Laura B. Rosner, M.D. - Family Medicine

Registration Form

Patient's Personal History

First Name________________ MI ______ Last Name________________

Date of Birth________________ Age______ Gender ☐ Male ☐ Female ☐ Other

Mailing Address ________________________________

Cell Phone #________________ Work Phone #________________

Email________________________________

Occupation____________ Employer____________ Type of Work____________

Race__________ Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Other Language spoken__________

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Other

Name of your Spouse / Partner ________________

If student, what school do you attend? ________________________

How did you hear about Dr. Rosner? ________________________

Chief complaint / Concerns________________________

Date of last physical ____________ Doctor____________

Allergies ☐ None

List allergies and reactions ________________________

Surgical History ☐ None

List Surgeries and dates________________________

____

Medications (Prescriptions and Over the Counter)

Name of Medication	Dose	# of Tablets/Daily	Purpose / Used for

Emergency Contact

Name________________ Phone #____________ Relationship____________

Social History

Smoke ☐ Yes ☐ No If yes, ______ packs per week for _____ years - When did you stop?______________

Alcohol ☐ Yes ☐ No If yes, how much?____

Exercise ☐ Yes ☐ No If yes, how often?____

Substance Abuse ☐ Yes ☐ No Describe____

Family History	Gender (M/F)	If Living – Health	If Deceased, Age & Cause
Father______________	M	______________	______________
Mother______________	F	______________	______________

Siblings____

____

____

Children____

____

____

Do you have any blood relatives with? (Circle and list relationship)

Alcoholism	Diabetes	Heart Disease	Migraines
Arthritis	Goiter	Kidney Disease	Stroke
Asthma	Hay Fever	Leukemia	Other
Cancer (Type?)		Mental Illness	

Insurance Information

Primary Insurance Name_______________________________ Policy #_______________________

Address____

Subscriber Name _____________________________________ DOB _______________________

Secondary Insurance Name______________________________ Policy #_______________________

Address____

Subscriber Name _____________________________________ DOB _______________________

Guarantor (If other than patient)

First Name___________________________ MI ________ Last Name_______________________

Date of Birth______________________ Gender ☐ Male ☐ Female ☐ Other

I, the patient signed below, certify that the above information is correct. I understand and agree that:

- **I am responsible to provide correct information on this form, and that I may become financially responsible for services if insurance information provided is incorrect or incomplete;**
- **I am responsible to pay all co-payments and deductibles at the time of service;**
- **TMG will file my insurance as required by contract, where applicable, and that I am responsible for full payment to TMG for services provided when TMG is a non-participating provider;**
- **TMG will hold me responsible to pay costs of collection through outside collection agencies or other legal means, should that become necessary;**
- **TMG will release pertinent medical records to insurance companies for documentation of today's service in order to process medical insurance claims.**

Patient's Name (Please Print):____

Signature:____ **Date:**__________________

Patient Communications Instructions, Patient's Release and Acknowledgement

TALLAHASSEE MEDICAL GROUP

Patient Name (PRINT): ______________________________

Date of Birth: ______________________________

Patient address: ______________________________

Please tell us what you would like to authorize or limit with this form (check all that apply):

___ I would like to UPDATE or CHANGE my telephone and/or email contact information.

___ I would like to AUTHORIZE or CHANGE MY AUTHORIZATION for certain individuals to have access to and/or receive communication and disclosures concerning my healthcare.

___ I would like to LIMIT or REVOKE my authorization for individuals that have previously had access to and/ or received communication and disclosures concerning my healthcare

Which of the following communication means are appropriate/acceptable for our office to communicate with you? (Please check all that apply.)

___ Home phone number—leave a message to return call with NO particulars Phone#__________

___ Home phone number—leave a message to return call WITH particulars Phone#__________

___ Work phone number—leave a message to return call with NO particulars Phone#__________

___ Work phone number—leave a message to return call WITH particulars Phone#__________

___ Cell phone number—leave a message to return call with NO particulars Phone#__________

___ Cell phone number—leave a message to return call WITH particulars Phone#__________

___ Email __________________(Please do not assume that email will be used by your physician for communication. Please talk to your physician about the use of email as a means of communication.)

