REGISTRATION FORM

How did you hear about CareMEDICA?
☐ Television Ad ☐ Social Media ☐ Website ☐ Referral ☐ Other: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

ADDRESS: _____ APT#/FL: _____

CITY: _____ STATE: _____ ZIP: _____

CELLULAR PHONE: _____ HOME PHONE: _____

BIRTH DATE: _____ SOCIAL SECURITY NUMBER: _____

EMAIL ADDRESS: _____ PREFERRED LANGUAGE: _____

MARITAL STATUS: (Please circle one) *SINGLE, MARRIED, DIVORCED, WIDOWED* SEX: *MALE, FEMALE, OTHER*

ETHNICITY: (Please circle one) *LATIN/HISPANIC, NON-LATIN/HISPANIC, REFUSE TO REPORT* RACE: _____

EMPLOYER: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

PRIMARY PHARMACY: _____ PHONE: _____

ADDRESS: _____

MAIL-AWAY PHARMACY: _____

CURRENT INSURANCE INFORMATION:

PRIMARY: _____ ID#: _____ GROUP#: _____

SECONDARY: _____ ID#: _____ GROUP#: _____

All professional services rendered by CareMedica is the responsibility of the patient set forth by their insurance carrier. If the patient feels to remit payments, disclose proper insurance information and/or does not list a CareMedica provider as their Primary Care Provider; patient will be turned over to collections. When an account is turned over to collections, the patient is responsible for any bills, interest and attorney fees incurred. **AUTHORIZATION OF PAYMENT:** I hereby authorize payment directly to the rendering Physician and/or CareMedica for services provided. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize my rendering provider and/or CareMedica to release any information required from my examination and/or treatment to my insurance company for payment of services or to another provider for continuation of medical care. **MEDICARE STATEMENT (if applicable):** Claims will be submitted to Medicare for you by CareMedica. Medicare may not cover some services in which the patient may be responsible to pay if no other supplemental policy exists. Such identified services may include yearly physicals etc. In addition, you will be responsible to pay for your Annual Medicare deductible and coinsurance set forth by Medicare if you have chosen a supplemental policy to Medicare then it might cover your balance based on the coverage.

SIGNATURE: _____ DATE: _____

CareMEDICA Florida
AUTHORIZATION TO RELEASE INFORMATION

3401 PGA Blvd, Suite 310, Palm Beach Gardens, FL 33410
Phone: (561) 776-8890 Fax: (561) 766-2159

PATIENT NAME:_____ Previous Names: _____

Address: _____ City:_____ State:_____ Zip:_____

Date of Birth:_____ Phone Number: _____ Email:_____

I hereby Authorize CareMedica to:

Please choose one: ☐ Release my Medical Information to ☐ Obtain medical information from

Name/Facility: _____ Attention: _____ Address: _____

Phone Number: _____ City:_____ State:_____ Zip:_____ Fax #:_____

Purpose of Request: ☐ Personal ☐ Referral or 2nd Opinion ☐ Legal ☐ Insurance ☐ Other: _____

Workers Comp (only) Date of Injury_____ Body Part(s) Treated _____

Specific Records/Report(s) to be released: (allow 7-10 days for turnaround of request)

Date of Service: _____

☐ Consultation/Progress Reports ☐ Radiology Reports ☐ Physical Therapy Notes ☐ All Immunizations ☐ Med List ☐ Problem List ☐ Labs ☐ Bills
☐ Other Please Specify_____

☐ Entire Record (ONLY when subsections of the record will not serve the intended purpose of the disclosure.)

Restricted Authorization to Release Protected Information:
IMPORTANT- It is extremely important that you select either "**DO**" or "**DO NOT**" for each item contained in this section **Authorization to Release Protected Information**. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays. Release Records? Check one

I ☐ DO ☐ DO NOT want **Mental/Behavior Health or Disability Services Provider Documentation *** released.
I ☐ DO ☐ DO NOT want **HIV/AIDS Screening Test Results** released.
I ☐ DO ☐ DO NOT want information about **Alcohol and/or Substance Abuse Treatment *****released.
I ☐ DO ☐ DO NOT want **Genetic Testing/Test Results ****released.
I ☐ DO ☐ DO NOT want **Confidential Communications with a Social Worker** released.
I ☐ DO ☐ DO NOT want information about **Rape/Sexual Assault Victim's Counseling** released.
I ☐ DO ☐ DO NOT want **Child/Elder Abuse or Neglect & Abuse of an adult with a Disability** released.
I ☐ DO ☐ DO NOT want information about **Sexually Transmitted Diseases (STD's)** released.
I ☐ DO ☐ DO NOT want information about **Domestic Violence Victims Counseling** released.

