SAFECARE MEDICAL CENTER
PATIENT REGISTRATION FORM

Patient's Name: _____ _____

Date of Birth: _____ Sex: M F Married/Single/Divorce/Widow (circle one)

Primary Language spoken: _____ Ethnicity: _____

Address: _____ (city) _____ (state) _____ (zip) _____

Home Phone: _____ Cell Phone: _____

E-mail: _____ ☐ *Check this box if you would like to sign up for electronic access to your medical records. View your health information online on your time.*

Employer's Name: _____ Employer's Phone: _____

Person responsible for bill: (Complete only if different from the patient)

Guarantor Name: _____ Social Security: _____

Relationship to patient: self/spouse/parent (circle one) Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer's Name: _____ Employer's Phone: _____

Who to call for an emergency:

Name: _____ Phone: _____

Address: _____

Primary Insurance Information:

Plan Name: _____ ID: _____

Address: _____Group Number: _____

_____

Policy Holder: _____ Effective Date: _____

Policy Holder's date of birth: _____ Sex: M F

Supplemental Insurance:

Plan Name: _____ ID: _____

Address: _____Group Number: _____

_____

Policy Holder: _____ Effective Date: _____

Policy Holder's date of birth: _____ Sex: M F

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? YES NO

I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to Safecare Medical Center. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

PATIENT HISTORY QUESTIONNAIRE NEW PATIENT YEARLY PHYSICAL

Patient's Name: _____ Date: _____

What is the primary reason for your visit to see the doctor today? _____

What symptoms are you experiencing and how long have your had them? _____

What treatment have you had towards these symptoms and when? _____

Primary language spoken: _____

Medical and Surgical History

List hospitalizations, surgeries, medical conditions, and serious injuries

_____

_____

_____

Social History (check all that apply)

Marital: Single Married Separated Divorced Widowed

Alcohol: Never Rarely _____ drinks/week

Tobacco: Never packs/day for _____ years Quit: _____

Drugs: Never Have used Use Type: _____

Caffeine (coffee/soft drinks) amount per day: _____

Prolonged exposure to: Fumes Dust Solvents Noise

Do you feel safe in your home? _____

Do you feel sad or cry at time for no reason? _____

Cancer Screening History

Please provide the dates and results of the most recent testing.

Colonoscopy: _____

Mammogram: _____

Pap smear: _____

Family Medical History

Specify current health status or cause of death, age or age at death Medical Problems.

Father: Age _____ Alive Y N Age at death _____
Medical conditions: _____

Mother: Age _____Alive Y N Age at death _____
Medical conditions: _____

Any Family History of Diabetes Mellitis, Heart disease or Cancer, If yes please list:

_____

_____

_____

Children

Age	Sex	Health
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

_____

_____

Have you ever had the following?

Diabetes	Yes	No
Hypertension	Yes	No
Cancer	Yes	No
Heart trouble	Yes	No
Arthritis/gout	Yes	No
Convulsions	Yes	No
Bleeding tendency	Yes	No
Acute infection	Yes	No
Hereditary disease	Yes	No
Gynecologic infections	Yes	No

Do you presently have any problems in the following areas? If "YES" give an explanation.

Eyes:	Yes	No	_____
Ears, Nose, Mouth,	Yes	No	_____
Cardiovascular (heart, blood vessels	Yes	No	_____
Respiratory (lungs/breathing)	Yes	No	_____
Gastrointestinal (stomach/intestines	Yes	No	_____
Genitourinary (genitals, kidney, bladder)	Yes	No	_____
Musculoskeletal (muscles/joints)	Yes	No	_____
Integument (skin, breasts)	Yes	No	_____
Neurological	Yes	No	_____
Psychiatric	Yes	No	_____
Endocrine (hormones/glands)	Yes	No	_____
Hematological/Immune (blood)	Yes	No	_____
Seasonal allergies (hay fever, etc)	Yes	No	_____

List your current medications and dosages

	NAME	DOSAGE
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

WOMAN ONLY

Age menstrual period began _____ Is it **Regular** or **Irregular**
Date of last period _____ Do you have Spotting in between **Yes No**
Length of period _____ days Flow is **Heavy Medium Light**
# of pregnancies _____ Deliveries ____ Aborted ____ C section _____
Have you had a hysterectomy? **Yes No** Do you take hormones? _____
What contraceptive method to you use? _____
Onset of menopause (change of life) _____

Patient's signature: _____

Physician Signature: _____

SAFECARE MEDICAL CENTER
Your Neighborhood Primary Care Physicians' office

C. David Ting, MD, FACP Board Certified in Internal Medicine
Richard J. Wilbur, MD Board Certified in Internal Medicine

CONSENT FORM FOR DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURE

I hereby consent to and authorize a physician of Safecare Medical Center, and other health Professionals as designated, to perform a physical examination and routine diagnostic procedures upon me. I also consent to and authorize Safecare Medical Center physicians to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) ordered by the Safecare Medical Center physician to be performed on me despite the risk involved and complications that might be involved which were explained to me at the time that they were considered.