___ Other (EXPLAIN AND PROVIDE DETAILS) __________________

___ Other (EXPLAIN AND PROVIDE DETAILS) __________________

Who are you authorizing our office to discuss your health situation with? (Please list all names)

___ Discuss with no one

___ Spouse: Circle AUTHORIZED or UNAUTHORIZED (Name:__________________)

___ Child: Circle AUTHORIZED or UNAUTHORIZED (Name:__________________)

___ Sibling: Circle AUTHORIZED or UNAUTHORIZED (Name:__________________)

___ Other: Circle AUTHORIZED or UNAUTHORIZED (Name:__________________)

___ Other: Circle AUTHORIZED or UNAUTHORIZED (Name:__________________)

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name: __________________ Relationship: __________ Phone:__________

This authorization will expire on: __________(If no date is specified, it will expire upon your written amendment and instructions through your execution of a change to the information contained on this form via a completion of a new/replacement form).

By signing below, I acknowledge that I have received and reviewed a copy of Tallahassee Medical Group's Notice of Privacy Policies.

______________________________ ______________________

Signature of Patient or Legal Guardian **Date**

If not the patient, explain relationship and legal authority:__________________

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

I understand that under Federal and State law I am entitled to have information regarding my physical and mental health condition and health care I have received remain private and confidential. Under certain circumstances Tallahassee Medical Group ("TMG") is limited in its ability to release such information, known as Protected Health Information, without my authorization.

I understand I have the right to review the Notice of Privacy Practices of Tallahassee Medical Group prior to signing this document, and I acknowledge that the TMG Notice of Privacy Practices, which includes a listing of my rights as a patient, has been provided to me. I understand that the Notice of Privacy Practices for Tallahassee Medical Group is also available on the website for TMG at www.TallahasseeMedicalGroup.com. I understand that my physician is a part of TMG, and that this notice applies to the protected health information that my physician, as a part of TMG, collects, receives, or creates for my past, present or future physical or mental health.

I hereby consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health-care bills, including my insurance carrier or health maintenance organization, to conduct healthcare operations of TMG, and/or any other permitted disclosure, as outlined in the Notice of Privacy Practices.

I also understand that TMG participates with and provides electronic medical records to certain health information exchanges. Information regarding health information exchanges, including as an example www.centralishealth.com is included on page 2 of this document. The information exchanged in these activities may include my protected heath information. I hereby authorize such transmissions. **I understand that I may opt out of this transmission at any time by sending a written request specifically stating my desire to opt out of Centralis Health activities directly to our Privacy Officer at 1511 Surgeons Drive, Tallahassee, FL 32308.**

TMG reserves the right to revise, make new provisions and or change the terms of these notices at any time. New notices will be effective for all protected health information that we maintain at that time. Such revised notice will be made available to you by posting a copy of the revised notice on our website at www.TallahasseeMedicalGroup.com.

I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act by any third-party payors is correct. I assign payment to TMG of all benefits due by me under the terms of said policies and programs. I assign payment to the physician rendering medical services and the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles; coinsurance or any other charges incurred which are not paid by my insurers or other third-party payers together with all costs of collection, if necessary, including collection fees charged by a third-party collection agency and reasonable attorney's fees if collected by or through an attorney-at-law.

A PHOTOSTAT COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

IMPORTANT INFORMATION RELATED TO HEALTH INFORMATION EXCHANGE

Important legislation in the American Recovery and Reinvestment Act of 2009, enacted by Congress, includes important provisions which impact health care providers and patients alike. Among the provisions of this Act is the concept of Health Information Exchange ("HIE").

Health information exchange (HIE) is defined as the mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

Tallahassee Medical Group. participates in and provides patient information to HIE's in certain circumstances in order to facilitate the coordinated continuum and exchange of healthcare information between facilities and providers.

For the purpose of informing you, our patient, concerning HIE in general, and our participation in and commitment to HIE, we have included a brief explanation and an example of a local resource of HIE in Tallahassee through Centralis Health (www.centralishealth.com)

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

Centralis Health is engaged to deliver easier ways to communicate information and share HIPAA-compliant medical correspondence between healthcare providers. From electronic faxing to intuitive interfacing and clinical data exchange, communications are electronically streamlined to reduce errors and increase staff and patient satisfaction
Unless you specifically opt out as provided below your personal health information will be provided to organizations such as Centralis Health under secure methods with HIPAA compliant agreements. Tallahassee Medical Group and our physicians support this health information exchange as an important part of healthcare technology that facilitates communication and community coordination of your patient care.

