Elite Medical Center

Patient Registration Form

Demographic Information

First Name: _____ M.I.: _____
Last Name: _____
DOB: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Phone No.: (____) _____ **Cell:** (____) _____
Email: _____
SSN: _____

Sex:
☐ Male ☐ Female ☐ Unknown
Marital Status:
☐ Divorced ☐ Married ☐ Partner ☐ Single
☐ Unknown ☐ Widowed ☐ Legally Separated
Preferred Language:
☐ English ☐ Spanish ☐ Sign Language
☐ Declined to specify ☐ Haitian/Haitian Creole
Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to report
Race:
☐ Caucasian ☐ African American ☐ Asian
☐ Hispanic ☐ Multi-Racial ☐ Other_____
☐ Native Hawaiian or Pacific Islander
Employment Status:
☐ Employed Full-Time ☐ Employed Part-Time ☐ Not Employed
☐ Self-employed ☐ Retired ☐ On active military duty
☐ Reserved for national assignment ☐ Unknown

Advanced Directive: ☐ PA - Power Attorney ☐ LW - Living Will
*If YES to either, please provide a copy to the front desk

Emergency Contact Information

Name: _____
Relationship to Patient: _____
Address: _____
Phone Number.: (____) _____

Preferred Pharmacy Contact Information

Name: _____
Address: _____
Phone Number: (____) _____

Elite Medical Center

PATIENT ACKNOWLEDGEMENT AND CONSENT
FOR MEDICAL TREATMENT AND RELEASE

Please initial and sign to complete the acknowledgement and consent for Medical Treatment, Release of Information, Notice of Privacy Practices, and Payment Policy.

☐ **Consent for Treatment**

I voluntarily consent to care and treatment performed by my physician and other healthcare providers at Elite Medical Center. Such care may include, but is not limited to, diagnosis, procedures, X-rays, blood draws, laboratory tests, medication administration, and other procedures deemed necessary by the healthcare providers treating me. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may carry risks, including injury or even death. I acknowledge that no guarantees have been made to me regarding the outcomes of any treatment or procedure. I understand that I have the right to consent or refuse to consent to any proposed treatment or procedure, and to discuss it with my healthcare provider. I understand that, in the course of my medical treatment, I may have one or more photographs of my skin or wounds taken to assist in monitoring my treatment and guiding healthcare provider interventions. I understand that individuals who are in training or who wish to learn about the roles of healthcare providers may observe the treatment I receive. I consent to this, but I have the right at any time to object to letting such an individual observe and, any such objection will be honored.

☐ **Authorization for Release of Information**

I authorize Elite Medical Center to utilize confidential medical information contained in my medical record as necessary for claims payment, medical management, or quality review purposes. I further authorize the release and disclosure of such confidential information to my insurance company or other health coverage plan, including government payers, as necessary for claims payment, medical management, or quality review activities conducted by such company or plan, or its designee. This authorization includes the release of any AIDS diagnosis or positive HIV antibody test results, alcohol and/or drug use information, genetic testing, medication history, congenital disorders, and mental health information to the extent permitted by applicable federal and state law. I understand that this authorization for release of information can be revoked by me in writing at any time, but only with respect to future treatment and not with respect to care and treatment that has already been rendered to me.

☐ **Notice of Privacy Practices**

By signing this document, I acknowledge review of Elite Medical Center Notice of Privacy Practices with a copy available upon request, as required by Health Insurance Portability and Accountability Act to ensure that I have been made aware of my privacy rights.

Elite Medical Center

Payment Policy

☐ **Payment Agreement (Health Insured)**

I request that payment of authorized insurance benefits, including Medicare and Medicaid be made on my behalf for any services provided to me by Elite Medical Center. I acknowledge that I have provided my insurance information and authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services by Elite Medical Center to my insurance company or other entity upon request to secure payment of my benefits. It is my responsibility to notify Elite Medical Center of any changes in my healthcare coverage.

☐ **Self-Pay**

By signing this document, I acknowledge I am fully responsible for all service(s) provided by Elite Medical Center. Payment is due in total at the time of services are rendered. I acknowledge and I fully understand that the service(s) requested today will not be billed to any insurance carrier(s) at my request.

_____ _____/_____/_____

Signature of Patient or Legal Representative **Date**

_____ _____

Printed Name **Relationship if not Patient**

Elite Medical Center

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations, as permitted by law.
- The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

_____ _____/_____/_____

Signature of Patient or Legal Representative **Date**

_____ _____/_____/_____

Printed Name **Relationship if not Patient**

Elite Medical Center

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Please check all that apply and list name(s) of spouse, child(ren) and other involved in care as applicable.

☐ You have permission to leave information on my answer machine or voicemail regarding my medical care and test results.

☐ You have my permission to speak with my spouse/partner about my medical care.

☐ You have my permission to talk with my children or other family members involved with my medical care.

