NEW PATIENTS · ABOUT TEN MINUTES

Register before your *first visit.*

Fill this in on your computer or print it and complete it by hand. Bring it to your first appointment along with your insurance card, a photo ID and a list of your medications, or fax it to the office at (954) 391-8834. Please do not send completed forms by regular email. Questions? Call (954) 441-9995. Se habla español.

OFFICE HOURS

Mon to Thu	9am to 5pm
Friday	9am to 12pm
Sat and Sun	Closed

Today's date _____

A Your details

FIRST NAME REQUIRED _____

LAST NAME REQUIRED _____

DATE OF BIRTH (MM/DD/YYYY) REQUIRED _____

SEX AT BIRTH REQUIRED

☐ Male ☐ Female

MARITAL STATUS

☐ Single ☐ Married ☐ Divorced ☐ Widowed

EMAIL _____

SOCIAL SECURITY NUMBER (OPTIONAL) _____

Social Security number is optional. It is only needed if you apply for a patient assistance program, and you can also give it at the front desk.

B Where you live

LOCAL ADDRESS REQUIRED _____

COMMUNITY NAME (IF ANY) _____

CITY REQUIRED _____

STATE REQUIRED _____

ZIP CODE REQUIRED _____

Secondary address, for example a seasonal or out of state home (optional)

SECONDARY ADDRESS _____

CITY _____

STATE _____

ZIP _____

C Phone

CELL PHONE REQUIRED _____

HOME PHONE _____

WORK PHONE _____

☐ **Text me to confirm and remind me of upcoming appointments**

By providing your cell phone number, you authorize our office to send you text messages to confirm and remind you of your upcoming appointments. If you do not have text capability, we will call the number on file. You may opt out at any time.

BRING TO YOUR FIRST VISIT

+ This completed form
+ A photo ID
+ Recent bloodwork or imaging, if you have it
+ Insurance card, front and back
+ A list of your medications and doses
+ Your questions, written down

D Background

Pharmacy and work details for your chart and prescriptions.

PHARMACY NAME AND LOCATION REQUIRED

PHARMACY PHONE

EMPLOYMENT STATUS

☐ Employed ☐ Not employed ☐ Retired ☐ Student

EMPLOYER

OCCUPATION

Asked of every patient for federal health reporting. It never affects your care, and declining is always an option. Choose one in each group.

RACE

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Caucasian White ☐ Multiracial ☐ Native Hawaiian or Pacific Islander
☐ Refused or declined

ETHNICITY

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused or declined

PREFERRED LANGUAGE

☐ English ☐ Spanish ☐ Sign language ☐ Other ☐ Declined to specify

E Insurance

Primary insurance

INSURANCE NAME REQUIRED

MEMBER ID

POLICYHOLDER NAME REQUIRED

POLICYHOLDER DATE OF BIRTH REQUIRED

RELATIONSHIP TO INSURED REQUIRED

☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary insurance (if any)

INSURANCE NAME

MEMBER ID

POLICYHOLDER NAME

POLICYHOLDER DATE OF BIRTH

RELATIONSHIP TO INSURED

☐ Self ☐ Spouse ☐ Parent ☐ Other

Please bring your insurance card, front and back, to your first visit.

G Office policies

Please read these before your first visit. They explain how billing works in our office.

FINANCIAL RESPONSIBILITIES

01 I understand that I am financially responsible for services rendered to me by the physicians and/or staff of Mark Jaffe, MD, PA. This includes providing current insurance information needed to submit claims to my insurance plan(s) on my behalf. Our office will submit claims only to primary and secondary insurance policies.

02 I understand that I am responsible for paying my co-pay, co-insurance or deductible at the time services are rendered.

03 I am aware if I have Medicare with no secondary insurance, I am responsible for keeping a credit card on file or paying the remaining 20% when services are rendered.

04 I understand that failure to provide current insurance information will result in my becoming responsible for payment of services rendered to me.

05 I authorize the physicians and/or the staff of Mark Jaffe, MD, PA to act as my designated representative as part of the appeal process should this be required by my insurance plan(s).