Clinical data exchange generally includes-a group of organizations and stakeholders that exchanges data electronically in a manner that is fully HIPAA compliant technologically and controlled by HIPAA compliant agreements between the parties in order to improve the quality, safety, and efficiency of healthcare delivery.

Example information on this effort and participation-can be found at www.centralishealth.com. Example information on HIE generally and the national efforts in that regard can be found at www.healthit.gov.

Patient name (Please Print): ____________________ **Patient DOB:** ______/______/______

Patient Signature: ____________________

Tallahassee Medical Group

FINANCIAL POLICY

- **Payment is due at time of service**: We accept cash, check, or credit card for payment of our estimate of your patient responsibility at the time of service. We make every effort to identify in advance of your scheduled visit all amounts that are owed or will be owed as your portion of responsibility, including deductibles, co-pays, and co-insurances. Insurers however ultimately reserve the right to process our claims and notify us of their final determination of your individual responsibility through the claims filing process. Our initial determination of your portion of financial responsibility prior to your scheduled service is therefore strictly preliminary and may be subject to adjustment when claims are processed by the insurer. We will notify you via our patient statements as soon as possible if there are changes to your financial responsibility that have occurred during claims filing based on your insurer's final determination. If requested, an itemized listing of services provided will be given to you.
- **PATIENTS WITH HIGH DEDUCTIBLE HEALTH PLANS AND PRIVATE PAY PATIENTS: Please be prepared to pay your full charges prior to service. We reserve the right to reschedule or delay service if you an unable to make payment in full at the time of service.**
- **Our Billing Services:** We will file charges on your behalf with most health plans. We are participating providers for most insurers in Tallahassee, but not all insurers – please refer to our website for a listing of our participation agreements with health plans. It is always a good idea to confirm your health plan information with your physician's office at the time of scheduling to ensure that there have been no changes in your coverage that might impact the filing and payment of your claims. **PLEASE NOTE TMG IS UNABLE TO BILL OR RECEIVE PAYMENT FROM ANY HMO PLANS UNLESS WE HAVE A SPECIFIC PARTICIPATION AGREEMNT WITH THE HMO PLAN. WE WILL BE UNABLE TO PROVIDE SERVICES TO YOU IF WE DO NOT HAVE A PARTICIPATION AGREEMENT WITH YOUR HMO.**
- **Co-Pays, Deductibles, and Co-Insurances:** Your share of co-pays, deductibles, and co-insurance are your responsibility and payment are due at time of service. The portions of our charges that are your responsibility are based on your contract with your insurer and are your part of the contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility under your contract. We are not permitted to waive or otherwise reduce this obligation on your behalf.
- **Secondary Insurances:** If applicable, secondary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any secondary coverage that you have at the time of your appointment.
- **Tertiary Insurance, if applicable:** Tertiary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any tertiary coverage that you have at time of the appointment.
- **Charges for missed appointments (generally termed "no-show fees"):** A **$25.00 - $50.00** fee will apply if you fail to present to an appointment without notifying us at least 24 hours in advance:
- **Statements:** We provide patient statements to our patients every month. The statements summarize the outstanding charges and claims activity. We expect payment of your statement balance in full upon your receipt of the statement. If you have a question or believe there is an error on your statement, or if you have any concern about your statement transactions, please contact us in a timely manner. We reserve the right to avoid the cost of sending statement to patient who have a small balance outstanding (usually less than $5.00). Our front staff will collect the balance at your next office visit for small balances.
- **Financial Promissory Agreement:** If you are unable to make payment in full for your portion of financial responsibility at time of service, you will be required to sign **a Financial Promissory Agreement** giving you 14 calendar days to submit payment in full. **If you do not make payment within 14 calendar days, we will assess an additional $25.00 administrative fee to the original co-pay, deductible, or co-insurance due.**
- **Collections**: If no payment is received within 90 days, your account is considered delinquent and may be referred to an outside collection agency. **Referral to outside collections may damage your credit, so we strongly urge you to contact our office to work out a payment arrangement in order to avoid this.**

*If you have questions or concerns about of Financial Policy procedures or fees your physician's office or billing department can help.