Signed: X_____

Patient or person authorized to sign for patient

Date:_____Time:_____AM/PM

Witnesses: _____

_____

Por la presente yo autorizo a un medico de Safecare Medical Center, y cualquier otro professional de salud que designe, para que lleve a cabo un examen fisico y procedimientos de rutina en mi, a fin de diagnosticar la condicion que afecta mi salud. Yo tambien consiento y autorizo a los medicos de Safecare Medical Center para que receten un regimen terapeutico que yo debo seguir. A menos que yo expresamente rehuse, consento que el o los procedimientos para un diagnostico ordenado por los medicos de Safecare Medical Center, sean llevado a cabo en mi, a pesar de los riesgos y complicacaciones que puedan estar asociados con dichos procedimientos, que me fueron explicados en el momento de ser ordenados.

Firma: X_____

Paciente o persona autorizad a firmar para el paciente

Fecha:_____Horas:_____AM/PM

Testigos:_____

E-PRESCRIBING CONSENT FORM

Patient's Name: _____ Date: _____

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribing Program. These include:

Filled status notification: Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

Formulary and benefit transactions: Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions: Provides the physicians with the information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Safecare Medical Center can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Safecare Medical Center to enroll me in the E-Prescribing Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient's Name (printed) Date of Birth

_____ _____

Signature of Patient or Patient representative Date

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Authorization for Release of Information

Patient Full Name: _____ Date of Birth: _____/_____/_____
Physician's Name: _____ Physician's Phone: (_____) _____-_____

I hereby authorize _____to release my medical records to:

Name: **SAFECARE MEDICAL CENTER**
Address: **1117 EAST HALLANDALE BCH BLVD, HALLANDALE, FL, 33009**
Office: (954) 454-6300 Fax: (954) 454-6325

Relationship to Patient: Physician____ Attorney_____ Legal Guardian ____ Insurance Company ____

This authorization is for all dates of service unless otherwise specified below.
This authorization only for these date(s) of treatment: from _____to_____.

Patient Signature: _____

I hereby authorize _____, Medical Record Dept., to Release Medical Records pertaining to Psychiatric, Mental Health, Alcohol Abuse and/or Drug Abuse including treatment:

Patient Signature: _____ Date: _____

I hereby authorize _____, Medical Record Dept., to Release Medical Records pertaining to AIDS and/or HIV positive including testing, diagnosis and/or treatment:

Patient Signature: _____ Date: _____

By authorizing the release of the above mentioned records, I understand that the medical records are confidential and cannot be disclosed without specific written consent of the person to whom they pertain, or as permitted by law. I hereby release the above facility and it's employees from any liability that may arise as a result of the use of the information contained in the records released.

I also understand that I may revoke this consent in writing at any time, except where disclosure has already been made or upon occurrence of the purpose for which this disclosure is authorized.

I agree to accept responsibility for payment of any Fee charged for the information requested. I understand that fees charged are within the allowable by Florida Law.

Patient Signature: _____Date:_____

Witness Signature: _____ Date: _____

Safecare Medical Center
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name_____**Date of Birth** _____

Address _____**Telephone**_____

To the Patient – Please read the following statements carefully.

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information with other healthcare providers and insurance companies to carry out treatment, payment activities and healthcare operations (including paper, oral and electronic interchange).

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information to carry out treatment, payment activities and healthcare operations. We encourage you to read our Notice of Privacy Practices carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices at any time. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our Protected Health Information (PHI) that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility or benefits.

Acknowledgement of receipt of Privacy Practices and consent to disclose: I have had full opportunity to read and consider the contents of this consent-form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my Protected Health Information (PHI) to carry out treatment, payment activities and healthcare operations.

I, _____, have received a copy of this office's Notice of Privacy Practices and provide consent for the disclosure of PHI as outlined in this document.

Signature_____**Date**_____

I also authorize my Healthcare provider to discuss or release my Protected Health Information (PHI) to:

_____, _____
(Name/Relationship) (Name/Relationship)

Signature_____ **Date**_____

For Office Use Only. Acknowledgement of receipt of our Notice of Privacy Practices could not be obtained because:
_____ Individual refused to sign
_____ Communication barriers prohibited obtaining signature
_____ An Emergency situation prevented us from obtaining signature
_____ Other_____

SAFECARE MEDICAL CENTER

Name _____ ***PLEASE PRINT***

Date of Birth _____

E-mail _____

How did you hear about us? Please check which applies.

