Coastal Nephrology & Hypertension Center, P.A.

641 University Blvd. Ste. 211 Jupiter, FL 33458
Phone: (561) 253-8121 Fax (561) 253-8021

Please print and complete as accurately as possible.

Today's Date: _____

Patient name: _____
Last First MI

Social Security #:_____ Date of Birth: _____ Sex: □ F / □ M

Cell Phone :_(_____) _____ Home Phone :_(_____) _____

Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Address: _____

Race: □ American Indian or Alaskan Native / □ Asian / □ Native Hawaiian or Other Pacific Islander

□ Black or African American/ □ White/□ Hispanic/□ Other Race/□ Other Pacific Islander/□ Unreported

Ethnicity: □ Hispanic or Latino/□ Not Hispanic or Latino/□ Refuse to report

Marital Status: □ Single / □ Married / □ Divorced / □ Widowed / □ Legally Separated

Occupation: _____

Employer & Employer Contact Phone: _____

How did you hear from us? □ Friend / □ Relative / □ Physician: _____ __

□ Hospital / □ Other: _____

Date of last physical exam: _____

What is the reason for your visit?

_____

Emergency Contact:
Name: _____ Phone: _ (____) _____
Relation to Patient: Spouse / Partner / Child / Friend / Other: _____
Address: _____
City: _____ State: _____ Zip Code: _____
HIPAA Authorized? □ Yes / □ No

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Insurance Assignment and Release:

I certify that I have Insurance coverage with:

_____
Name of Insurance Company (ies)

I hereby assign directly to Coastal Internal Medicine of Jupiter, P.A. the right to payment of all insurance benefits payable for my medical care and treatment, the right to receive payment of all insurance benefits paid for my medical care and treatment, and if a claim is denied, in whole or in part, at its option, the right to pursue all administrative appeals and litigation necessary to pursue payment of my insurance benefits. I understand that I am financially responsible for all charges for medical services and treatment rendered by Coastal Internal Medicine of Jupiter, P.A. of whether or not paid by insurance, an in the event any portion of my medical care and treatment is uncovered by insurance for any reason whatsoever, I hereby agree to pay Coastal Internal Medicine of Jupiter, P.A. the outstanding balance due within ten (10) days of demand for payment by Coastal Internal Medicine of Jupiter, P.A., except for medical services that are determined not to be covered by insurance at or about the time the services are rendered, in which event I shall pay the full cost thereof to Coastal Internal Medicine of Jupiter, P.A. at the time the services are rendered.

Coastal Internal Medicine of Jupiter, P.A. may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of determining insurance benefits and for obtaining payments of such benefits for medical services rendered me.

MEDICARE AUTHORIZATION
I request that payment of authorized Medicare Benefits and, if applicable, Medical benefits, be made either to me or on my behalf to Coastal Internal Medical of Jupiter, P.A. (name of doctor or clinic) for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medical Insurer, and their agents any information needed to determine these benefits for medical services and the payment thereof.

Signature:_____ Date:_____
Signature of patient, parent, guardian, or personal representative

Print name:_____ Relationship to patient:_____
Please print name of patient, parent, guardian, or personal representative

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HIPAA Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. We are to inform you about our privacy practices by providing you with this notice. We will not disclose of your information without your written consent unless you have listed the persons below.

Patient Name:_____ Date of Birth:_____

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME TO BE GIVEN TO:

1. Name:_____ Phone:_____Fax:_____
   Address:_____
   Relationship to patient:_____

2. Name:_____ Phone:_____Fax:_____
   Address:_____
   Relationship to patient:_____

3. Name:_____ Phone:_____Fax:_____
   Address:_____
   Relationship to patient:_____

PLEASE INITIAL BELOW GIVING CONSENT FOR THE FOLLOWING:

- We may disclose and/or share your healthcare information with other health professionals who provide treatment and/or service you. (_____)
- We may use and disclose your health information to seek payment for services we provide to you. (_____)
- We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsibly for your care, in case of any emergency involving your care, your location, your general condition or death. (_____)
- We may use or disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, postcards or letters. (_____)

Patient Signature:_____ Date:_____

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Please print and complete as accurately as possible.

