GUTLEBER MEDICAL GROUP

****Today's Date:** _____ Staff *Name*: _____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ ***Social Security #:** _____

***Date of Birth:** _____ **Age:** _____ ***Sex:** _____ **Marital Status:** _____ **Drivers Lic#:** _____

ALLERGIES: _____

_____ **Work Phone #:** (_____) _____-_____

E-Mail Address: _____ **Cell Phone #:** (_____) _____-_____

Emergency Contact Name: _____ PHONE#: (_____) _____-_____

Please tell us how you heard about us: _____ *Referred by* _____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

***Relationship of Guarantor to Patient:** **Self** ____ **Spouse** ____ **Parent** ____ **Other** _____

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ ***Social Security #:** _____

***Date of Birth:** _____ **Age:** _____ ***Sex:** **Female** _____ **Male** _____

***Employer Name and Address:** _____

_____ **Work Phone #:** (_____) _____-_____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name : _____ ***Insured's Name:** _____

Insured's Social Security #: _____ ***Insured's Date of Birth:** _____

***Policy / ID #:** _____ ***Group #:** _____ **Eff Date:** _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name : _____ ***Insured's Name:** _____

***Insured's Social Security #:** _____ ***Insured's Date of Birth:** _____

***Policy / ID #:** _____ ***Group #:** _____ *** Eff Date:** _____

Claims Address & Phone: _____

***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING.** ***ATTACH COPY OF INSURANCE CARDS.**

Please read and sign back of form.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to MedicalEdge Healthcare Group or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that MedicalEdge is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to MedicalEdge Healthcare Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the MedicalEdge Healthcare Group Patient Information Privacy Policy. I hereby authorize MedicalEdge Healthcare Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a MedicalEdge Healthcare Group representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying MedicalEdge Healthcare Group to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my MedicalEdge physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____

GUTLEBER MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. These notices will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Law Requirements Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change or privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that keeps, including information previously created or received before the changes.

   Notice of change to privacy:

   Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request. The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

   For treatment:

   We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you with your other health care providers to assist them in treating you.

   For Payment:

   We may use any disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

   For Health Care Operations: we may use and disclose your medical information for our health care operations.

Gutleber Medical Group
139 NE 15 Street
Homestead, FL 33030
Tel: 305-247-1213 Fax: 305-247-5701

Patient Responsibility Agreement:

- I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, lab testing, and any other screening ordered by the doctor or staff.
- I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.
- I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.
- By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. Gutleber Medical Group provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Acuerdo de Responsabilidad del Paciente:

• Entiendo y acepto que soy financieramente responsable de todos los cargos por todos y cada uno de los servicios prestados. Esto incluye cualquier servicio o visita médica, examen de rutina, análisis de laboratorio y cualquier otro examen de detección ordenado por el médico o el personal.

• Entiendo que si bien mi seguro puede confirmar mis beneficios, la confirmación de los beneficios no es una garantía de pago y que soy responsable de cualquier saldo impago. Entiendo y acepto que es mi responsabilidad saber si mi seguro tiene algún deducible, copago, coseguro, límite habitual y habitual fuera de la red, requisitos de autorización previa o cualquier otro tipo de limitación de beneficios para los servicios que recibo. y acepto hacer el pago completo.

• Acepto informar a la oficina de cualquier cambio en la cobertura de mi seguro. Si mi seguro ha cambiado o se cancela en el momento del servicio, acepto que soy financieramente responsable del saldo total. Si soy paciente de Medicare, entiendo que debo proporcionar al consultorio mi tarjeta de identificación de Medicare y mi tarjeta de identificación secundaria. Si la oficina no tiene la información adecuada para un seguro secundario, no se facturará al secundario. Será mi responsabilidad pagar el saldo y luego presentar una reclamación a la secundaria para el reembolso.

• Al firmar este formulario, doy mi consentimiento para el uso y la divulgación de mi información médica protegida para tratamiento, pago y operaciones de atención médica, y / o según lo requiera la ley. Gutleber Medical Group proporciona este formulario para cumplir con la Ley de Portabilidad y Responsabilidad del Seguro Médico de 1996 (HIPAA).

Patient Name/Nombre del Paciente: _____

Patient Signature/Firma del Paciente: _____

Date of Birth/Fecha de Nacimiento: _____ Date/Fecha: _____