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

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:_____

Q:\Safecare\Safecare Shared Folder (1)\OFF_DOC\forms for office

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 954.454.6325

www.safecare.com

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Chiapone Ting, MD, FACP *Board Certified in Internal Medicine*
Susan Budowsky, MMS, PA-C *Certified Physician Assistant*
Sulema Roman, MMS, PA-C *Certified Physician Assistant*

Financial Consent and Understanding

We appreciate you choosing Safecare Medical Center for your healthcare. We will adhere to the following financial policy to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required but my contract with my insurance plan and state regulations.

- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.

- I understand that my contract with my insurance entity may or may not cover some services inclusive to lab work. Standard lab work for Yearly Physical Exams, ordered by the physician is posted in the laboratory and waiting area. A copy is attached for you to keep. All insurance policies are not the same. Safecare Medical Center is not responsible or able to know every policy available and what is covered. It is my responsibility to verify applicable coverage prior to receiving services. I am aware that I may be responsible for all charges that are incurred.

Thank you for your understanding and cooperation with this policy, it is our privilege to provide your medical care.

I have read and understand the Financial Policy stated above and agree to accept full responsibility as described above.

_____ _____

Patient/Responsible Party Signature **Date**

_____

Patient/Responsible Print Name

AUTHORIZATION TO PAY BENEFITS TO SAFECARE MEDICAL CENTER, INC.
AND RELEASE MEDICAL INFORMATION

Please read and sign so we may facilitate processing of your insurance claims.

1. I hereby assign to SAFECARE MEDICAL CENTER, INC all insurance benefits to which I am (or my child is) entitled, including but not limited to Medicare, Private Health Insurance, Medigap and any other form of coverage paying benefits.
2. I hereby authorize SAFECARE MEDICAL CENTER, INC to release all necessary information to secure payment.
3. I understand that I am financially responsible for all charges, whether covered or paid by said insurance. Should SAFECARE MEDICAL CENTER, INC participate with my insurance plan all co-payments and co-insurance payments are due at the time services are rendered. Should SAFECARE MEDICAL CENETER, INC not participate with my insurance plan payment is due **in full** at the time services are rendered until I have made arrangements in advance with SAFECARE MEDICAL CENTER, INC.
4. I understand and agree that, in the event that I fail to make payment for services rendered to my child or myself, SAFECARE MEDICAL CENTER, INC may turn my account and all information over to an attorney or collection agency. I further understand that regardless of insurance coverage, that after default I will be responsible and agree to pay all fee's incurred in the collection of any outstanding balance. This may include but is not limited to, court cost, reasonable attorneys and/or collection agency fees, together with all additional costs and expenses of collections to the present extent of the law.
5. This office reserves the right to charge a monthly billing fee and or interest on all services.
6. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

I hereby state that I have read and fully understand the above.

_____ _____
Signature Date Print Name

FILL OUT BELOW ONLY IF YOU HAVE MEDICARE: (required by Medicare)
Please update my records to reflect the following information:
Are you currently employed? Yes_____ No _____
If yes, are there more than 20 employees in your company? Yes_____ No _____
If retired, effective date of retirement Month _____ Year _____
Is your spouse currently employed? Yes_____ No _____
If yes, are there more than 20 employees in the company? Yes_____ No _____
If retired, effective date of retirement of spouse Month _____ Year _____
Are you or your spouse covered under any other insurance plan through a current employer? Yes____ No____
If retired, were you or your spouse covered under any other insurance plan while employed? Yes____No_____

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS PLEASE COMPLETE THE FOLLOWING:
Spouse's name: _____
Date of Birth: Month _____ Day_____ Year_____
Name and address of Employer Group Health Plan:_____
_____
Is the insurance through a current employer, a retiree program or Medigap Plan?_____
Plan ID Number:_____Group/Plan Number:_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____Date:_____

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: _____

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_____

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

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)

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2026

Attention Patients

Our physicians order a set of yearly physical laboratory tests in our patient's best interest.

This set of tests includes:

Test Name	**CPT Code**	**Price**
CMP (Complete Metabolic Panel)	80053	$25
CBC (Complete Blood Count)	85025	$15
Lipid Panel (Cholesterol Panel)	80061	$15
TSH (Thyroid Stimulating Hormone)	84443	$15
Urinalysis, reflexes to Urine Culture, and Sensitivity if needed.	81002	$50 / $89 if positive
PSA (Prostate Specific Antigen) for Men over the age of 50.	84153	$18
HgA1c (Hemoglobin A1C) diabetics only	83036	$15
M/A Urine (Microalbumin with Creatinine) diabetics only	82043	$60

Test recommended by our physicians are part of a Yearly Physical Exam (YPE)

Your health insurance may not cover some of the above- mentioned laboratory tests and you may be responsible for payment of some of these tests to the laboratory.

Your Health insurance may ask for a copay, coinsurance, or deductible as part of your financial responsibility to the lab company that processes these tests,

Please contact your insurance to determine the laboratory tests that are covered under your health insurance plan.

Blood tests not covered by insurances unless "medically necessary" diagnosis.

Prices for private pay (Self Pay).

Test Name	**CPT Code**	**Price**
Blood Type ABO group, Rh type	86900 or 86901	$20
Homocysteine	83090	$65
PSA (prostate specific antigen)	84153	$18
Testosterone Total Only	84403	$54
Testosterone Free & Total	84402 & 84403	$110
Vitamin D, 25; Hydroxy	82306	$105

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Office Appointment Policies

Please review and follow the guidelines below to ensure a smooth and timely visit.

Fasting Details

- If you are scheduled for fasting blood work, you must fast for 8 hours before your appointment.
- You may drink water only — no food, other beverages, or smoking.
- Not all blood tests require fasting. Please confirm with your healthcare provider.

Yearly Physical Exams (YPEs)

- Patients 65 years and older: Arrive 15 minutes early to complete required paperwork. This is required for every YPE.
- If this is your first appointment of the year, arrive 5 minutes early to update your insurance and personal information.

Lab Orders, Imaging, and External Test Results

- If you have had lab work, imaging, or tests done through another provider, please notify us ahead of time so we can ensure we have the results on file.
- If the results have not yet been received, please bring a copy with you to your appointment.
- Lab Orders and Referrals
- If you have lab orders or referral requests from another doctor, please bring them with you and submit them to the front desk upon arrival.

New Patients

- New patients should arrive 30 minutes early to complete check-in and paperwork.
- If you have already completed and submitted the registration forms in advance, you do not need to arrive early.

Contact & Insurance Information Updates

- If your phone number, address, or insurance has changed, it is crucial that you call us in advance or arrive early to update this information.
- Insurance updates must be completed before your appointment to avoid delays or rescheduling.

Late Arrival, Cancellations, Rescheduling, Grace Period & No-Show Policy

- Please provide at least 48 hours' notice for any cancellations or rescheduling.
- If you are running late, you must call ahead.
- A 15-minute grace period is allowed only with notice. If you fail to contact us and arrive more than 15 minutes late, you will be marked as a no-show.
  - **No-show fees apply as follows:**

a) $50 for existing patients
b) $75 for new patients

These fees must be paid upon arrival at your next appointment.

Acknowledgment

By signing below, I confirm that I have read and acknowledge the Office Appointment Policies outlined above.

Signature: _____ **Date:** _____