one): ☐ Yes ☐ No

Medical Information and test results may be sent to me via text message to my cellular phone
(Check one): ☐ Yes ☐ No

Would like medical information and test results faxed to me at my personal fax number
(Check one): ☐ Yes ☐ No
If yes, please provide personal fax number _____

I agree to allow **HAPB** to contact the following family or friends as necessary to provide appointment reminders, to obtain payment and to receive information of my location and general condition. I understand that **HAPB** may contact these identified: individual is for these purposes unless I later instruct HAPB otherwise (check one):

☐ Yes ☐ No

If yes please provide the following – Name, Address, Phone number, Relationship

_____

_____

I HAVE READ, UNDERSTOOD AND FULLY AGREE TO each of the above statement and sign below as my free and voluntary act.

Patient or Authorized Person Signature:_____

Relationship to patient:_____

Patient Name:_____

Date:_____

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CONTROLLED SUBSTANCE PATIENT AGREEMENT FORM

Patient Name:_____

I understand that prescription/controlled substances, now or in future, may cause addiction and is only one part of the treatment plan for my medical conditions.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:

- **I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.**
- **Medication will not be called into pharmacy. It is my responsibility to keep track of my medication schedule.**
- **I will not increase my medicine until I speak with my doctor or nurse.**
- **My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.**
- **Lost or stolen medication will not be refilled under any circumstance. It is my responsibility to protect and secure my medications. This includes keeping the medication out of reach of children.**
- **My doctor may request specialist evaluation of my treatment and I agree to keep appointments.**
- **I agree to give a blood or urine sample, if asked, to test for drug use.**
- **I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.**
    - **The name of my pharmacy is:**_____

Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.
I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working. I agree to provide primary care for you even if you are no longer getting controlled medicines from me.

_____ _____

Patient Signature Date

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD

PATIENT NAME:_____ **DATE OF BIRTH:**_____

CITY/STATE/ZIP_____

The information you may release subject to this signed release form is as follows:

- ☐ 2 year from the last date seen
- ☐ History and Physical, Progress Notes
- ☐ Care Plan, Lab Records, Radiology Reports
- ☐ Pathology Records, Treatment Records, Medication Records
- ☐ Other Records (Please Specify): _____

Physician Name:_____

Address

Release my protected health information to the following physician person facility or entity and/or those directly associating in my medical care to:

HEALTHCARE ASSOCIATES OF PALM BEACH, LLC
Mark Rogovin, DO | Trudell Doctor, MD
7730 Boynton Beach Blvd Suite 3
Boynton Beach, FL 33437
Dr Rogovin's Fax: 561-742-4480
Dr Doctor's Fax: 866-950-0144

- ☐ Change of Insurance or Physicians.
- ☐ Continuation of Care
- ☐ Referral
- ☐ Other:_____

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Your rights with respect to this authorization:

I understand that I must be provided with a sign copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how withdraw my authorization by contacting the office above. I understand that HAPB will not be able to release my records to someone without a signed consent. By signing this form, I do expressly and voluntarily consent to the disclosure of the information checked above. I understand that if the persons listed above are not mandated by the federal privacy standards the health information disclosed because of this authorization may be redisclosed without by obtaining my authorization. I understand that there may be a fee for copying of medical records.

_____ _____

Patient/Representative Signature Date

Physician Signature:_____

Date:_____