JOSEPH SURGERY

Patient Information:

Name_____DOB_____Age ____
First Middle Last

Home Phone_____ Cell Phone_____

Address_____
City State Zip Code

Email_____ Occupation_____

SSN_____ Sex M / F Race_____ Ethnicity_____

Primary Care Dr._____ Ph_____ Fax_____

Marital Status: Married____ Single____ Divorced____ Widow____ Other____

Financial Information

Self Pay_____ Interested in Financing options (only cosmetic procedures)_____

Insurance

Name of the Company_____ Group_____ Policy_____

If you are not the primary insurer, who is_____
First & Last Name DOB

Secondary Insurance_____ Group_____ Policy_____

Emergency Contact

Name_____
First & Last Relation to the Pt Phone

Authorization

I authorized Dr. Romane Joseph to bill my insurance. All co-pays, deductible, coinsurance will be required prior rendering medical and surgical services.

Print Name _____ Signature _____ Date_____

JOSEPH SURGERY

Name_____ Date_____

What is reason for your visit?

_____

Medical History

Do you have any medical conditions?

_____

_____

Have you had any surgery before? If so, when:

_____

_____

Do you smoke? _____ Yes / No_____ How many daily?_____ For how long? _____ Did you quit?_____

Do you drink alcohol? _____ Yes / No_____

Family History

Do your parents have any conditions or surgeries?

_____

Medications

_____

_____

Are you allergic to any medication?

_____

JOSEPH SURGERY

Authorization to Discuss Protected Health Information

I _____ authorize_____
To release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named persons:

1. _____ 3. _____

2. _____ 4. _____

PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.

YOU ARE NOT REQUIERED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

Please list phone numbers where you would like to us to contact you for:

* Reminder Notices

* Changes on scheduled appointments

* Messages for the above can be left on an answering machine - ___Yes ___No

1. _____ 3. _____

2. _____ 4. _____

Patient Name, (Please Print): _____

D.O.B: _____ SSN: _____

_____
Patient Signature or Legal Guardian and DATE

JOSEPH SURGERY

HIPPA
By signing you authorize us to use your protected information to treat you and bill you and your insurance and also that you have received a notice of privacy practices.

Name_____ Signature _____

Malpractice Insurance

By signing you acknowledge that Dr. Romane Joseph DOES NOT carry malpractice insurance pursue 458.320 Financial Responsibility Florida Statutes.

Name _____ Signature _____

Arbitration

By signing this contract, you agree to have any issue of alleged medical negligence or breach of contract between you and your MCP decided by binding arbitration in which both parties give up their right to a trial by jury, or trial by a judge. I hereby agree that all provisions of this agreement are in full effect, and no word, sentence, paragraph, or provision may be crossed out, excised, or removed. To be completed by the patient, parent or authorized representative.

Name _____

Your relation with the patient (check one)

_____ Self _____ Parent _____ Guardian _____ other (please specify) _____

Signature _____ Date _____

JOSEPH SURGERY

1. *CANCELLATION / NO SHOW POLICY FOR DOCTOR APPOINTMENT*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. Conversely the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance, you will be charged Fifty dollars ($50) fee; this will not be covered by your insurance company.

2. *CANCELLATION / NO SHOW POLICY FOR SURGERY*

Due to the large block of time needed for surgery, the time spent to obtain authorization, medical clearance and the great deal of coordination that involves to schedule a surgery, not to mention the fact that you are occupying the place of someone else in need of surgical treatment, last minute cancellation causes significant problems. It makes other patients wait unnecessarily and add expenses

There will be a one hundred ($100) refundable fee due the day your surgery is scheduled. It will be returned to you within 7 business day after your surgery or in your postoperative visit.

If surgery is not cancelled at least 7 days in advance or you don't show up for surgery, your deposit will be forfeit, this fee will be not covered by your insurance company. If you want to reschedule you will be charge two hundred and fifty dollars ($250) refundable fee and it will subject to the cancellation /no show policy above. We will not reschedule you a third time.

3. *ACCOUNT BALANCES*

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice unless arrangement is made by us. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and discuss their concerns.

Patients with balances over $100 must take payment arrangements prior to future appointments being made.

_____	_____	_____
PATIENT NAME	SIGNATURE	DATE

JOSEPH SURGERY

PHARMACY INFORMATION

Pharmacy Name:_____

Address:_____

Phone #:_____

I authorize the office of Dr. Romane Joseph to send over my prescription to the pharmacy

_____ _____ _____

Patient Name Signature Date