*This Authorization is not valid for use or disclosure of psychotherapy notes
** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryos created during IVF.
*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general Medical Facility.

I understand the following:
A: I may revoke this authorization at any time by providing written notice to the practice.
B: I may not be able to revoke this information if the practice has already acted utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance information.
C: The practice will not condition treatment or payment based on my signing this authorization.
D: I am signing this authorization freely.
E: No one has pressured me to sign this authorization.
F: The information disclosed in this authorization for may be subject to re-disclosure by the practice and no longer protected by federal law. **G:** I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
H: I have received a copy of this authorization.
I: I understand that, based on state guidelines, there is a per page fee for my records. I will receive an invoice from Datavant.

This authorization shall automatically expiration 6 months from the date of signature unless otherwise specified in the space provided here. **Date of Expiration:**_____

Signature of Patient and/or Personal Representative of Patient: _____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: _____

Print Name: _____

Date: _____

Do you wish to release your medical information to a family member, guardian, or other individual involved in your care? If yes, please print the family member, guardian, or other individual's full name and date of birth below:

Family member, guardian, or other individual's name: _____

Family member, guardian, or other individual's date of birth: _____

Date: _____

Signature: _____

CareMedica

Patient Medical History Intake Form

Patient Name: _____DOB: _____ Today's Date:_____

Reason for Today's Visit:

❑ New Patient ❑ Illness ❑Pre-Surgical Clearance
❑Hospital Discharge Follow-Up ❑ Work Injury ❑ Auto Accident
❑ Hormone Replacement ❑Medically Supervised Weight Loss Program

Preferred Pharmacy:_____ Pharmacy Phone: _____

Pharmacy Address: _____

Mail Order Pharmacy: _____

Current/Previous Primary Care Provider(s)

Name: _____ Phone: _____

Name: _____ Phone: _____

Current/Previous Specialists:

Cardiologist: _____ Phone: _____

Dermatologist: _____ Phone: _____

Gastroenterologist: _____ Phone: _____

Ophthalmologist: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Any Current Concerns? _____

Allergies and sensitivities to medications, food, animals, other. Please include the reactions:

_____

_____

_____

❑ No known allergies

Medication Name	Frequency	As of	Prescriber

ALL current medications (List all prescription and non-prescription medications, contraceptives, vitamins, and supplements):

❑ Not taking medications

PAST MEDICAL HISTORY	YES	NO	PAST MEDICAL HISTORY	YES	NO
Anemia	☐	☐	HIV/AIDS/Hepatitis	☐	☐
Asthma	☐	☐	Hypo/Hyperthyroidism	☐	☐
Blood Clot/DVT	☐	☐	Lyme Disease	☐	☐
Cancer:	☐	☐	Osteoporosis/Osteopenia	☐	☐
COPD	☐	☐	Peripheral Vascular Disease	☐	☐
Diabetes Type I/Type II	☐	☐	Psoriasis	☐	☐
Gout	☐	☐	Renal Failure/Kidney Disease	☐	☐
Heart Attack/Angina	☐	☐	Rheumatoid Arthritis/Lupus	☐	☐
Heart Disease/Pacemaker	☐	☐	Stroke	☐	☐
High Blood Pressure	☐	☐	Tuberculosis	☐	☐
History of Blood Transfusion	☐	☐	Ulcer/Acid Reflux/GERD	☐	☐
History of Prednisone or Steroid Medication	☐	☐	Other:	☐	☐

PAST SURGERIES	REASON	SURGEON	DATE

PAST HOSPITALIZATIONS	REASON	DATE

Preventative Care

Please list the date of your most recent, if unknown please check unknown:

