PATIENT REGISTRATION FORM

Patient information

Patient Name: _____ Nickname (if any): _____

Date of Birth: _____ Age: _____ Sex □ Male □ Female

Patient SSN: _____ - _____ - _____ Driver's License State/Number: _____

Address: _____

City/State/Zip: _____

Home Phone#_____ Cell #_____ Work#_____

E-mail Address: _____

Ethnicity:

□ Non-Hispanic □ Hispanic

Language Preference:

□ English □ Spanish □ Other: _____

Race:

□ Caucasian or European American □Black or African American □Asian or Asian American

□ Native American or Native Alaskan □ Native Hawaiian or Other Pacific Islander □ Other

Religion:

□ Catholic □ Christian □ Jewish □ Muslim □ Other: _____

Employment Status:

☐Employed: Employer Name: _____ Profession: _____

☐Retired ☐Unemployed ☐Student

Marital Status:

☐Single ☐Married ☐Divorced ☐Widowed

Emergency Contact:

Name: _____ Relation: _____

Address: _____ Phone: _____

Whom may we thank for telling you about our practice?

☐Physician ☐Family Member ☐Friend ☐Insurance ☐Website

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES TO MY ADDRESS, PHONE NUMBER, AND INSURANCE.

_____

Signature of Patient, Insured, or Beneficiary Date

ANGELA M GIRON MD PA

3661 S. Miami Ave # 1002, Miami, FL 33133 • TEL. 786.502.2688 • Fax: 786.502.2699

INSURANCE INFORMATION

Insurance company: _____ Tel. #: _____

Group #: _____ Policy #: _____ Eff. Date: _____

Insured Name: _____ Relationship: _____

Secondary Insurance_____

Policy #: _____ Group #: _____

PLEASE PRESENT INSURANCE CARD AND PICTURE I.D.

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Angela M Giron MD PA and any assisting medical provider for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider the release of any information relating to all claims for benefits submitted on behalf of me and/or dependents. I further expressly agree and authorize Angela M Giron MD PA to submit claims for benefits for services rendered or services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned personally signed the particular claim. I further understand that any sums due me if less than $50.00 will be credited to my medical account.

I agree that a photocopy of this agreement shall be as valid as the original.

_____ _____

Authorized Signature Date

ANGELA M GIRON MD PA

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PATIENT BILLING AND ACCOUNT POLICIES

1. The scheduling of an appointment constitutes an agreement to pay for professional time reserved exclusively for you. You are responsible for updating your address, telephone number and insurance at each visit. A complete information/financial form should be completed yearly.
2. We bill your insurance company for services rendered as a courtesy to you. In certain cases we may find it necessary to collect from you the fee for our services that were rendered to you even if you have insurance. For example, we were unable to verify that you have active insurance or the benefits available to you under your insurance policy could not be verified or are unclear. The amount collected is placed on account and if your insurance company pays for the services your payment will be refunded.
3. Your insurance company determines what services we provide will be paid for under the provisions of your policy. We have neither a guarantee of payment nor any control over your insurance company's decision to pay or deny a claim. You are responsible for any service rendered that is not paid for by your insurance company. Since we do not have knowledge of the details of every insurance plan available, we must rely on you to determine if we are participating providers with your insurance. Since every plan is different, please be sure to check your coverage if you have questions as to what your insurance will cover or pay for.
4. Please verify and ensure that we participate with your insurance plan as participation may have changed. If you are seen and our provider is not in network with your current plan or you were required to provide a referral and did not, you will be responsible for payment for services rendered. You are ultimately responsible for your insurance benefits, as well as the cost of your health care.
5. We are happy to share with you the information we have received regarding your plan benefits. We do not guarantee coverage by your insurance company and you should contact your insurance company regarding covered benefits if you are unsure about what your plan covers. If you have questions about your insurance policy and benefits, please refer to your health plan. If you have questions regarding our billing statement, please contact our **billing office at (305) 629-2669.**
6. All office visit co-payments and co-insurance are collected in accordance with the terms of your insurance company. We cannot waive co-payments, deductibles, co-insurance or non-covered service amounts under the terms of our contract with the various insurance plans. **Payment of co-payments and co-insurance are due at the time of the office visit.**
7. Any amounts that your insurance company identifies as 'patient responsible' that were not collected at the time of your visit are billed to you on a monthly statement. Statements are mailed monthly and balances are due at end of each month. It is your responsibility to send the amount due within 45 days of your statement to avoid being sent to collections and having your account closed with our practice.
8. Appointments must be cancelled **IN ADVANCE.** Our office gives a reminder call 48 hours in advance of scheduled appointments. If you need to cancel or reschedule please give us at least 24 hours' notice. If we do not have adequate notice we are unable to fill the appointment slot that we had reserved for you. In addition, no medications will be given for cancelled/no-show appointments. **There is a no show fee charged for missed appointments: $50 for a provider appointment, $35 for a Lab appointment.** This fee is not covered by insurance carriers or Medicare and will be your responsibility to pay before your next visit.
9. All healthcare providers bill for services using billing codes. These codes tell the insurance company what was done and why. Routine and preventative services cause confusion for many patients. It is not uncommon for patients in the course of a visit to receive both treatment for a problem and preventative service. If you discuss symptoms of acute or chronic diseases at your Preventative Care Visit (Physical) it is considered "diagnostic" and you will most likely be required to pay a copayment.
10. You may receive a statement from outside providers for services ordered by our providers such as labs, x-ray, etc. even when we have collected the specimens in our office. If you have questions about these statements please contact them directly. You should always inquire about your financial obligation with your insurance company for services rendered to you before they are performed. You are ultimately responsible for your insurance benefits, as well as the cost of your health care.
11. We charge $35 for returned checks, plus an additional $12.00 fee each time a check is returned unpaid by your bank. We may at our discretion, require that all future payments be made in the form of cash, cashier's check or money order.
12. Please be advised that if a balance remains unpaid without an attempt to pay the debt, you may be discharged from the practice. Once your account reaches 90 days past due we may turn the account over to an outside collection agency for payment. It is the policy of this office that when your account is placed into collections we will no longer see you as a patient and you will be required to transfer your care to another physician. All collection fees will be the patients' responsibility.