☐ Other, please describe

_____

_____

_____

NAME	RELATIONSHIP	CONTACT #

Upon request, I may limit the amount of time that this consent for release of information is valid, subject to applicable law. I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

_____ _____/_____/_____

Signature of Patient or Legal Representative **Date**

_____ _____/_____/_____

Printed Name **Relationship if not Patient**

Elite Medical Center

PATIENT INFORMATION	
Patient Name:	**Date of Birth:**
Social Security No:	**Telephone No:**
Address:	

RELEASE TO

I authorize **ELITE MEDICAL CENTER** ; **to release** the health information indicated below to: **And** for the purpose of alternative means of confidential communication the use of the following Email Address:

Person/Organization Name:	
Address:	
Telephone No:	**Email Address:**
Dates of Medical Record Release:	

ELITE MEDICAL CENTER., (EMC) offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **EMC** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **EMC** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and I consent to the conditions outlined herein. Any questions I may have had were answered.

REASON FOR DISCLOSURE

☐ **Continuing Care** ☐ **Insurance**	☐ **Legal** ☐ **Personal Use**	☐ **Other Purpose** *(please specify)*

INFORMATION TO BE RELEASED

☐ **Complete Medical Record** ☐ **Lab Reports**	☐ **Operative Reports** ☐ **Pathology *Reports***
☐ **Radiology Reports** ☐	☐ ☐
☐ **Other** *(please specify)*	

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ **Drug/Alcohol Abuse or Treatment** ☐ **HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses**	☐ **Genetic Testing Information** ☐ **Mental Health Treatment or Psychotherapy Notes** *(The release of Psychotherapy Notes require a separate authorization)*

This consent is subject to revocation at any time except to the extent the action has been taken thereon. ***This authorization and consent will expire one year from the date of authorization written below.*** Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

Patient Signature: *(Guardian/Legal Representative)*	**Date Signed:**
Print Name: *(Please Print)*	**Relationship If Other Than Patient:**

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care).*

Elite Medical Center

PATIENT INFORMATION	
Patient Name:	**Date of Birth:**
Social Security No:	**Telephone No:**
Address:	

REQUEST TO	
Name of Healthcare Facility from which Records are Requested:	
Telephone No.:	**Fax No.:**
Address:	
Dates of Treatment Requested:	**Reason For Disclosure:**

I hereby authorize **ELITE MEDICAL CENTER., (EMC) to obtain** the health information indicated below ***AND*** for the purpose of alternative means of confidential communication the use of their email address. **EMC** offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **EMC** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **EMC** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and consent to the conditions outlined herein. Any questions I may have had were answered.

Mail Information To:	**ELITE MEDICAL CENTER**	**Address: 13005 Southern Blvd, NO.:213, Loxahatchee, FL 33470**
Or Fax To:	**561.839.5955**	**Email: info@theelitemedicalcenter.com**

INFORMATION TO BE RELEASED

☐ **Complete Medical Record** ☐ **Radiology Reports**	☐ **Operative Reports** ☐ **Pathology Reports**
☐ **Lab Reports** ☐	☐ ☐
☐ **Other** *(please specify)*	

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ **Drug/Alcohol Abuse or Treatment** ☐ **HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses**	☐ **Genetic Testing Information** ☐ **Mental Health Treatment or Psychotherapy Notes** *(The release of Psychotherapy Notes require a separate authorization)*

This consent is subject to revocation at any time except to the extent the action has been taken thereon. ***This authorization and consent will expire one year from the date of authorization written below.*** Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your healthcare information by the recipient may no longer be protected by law.

Patient Signature: *(Guardian/Legal Representative)*	**Date Signed:**
Print Name: *(Please Print)*	**Relationship If Other Than Patient:**

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18. **For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.*

Elite Medical Center

OFFICE POLICY REGARDING NO-SHOW APPOINTMENTS AND NON-SUFFICIENT FUNDS

"NO-SHOW APPOINTMENTS"
An unanticipated event may prevent you from keeping your appointment, but please be advised that YOU are responsible for a $25.00 fee if you do not call to reschedule or cancel your appointment in a timely manner. If you call to reschedule or cancel your visit at least 24 hours prior to the appointment time, there will be no charge. If you don't contact our office, it is considered a "no-show" and you will be charged the fee of $25.00. No-show appointments are very costly, because our office plans time to re-schedule another patient in your timeslot. The normal patient care is also impacted. This policy enables us to maintain a high level of service for all our patients.

"NON-SUFFICIENT FUNDS"
If you pay by check and the check is returned for non-sufficient funds it will be necessary for us to pass on our $25.00 **NSF** fee from the bank. Your use of a check constitutes acceptance of this agreement. A zero balance regarding non-sufficient funds must show on your account in order for you to be seen.

I have read and agree to the above policies.

_____ _____/_____/_____

Signature **Date**

Elite Medical Center

HIPAA - PATIENT CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with **ELITE MEDICAL CENTER ., "**Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Patient Name: *(please print)* _____

Patient Signature *(or legal representative; proof may be requested)* _____

Date: _____

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **ELITE MEDICAL CENTER., (EMC)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **EMC** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **EMC** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **EMC** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

Patient Acknowledgment & Agreement

My Consented Email Address is: _____

My Consented Mobile Number For Text Messaging is: _____

Patient Signature: _____ **Date:** _____

IN CASE OF EMERGENCY: *Please call 911 or proceed to the nearest emergency room.*
Do not use this way of communication for that purpose.