Complete Physical:	Date:	❒Unknown
Colonoscopy:	Date:	❒Unknown
Dental Cleaning:	Date:	❒Unknown
Eye Exam:	Date:	❒Unknown
COVID Vaccine:	Date:	❒Unknown
COVID Booster:	Date:	❒Unknown
Tuberculosis Test:	Date:	❒Unknown
Tetanus Immunization:	Date:	❒Unknown
Prevnar 13:	Date:	❒Unknown
Pneumovax 23:	Date:	❒Unknown
Shingles:	Date:	❒Unknown
HPV:	Date:	❒Unknown
Meningitis:	Date:	❒Unknown
TDAP:	Date:	❒Unknown
Influenza Vaccination:	Date:	❒Unknown
Measles Immunization:	Date:	❒Unknown
Hepatitis A Immunization:	Date:	❒Unknown
Hepatitis B Immunization:	Date:	❒Unknown

Family History

Relationship	Living or Deceased?	Please list any inherited diseases, chronic illness or cause of death
Mother		
Father		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Brothers		
Sisters		
Sons		
Daughters		

Social History

Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed

What do you consider your stress level is? ❒Low ❒Medium ❒High

Do you have a family history of medical, mental, or hereditary problems? ❒Yes ❒No
Please list:_____

_____

_____

Travel Outside the U.S within the past three years? ❒Yes ❒No

Where and when?_____

_____

Do you have a living will? ❒Yes ❒No

Is your time well balanced between your jobs, family and hobbies? ❒Yes ❒No

Do you wear seat belts? ❒Always ❒Usually ❒Occasionally ❒Never

If you ride a bicycle or motorcycle, do you wear a bike helmet? ❒Yes ❒No

Do you have frequent falls? ❒Yes ❒No

If there is a gun in your home, is it out of children's reach and unloaded? ❒Yes ❒No

If you are a female, do you do a monthly self-breast exam? ❒Yes ❒No

If you are a male, do you do a monthly self-testicular exam? ❒Yes ❒No

Do you practice "safe sex"? ❒Yes ❒No

Have you used illegal drugs? ❒Yes ❒No

How would you describe your dietary intake? _____
_____

How many cups of coffee or caffeinated drinks do you drink daily? _____

What (if any) physical activity/exercise do you engage in and how often?_____
_____
_____

Do you smoke? ❒Now ❒Past ❒Never
If so, how many per day and for how long? _____

How much alcohol do you drink? _____per day _____per week
If yes, how many times in the past month have you had more than 4 alcoholic drinks in one day?
_____

Are you currently experiencing any of the following? Please circle all that apply:

Loss of interest in things you used to enjoy
Chronic sadness
Problems concentrating/decision making
Restlessness, inability to sit still
Hopelessness
Thought of death/suicide.
Feelings of worthlessness, guilt.
Loss of energy/exhaustion.
Changes in appetite.
Other: _____

For Females Only

Last Menstrual Period: _____ Length of Period: _____

Form of Birth Control: _____

Last Pap Smear: _____

Provider: _____ Phone # _____

Last Mammogram: _____

Ordering Provider: _____ Phone #: _____

Are you experiencing or actively in menopause? Yes or No (circle one)

Last Pregnancy: _____

Have you ever had any miscarriages? Yes or No (circle one) If yes, how many_____.

Live Births? Yes or No If yes, how many _____.

Terminations? Yes or No (circle one) If yes, how many_____.

CareMEDICA Social Determinants of Health Questionnaire

Social determinants of health are conditions in the places people live, learn, work and play that affect a wide range of health and quality of life risks and outcomes*

Patient Name: _____ D.O.B: _____

Patient Signature:_____ Date: _____

What is your current housing situation?

- ☐ I have housing
- ☐ I do not have housing (I live with others, in a hotel or a shelter)
- ☐ I choose not to answer this question

Are you worried about losing your housing?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

What is the highest level of education you have completed?

- ☐ Less than high school degree
- ☐ High school diploma or GED
- ☐ More than high school
- ☐ I choose not to answer this question

What is your current work situation?