My signature below indicates my full understanding and consent to the above described policies.

_____ _____

Signature of Patient/Client/Guardian Date

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OFFICE POLICIES AND PROCEDURES

EMAIL: We will never disclose your email address to any third party. By providing us with your email address you are expressly authorizing us to communicate with you via email. We encourage all of our patients to use our HealthTracker system.

MEDICAL FORMS: We charge an administrative fee to complete certain work or insurance related documents presented by patients not directly related to medical insurance reimbursement of charges incurred at our office. We charge $25 per form due prior to releasing the form. Please allow 7 business days to complete your form. You are responsible to complete your portion of the form and return it to the appropriate institution.

RETURN PHONE CALLS: Any requests for a return call from our providers must be explained to the office staff prior to receiving a return call. Many times, the office staff can resolve the issue/answer your question or you may speak with the Office Manager. Any "private medical matters" you do not want to discuss with our staff, will require a scheduled appointment. All non-emergent issues will be handled accordingly.

REFERRALS: If your insurance company requires us to issue a referral or prior authorization to another medical specialist or facility please review your benefits available for that specialist/facility directly with them. We make a reasonable effort to refer to specialists/facilities that participate with your insurance company, but we cannot guarantee their participation at the time of your visit. You should always inquire about your financial obligation for services rendered to you BEFORE THEY ARE PERFORMED. Additionally, it is your responsibility to provide any necessary referral information to us that your insurance requires prior to your visit with our office. If you are seen and our provider is not in network with your current plan or you were required to provide a referral and did not, you will be responsible for payment for services rendered.

LAB ORDERS: For your convenience labs ordered by our providers can be drawn in our office. However, at your request, we can give you a lab requisition to do your labs at Labcorp or Quest. Please call 2 days in advance so we can process your lab requisition. Since we have electronic interfaces with the labs, your lab orders, once printed, are good for five days (including weekends). Patient is responsible for picking up hard copy of requisition.

LAB RESULTS: It is important to us that you fully understand the results of your tests and the recommendations and treatment plans that may be necessary. We do not give results over the phone, mail or email. We require patients schedule an appointment to discuss test results in person with a healthcare provider. Once the results have been discussed with the provider, you will be given a hard copy of your results. Please save this copy to give to your case managers, other doctors, etc. as we will not fax results. You may access your lab results using our HealthTracker patient portal after being seen.

PRESCRIPTION REFILLS: It is the patient's responsibility to ensure not to run out of medication. Refills will be handled at the time of your office visit. If you need a refill, prior to a scheduled appointment and you have been seen within 3-6 months, your script may be refilled at the doctor's discretion. Many medications require close monitoring of labs; therefore, you may need to be seen in order to get a refill. When you need a refill of a medication that has been previously prescribed by us for you, please call your pharmacy and ask them to fax a refill request to our office at (786) 502-2699. If you are planning to travel out of town, make sure that a sufficient supply is available for use on your trip prior to travel. All prescription refills are done Monday to Friday between 9 a.m. and 5 p.m. Requests received after 2 p.m. will be handled the next business day. New prescriptions/antibiotics require an appointment to evaluate the appropriateness of the medication for you.

