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: _____ EMAIL: _____

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

AUTHORIZATION TO RELEASE INFORMATION

52 Washington Ave, Suite 4,
North Haven, CT 06473
Fax: (203) 672-2801

821 N Main Street Ext, Suite 210
Wallingford, CT 06492
Fax: (203) 672-2801

451 State Street, STE A,
North Haven, CT 06473
Fax: (203) 672-2801

3401 PGA Blvd, Suite 310
Palm Beach Gardens, FL 33410
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: _____

Date: _____