- ☐ Unemployed and seeking work
- ☐ Part time or temporary work
- ☐ Full time work
- ☐ Otherwise unemployed but not seeking work
- ☐ Retired
- ☐ I choose not to answer this question

In the past year, have you spent more than 2 nights in a row in jail?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

What country are you from?

- ☐ United States of America
- ☐ Country other than the United States
- ☐ I choose not to answer this question

Do you feel physically and emotionally safe where you live?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

In the past year, have you been afraid of your partner or ex-partner?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I have not had a partner in the past year
- ☐ I choose not to answer this question

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?

- ☐ Food
- ☐ Clothing
- ☐ Utilities
- ☐ Child Care
- ☐ Medicine
- ☐ Phone
- ☐ Other
- ☐ I do not have any problems meeting my needs

Has lack of transportation kept you from medical appointments, work, meetings or getting things needed for daily living?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

How often do you see or talk to people that you care about and feel close to?

- ☐ Less than once a week
- ☐ 1 or 2 times a week
- ☐ 3 or 5 times a week
- ☐ More than 5 times a week
- ☐ I choose not to answer this question

Are you a refugee?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

How stressed are you? Stress is when someone feels tense, nervous, anxious or can’t sleep.

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much
- ☐ I choose not to answer this question

CareMEDICA
Primary Care

VISIT POLICIES AGREEMENT

CANCELLATIONS & NO-SHOW POLICY

When we make your appointment, we are reserving a room for your healthcare needs. If you must change and/or cancel your appointment, please give us **24 hours notice**. Your courtesy will make it possible to give your reserved spot to another patient who needs to be seen.

All cancellations and no-shows canceled less than 24 hours notice will be subjected to a **$25.00 fee** for Routine Office Visits and a **$50.00 fee** for New Patient Visits, Physicals or Pre-Surgical Exams, and In-Office Procedures—**$75.00 fee** for Echo/Carotid Scans. Repeated missed or canceled appointments will result in the loss of future appointment privileges. The fees are the sole responsibility of the patient and must be paid in full prior to the next appointment.

VISIT POLICY

ARRIVALS: Please plan to arrive approximately 10-15 minutes before your scheduled appointment.

ALL PATIENTS upon arrival should bring the following:

- Active Insurance & Prescription Card
- Photo ID
- Current list of medication(s)/and or supplement(s)
- Form of payment for co-payment and/or deductible that is set forth by your insurance carrier
    - *NOTE: CareMedica accepts Cash, MasterCard, Visa, Discover, and American Express*

EXISTING PATIENTS should plan to complete an annual updated registration form, even if there are no changes from the previous year's information.

NEW PATIENTS should be prepared to complete and sign all New Patient Paperwork, including:

- CareMedica Registration Form
- Authorization to Release Form
- Medical History Form
- Social Determinants of Health Form

NOTE: If your insurance eligibility cannot be obtained at the time of your appointment, you will be asked to pay for your visit or procedure. If you are not able to pay at the time of service, you will be asked to reschedule

LATE ARRIVALS: Arriving late for your scheduled appointments may result in having to reschedule your appointment.

PER YOUR INSURANCE: Please note that your insurance carrier may require you to pay an additional copayment and/or deductible for the following:

- Chronic and/or new conditions addressed during an annual physical exam
- EKG, diagnostic in house procedures, and injections

PHYSICAL EXAMINATIONS: Please be advised that during your yearly physical exam, your provider will focus on preventative care services as outlined by your health plan. If, during the course of your visit, you discuss new or existing health concerns, symptoms, or conditions that require evaluation or management beyond the scope of the routine physical, an additional office visit charge may be billed to your insurance.

Some beyond-the-scope examples:

- Abnormal lab results that may or may not require a prescription
- Forms that need to be filled out
- Chronic conditions that are addressed

This may result in a separate copay, coinsurance, or deductible depending on your individual health insurance plan. If you have any questions about what is considered part of a preventive physical examination versus a problem-focused visit, please ask our staff prior to your appointment. Thank you for your understanding.

VALUABLES: Please keep your valuables with you at all times during your appointment. We regret that we cannot be held responsible for any lost or stolen items.