Patient Name:_____ DOB:_____ Date:_____

Exam	*Did you have exam?*	*Date of exam*	*Name of doctor seen for exam or test*
Eye	☐No ☐Not Sure ☐Yes		Dr.
Dentist	☐No ☐Not Sure ☐Yes		Dr.
Chest X-ray	☐No ☐Not Sure ☐Yes		Dr.
Colonoscopy	☐No ☐Not Sure ☐Yes		Dr.
EGD	☐No ☐Not Sure ☐Yes		Dr.
Stress Test	☐No ☐Not Sure ☐Yes		Dr.
Holter Monitor	☐No ☐Not Sure ☐Yes		Dr.
EKG	☐No ☐Not Sure ☐Yes		Dr.
Echocardiogram	☐No ☐Not Sure ☐Yes		Dr.
Carotid Doppler	☐No ☐Not Sure ☐Yes		Dr.
Bone Density	☐No ☐Not Sure ☐Yes		Dr.
P-Vax	☐No ☐Not Sure ☐Yes		Dr.
Flu Shot	☐No ☐Not Sure ☐Yes		Dr.
Shingles Shot	☐No ☐Not Sure ☐Yes		Dr.
***Men Only:* PSA test**	☐No ☐Not Sure ☐Yes		Dr.
Women Only:			
Pap	☐No ☐Not Sure ☐Yes		Dr.
Mammogram	☐No ☐Not Sure ☐Yes		Dr.
Breast US/MRI	☐No ☐Not Sure ☐Yes		Dr.

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Name: **Drug allergy:**

DOB:

Medication & Dose **Date:**

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Patient Financial Responsibility Form

Thank you for choosing Coastal Internal Medicine of Jupiter, P.A. 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 and agreement to our patient financial policies.

INSURANCE COVERAGE

•It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and imitations as well as authorization requirements. This information is furnished by your insurance carrier.

•We attempt to verify that your coverage is valid at the time of your first visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours.

INSURANCE CHANGES

• If you have had any changes in your insurance coverage - even if there is only a small change in the co-payment amount or a change in the expiration date of the policy - you must notify us before further services are rendered. Even a small discrepancy on the claim form can lead to a claim denial costing you additional money.

CO-PAYMENTS, CO-INSURANCE AND DEDUCTIONS

• Co-insurance and co-payments are the patient's responsibility. Co-pays are due at the time of visit.

• Deductibles are the patient's responsibility. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each person's deductible is and how much has been met at the time of your visit.

NON-COVERED SERVICE

• All patients are responsible for "non-covered" services if denied by their insurance carrier, if coverage for the services are excluded under your policy, or if the services are not payable due to an unmet deductible.

INSURANCE REQUEST

• You are responsible for responding to any request from the insurance company for further information. Not doing so may result in a claim denial and you will be responsible for payment.

INSURANCE PAYMENTS SENT TO YOU

• If insurance payments are sent to you for payment of our medical services, you are responsible for forwarding them to our office with a copy of the explanation of Benefits (EOB) received and you agree to cooperate with us in negotiating any such payment(s) for our exclusive benefit.

COLLECTION ACCOUNTS

• In the case your account is forwarded to a collection agency or an attorney for collection, you hereby agree to pay our reasonable attorney fees and costs necessitated by our efforts to collect your account, and pre-judgment interest at the rate of 1% per month on the past-due balance of your account until paid in full.

• You will be responsible for a $25.00 service fee if your check is returned for non-payment by the bank. Any NSF check received by us will result in your being

Signature: _____ Date: _____

Signature of patient, parent, guardian, or personal representative

Print name:_____ Relationship to patient:_____

Please print name of patient, parent, guardian, or personal representative

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Authorization for Release of Medical Records

Patient Name (Print): Social Security #: Patient DOB:

_____ I authorize Coastal Internal Medicine of Jupiter, P.A.to use or release/disclose my health information as described below.

Please identify the information to be released:

- ☐ Please release my entire record
  -OR-
- ☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):
  - ☐ Problem list
  - ☐ Medication list
  - ☐ List of allergies
  - ☐ Immunization records
  - ☐ Most recent history
  - ☐ Most recent discharge summary
  - ☐ Lab results (dates):_____
  - ☐ X-ray and imaging reports (dates):_____
  - ☐ Other (please describe): _____

The identified information will be used for the following purpose:

- ☐ My personal records
- ☐ Sharing with other health care providers as needed
- ☐ Other (please describe): _____

Please initial each item below to indicate your understanding.

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

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

Signature of patient, parent, guardian, or personal representative Date

_____

Witness Signature Date

*This authorization will expire twelve (12) months from the date on which it was signed.