My signature below certifies that I have read, understand, and agree to the terms and conditions of this Financial Policy.

Patient Name (PLEASE PRINT): ______________________________ **Patient DOB** ______/______/______

Patient Signature: ______________________________

Patient Authorization for Release of Protected Health Information and Medical Records

Patient's Name ______________________________
(Last, First, Middle/Maiden)
Patient's Address: ______________________________ **City** __________ **State** _____ **Zip**________
Date of Birth ____________________ Phone Numbers______________________________

I authorize my physician and/or administrative and clinical staff at Tallahassee Primary Care Associates or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

Person or Entity to Receive Information:	**Person or Entity to Disclose Information:**
Name/Organization: **Dr. Laura B. Rosner**	Name/Organization: ______________________
Address: 317 Norton Drive, Suite 203	Address: ______________________
City, State, Zip: Tallahassee, Fl. 32308	City, State, Zip: ______________________
Phone: (850)878-3555 Fax: (850)325-6008	Phone: ____________ Fax: ____________

SPECIFIC INFORMATION TO BE DISCLOSED (check all that apply):
__ Complete Medical Record __ Billing Records __ Office Notes __ Ultrasound Reports
__ Lab Reports __ Surgery Records __ Mammogram Reports
__ Obstetrical (OB) Records __ Pap smear / Biopsy Reports __ other (specify): ______________
DATES OF SERVICE:
____

PURPOSE: ___ Changing Physicians, ___ Personal Copy to Patient, ___ Attorney, ___ Insurance, ___ Workers' Comp. ___ Other________________
This authorization will expire on: ____________________ (If no date is specified, it will expire 60 days after date signed).

CHECK AND INITIAL BELOW:
___**I DO** ___ **I DO NOT** authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions**, and all medical records and clinical information relating thereto.
*Initials of individual giving authorization:*________
___**I DO** ___ **I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions**.
Initials of individual giving authorization: ________
___**I DO** ___**I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/or **alcohol-related** treatment.
*Initials of individual giving authorization.*________

I have read and understand the nature of this authorization and I have been provided a copy of TMG's Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at ***Tallahassee Medical Group, 1511 Surgeons Dr, Tallahassee, Florida 32308.*** I understand that a revocation is not effective to the extent that my physician or Tallahassee Medical Group has taken action in reliance upon this authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I also understand that such revocation does not affect TMG's right to use or disclose any information as otherwise provided for in the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

______________________________ ______________________

Signature of Patient or Patient's Representative: **Date:**

______________________________ ______________________

Relationship to Patient (If applicable, attach document of guardianship or Power of Attorney) Witness:

FEE FOR COPIES **INSTRUCTIONAL PAGE – FOR INTERNAL OFFICE USE**

TALLAHASSEE MEDICAL GROUP

Provider Notification:

The practice uses a variety of professional healthcare providers in order to provide patients with the best and most timely care. These providers include Advanced Registered Nurse Practitioners (APRN), Licensed Practical Nurses (LPN), and Medical Assistants (CMA/RMA). While all of these individuals may be involved in your care, patient care is always overseen by the physician. These individuals work together as a team to improve and provide comprehensive patient care. If you join this practice, your appointment may be with the physician doctor or APRN, all care is reviewed by the doctor even if you are not physically seen by the physician that day. If this type of practice does not work for you, then unfortunately we will be unable to meet your needs.

Late Policy:

If you arrive more than 15 minutes past your appointment time, we will make every effort to work you back into the schedule that day, but we may be forced to reschedule to another date/time depending on the patient load for that day.

Cancellation Policy:

When changing an appointment, we require a minimum of 24-hour notice. As a courtesy, we call and remind you of your appointments, so this gives you ample time to make changes.

Charges for failing to come to your appointment or failing to cancel your appointment:

No Show Fee $50

Same Day Cancellation fee $25

Excessive no shows, same day cancellations or rescheduling your appointment with less than 24-hour notice could result in a discharge from the practice.

I have read the above and agree to these polices:

____

Printed Name

____________________________________ ____________

Signature Date