

REGISTRATION FORM

Patient Information:

Name of Patient: _____ Maiden Name: _____
Social Security #: _____ Date of Birth: _____ Sex: M F
Marital Status: _____ Race: _____ Ethnic Group: _____ Language: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home phone: _____ Cell Phone: _____
Work phone: _____ E-Mail address: _____
Preferred Contact Method: _____ Preferred Reminder Method: _____
Drivers License #: _____ Date Expired: _____ State: _____
Employer: _____

Guarantor Information:

Guarantor Name: _____ Relationship to Patient: _____
Social Security #: _____ Date of Birth: _____ Sex: M F
Address: _____
City: _____ State: _____ Zip Code: _____
Home phone: _____ Cell Phone: _____
Work phone: _____ E-Mail address: _____
Employer: _____

Insurance Information #1:

Primary Insurance: _____
Policy #: _____ Group #: _____
Address: _____
Telephone #: _____ Contact Person: _____
Name of Insured: _____ Relationship to patient: _____
Insured Date of Birth: _____ Social Security #: _____

Insurance Information #2:

Primary Insurance: _____
Policy #: _____ Group #: _____
Address: _____
Telephone #: _____ Contact Person: _____
Name of Insured: _____ Relationship to patient: _____
Insured Date of Birth: _____ Social Security #: _____

Emergency Contact Information:

Name: _____ Telephone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Relationship to patient: _____

I hereby grant permission to Lakeland Medical Associates to employ such medical, lab, and x-ray procedures as considered necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release, to my insurance carrier, government agency, or its intermediary, any information needed for this or any related insurance claim. I further permit a copy of this authorization to be sued in place of the original. I authorize payment of medical benefits to the physician for services rendered. I understand that I am financially responsible for the charges regardless of insurance coverage and/or payment.

Signature of Patient: _____ Date: _____

Signature of Responsible Party: _____ Date: _____



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Assignment of Benefits

To accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is very difficult for us to keep track of all the individual requirements of the plans. Each plan has different restrictions regarding how often services may be rendered and, more importantly, where you should obtain these services.

Even within a single insurance company, the plans differ, depending on what type of contract your employer has negotiated.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible.

Unfortunately, if you do not inform us of special requirements by your healthplan and we order services that you need, such as lab work, hospitalization, and supplies that are not covered by your plan, we may bill you directly for those charges. Payment for these services may be your responsibility.

With your cooperation and our help, you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on your medical needs.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Patient/Parent Signature: _____ Date: _____



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Consent For Treatment

I hereby grant permission to Lakeland Medical Associates physicians to provide medical services, as they deem necessary.

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following statement of our financial policy, which we require you to read, agree to, and sign prior to any treatment by our physicians.

- Our office will file insurance claims for you, however your share of the cost of our services is due at the time of service.
- We accept cash, checks, VISA, Discover, MasterCard, AmericanExpress and CareCredit.
- We do not file third party insurance claims such as auto insurance or accident insurance. It is your responsibility to pay for services rendered. You can collect from the insurance company with your paid receipt from us.
- The adult bringing a minor (under age 18) for treatment is the responsible party for payment of our services.
- Co-pays: Your co-pays and deductibles are due at the time of service. In order to be eligible participants, we must sign contracts agreeing to collect co-payments at the time service is rendered; therefore, we must collect your co-pay prior to seeing the doctor. We are unable to bill for co-payments, so please do not ask for us to do this. Our office is simply following the orders of your managed care contract or insurance company. If we do not collect this co-payment, your insurance company has the right to terminate our provider privileges.
- Medicaid Pending: If your Medicaid coverage is pending or you are unable to provide our office with proof of coverage, you will be required to pay, just as if you were private pay, until you receive your Medicaid card.
- Insurance cards: If you do not bring your insurance card and we are unable to verify your insurance, you will be required to pay your visit in full at the time of service.
- If you are unable to take care of payment today, please ask to speak with the financial counselor so that we can authorize arrangements with your treating doctor.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Patient/Parent Signature: _____ Date: _____



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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Furthermore, I authorize my physician and his/her staff, to contact me by the designated means noted below.

Home Phone: _____ *Circle One:* Call only / Call & Voicemail
Work Phone: _____ *Circle One:* Call only / Call & Voicemail
Cell Phone: _____ *Circle One:* Call only / Call & Voicemail
Email/Patient Portal: _____

Additionally, I authorize my physician and his/her staff, to communicate information regarding appointments, medical results and billing issue to the following person(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

This Authorization shall remain in force until revoked in writing, Attention of Privacy Officer.