☐ A. Internet search _____
(Please specify search engine)

☐ B. Health, Medical, or Insurance website _____
(Please specify website URL)

☐ C. Facebook _____

☐ D. Individual Referral, e.g., Friend, Family, Employee, Physician, etc. _____
(Last Name, First name and relationship)

☐ E. Newspaper ad or Yellow Pages _____
(Please specify name of newspaper)

☐ F. Insurance phone call or Insurance book _____
(Please specify method)

☐ G. Event _____
(Please specify event name and location)

☐ H. Other _____
(Please explain)

Hallandale Location 1117 E Hallandale Beach Blvd, Hallandale Beach, FL 33009 · 954.454.6300 · Fax 954.454.6325
Hollywood Location 4050 D Sheridan Street, Hollywood, FL 33021 · 954.989.7441 · Fax 954.989.7454

www.safecare.com

PRIVACY STATEMENT

SAFECARE MEDICAL CENTER

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.

Understanding Your Health Record

A record is made each time you visit a physician, hospital, or other health care provider. Your symptoms, examination and test results, diagnoses, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professional who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy, and enable you to relate to whom, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding Your Health Information Rights

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our Responsibilities

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information

we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires.

Our office sends and receives Health Information from other healthcare providers via fax, telephone and US Mail and Internet or electronically. We also send and receive lab reports and prescriptions, via US Mail, fax, courier, (private and public e.g. FedEx), Internet, electronically or by telephone to and from other health care providers and to and from our patients.

Our office leaves messages by phone regarding appointment information and prescription information.

This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your Medical file.

Other than for reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

YOUR HEALTH INFORMATION WILL BE USED FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Treatment – Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment in your best interest. This consists for your physician recording his/her own expectations and those of others involved in providing your care. The sharing of your health information may progress to others involved in your care, such as specialty physicians, lab technicians, pharmacies, hospitals, insurance companies, home health agencies and other healthcare professionals.

PAYMENT - Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

HEALTH CARE OPERATIONS –The medical staff in this office will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness for the care and services we provide.

UNDERSTANDING OUR OFFICE POLICY FOR SPECIFIC DISCLOSURES

Business Associates – Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. For example, it may be necessary to obtain specialized assistance to process certain laboratory test or radiology images. To protect your health information, we require this Business Associate to follow the same standards held by this office through terms detained in a written agreement.

Notification – Your health record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or your whereabouts.

Communications with Family – Using best judgment, a family member, or close personal friend, identified by you, may be given information relevant to your care and or recovery.

Funeral Directors – Your health information may be disclosed consistent with laws governing mortician services.

Organ Procurement Organizations - Your health information may be disclosed consistent with laws governing entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.

Marketing – This office reserves the right to contact you with appointment reminders of information about treatment alternatives and others health related benefits that may be appropriate to you.

Food and Drug Administration (FDA) – This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.

Worker's Compensation – This office will release information to the extent authorized by law in matters of worker's compensation.

Public Health- This office is required by law to disclose health information to public health and or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, injury or disability.

Law Enforcement – (1) Your health information will be disclosed for law enforcement purposes a required under state law or in response to a valid subpoena. (2) Provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more patients, workers, or the general public.

Correctional Facilities – This office will release medical information on incarcerated individuals to correctional agents or institutions for the necessary welfare of the individual or for the health and safety of other individuals. The rights outlined in this Notice of Privacy Practices will not be extended to incarcerated individuals.

Military and National Security – We may disclose to military authorities the personal and health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials personal and circumstances. We may disclose to authorize federal officials personal and health information required for lawful intelligence, counterintelligence, and other national security activities.

Our office policy is as follows for the review of your medical records:

1. You may request a review of your records by making an appointment with our Privacy Officer, Sylvia Pedraza, at 954-454-6300. An appointment will be made within 30 days of your request, unless records are stored off site. Then an appointment will be made within 60 days of your request. This office has the right to deny access to this request. If this happens you will receive a Reviewable Denial of Access to Requested Patient Information letter.
2. Patients do have the right to review:
    a. Medical Records
    b. Billing records
3. Patients do not have the right to access:
    a. Psychotherapy notes.
    b. Information compiles for civil, criminal, or administrative investigations.
    c. Information protected by Clinical Laboratory Improvements Act (CLIA).
4. You also may be denied access in certain circumstances:
    a. Unreviewable grounds (inmates, confidential records)
    b. Reviewable grounds (may cause harm to patient or someone else.

5. After reviewing your records you may request an amendment to your records. This office is not required to comply with this request.
6. There will be a fee charged for copies of your medical records.
    a. This fee will be $1.00 per page for the first 25 pages, and $.25 for pages thereafter.

TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM

For further explanation of this notice you may contact the Privacy Officer, Sylvia Pedraza at 954-454-6300.

If you believe your privacy rights have been violated, you have the right to file a complaint with this office by contacting the individual above, or by contacting the Secretary of health and Human Services, with no fear of retaliation by this office. The address is as follows:

Federal Trade Commision

600 Pennsylvania Ave NW H-342

Washington, DC 20580

NOTICE OF PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be available where registration occurs. You may request a copy of this statement.