THE MEDICAL GROUP
OF SOUTH FLORIDA, INC.

PATIENT HEALTH QUESTIONNAIRE

PATIENT INFORMATION			
Name		Age	Date of Birth / /
Address		City/State	Zip
Secondary Address		City/State	Zip
Home Phone ( )	Cell Phone ( )	Work Phone ( )	
SS#	Email Address		
Marital Status ☐M ☐S ☐D ☐W	Name of Spouse		
Occupation		Employer	
Emergency Contact Name		Emergency Contact Number ( )	
CURRENT PCP		**PCP Phone Number ( )**	

INSURANCE INFORMATION			
Insurance Company	Policy #	Group #	
Is insured Information Same As Above ☐Yes ☐No (if "No", Please Complete Information Below)			
Insured Name	SS#	Date of Birth / /	Employer
Insured Address	City/State	Zip	
Secondary Insurance Company	Policy #	Group #	
Is insured Information Same As Above ☐Yes ☐No (if "No", Please Complete Information Below)			
Insured Name	SS#	Date of Birth / /	Employer
Insured Address	City/State	Zip	

WORKMAN'S COMP / PIP INFORMATION		
Workman's Comp	Policy #	Group #
Adjuster's Name	Phone ( )	Email
PIP Insurance Name	Policy #	
Adjuster's Name	Adjuster's Phone ( )	
Attorney Name	Attorney Phone ( )	

THE MEDICAL GROUP
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HEALTH HISTORY
ALL PATIENTS MUST COMPLETE THIS SECTION

CHIEF COMPLAINT

IMMUNIZATION RECORDS			
Tetanus Shot Date / /			Number of Living Children
Pneumonia Vaccine Date / /			
Flu Shot Date / /			
Any Cancers In	Children ☐ Yes ☐ No	Type of Cancer?	
	Parents ☐ Yes ☐ No	Type of Cancer?	
	First Degree Relatives ☐ Yes ☐ No	Type of Cancer?	
Height			Weight
If You Are Male	Do you examine your testicles monthly? ☐ Yes ☐ No		
If You Are Female	Do you examine your breasts monthly? ☐ Yes ☐ No		
	Last Mammogram Date / /		Last PAP Date / /
	Physician/Facility Performed By		
	Number of Pregnancies	Number of Live Births	Weight of Largest Baby at Birth lbs ounces
	Is it possible you are pregnant? ☐ Yes ☐ No		

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HEALTH HISTORY
ALL PATIENTS MUST COMPLETE THIS SECTION

PLEASE CIRCLE ALL SYMPTOMS OR DIAGNOSIS YOU HAVE BELOW

Abdominal Pain	Blood in Stool	Dizziness	Irritable Colon	PMS	Disorder
ADD	Blood in Urine	Fainting	Joint Pain	Polio	STD
Allergies	Breast Cancer	Fever / Sweats	Kidney Disease	Problem Walking	Stroke / TIA
Alzheimer's	Breast Mass	Frequent Urination	Kidney Stones	Prostate Disease	Thyroid Problem
Angina	Bulimia	Headache	Liver Disease	Scoliosis	Ulcer
Anorexia	Cancer	Heart Attack	Lung Disease	Short of Breath	Vaginal Bleed After Menopause
Anxiety	Change in Vision	Heart Disease	Migraine	Sickle Cell Anemia	Seeing Pain Management
Arthritis	Chest Pain	High Blood Pressure	MS	Seizures	
Asthma	Cough	HIV / AIDS	Osteoporosis	Sinus Trouble	
Blood Disorder	Depression	Intestine Disorder	Panic Disorder	Spinal Disc	

List Any Other Medical Condition

List Any Medical Conditions That Run In Your Family

Do You Live With Someone Other Than Yourself

Patient Exercises ☐ Regularly ☐ Moderately ☐ Rarely ☐ Never

Use of Alcohol ☐ Regularly ☐ Moderately ☐ Rarely ☐ Never

Use of Tobacco ☐ Current, How Many Per Day ☐ Never ☐ Former

If Former, How Long Months Years

Allergies ☐ Dust ☐ Penicillin ☐ Pollen ☐ Sulfa Drugs ☐ Dander ☐ Dairy Products ☐ Latex ☐ Perfumes

☐ Secondary Smoke ☐ Eggs ☐ Contrast Dye ☐ Meds (list Below)

Other

PAST SURGICAL & HOSPITALIZATION HISTORY

Type of Surgery/Cause of Hospitalization		Date / /
Where	Surgeon	Complications
Type of Surgery/Cause of Hospitalization		Date /
Where	Surgeon	Complications

LIST ALL MEDICATIONS / SUPPLEMENTS YOU ARE TAKING

Are You Taking Nutritional Supplements? ☐ Yes ☐ No

If Yes, What Vitamin Supplements?

Are You Taking Prescription Medications? ☐ Yes ☐ No If YES, Please List Medications Below

Name/Dose	Name/Dose
Name/Dose	Name/Dose
Name/Dose	Name/Dose
Pharmacy & Location	Phone ( )

THE MEDICAL GROUP
OF SOUTH FLORIDA, INC.

AGREEMENT & INQUIRY

INSURANCE AGREEMENTS

I understand and agree that insurance policies are an arrangement between my insurance carrier and myself. The Medical Group of South Florida, Inc. will prepare and file all claims on my behalf to my insurance company. I authorize payment to be paid directly to The Medical Group of South Florida, Inc., which will be credited to my account upon receipt for any services furnished me by The Medical Group of South Florida, Inc. I understand that my signature also authorizes release of medical information necessary to pay the claim. This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that all services rendered to me are charged directly to me and I am personally responsible for payment if my insurance company refuses to pay the claims in a timely manner (45 days from initial filing shall be considered a timely manner).

