Palm
PRIMARY CARE

Patient Registration Form

Demographics:

Patient First, Middle Initial and Last Name: _____

Street Address: _____

Mailing Address: _____ _____ _

Home Phone: _____ _____ _____ Cell: _____ _____ _____

Work Phone: _____ _____ _____ Leave Message: Yes ____ No ____

Date of Birth: _____ _____ _____ Social Security Number: _____ _____ _____

Marital Status: _____

Email Address: _____

Authorization to share PHI

Please indicate full name and relationship of the person(s) with whom we may discuss your Protected Health Information (PHI):

First and Last Name/Relationship: _____ _____

First and Last Name/Relationship: _____ _____

Insurance Information:

Primary Insurance: _____ Phone Number: _____ _____ _____

Insurance Address: _____

Subscriber Name: _____ Date of Birth: _____ _____ _____

Subscriber ID: _____ Group Number: _____

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Secondary Insurance Information:

Secondary Insurance: _____ Phone Number: _____ _____ _____

Insurance Address: _____

Subscriber Name: _____ Date of Birth: _____ _____ _____

Subscriber ID: _____ Group Number: _____

Employer Information:

Employer Name: _____ Phone Number: _____ _____ _____

Employer Address: _____

Emergency Contact:

Contact Name: _____ Phone Number: _____ _____ _____

Pharmacy Name: _____ Phone Number: _____ _____ _____

Patient Signature: _____ Date: _____ _____ _____

Patient Registration Form 2024

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PATIENT HEALTH HISTORY QUESTIONAIRE

Name: _____ Sex: M / F
DOB: _____ _____ _____ Date:_____ _____ _____

List all prescriptions and over-the-counter medications, supplements and vitamins you take including the dose or strength

_____

_____

_____

Allergies: _____. Latex Allergy Yes / No

PAST SURGICAL HISTORY

Please list any operations you have had:

_____

_____

_____

FAMILY/SOCIAL HISTORY

Occupation: _____

Marital Status: Single Married Widowed Divorced

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PAST MEDICAL HISTORY

Do you have now, or have you ever had any of the following?

Heart Disease:	Yes No	Rheumatoid Arthritis:	Yes No
Hyperthyroid:	Yes No	Psoriasis:	Yes No
Heart Attack:	Yes No	Lyme Disease:	Yes No
Kidney Stones:	Yes No	High Cholesterol:	Yes No
Heart Arrhythmia:	Yes No	Depression:	Yes No
Kidney Disease:	Yes No	Lung Disease:	Yes No
Atrial Fibrillation:	Yes No	Osteoporosis:	Yes No
Stroke:	Yes No	Asthma:	Yes No
Congestive Heart Failure:	Yes No	Neuropathy:	Yes No
Gallbladder Disease:	Yes No	Reflux Disease (GERD) :	Yes No
Hypertension:	Yes No	Hypothyroidism:	Yes No
Anemia:	Yes No	Ulcers:	Yes No
Vascular Disease:	Yes No	Fibromyalgia:	Yes No
Chronic Back Pain:	Yes No	Cancer (location):	Yes No
Diabetes:	Yes No	Colitis:	Yes No
* Insulin Dependent	Yes No	Blood Clots (DVT or PE):	Yes No
Non-Insulin Dependent	Yes No		

Other:

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Your personal habits: Do you?		**Do you have a family history of: Relationship?**	
Exercise Regularly:	Yes No	Heart Disease:	Yes No
Smoke or Use Tobacco:	Yes No	High Blood Pressure:	Yes No
How much: _____		Diabetes:	Yes No
For how many years: _____		Stroke:	Yes No
Used Tobacco in the Past:	Yes No	Cancer:	Yes No
Drink Alcohol:	Yes No	Thyroid Disease:	Yes No
How Much: _____		Depression:	Yes No
Recent Tick Bites:	Yes No	Blood Clots:	Yes No

Have you recently been troubled with any of the following symptoms?

