TCMAi TREASURE COAST MEDICAL ASSOCIATES, INC

STUART • OKEECHOBEE • SEBRING

NEW PATIENT DEMOGRAPHICS

Today's Date: _____/_____/_____ Primary Care Physician: _____

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

Is this your Legal Name? ▢ Yes ▢ No If not, Legal Name: _____

Title: ▢ Mr. ▢ Mrs. ▢ Miss. ▢ Ms. ▢ Dr. Marital Status: ▢ Single ▢ Married ▢ Widowed ▢ Divorced

Date of Birth: _____/_____/_____ Age: _____ Social Security Number: _____-_____-_____

Language: _____ Race: _____ Ethnicity: _____

CONTACT INFORMATION

Home Address: _____ City: _____ State: _____ Zip Code: _____

P.O. Box (if applicable) : _____ City: _____ State: _____ Zip Code: _____

Phone: Home: (_____) - _____ - _____ Cell: (_____) - _____ - _____ Work: (_____) - _____ - _____

Email Address: _____ Preferred Phone: ▢ Home ▢ Cell ▢Work

Occupation: _____ Name of Employer: _____ Supervisor: _____

Employment Type: ▢ Full Time ▢ Part Time ▢ Student Full Time ▢ Student Part Time ▢ Unemployed ▢ Retired ▢ Disabled ▢ Child

Name of Legal Guardian (if applicable): _____ Relationship to Patient: _____

Phone: (_____) - _____ - _____ Alternate Phone: (_____) - _____ - _____

Emergency Contact : _____ Relationship to Patient: _____

Phone: (_____) - _____ - _____ Alternate Phone: (_____) - _____ - _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Number :_____ Group Number: _____

Subscriber's Name: (If different from Patient) _____ Subscriber's SSN: _____ - _____ - _____

Subscriber's Relationship to Patient: ▢ Self ▢ Spouse ▢ Parent ▢ Other

Secondary Insurance: _____ Policy Number :_____ Group Number: _____

Subscriber's Name: (If different from Patient) _____ Subscriber's SSN: _____ - _____ - _____

Subscriber's Relationship to Patient: ▢ Self ▢ Spouse ▢ Parent ▢ Other

Please initial one of the following options:

_____ I authorize TCMA to leave a detailed voicemail message including lab results and diagnostic testing results on the following authorized phone number: _____

_____ I DO NOT authorize TCMA to leave a detailed message on my answering machine or voicemail. I acknowledge that by choosing this option that I, the Patient, assume full responsibility for contacting TCMA for the results of all testing.

Co-pays and/or deductibles are due at the time of service. Our staff uses the most current information available to us to verify your insurance on your date of service. Although the information we are given is current, there may be a balance due after your insurance company processes your claim. Please refer to your insurance contract for your individual policy coverage details.

Please sign acknowledging that the information you have provided is true and correct and that you understand the above statement.

Patient/Guardian Signature: _____ Date: _____

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HIPAA DISCLOSURE AND PRIVACY POLICY

PATIENT NAME: _____ **DOB:** _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Preferred phone number in case we need to contact you: _____

Level of information you would like left on your voicemail:

▢ Detailed message with Lab/Imaging results. ▢ Name of facility and reason for calling.

▢ Name of Facility and Callback Number only. ▢ Please do not leave a message

I, the patient, hereby authorize Treasure Coast Medical Associates Inc. and its affiliates to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following individuals

Name: _____ DOB: _____ Relation: _____

I further release my medical information to the following physicians, clinic, and/or hospitals by whom I am being treated:

Name: _____ DOB: _____ Relation: _____

FINANCIAL POLICY AGREEMENT

I authorize the release of any medical information necessary to process my insurance claim(s) related to services provided by TCMAi. I authorize any and all insurance benefits related to the services provided to be paid directly to TCMAi. I understand and agree that I am financially responsible for any unpaid portion of the agreed upon funds due to TCMAi that are not paid by my insurance carrier, including, but not limited to, co-pays, co-insurance and deductibles. I will also be responsible for any and all services or products provided to me that are not covered by my insurance carrier.

Initial that you have read and understood the Financial Policy: _____

PERSONAL CHECK POLICY AGREEMENT

I understand that Treasure Coast Medical Associates does not accept personal checks as a form of payment at the time services are rendered. It is the policy of this facility to make a good faith effort to inform our patient of the amount due for services rendered on the date of service and collect for those services on that date. If for any reason there are additional funds due to this facility, a statement will be sent to the responsible party detailing the remaining account balance. TCMAi will accept personal or business checks to settle account balances after the date of service as a courtesy to our patients. An additional fee of $50.00 will be added to any account for checks returned by a financial institution as un-cashable and checks will no longer be accepted as payment toward that account.

Initial that you have read and understood the Personal Check Policy: _____

PRIVACY RIGHTS

I hereby acknowledge that a written Notice of Privacy Practice is available upon request and posted for me to review. The Privacy Practice provides a complete description of how my health information may be used or disclosed. I understand that I have the right to review the practice notice prior to signing this consent. I understand that TCMAi reserves the right to change their Notice and Information practices. I may obtain a copy of the revision by written request to the TCMAi Medical Records Department at 3405 NW Federal Hwy, Jensen Beach, FL 34957. I understand that I have the right to restrict how TCMAi uses or discloses my protected health information to carry out treatment, receive payment and conduct healthcare operations TCMAi is not required to agree to restriction. TCMAi is bound by restrictions to which it agrees.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____