CONTROLLED/NARCOTIC PRESCRIPTIONS: Due to DEA regulations, prescriptions for controlled/narcotic medications will be handled at the time of your office visit. If you need a refill, prior to a scheduled appointment, and you have been seen within 3 months, your script may be refilled at the doctor's discretion. It will need to be picked up in person at our office at the doctor's discretion. Controlled/narcotic prescriptions will not be called-in or faxed nor can dosages be changed by phone. Be prepared to show your photo ID when picking up these prescriptions. This office does not replace lost/stolen prescriptions or medications. By signing this form, you agree that you received a copy and have had the opportunity to read our *Controlled Substance (Narcotic) Agreement* and agree to the terms set forth. You indicate that you understand any discussion about the use of narcotic medications, including side effects, and agree to start your treatment (if applicable) under the terms set by Angela M Giron MD PA.

PRIOR AUTHORIZATIONS: Your insurance may require a prior authorization (PA) on a prescribed medication. Your options are to pay for the medication out of pocket, have us choose another medication, or have us file PA paperwork to your insurance. As a courtesy, we will file PA paperwork (at your request) free of charge (1) time per medication. Requests received after 2 p.m. will be handled the next business day. If denied, and you request we appeal your insurance's decision; there will be a $25 fee. Submitting a PA does not guarantee an approval, the decision is ultimately made by your insurance company. PA's can take up to 30 days to obtain insurance company approval.

PATIENT ACCESS TO MEDICAL RECORDS: Medical records are confidential documents and will be released only when permitted by law or with proper written authorization by the patient. *Patients can access their records through our Patient Portal.* We also provide patients a copy of their consult/lab results at the end of each office visit. Medical records will be copied for transfer to another physician at no cost to the patient the first time they are requested. For any additional requests, there will be a reasonable fee for the preparation and/or photocopying of medical records. Note, provider has up to 30 days to furnish complete medical records.

NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our practice to ask questions about our privacy practices. By signing this form, you agree that you received a copy and have had the opportunity to read our Notice of Privacy Practices.

My signature below indicates my full understanding and consent to the above described policies.

_____ _____

Signature of Patient/Client/Guardian Date

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Primary Physician Name: _____

Primary Physician Number: ( )_____-_____

Pharmacy Name & Location: _____

Pharmacy Phone Number: ( )_____-_____

Medications:

Name of Medication:	Dosage:	Name of Medication:	Dosage:

Allergies: _____

_____

Reason for Visit: _____

_____

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Past Medical History:
Please place check next to all conditions that apply.

Alcoholism	Depression	Kidney Infections
Allergies/Hay fever	DM Type 1	Kidney stone
Anemia	DM Type 2	Migraines
Anxiety	Epilepsy	Multiple Sclerosis
Asthma	Fracture	Myocardial Infarction
Atrial Fibrillation	Gastric ulcer	Obesity
Blood Transfusions	Gastrointestinal Disease	Osteoarthritis
CAD	Gastroesophageal Reflux Disease	Osteoporosis
Cancer	Gestational Diabetes	Pneumonia
Cardiac Pacer	Glaucoma	Progressive Neurological Disorder
CHF	Heart Murmur	Pulmonary Disease
Cardiovascular Disease	Hepatitis	Rheumatic Fever
CHF	High Cholesterol	Rheumatoid Arthritis
Chicken Pox	Hyperlipidemia	Shingles
Cirrhosis	Hypertension	STD
Colitis	Hyperthyroidism	Terminal Illness
COPD	Hypothyroidism	Thyroid Disease
Chronic Renal Failure	Insulin Pump	TIA
Crohn's disease	Joint Pain	Tuberculosis
CVA	Kidney Disease	Valvular Problems
DVT		

Hospitalizations: _____

_____

Medical History: _____

_____

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Surgical/Procedural
Please place check and date next to all that apply.

□ No prior surgical history

Appendectomy	Endometrial Ablation	Mastectomy
Breast Lumpectomy	Gall Bladder	Myomectomy
Cardiac Surgery	Heart Surgery	Oophorectomy
Cataract Surgery	Hemorrhoids	Ostorny
Colectomy	Hernia	Prostate Surgery
Subtotal Colectomy	Hysterectomy	Splenectomy
Cone Biopsy	Joint Replacement	Tonsil/Adenoldectomy
D&C	Laparoscopy	Tubal Ligation

OB/Gyn History (Female Only)
Please place check and date next to all that applies.