Bloody Sputum	Yes	No	Backache	Yes	No
Indigestion	Yes	No	Leg Pain	Yes	No
Abdominal Pain	Yes	No	Painful Joints	Yes	No
Diarrhea	Yes	No	Headaches	Yes	No
Constipation	Yes	No	Double Vision	Yes	No
Change in Bowel Habits	Yes	No	Difficulty Swallowing	Yes	No
Abnormal Bleeding	Yes	No	Hoarseness	Yes	No
Blood in Stool	Yes	No	Nosebleeds	Yes	No
Pus in Urine	Yes	No	Shortness of Breath	Yes	No
Yellow Jaundice	Yes	No	Dizziness	Yes	No
Depression/Anxiety Weight Gain	Yes	No	Chest Pain/Pressure	Yes	No
*How many pounds _____			Irregular Heartbeat	Yes	No
Weight Loss	Yes	No	Swelling of Feet	Yes	No
*How many pounds _____			Cough	Yes	No

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Patient Signature (Parent for Minor) Date

Provider Signature Date

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Patient Authorization for Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: ____ _____ _____

Address: _____City: _____ State: ____

Zip: _____ E-mail Address: _____

Phone: ____ _____ _____

I request that my protected health information (PHI) from _____ be disclosed to:

Address: _____City: _____ State: ____

Zip: _____ E-mail Address: _____

Phone: ____ _____ _____

I authorize the following PHI to be released from my medical record(s): All records including hospital discharges, pathology reports, test results (labs, radiology, EKG, Mammogram, etc.), Progress notes, Treatment plans, Immunization records, Psychological and Psychiatric evaluations.

Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment of alcohol or drug and sexual abuse. State and federal law protects the following information, as defined in HIPAA at 45 CFR 164.501. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records □ Yes □ No Dates:_____

HIV/AIDS Testing and Results □ Yes □ No Dates:_____

Mental Health (Psychiatric & Psychological) □ Yes □ No Dates:_____

Psychotherapy Records □ Yes □ No Dates:_____

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Covering the period of healthcare: Specific Date(s): from to OR all past, present and future encounters/visits:_____

Purpose for requesting information: Legal Insurance Personal Continuation of Care Other: _____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal and state laws and regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 4400 Oak Park Lane Fort Worth, TX 76109, USA. Revocation will not apply to information that has already been disclosed in response to this authorization. Unless otherwise revoked, this authorization will expire one year from date signed.
- I understand that these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that these records will not be release to entities other than those designated by myself or my personal representative as provided by state or federal laws.

_____

Patient or Authorized Representative Signature Date

_____

Print Name Date

_____

Relationship to Patient

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Consent for Medical Treatment and Care

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition

which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and Consent fully and voluntarily to its contents.

Patient Name (PRINT): _____ Date: _____ _____ _____

Signature: _____

If Personal Representative, please PRINT Name: _____

Relationship to Patient (PRINT): _____

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Patient First and Last Name: _____

Thank you for choosing Palm Primary Care as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies as an essential element of your medical care and treatment.

PATIENT FINANCIAL RESPONSIBILITIES

I understand that it is my responsibility to know what the terms of my insurance are, and in compliance with those terms, I agree to the following:

- I understand that as a recipient of medical care, I am ultimately responsible for the payment of my medical treatment and care.
- I understand that I am responsible for the payment of copayments, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I agree to pay co-payments and deductibles at the time of service.
- If I don't have medical insurance, Palm Primary Care will provide a fee schedule for selfpay patients. I understand that full payment due at the time of service except if otherwise arranged. or mandated by law.
- I understand that if I have a high deductible policy or coinsurance, I agree to pay an estimate of charges in the amount of $30.00, for my office visit in advance and understand. That other charges may apply. I payee to pay my outstanding balances as they become due.
- I understand that I must provide Palm Primary Care with complete and accurate billing information, including, but not limited to, a current-insurance card, authorization numbers, and/or referral forms for each visit and/or procedure.
- I am responsible for all visits and procedures not properly authorized or any charges incurred if the insurance information provided to Palm Primary Care is not current or valid.
- By my signature below, I hereby authorize Palm Primary Care to release medical and other information acquired during my examination and/or other treatment, which includes my protected health information (PI-L), to my health plan and/or other health care providers, physicians and/or entities required to participate in my medical care.

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ASSIGNMENT OF BENEFITS

- I hereby authorize assignment of my insurance benefits directly to Palm Primary Care. Any insurance benefits when received by Palm Primary Care, will be credited to my account in accordance with my insurance company's assignment. Any unpaid charges are my responsibility.
- I hereby authorize the release of all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all legally authorized parties to submit to obtain benefits, for services rendered, without obtaining my signature on each claim to be submitted for myself and/or dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.
- Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an Explanation of Benefits outlining payments and patient balances. For your convenience, we accept Visa, MasterCard, Discover, or American Express.
- Accounts with no activity for 60 days may be forwarded for further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. All advance collection fees incurred by the practice will be included in my final bill.

