# THE CENTRE FOR INTERNAL MEDICINE

WELCOME TO OUR OFFICE

## PATIENT REGISTRATION

(PLEASE PRINT)

DATE:______________________

FIRST NAME:____________________________INT.:___LAST NAME:________________________________

ADDRESS:_____________________________APT_____CITY:________________________STATE:_____ZIP:_______

SEX:M___F___SS#:___________________________AGE:_______DATE OF BIRTH:___/___/____RACE:__________

HOME PH#______________________WORK PH#____________________CELL#_____________________

OCCUPATION:__________________________________EMPLOYER:________________________________________

SPOUSE'S NAME:__________________________SPOUSE'S DOB:__________________________________
SPOUSE'S PH#:____________________________SPOUSE'S SS#:________________________________

IN EMERGENCEY NOTIFY:_____________________________PHONE#:______________________________
RELATIONSHIP TO YOU:_________________________________________

REFERRED BY:_______________________________DO YOU HAVE A LIVING WILL?_______________
LANGUAGE SPOKEN:______________DRUG ALLERGIES:___________________________________________

PRIMARY INSURANCE CO.:______________________________CONTRACT #:_____________________________
GROUP#:______________________NAME OF POLICY HOLDER:______________________________________

SECONDARY INSURANCE CO:______________________________(IF NONE PLEASE INDICATE)
CONTRACT #:______________________________POLICY HOLDER:_______________________________________

WE CANNOT RELEASE MEDICAL INFORMATION WITHOUT WRITTEN CONSENT FROM THE PATIENT
OKAY TO RELEASE INFORMATION TO:____________________________RELATIONSHIP:__________________
PATIENT SIGNATURE:__________________________________

EMAIL ADDRESS:______________________________________________________
IS YOUR EMAIL CONFIDENTAL TO RECEIVE MEDICAL RESULTS?

**PLEASE NOTE!** All patients are responsible for understanding their insurance benefits. This office cannot guarantee payment from your insurance co. for services rendered. You may be responsible for payment of services not allowed or considered noncovered by your insurance co.

### ASSIGNMENT AND RELEASE

I. the undersigned, certify that I (or my dependent) have coverage with________________________and assign directly to The Centre for Internal Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature:__________________________________Date:______________________________

# THE CENTRE FOR INTERNAL MEDICINE

## COMMUNICATION FORM

**Please take a minute to help us update a means of communication with you for test results.**

**What is the best phone number to contact you during our office hours??**

**Best Phone to Call:**________________________
**Next Best Phone #:**________________________
**Next Best Phone #:**________________________

**Drs. Quintela and Greenstein have the ability to deliver results to their patients via E-Mail. If you would like to receive laboratory and x-ray results via E-Mail, please provide us with your E-Mail address.**

____________________________________________________

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE/VOICE MAIL?
☐ YES ☐ NO

PLEASE NOTE: WE CANNOT RELEASE YOUR MEDICAL INFORMATION TO ANYONE WITHOUT YOUR WRITTEN PERMISSION.

IF YOU WANT US TO RELEASE MEDICAL INFORMATION, PLEASE INDICATE:

NAME________________________________RELATIONSHIP:____________________

PLEASE PRINT YOUR NAME: ____________________________________

YOUR SIGNATURE: ____________________________________

DATE: ____________________________________

WITNESS: ____________________________________

CFIM Initials______________

# THE CENTRE FOR INTERNAL MEDICINE

## *NOTICE OF PRIVACY PRACTICES*

***THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.***

### *OUR LEGAL DUTY*

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect on April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### *USES AND DISCLOSURES OF HEALTH INFORMATION*

We use and disclose health information about you for treatment, payment and healthcare operations; for example:

***Treatment.*** We may use or disclose your health information to a physician or other healthcare providers providing treatment to you.

***Payment.*** We may use and disclose your health information to obtain payment for services we provide to you.

***Healthcare Operations.*** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

***Your Authorization.*** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

***To Your Family and Friends.*** We must disclose your health information to you, as described in the Patient Rights of this Notice. We may disclose your health information to a family member, friend or any other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

***Persons Involved in Care.*** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

***Marketing Health-Related Services.*** We will not use your health information for marketing communications without your written authorization.

***Required by Law.*** We may use or disclose your health information when we are required to do so by law.

***Abuse or Neglect.*** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

***National Security.*** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

***Appointment Reminders.*** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

## PATIENT RIGHTS

***Access.*** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses, such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1 per page for the first 25 pages of written material and 25 cents for each additional page and $0.00 per hour of staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

***Disclosure Accounting.*** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a twelve (12) month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

***Restriction.*** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

***Alternative Communication.*** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

***Amendment.*** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

***Electronic Notice.*** If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You also may submit a written complaint to the U. S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

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| Contact: | Office Manager @ | The Centre For Internal Medicine |
| Telephone: | (954) 437-1500 | 9850 Stirling Road, Suite 103 |
| Fax: | (954) 437-0136 | Cooper City, FL 33024 |

# THE CENTRE FOR INTERNAL MEDICINE

*RECEIPT OF NOTICE OF PRIVACY PRACTICES*
*WRITTEN ACKNOWLEDGEMENT FORM*

I, ____________________________, have received a copy of The Centre For Internal Medicine's Notice of Privacy Practices.

_____________________________
Signature of Patient/Guardian

*For Office Use Only* We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other_________________________________________________________

CFIM Initials____________