□ Currently Pregnant □ Never Pregnant
Number of Past Pregnancies: _____
Number of Vaginal Deliveries: _____
Number of C-Sections: _____
Other OB-Gyn History: _____
_____
_____

Social History:
Please place check next to all that applies.

Children:
□ None □ Son(s); #_____ □ Daughter(s); # _____

Lives with:
□ Alone □ Spouse □ Significant Other □ Parents □ Roommate □ Other: _____

Pets:
□ None □ Dog(s) □ Cat(s) □ Bird(s) □ Reptile(s) □ Horse(s) □ Others: _____

Nutrition:
□ Vegetarian □ Poor Diet □ Average Diet □ Good Diet □ Excellent Diet

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Social History (continues):
Please check next to all that applies.

Exercise:

□ None □ Sedentary □ Occasionally; ____ days per week □ Regular; ____ days per week

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Sexual Orientation:

□ Heterosexual □ Homosexual □ Bisexual □ Other: _____ □ Chose not to disclose

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Contraception:

□ None □ Diaphragm □ Vasectomy □ Condoms □ Hysterectomy
□ Menopause □ Oral Contraceptives □ Tubal Ligation □ Intrauterine Device □ Abstinence

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Smoking:

□ Never Smoked □ Current Smoker □ Former Smoker □ Secondary Smoking Exposure

Smoking Details:

Number smoked in a day: _____cigarettes _____ pack(s)
Smoking onset age: _____ Age when quit: _____

Alcohol:

□ Never □ Rare □ Occasional □ Socially □ Dependent □ Former Drinker □ Recovering Alcoholic

Alcohol Details:

Number of drinks: _____ in a **day**; _____ in a **week**
□ Occasionally binge drinker □ Frequent binge drinker
Alcohol onset age: _____ Age when quit: _____

Illicit Drug(s):

□ Never □ Cocaine □ Crack □ Ecstasy □ Heroine □ LSD (Acid) □ Marijuana
□ Crystal/Methamphetamine □ Opium □ PCP-Phencyclidine (Angel Dust) □ Psicocybin Mushroom
□ Poppers □ Other: _____

Illicit Drug(s) Status:

□ Never □ Rare □ Occasional □ Socially □ Dependent □ Former User □ Drug Dependency □ Recovering
Drug(s) onset age: _____ Age when quit: _____

Seatbelt:

□ Yes □ No □ Occasional

Family History
Please place check next to all conditions that apply.

Mother: □ Unknown History □ Alive □ Deceased

Alcoholism	Congenital Anomaly	Hypertension
Anemia	COPD	Hypothyroidism
Anxiety	Crohn's Disease	Kidney Disease
Asthma	Depression	Liver Disease
Birth Defects	Diabetes	Multiple Births
CAD	Epilepsy	Osteoarthritis
Cardiovascular	GERD	Osteoporosis
CHF	Hypercholesterolemia	Pulmonary Disease
Cancer: _____	Hyperlipidemia	Stroke
		Substance Abuse

Father: □ Unknown History □ Alive □ Deceased

Alcoholism	Congenital Anomaly	Hypertension
Anemia	COPD	Hypothyroidism
Anxiety	Crohn's Disease	Kidney Disease
Asthma	Depression	Liver Disease
Birth Defects	Diabetes	Multiple Births
CAD	Epilepsy	Osteoarthritis
Cardiovascular	GERD	Osteoporosis
CHF	Hypercholesterolemia	Pulmonary Disease
Cancer: _____	Hyperlipidemia	Stroke
		Substance Abuse

Sibling(s): □ Unknown History □ Alive □ Deceased

Alcoholism	Congenital Anomaly	Hypertension
Anemia	COPD	Hypothyroidism
Anxiety	Crohn's Disease	Kidney Disease
Asthma	Depression	Liver Disease
Birth Defects	Diabetes	Multiple Births
CAD	Epilepsy	Osteoarthritis
Cardiovascular	GERD	Osteoporosis
CHF	Hypercholesterolemia	Pulmonary Disease
Cancer: _____	Hyperlipidemia	Stroke
		Substance Abuse

Dr. Angela M Giron

3661 S Miami Ave, Ste 1002 | Miami, FL 33133
Phone: 786.502.2688 | **Fax: 786.502.2699** | Info@DocGiron.com |

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Previous Name: _____

Social Security #: _____

I request and authorize Dr. _____ to release healthcare information of the patient named above to:

Doctor Address: _____

_____

Doctor Telephone: _____

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

List: _____

◉ All healthcare information ○ Other

Addition Information: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No — I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No — I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.