I HAVE READ AND UNDERSTAND PALM PRIMARY CARE'S FINANCIAL POLICY AND AGREE TO THE TERMS OUTLINED IN THE POLICY.

_____

Printed name of Patient / Parent / Legal Guardian or Authorized Representative

Date: _____

_____

Signature of Patient/Parent/Legal Guardian or Authorized Representative

Date: _____

_____

If Legal Guardian or Authorized Representative, indicate Relationship to patient:
Guardian or Authorized Representative must provide documentation of such status

Palm PRIMARY CARE

Patient Authorization for Disclosure of Protected Health Information

Patient Name				Date of Birth			
Address:		City:		State:		Zip:	
E-mail Address:				Phone:			
I request that my protected health information (PHI) from							
Phone:		Fax:			be disclosed to:		
Recipient Name:							
Address:		City:		State:		Zip:	
E-mail Address:		Phone:			Fax:		

I authorize the following PHI to be released from my medical record{s): All records which include hospital discharges, pathology reports, test results (labs, radiology, EKG, Mammogram, etc.), Progress notes, Treatment plans, Immunization records, Psychological and Psychiatric evaluations

Other:_____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment of alcohol, drug, or sexual abuse.

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State and federal law protects the following information, as defined in HI PAA at 45 CFR 164.501. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

_____

Alcohol, Drug, or Substance Abuse Records		Yes		No	Dates:	
HIV/AIDS Testing and Results		Yes		No	Dates:	
Mental Health (Psychiatric & Psychological)		Yes		No	Dates:	
Psychotherapy Records		Yes		No	Dates:	

Purpose for requesting information:

Legal | Insurance | Personal | Continuation of Care

Other: _____

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By signing this authorization form, I understand that:

Requests for copies of medical records are subject to reproduction fees in accordance with federal and state laws and regulations.

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 4400 Oak Park Lane Fort Worth, TX 76109, USA. Revocation will not apply to information that has already been disclosed in response to this authorization. Unless otherwise revoked, this authorization will expire one year from date signed.
- I understand that these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that these records will not be release to entities other than those designated by myself, or my personal representative as provided by state or federal laws.

Patient or Authorized Representative Signature

Date

Print Name

Relationship to Patient

Patient Authorization for Disclosure of Health Information Rev. 05.10.2022

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Informed Consent to Photograph

I hereby give consent for Palm Primary Care or its staff to take and/or display photographs of my face and smile.

These photographs will be used for identification purposes within the office and may be stored on the office's Electronic Medical Records. The doctors, office, and staff will ensure that my personal information, such as my name, age, and date of birth, is protected and not displayed.

Patient Name (PRINT}: _____

Signature:_____

Date:_____

If Personal Representative, please PRINT Name: _____

Relationship to Patient (PRINT): _____

Notice of Privacy Practices

November 6, 2018

This Notice explains how Palm Primary Care fulfills our commitment to respect the privacy and confidentiality of your Protected Health Information (PHI) and how we may use and disclose your information. This Notice also tells you about your rights under federal and state laws. This notice applies to all records held by Palm Primary Care, regardless of whether the record is written, electronic, or in any other form. We are required by law to provide you with this Notice and maintain the privacy of your PHI. All healthcare providers, employees, and business associates of Palm Primary Care are required to follow the privacy practices required by law and described in this Notice.

Protected Health Information (PHI) refers to:

- Information about your health, such as medical conditions and diagnostic test results
- Information about health care services and treatments you have received or may receive in the future
- Information about your health care benefits under an insurance plan
- Geographic information, such as where you live or work
- Demographic information, such as your race, gender, ethnicity, or marital status
- Unique identifiers, such as your social security number, date of birth, phone number, address, or driver's license number
- Full-face photographs

We may use and disclose your Protected Health Information for:

Your medical treatment - We may use or disclose your PHI to provide, coordinate, or manage your medical treatment or services. We may disclose information about you to doctors, nurses, technicians, or other personnel involved in your medical care. With your written consent, we may disclose your information to individuals and entities outside of Palm Primary Care involved in your continuing medical treatment after you leave our care, such as other healthcare providers, home health agencies, and transportation companies.

