FLAGLER MEDICAL ASSOCIATES, P.A.

MARK D. RATTINGER, M.D., F.A.C.P.
TIMOTHY W. MARK, M.D.
ROBERT A. STEINBERG, M.D.
IRA BRASSLOFF, M.D.

DANIEL E. FORTIER, M.D., F.A.C.P.
MIRTA GALANTE, M.D.
SRIDHAR R. VENNAMANENI, M.D.
NORBERTO VAZQUEZ, M.D.

1552 Palm Beach Lakes Blvd.
West Palm Beach, Florida 33401
Phone: (561) 659-7411 • Fax (561) 659-7423

****Please provide ALL information requested****

PATIENT INFORMATION

Name: _____ SSN: _____

Florida Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Employer: _____
Email Address: _____ Cell Phone: _____

2nd Address: _____ City: _____ ST: ____ Zip: _____
Phone: _____ Alt. Phone: _____

Sex: ____ Age: _____ DOB: _____ Marital Status: _____ Race: _____ Language _____
Referring Physician: _____ Which doctor are you seeing today? _____
Emergency Contact Name: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Name of Insured as it appears on card: _____ Sex: _____
Relation to patient: _____ SSN: _____ DOB: _____
Address: _____
Home Phone: _____ Work Phone: _____ Employer _____
PRIMARY INSURANCE COMPANY NAME: _____
ID#: _____ Group Control #: _____ Copayment: _____

SECONDARY INSURANCE INFORMATION

Name of Insured as it appears on card: _____ Sex: _____
Relation to patient: _____ SSN: _____ DOB: _____
Address: _____
Home Phone: _____ Work Phone: _____ Employer _____
SECONDARY INSURANCE COMPANY NAME: _____
ID#: _____ Group Control #: _____ Co-payment: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____

and assign directly to Flagler Medical Associate, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

Signature: _____ Date: _____

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Designation for Release of Medical Information to a Family Member, Friend or Legal Representative

Introduction:
It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Privacy Statement of Flagler Medical Associates, P.A. ("FMA") is the basis for how we treat your Protected Health Information (PHI). HIPAA allows physician to use their professional judgment on disclosing certain PHI to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. *Drs. Rattinger, Mark, Steinberg, Brassloff, Fortier, Galante, Vennamaneni, and Vazquez* realize that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical need. Your doctor wants you to be able, if you so desire, we would ask that you complete the form below. Please note the following points:

- Only one person can be designated for this role
- The designation is valid until you cancel it in writing
- If you designate no one, FMA may not be able to release information to any family member or friend.

Designation Statement:
I, _____, designate the following person to be able to speak to a physician at FMA, a nurse or other staff member, should it be necessary, on my behalf. I hereby give permission to FMA through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release FMA, its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: _____

Relationship: _____ Phone Number: _____ (home/work/cell)

Patient's Signature: _____

Date: _____ Witness: _____

I decline to designate another person to speak to my physician or clinical staff.

Patient's Signature: _____

Date: _____ Witness: _____

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NO SHOW POLICY

In an effort to address this concern and continue to meet the needs of our patients, we have developed the following "NO SHOW POLICY":

1. Unless there is an unforeseen emergency, we request at least 48 hours advance notice when canceling your appointment.

There is a **$25 fee for appointments cancelled with less than 24 hours notice** to cover administrative expenses.

Patients who do not reschedule within 30 days or have a history of repeatedly not showing may be subject to dismissal for "non-compliance".

We believe this policy will result in improved patient care, and we appreciate your understanding in this matter.

Name: _____

Date: _____

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Adult Medical History Form _____

Please complete BOTH PAGES *NAME (first, last)*

Your answers on this form will assist your clinician to understand your medical concerns and conditions better. If you are uncomfortable with any question, please feel free not to answer it. Best estimates are fine if you cannot remember specific details. Thank you!

Pharmacy Name_____Phone _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, birth control pills:

Medication	Dose	times per day	Medication	Dose	times per day

ALLERGIES or REACTIONS TO MEDICATIONS:

Medication	Reaction or Side Effect

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems *(with approximate date of illness or diagnosis):*

❑ Heart Disease: ***specify***_____
❑ Hypertension (High Blood Pressure)
❑ Diabetes
❑ High Cholesterol
❑ PAD
❑ Stroke
❑ Osteoporosis
❑ Thyroid problem
specify type _____

❑ Cancer (Malignancy)
specify type _____

❑ Depression/anxiety

Other problems

_____
_____
_____

SURGICAL HISTORY (Please list all prior operations and dates):

Operation	Date	Operation	Date

SOCIAL AND PREVENTATIVE HISTORY:

Do you currently smoke or chew tobacco? ❑Yes ❑No If no, have you in the past? ❑Yes ❑No
How many packs per day?

Do you drink alcohol, beer or wine? ❑Yes ❑No If no, have you in the past? ❑Yes ❑No
How many drinks per week?

Do you exercise? ❑Yes ❑No If yes, number of times per week? _____

Have you been gaining or losing weight? ❑Yes ❑No If yes, how many pounds? _____

FAMILY HISTORY:

Please indicate whether you have had any of the following medical problems *(with approximate date of illness or diagnosis):*

	Living	Age (or age at death)	List serious illnesses
Mother	❑Yes ❑No	_____	_____
Father	❑Yes ❑No	_____	_____
Sisters	❑Yes ❑No	_____	_____
	❑Yes ❑No	_____	_____
	❑Yes ❑No	_____	_____
Brothers	❑Yes ❑No	_____	_____
	❑Yes ❑No	_____	_____
	❑Yes ❑No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses?

Illness	Which family member?
Cancer	_____
Diabetes	_____
Heart Disease	_____
High Blood Pressure	_____
High Cholesterol	_____
Thyroid Disease	_____
Stroke	_____
Other Serious Illness	_____

Living Will _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ Date _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient:

Name of Patient/Previous Names

Birth Date/Medical Record Number

Street Address

City, State, Zip

Authorizes:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

Release Of Protected Health Information To:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

Information To Be Released:

___ Medical History, Examination, Reports
___ Treatment or Tests
___ Allergy Records
___ Consultations
___ Other (Specify): _____

___ Surgical Reports
___ Hospital Records Including Reports
___ Laboratory Reports
___ Entire Record

___ Immunizations
___ X-ray Reports
___ Prescriptions

Purpose For Need Of Disclosure: (Check applicable categories)

___ Further Medical Care
___ Insurance Eligiblity/Benefits
___ Other (Specify): _____

___ Legal Investigation or Action
___ Changing Physicians

___ Personal

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights With Respect To This Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting _____. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact:_____. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature Of Patient or Legal Representative: _____ **Date:** _____

(If signed by other than patient, state relationship and authority to do so.)

Witness: _____