AUTO ACCIDENT PATIENTS are required to arrive with the following:

- Auto Policy Declaration page defining the medical provision coverage (Med Pay)
- Date of Accident
- Auto Insurance Carrier Card listing their contact info, and address
- Adjuster's name and contact info
- Claim Number
    - *NOTE: We do not accept Letter of Protection (LOP)*
    - *NOTE: If your policy does not have Med Pay, you will be responsible for paying your copayment and/or deductible set forth in your health insurance policy*

WORKERS COMPENSATION PATIENTS are required to arrive with the following:

- *Name of employer, and their contact information*
    - ****Contact Information includes: Name, Address, and Phone # of the Worker's Compensation insurance company*
- *Date of Injury*
- Adjuster's name and contact info
- Claim Number

NOTE: If your Worker's Compensation claim is denied, our billing office will be your health insurance carrier and you will be responsible for paying your copayment and/or deductible set forth in your health insurance policy as we will.

PAYMENT/COLLECTION POLICY

We will file a claim to your insurance company; however, all the insurance copayments/coinsurance and/or deductible amounts are due at the time of service. Any outstanding patient balances or uncovered amounts are to be paid prior to being seen. Failure on our part to waive copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Please be aware that some, if not all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You will be billed for these services. If your insurer changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. The practice will send out a maximum of 3 bills. If an account is

not paid in full or payment arrangements have not been made, the account will go to collection. Once an account is in collections, it must be paid in full in order to schedule future appointments. There will be no exceptions made.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary changes for our area.

BILLING CONSENT POLICY

All professional services rendered by CareMedica are the responsibility of the patient set forth by their insurance carrier. If a patient fails to remit payments, disclose proper insurance information and/or does not list a CareMedica provider as their Primary Care Provider; the patient will be sent to collections.

When an account is sent to collections, the patient is responsible for any and all bills, interest and attorney fees incurred.

PLEASE NOTE that if we are not listed as your primary care provider (PCP) with your insurance, it is your responsibility to contact your insurance provider as soon as possible to update and, if necessary, backdate this information. Any claims that are denied must be paid in full.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the rendering Provider and/or CareMedica for my charges.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician and/or Caremedica to release any information incurred in the examination and/or treatment to the insurance company in writing, fax and/or e-mail.

MEDICARE STATEMENT (if applicable): Claims will be submitted to Medicare for you by CareMedica. Medicare may not cover some services, which the patient may be responsible for paying if no other supplemental policy exists. Such identified services may include yearly physicals, etc… In addition, you will be responsible for paying for your Annual Medicare Deductible and coinsurance set forth by Medicare. If you have chosen a supplemental policy to Medicare, then your supplemental policy will cover balances based on your coverage.

Patient Name (printed): _____ Date: _____

Signature: _____

CONSENT TO THE USE OF AI SCRIBING SOFTWARE DURING MEDICAL ENCOUNTERS

Dear Patient,

At CareMedica we are committed to providing the best possible care for you, and as part of this commitment, we are continually looking for ways to enhance our services.

We would like to inform you about a new technology that we might be using during your visit called AI Scribing, an artificial intelligence (AI) tool that assists us during patient encounters by generating clinical notes based on our conversations. This tool allows us to focus more on you, the patient, and less on computer documentation.

WHAT IS AI SCRIBE?
AI Scribing is a tool that listens to the conversation during a medical consultation and generates a written summary or "note" based on that conversation. This note is then reviewed and approved by your doctor.

HOW WILL THIS AFFECT YOU?
The AI tool does not interact with you directly. It merely listens to the conversation and creates a summary. This can allow the doctor to focus more on the visit and less on taking notes.

DATA PRIVACY AND CONFIDENTIALITY
We want to assure you that your privacy is our utmost priority. The AI tool adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes.

YOUR CONSENT
Your participation is completely voluntary. If you agree to the use of AI Scribing during your consultations, please sign and date the form below. If you have any questions or concerns, please feel free to discuss them with us.

Thank you for your understanding and cooperation.

CareMedica Management

****

I, _____, consent to the use of AI Scribing during my medical encounters.

Signature: _____ Date: _____