Payment: We may share your protected health information with insurance companies, third parties, and other service providers to receive payment for the services we provide to you. This may include sharing information with doctors, facilities, ambulance companies, and subcontractors who have treated or provided services to you. Insurance companies and other third

parties may require your social security number and date of birth for verification and payment purposes.

Healthcare Operations: We may use your protected health information to support our business practices and improve the quality of your care. For instance, we may use it to review your treatment and services and to evaluate our staff's performance. We may also share your information with our staff for review and training purposes.

Appointment Reminders: We may use and share your protected health information to contact you and remind you of appointments for treatment or medical care. This may include reminders from entities where testing is performed.

Business Associates: We may share your protected health information with business associates such as billing companies or medical transcription services. These associates are required by law to keep your information confidential.

Treatment Options and Other Health-related Benefits: We may use your information to contact you about treatment options and other health-related benefits provided by Palm Primary Care that may be of interest to you. We will not use your information for marketing activities (other than face-to-face communications) without your authorization.

Individuals Involved in Your Care: Unless you object, we may release your protected health information to individuals involved in your medical care or payment, such as family members or others. Parents and legal guardians are authorized representatives for minors unless minors are legally permitted to make their own medical decisions. You must notify us in writing if you do not want information released to those involved in your care.

Disaster Relief Efforts: We may share your protected health information with organizations assisting in disaster relief efforts to notify your family or significant others of your condition, status, and location.

Research: Researchers may contact you about participating in research studies after obtaining your authorization or approval from an Institutional Review Board (IRB). IRBs are committees that protect the rights and welfare of research participants. Enrollment in most studies requires your informed consent, which is obtained after you have been informed about the study and sign an authorization or consent form approved by an IRB. In some cases, federal law allows us to use your protected health information for research without your authorization, with approval from an IRB or other special review board. This will not affect your treatment or welfare and your information will remain protected.

Legal Proceedings, Lawsuits, and Other Legal Actions: We may share your protected health information with courts, attorneys, and court employees when we receive a court order, subpoena,

discovery request, warrant, or summons, and when required by law during other lawful judicial or administrative proceedings

Law Enforcement: We may disclose your protected health information as authorized or required by law or in response to a valid judicial order or subpoena:

- To identify or locate a suspect, fugitive, material witness, or missing person
- In criminal investigations
- To protect victims of abuse, neglect, and domestic violence
- If a death is suspected to be the result of criminal conduct
- To prevent a serious health or safety threat
- If you are an inmate in a correctional institution or under the custody of a law enforcement official, we may release your protected health information to the institution or official.

Workers' Compensation: We may share your protected health information for Workers' Compensation or similar programs that provide benefits for work-related injuries or illnesses.

Special Government Functions: If you are a member of the armed forces, we may share your protected health information with military authorities to allow them to carry out their duties under the law. We may also disclose your information if it relates to national security and intelligence functions.

Regulatory Agencies: We may disclose your protected health information to local, state, or federal government authorities responsible for medical oversight, as authorized by law. This includes licensing, auditing, and accrediting entities and agencies that administer public health programs such as Medicare and Medicaid.

Coroners, Medical Examiners, and Funeral Directors: We may release your protected health information to coroners or medical examiners as necessary to identify a deceased person or determine the cause of death. We may also release protected health information to funeral directors for the performance of their duties.

Organ Donation: If you are an organ donor, we may release your protected health information to organizations that handle organ, eye, or tissue transplants, including donation banks.

Public Health Risks: As required by law, we may disclose your protected health information to public health authorities for purposes related to:

- Preventing or controlling diseases, injuries, or disabilities

- Reporting vital events such as births and deaths
- Reporting child abuse or neglect
- Reporting domestic violence
- Reporting reactions to medications or problems with medical products
- Notifying patients of recalls, repairs, or replacements of products they may be using
- Notifying a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease
- Reporting to your employer findings concerning work-related illnesses or injuries so the workplace can be monitored for safety.

Other Uses and Disclosures Not Covered in this Notice:

Other uses and disclosures of your protected health information, not described in this Notice or permitted by law, will only be made with your written authorization. We will obtain your authorization for most uses and disclosures of psychotherapy notes. If you give us authorization to use or disclose your protected health information, you may revoke it in writing at any time. Please note that we cannot retract any disclosures already made with your prior authorization.

