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: _____

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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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Trudell Doctor MD and Associates
6080 Boynton Beach Blvd, Suite 230
Boynton Beach, FL 33437
P: 561-807-7780

Patient Consent & Financial Agreement

Patient Name: _____

Date of Birth: _____

Consent for Treatment

I consent to evaluation and treatment by Trudell Doctor MD and Associates. I understand that medical providers in training may assist in my care. I understand that medicine is not an exact science and that no guarantees can be made regarding results.

I authorize Trudell Doctor MD and Associates to examine, use, and store any specimens collected during my treatment. This consent applies to all future visits unless revoked in writing.

Financial Agreement

I agree to pay Trudell Doctor MD and Associates for all services provided.
If I have insurance, I authorize the office to bill my insurer and receive payment directly. I understand that I am responsible for any remaining balance, including deductibles, copays, coinsurance, or uncovered services. I understand that certain payments may be required at the time of, or in advance of the service being charged. I understand that I will be billed for any charges not paid by my insurance company. During my annual exam if the provider feels I have any risk factors, or my provider decides to treat me for any specific condition on my records, this may be billed in addition to my annual preventive care visit. This additional charge will be billed with my annual preventive visit to my insurance company. If my insurance company denies payment, then the balance may become my financial responsibility.

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If I choose to "Self-pay" for services, I agree to pay in full prior to services being provided.

I understand it is my responsibility to get any required insurance authorizations before my specialist's visits. If I fail to do so this may delay that specialist's appointment.

Assignment of Benefits

I assign all insurance and Medicare benefits directly to Trudell Doctor MD and Associates for services provided and authorize release of information needed to process claims.

Collections and Communication

If my account defaults and goes to collections, I agree to pay reasonable collection and attorney fees and applicable interest.
I agree that Trudell Doctor MD and Associates may contact me by phone, text, or email using the information I provide.

Patient Rights and Responsibilities

- I have the right to participate in my care and to be informed about my treatment.
- I will provide accurate and complete health information.
- I understand my medical information may be recorded and shared securely with other healthcare providers as needed for my care or payment.
- I consent to the release of necessary records, including those related to mental health, substance use, or HIV status, to treating providers or insurers for payment purposes.

Patient Signature: _____

Date: _____

Trudell Doctor M.D. and Associates 6080

Boynton Beach Blvd Suite 230

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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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HIPPA PATIENT PRIVACY NOTICE ACKNOWLEDGMENT

While completing my registration process I hereby acknowledge receipt of:
-HIPPA "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 be 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.

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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 _____

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PATIENT FINANCIAL RESPONSIBILITY AND LAB SERVICES NOTICE

Patient Name: _____ **DOB:** _____

2025 - 2026 year

Lab Company: **Labcorp** **or** **Quest**

Lab Services disclosure
During your visit today, bloodwork may be collected here in the office as a courtesy to our patients, and sent to the lab that your insurance is contracted with.

Please note:

- Trudell Doctor MD and Associates does not know the exact details of your insurance plan, including **lab coverage, deductibles, copays, or coinsurance.**
- It is your responsibility to check with your insurance company to confirm if lab services done in our office are covered.
- We provide lab collection in-office as a convenience.

If your insurance does not cover a lab service(s), you will be responsible for the cost.

Important Information
- Trudell Doctor MD and Associates, LLC has no financial interest in the labs we refer to. - Referrals are based only on medical necessity and what you and your provider discuss at your visit. - You may choose to decline bloodwork in our office. If you do, **we will** give you a lab order form so you can arrange testing directly with the lab of your choice.

Patient Signature: _____ Date: _____

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