Patient/Representative Signature: _____ **Date:** _____

**If not signed by Patient,* Name of Authorized Representative: _____

Relationship to Patient: Parent/Guardian POA Other: _____



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Mid-Level Provider Acknowledgement

Our facility has on staff a Physician Assistant and/or Nurse Practitioner to assist in the delivery of medical care.

A Physician Assistant (PA)/Nurse Practitioner (NP) is not a doctor. A PA/NP is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a PA/NP can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A Physician Assistant/Nurse Practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting in surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a Physician Assistant and/or Nurse Practitioner for my health care needs.

I understand that at any time I can refuse to see the Physician Assistant/Nurse Practitioner and request to be consulted by the supervising physician. I understand that the supervising physician will review my case, but is not obligated to accept my request for consultation.

Patient/Parent Signature: _____ Date: _____

MEDICAL HISTORY

Date: _____
 Name: _____
 Occupation: _____
 Education Level: _____
 Pharmacy: _____

Are you allergic to any medications? YES NO
 List all drug allergies: _____

List all current medications: _____

Do you use over-the-counter Medications? Yes No
 Please List: _____

PERSONAL HISTORY:

Have you ever had: (Place X in the appropriate box)

	YES	NO	Type / Comment
Stroke			
Eye Disease			
Headaches			
Heart Disease			
Heart Murmur			
High Blood Pressure			
Tuberculosis			
Asthma/COPD			
Colon Disease			
Intestinal Disease			
Hepatitis			
Rectal Bleeding			
Kidney Disease			
Breast Lumps			
Cancer			
Skin Cancer			
Arthritis			
Diabetes			
High Cholesterol			
High Triglycerides			
Thyroid Disease			
Depression			
Anxiety			
Alcohol Problems			

List previous surgical procedures:
 Date Procedure

List other medical problems and hospitalizations:
 Date Procedure

Most Recent Tetanus Shot: _____
 Most Recent Pneumonia Vaccine: _____
 Most Recent TB Skin Test: _____
 Have you ever had a colonoscopy? YES NO
 When? _____

Women:
 Last Menstrual Period: _____
 Do you use birth control? YES NO
 If yes, which method? _____
 Most recent pap smear: _____
 Most recent mammogram: _____
 Have you ever been pregnant? YES NO #: _____
 Are menses? ___ Normal ___ Abnormal

Men:
 Most recent PSA: Date: _____
 Most recent prostate exam: Date: _____

Are you on a special diet? YES NO
 Do you exercise? YES NO

FAMILY HISTORY:

Has a blood relative had: (Place X is appropriate Box)

	YES	NO	Type	Relative
Cancer				
Diabetes				
Heart Attack				
Stroke				
Hypertension				
Alcoholism				
High Cholesterol				

Circle Correct Answers Below:
 Do you use tobacco? YES NO
 Cigarettes: YES NO Smokeless: YES NO
 Currently or Past? _____ Quit Date: _____

Do you use illegal drugs? YES NO
 Do you drink? (i.e. beer, wine or liquor) YES NO
 When was the last time you had (Women 4 or more / Men 5 or more) drinks in one day?
 _____ Never
 _____ More than 12 months ago
 _____ 3 – 12 months
 _____ Within the last 3 months



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Medication History Authority Consent

Lakeland Medical Associates has adopted an electronic medical record system to improve the quality of our services. **This system also allows us to collect and review your “medication history.” A medication history is a list of all prescription medicines that we or other doctors have prescribed for you.** This list is collected from a variety of sources including: your pharmacy, your health insurer and other healthcare providers. An accurate medication history is very important in helping us treat you properly and avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines used to treat AIDS/HIV, substance addiction and/or mental health conditions. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make medication histories available to us and the medication history from your health plan might not include medication that you purchased without using your health insurance. Your medication history might not include over the counter medicine, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking and for you to point out and report any errors in your medication history to our staff.

PATIENT ACKNOWLEDGEMENT

By signing below, I give permission for LAKELAND MEDICAL ASSOCIATES to obtain my medication history from my pharmacy, my health plans and other healthcare providers.

Patient/Parent Signature: _____ Date: _____