Your Rights Concerning Your Protected Health Information: Unless otherwise required by law, your medical health record is the property of the Palm Primary Care or facility that compiled it. You have the following rights regarding your protected health information:

Right to Receive a Copy of this Notice: You will be provided with a hard copy of this notice at the time of first service. You may also request a copy at any time. The center reserves the right to change or update its practices regarding protected health information. If changes are made, a revised notice will be provided.

Right to Ask to See and Obtain a Copy of Your Records and Protected Health Information: You have the right to request to see and obtain a copy of the protected health information used for decision making about your care. Your request must be made in writing. The center may deny access in certain limited circumstances, and a written explanation will be provided if this occurs. If your request is denied in whole or in part, you may request a review of the denial.

Right to Ask for an Amendment or Addendum: If you believe your protected health information is incorrect or incomplete, you may request an amendment. Your request must be in writing and include supporting documentation. The center may deny the request if the information was not created by the center, if it is not part of the center's protected health information, or if the information is deemed accurate and complete. If the request is denied, a written explanation will

be provided, and documentation of the request and decision will be included in your medical record.

Right to Ask for an Accounting of Disclosures: You have the right to request a list of individuals or entities that have received your protected health information from the center. Your request must be in writing and specify the dates of the requested disclosures. This list will not include disclosures made to you, authorized parties, for your care, treatment, payment, or health care operations, or disclosures incident to permitted use or disclosure under law, such as government and regulatory agencies, national security, or intelligence services, or to correctional institutions or law enforcement officials.

Right to Revoke Certain Authorizations and/or Request Restrictions: You have the right to revoke previously authorized consents or request restrictions or limits on your protected health information. The center may consider your request but is not obligated to agree. You also have the right to request restrictions on protected health information disclosed to someone you authorized for your care or payment. Your request for restriction or revocation must be made in writing.

Right to Confidential Communications: You have the right to request that we communicate with you about medical matters in a confidential manner of your choosing. For example, you can ask that we contact you only at home, through a personal or business phone, email, or regular mail. Your request must be made in writing. You do not need to provide a reason for your request, and we will comply with all reasonable requests. However, if we are unable to contact you using your requested means, we may contact you using other information you have provided us.

Right to Receive Notice of a Breach: You have the right to be notified in the event of a breach of the privacy of your protected health information by Palm Primary Care or its business associates. You will be notified as soon as reasonably possible, but no later than 60 days after the discovery of the breach. The notice will provide you with the date of discovery, a description of the type of information involved, the steps we are taking to investigate and mitigate the situation and contact information for you to ask questions and obtain additional information.

Right to File a Privacy-Related Complaint: If you believe that your privacy rights have not been followed as mandated by federal and/or state law or as explained in this notice, you may file a written complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. The complaint must be in writing, describe the subject matter of the complaint, and name the individual(s) or organization that you believe violated your privacy. You will not be subjected to retaliation or denied any health care services if you file a complaint. The contact information for both the Palm Primary Care' Compliance Department and the U.S. Department of Health and Human Services is provided.

Director of Compliance and Risk Management

Odalys Gonzalez

2600 Douglas Road, Suite 308,

Coral Gables, Florida 33134

Phone: (786) 316-3685 | **compliance@palmmedicalcenters.com**

US Department of Health and Human Services Office of the Secretary

200 Independence Avenue, SW

Washington, DC 2020J

Phone: (202) 619-0257 Toll Free: l-877-696-6775

www.usa.go

Notice of Privacy Practices Signature and Acknowledgement

Authorization to share PHI

Please indicate full name and relationship of the person(s) with whom we may discuss your Protected Health Information (PHI):

First and Last Name/Relationship: _____

First and Last Name/Relationship: _____

I hereby acknowledge that I have read, understand, and received a copy of the Palm Primary Care Notice of Privacy Practices.

Patient Name (PRINT): _____

Patient Date of Birth: _____ _____ _____

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PRIMARY CARE

_____ _____

Patient Signature Date

I am the parent, legal guardian, or authorized representative of _____ (patient name). I hereby acknowledge that I have read, understand, and received a copy of Palm Primary Care Notice of Privacy Practices.

Name of Parent, Legal Guardian, or Authorized Representative (PRINT):

_____

Relationship to Patient:_____

_____ _____

Parent, Guardian, or Authorized Representative Signature Date