06 I authorize my insurance plan(s) to communicate with the physicians and/or staff of Mark Jaffe, MD, PA in all aspects of the submission and appeal process.

07 I understand that Mark Jaffe, MD, PA will put forth its greatest effort in collecting payment from my insurance plan(s). If they have exhausted all efforts, I will be responsible to pay for the services received.

COLLECTIONS AND ASSOCIATED FEES

I understand services rendered to me by the physicians and/or staff of Mark Jaffe, MD, PA are my responsibility. Refunds which may be due will be returned via check mailed to your address on file. I understand that any account balance that is not paid within 60 days may begin our collection process. Balances remaining unpaid by 90 days may be reviewed and sent to a collection agency. If my account is sent to a collection agency, I will be responsible for all costs relating to the collection of my debt. This could include, but not be limited to, an additional 40% in fees assessed by the agency to which my account is sent.

SPECIAL ACCOMMODATIONS

If you require a special accommodation for your appointment, you or your representative must notify our office at least one week (7 days) in advance of your appointment. If you are a new patient, notice must be provided at the time your appointment is scheduled. Under the Americans with Disabilities Act, “Providers are responsible for incurring all costs incurred for providing reasonable aid and cannot pass the charge onto the patient or their insurance company.” However, if you have requested an accommodation and you either do not show or do not cancel 24 hours prior to your appointment, you could be responsible for the cost incurred by the third party responsible for providing these services to you.

PATIENT EXPECTATIONS

We have a safe and healing environment. Foul language, aggression, and disrespect towards our staff is not acceptable. Verbal threats or inappropriate behavior will not be tolerated and could result in termination from our practice.

☐ **I have read and understand the office policies above.**

H Special service fees

Fees that may apply outside of your regular visit. These fees are subject to change without notice.

Cancellation fee	We require at least 24 hours notice to cancel your appointment	$50.00
Copies of medical records	Third party requests, up to 25 pages	$1.00 per page
	Third party requests, 26 pages or more	$0.50 per page
Returned check or chargeback		$30.00
Collection fees	Of the amount turned over to the collection agency	40%
Completion of forms	Parking permits	$35.00
	FMLA, school board and/or physical exam forms	$65.00
	Disability forms	$100.00
	Letters to attorneys, insurance companies, etc.	$60.00
	Other forms, plus additional fees on a case by case basis	From $60.00
	Changes made to completed forms at the patient's request	$25.00

☐ **I have read the list of special service fees.**

F Your doctors

PRIMARY CARE PHYSICIAN

PHONE

REFERRING PHYSICIAN (OPTIONAL, NO REFERRAL NEEDED TO BOOK)

PHONE

IS THIS VISIT RELATED TO AN AUTO ACCIDENT OR A WORK-RELATED ACCIDENT? REQUIRED

☐ Yes ☐ No

Our office is unable to treat any new patient whose visit is related to an auto or work-related accident.

I Notice of Privacy Practices

We are required to make available to you a copy of our Notice of Privacy Practices and provide you with a copy if requested.

ACKNOWLEDGEMENT OF NOTIFICATION

How medical information about you may be used and disclosed, *and how you can get access to it.*

A copy of the notice is available at the front desk and on request. Please sign below to acknowledge that you have been advised and made aware of our Notice of Privacy Practices.

☐ **I acknowledge that I have been advised and made aware of the Notice of Privacy Practices.**

☐ **I decline to sign this acknowledgement. You may refuse to sign.**

REASON FOR REFUSAL (ONLY IF YOU DECLINE)

J Review and sign

By signing below, I acknowledge that I have read and understand the office policies, the list of special service fees, and the Notice of Privacy Practices, and that the information on this form is correct to the best of my knowledge.

PATIENT NAME (PLEASE PRINT) REQUIRED

DATE REQUIRED

PATIENT SIGNATURE REQUIRED

×

Sign by hand after printing, or bring the form unsigned and sign at the front desk.

IF SIGNED BY A REPRESENTATIVE: NAME

RELATIONSHIP TO PATIENT

K List of current medications

Please list every medication you take, including over the counter medicines, vitamins and supplements.

MEDICATION NAME	DOSE	HOW OFTEN	PRESCRIBED BY