



CARING DOCTORS

2520 SE Federal Hwy, Stuart FL 34994
PH: (772) 288-4911 Fax: (772) 288-0691

Patient Registration Form

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (cell or work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M F Social Security Number: _____

Marital Status: Married Single Divorced Widowed

Patient's Employer: _____

Employment Status: Full time Part time Unemployed
 Retired Student Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): _____ Relationship to Patient: _____

Caring Doctors reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hours notice
2. Are missed without calling to cancel (no show)

Cancellation Fee schedule: New Patient \$50.00; Established Patient: \$35.00

Patient / Parent or Guardian Signature: _____ Date: _____



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REASON FOR TODAY'S VISIT

Are you here because of a specific health problem or concern?

Yes No

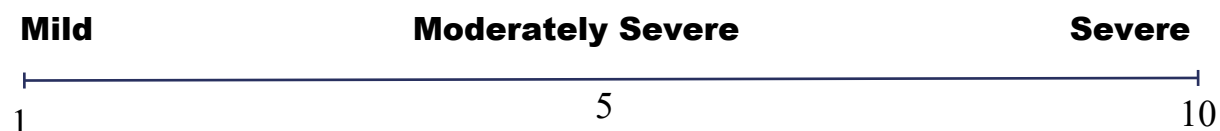
If you answered Yes, please continue and answer the questions below.

Describe the problem you are experiencing:

How long have you been having this problem?

How often does this problem occur?

How severe is it?



Are there things that make this problem worse?

Are there things that make this problem better?

What activities can you no longer do because of this problem?

Do you experience this problem with movement? Yes No

Do you experience this problem at rest? Yes No



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Authorization for Claims Payment and Reviews

1. Assignment and Coordination of Insurance Benefits - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Caring Doctors and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Caring Doctors, the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. Unauthorized, Non-Covered, or Out of Plan Services - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Caring Doctors for this admission or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge. In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. For Medicare Recipients Only - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4. Residents, Interns or Medical Students- I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Caring Doctors education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable fees and other collection costs incurred by Caring Doctors. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to Caring Doctors, unless specifically rescinded in writing by me.*

Patient Signature: _____ Date: _____

Relationship to Patient: _____



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Malpractice Disclaimer

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

IMPORTANT - YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE:

**Rimal Patel, MD
Diplomate, American Board of Internal Medicine**

**Kerri Dembowske, DO
Diplomate, American Osteopathic Board of Family Physicians**

This is permitted under Florida law, subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION

**ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF
MALPRACTICE COVERAGE**



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Notice of Privacy

I certify that I have been made aware of Caring Doctors **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Caring Doctors health care operations. The Notice also describes my rights and Caring Doctors duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Caring Doctors web site at www.Caringdrs.com I may request that a copy be mailed to me by calling 772-288-4911.

Caring Doctors reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Caring Doctors web site listed above to view the most current version.

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION

**ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF
PRIVACY PRACTICES**