All bills that you receive will say The Medical Group of South Florida, Inc. If you have any questions regarding this, please call our billing department 561.622.1975.

Patient Signature	**Date** / /
Print Name	
Guardian Signature	**Date** / /

CONSENT FOR RX HUB INQUIRY

I hereby provide my consent for The Medical Group of South Florida to obtain my Rx history using the SureScripts-RxHub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that Sure Scripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

Patient Signature	**Date** / /
Print Name	

THE MEDICAL GROUP
OF SOUTH FLORIDA, INC.

FINANCIAL AGREEMENT

We, at The Medical Group of South Florida, Inc., appreciate the opportunity to be of service to you. To help you understand our policies, please read this agreement. If there is anything you do not understand, please clarify with our staff prior to signing.

I understand and agree that:

- I am financially responsible for all professional services rendered to me
- These services are payable at the time of service

As a courtesy, our office will file your insurance if proper information is received. Please be aware that you are responsible for:

- Payment of your co-pay, co-insurance and/or deductible at the time of the visit
- Follow-up with your insurance carrier on any unpaid claims over 60 days
- Full Payment of unpaid claims over 60 days

Please note that it is your responsibility to notify us of any insurance changes, new insurance or address changes.

Service fees could be applied to your account for any or all of the following reasons:

- $1.00 per page for copies of records up to 25 pages and $0.25 for each page thereafter and any postage
- $5.00 fee for each time we bill you for unpaid balances after the first statement
- $25.00 fee for each missed appointment; please provide 24 hour notice if you need to cancel
- $32.00 fee for checks returned from the bank
- $25.00 fee if your account is sent to a collection agency, in addition to, but not limited to, postage, court fees, attorney fees, interest and collection agency fees
- $10.00 one-time set up fee for payment plan for ePay

Additionally, I authorize the Medical Group of South Florida, Inc. to:

- Submit Medicare or other insurance claims using my signature on file below
- Be paid directly for medical services described on the claim form by the practitioner
- Release medical records when necessary to authorized physicians and hospitals
- Consent to be medically treated

Patient Signature	**Date** / /
Print Name	
Guardian Signature	**Date** / /

THE MEDICAL GROUP
OF SOUTH FLORIDA, INC.

AUTHORIZATION FOR OTHER DISCLOSURES OF HEALTH INFORMATION

NOTE: YOUR SIGNATURE ACKNOWLEDGES THAT YOU UNDERSTAND THIS AGREEMENT

By signing below, you are authorizing additional use and disclosure of your health information. We may not deny you treatment if you refuse to grant this requested Authorization.

I authorize The Medical Group of South Florida to use or disclose my health information to Health Awareness, Inc. ("HAI") for the purpose of determining my eligibility, availability, and qualification to participate in one or more clinical trial and research studies conducted or sponsored by HAI. My health information will not be used for any purpose other than an initial determination of qualification to participate in the HAI study or studies unless and until I have been contacted by HAI and expressly agreed to participate in one or more of the HAI programs.

Patient Signature	**Date**	/	/
Print Name	**Date of Birth**	/	/
Social Security Number			

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Initials	**Date**	/	/
Reason			

THE MEDICAL GROUP
OF SOUTH FLORIDA, INC.

HIPAA NOTICE OF PRIVACY -
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION (PURSUANT TO 45 CRF 164.508	
Patient Name	**Date of Birth** / /

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with legal claim. I expressly request the designated record custodian of information including under HIPAA indentified above disclose full and complete protected medical information including the following:

- All medical records, meaning full disclosure, but not limited to: office notes, face sheets, history and physical, consults, treatments, and test results.
- All outside consults, physical, occupational and rehab request and record receive by other medical providers.
- All pharmacy/prescription records. All billing records.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I hereby authorize The Medical Group of South Florida, INC. to disclose my medicine records as stated above to:

Name	**Relationship**
Name	**Relationship**

I understand the following: See CFR § 164.508(c)(2)(i-iii)

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize. you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Signature of Patient or Legally Authorized Representative
Date / /
Name and Relationship of Legally Authorized Representative to Patient
Date / /
Witness
Date / /

THE MEDICAL GROUP
OF SOUTH FLORIDA, INC.

NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGMENT

Patient Name	
SS#	**Date of Birth** / /
By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.	
☐ **I have received the Notice of Privacy Practices (effective date / /)**	
Patient's (or Legal Representative's) Signature	
Date / /	
Relationship of Legal Representative	

OFFICE USE ONLY	
To be completed only if Acknowledgment is not signed.	
1. Was the patient given a copy of the Notice of Privacy Practices? ☐ **Yes** ☐ **No**	
2. Please explain why the patient was unable to sign this Acknowledgment and our efforts to try to obtain the patient's signature:	
Name/Title	**Date / /**

THE MEDICAL GROUP
OF SOUTH FLORIDA, INC.

MEDICAL RECORDS RELEASE AUTHORIZATION

NOTE: YOUR SIGNATURE ACKNOWLEDGES THAT YOU UNDERSTAND THIS AGREEMENT	
Patient Name	Patient's Date of Birth / /
Address	
Doctor/Hospital	
I hereby authorize the release of my Medical Records to be sent to the any of these locations, Medical Group of South Florida	
☐ 1094 Military Trail, Jupiter, FL 33458	Fax 855.215.9930
☐ 4700 N. Congress Suite # 103, West Palm Beach, FL 33407	Fax 855.346.3451
Patient Signature	Date / /
Print Name	
Guardian Signature	Date / /
Witness to Above Signature (print name)	