TRUDELL DOCTOR MD
AND ASSOCIATES, LLC
6080 Boynton Beach, Suite 230. Boynton Beach, FL 33437
Phone: 561-807-7780 Fax: 833-471-3203
Trudelldoctormd.com

NEW PATIENT REGISTRATION

Last Name _____ First Name _____

Date of Birth _____ Gender: ☐ Male ☐ Female____

Other_____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Widowed

Race _____ Ethnicity_____

Language_____

Address_____ Apt _____

City_____State _____ Zip Code _____

Home # _____ Cell # _____

Email:_____Emergency contact: _____

Place of

Employment_____

Occupation _____Work # _____

Medical Insurance Information

Primary Insurance _____ID: _____

Secondary Insurance_____:ID#_____

- Release: : I grant permission to view my prescription 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 I am responsible for all copays and/or balances associated with my insurance plan and are due at the time of visit.

Release

-I am aware that all form/letter requests have a $25-$50 charge depending on form type.

-**I understand that it is MY responsibility to notify the office if there is a change in my insurance and demographic information.** ***Patient Initials*** _____Date: _____

TRUDELL DOCTOR MD
AND ASSOCIATES, LLC

MEDICATION LOG

Do you have an allergy to any prescriptions or over the counter medications?

_____

_____ ☐ NONE

Pharmacy _____ Phone # _____

*Please be aware that as of June 2021, if you are taking a narcotic or benzodiazepines, you MUST schedule an in-office visit to refill per state regulations.

FREQUENCY	STRENGTH	MEDICATION

TRUDELL DOCTOR MD
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HIPAA PATIENT PRIVACY NOTICE ACKNOWLEDGMENT

While completing my registration process I hereby acknowledge receipt of:
-HIPAA "PRIVACY NOTICE:

-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 explain these materials to me in more detail.

I understand the following:
-That these materials are to inform me of my privacy rights as a patient
-I have been given information that 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.
- 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 access to my health information:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient Signature _____ Date _____

Patient Name _____

Relationship: ☐ Self Other _____

This acknowledgment expires seven years from the date of the signature above.

TRUDELL DOCTOR MD
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Patient Name: _____ **DOB:** _____

-I consent to evaluation and treatment of the condition for which I, or my child or dependent, have come to Trudell Doctor MD and Associates, LLC. I authorize the physicians and other health care providers affiliated with Trudell Doctor MD and Associates, LLC 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 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 Trudell Doctor MD and Associates, LLC. I authorize Trudell Doctor MD and Associates, LLC to examine, use, store and dispose of all fluids, or specimens removed from my body (ex: urine and blood).
I acknowledge and agree this consent will be applicable to all visits or episodes of evaluation and treatment at Trudell Doctor MD and Associates, LLC.

-I agree to pay Trudell Doctor MD and Associates, LLC for such treatment. If private health insurance, Medicare, other governmental or other insurance programs cover the treatment, authorize Trudell Doctor MD and Associates, LLC to bill any such insurer for all charges incurred, in connection with the diagnosis, care, and treatment. My insurance coverage may pay some amount of the bill, any balance will remain my personal responsibility, such as my deductible, co- payment, co-Insurance, or charges not covered by my health insurance, Medicare, 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 that during my annual exam if the provider feels I have risk factors or treats me for any specific condition, this may be billed in addition to an annual preventive care visit, an extra charge may occur to my insurance, and then to me.**

-**If I elect to pay for medical treatment in cash (self pay), payment is due 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.**
-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 for paying all list charges for the treatment and services received. I understand my insurance is MY responsibility, and making certain that Trudell Doctor MD and Associates is in network at the time services are rendered.

-I hereby assign to Trudell Doctor MD and Associates & the professionals involved in my care, all my rights and claims for reimbursement under any private health Insurance policy, Medicare, 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 Trudell Doctor MD and Associates, LLC.

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

-patient Initials _____ Date: _____

TRUDELL DOCTOR MD
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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 Trudell Doctor MD and Associates, LLC.

-I understand and acknowledge that Trudell Doctor MD and Associates, LLC 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 during my treatment, for payment purposes and to support healthcare operations.

-I give Trudell Doctor MD and Associates, LLC, 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 Trudell Doctor MD and Associates 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, other governmental insurance programs or other third-party payer that I identify to obtain payment for the treatment and services provided to me.

Signature: _____ Date: _____

TRUDELL DOCTOR MD
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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

- 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
-I may get addicted to this medicine.
-If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
-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 the 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.

Pharmacy Name _____ **Phone number**_____

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 RECORDS

Patient Name _____ DOB _____

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

- ☐ Two years from the last seen date
- ☐ History and Physical, Progress Notes
- ☐ Care Plan, Lab Records, Radiology Reports
- ☐ Pathology Records, Treatment Records, Medication Records
- ☐ Other Records _____

RELEASE FROM:

PHYSICIAN:_____

ADDRESS:_____PHONE:_____

FAX:_____

Please release my protected health information to the following physician:

Trudell Doctor, MD and Associates, LLC

6080 Boynton Beach Blvd, Suite 230, Boynton Beach FL, 33437

Phone: 561-807-7780 Fax: 833-471-3203

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care
- ☐ Referral
- ☐ Other : CHANGE OF OFFICE LOCATION

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 Trudell Doctor MD 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 re-disclosed 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 _____