ACCORD MEDICAL GROUP,PLLC
Delivering Compassionate Care

5112 N. Habana Ave. Tampa, FL 33614 | Phone: (813)374-2406 | Fax: (813)374-2407
www.AccordMedicalGroup.com

PATIENT REGISTRATION FORM

Patient Name: _____ _____ _____
Last First Middle Initial

Date of Birth: _____ Gender : □Male □Female □Transgender Social Security #:_____

Marital Status : □Single □Married □Divorced/Separated

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

Personal email: _____

Primary Phone: _____ Type: □Home □Cell Phone □Work Phone

Secondary Phone: _____ Type: □Home □Cell Phone □Work Phone

Emergency Contact's Name: _____ Phone:_____

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino Race: ❑ American Indian or Alaska Native ❑ Asian

❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other:_____

Employment Information

Company Name: _____

Phone:_____ Ext:_____

Insurance Information

Primary: _____ Secondary: _____

Policy holder ID:_____ Policy holder ID:_____

Policy holder name:_____ Policy holder name_____

Policy holder DOB:_____ Policy holder DOB:_____

Patient relationship to policy holder:_____ Patient relationship to policy holder:_____

Policy holder sex: ❑ Female ❑ Male Policy holder sex: ❑ Female ❑ Male

Pharmacy:_____ Location:_____

Pharmacy phone:_____

How did you hear about Accord Medical Group?

□Doctor □Family/Friend □Insurance □Event □TV □Radio □Mail

□Website / Internet □Phonebook □Building Sign □Other (Otro):_____

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FINANCIAL RESPONSIBILITY

Statement of Financial Responsibility -I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.

Notice of "Non-Covered" Services -I am aware that some services performed by the Practice may be considered "non-covered" by my insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.

Waiver of "Usual, Customary and Reasonable" Clauses (For patients with "Out-of-Network" coverage) -I acknowledge that the fee charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable," due to specialized services and staff. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

Bill To/Payment Instructions

_____ Commercial Insurance/Third Party Payor _____ Medicare _____ *Medigap
Initial Initial Initial

I hereby authorize the Practice to bill my insurance company and/or Medicare (indicated or initialed above) for services provided to me and request that payments for such services to be made to the Practice on my behalf.

***If Medigap**_____ _____ _____
Name of Beneficiary Medigap Policy Number Health Insurance Claim Number

List Names of Those with Whom You Want Us to Share Your Financial Responsibility Information:

Name: Relationship:

_____ _____

_____ _____

_____ _____

Financial Agreement - The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection and attorney fees for collection expenses.

Patient's name: _____
(please print)

Patient (or legal guardian's) signature: _____ Date: _____

If legal guardian, relationship to the patient: _____

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HEALTH INFORMATION QUESTIONAIRE

This is a confidential record of your medical history and will be kept in the office. Information contained here will not be released to any person unless you have authorized us to do so.

Name:_____ Date:_____ /_____ /_____

DOB:_____ Age:_____ ❑ New patient ❑ Established patient

What medical/health concerns bring you to our office today? _____

Medications- List all medications you take on regular basis (include over-the-counter, herbal or natural remedies).

Medication Name	Strength	Daily Frequency	Medication Name	Strength	Daily Frequency

Medical History- Have you ever had or been diagnosed to have (check all that apply)?

❑ Alzheimer's disease
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Atrial fibrillation
❑ Bleeding disorder
❑ Blood transfusion
❑ Cancer: What kind? _____
❑ Cataracts
❑ Chicken pox
❑ Colon polyps
❑ Depression
❑ Diabetes/prediabetes
❑ Fracture
❑ Glaucoma
❑ Heart attack
❑ Heart disease
❑ Heart failure
❑ Heart murmur
❑ Heartburn
❑ Hemorrhoids
❑ High blood pressure
❑ High cholesterol
❑ Irritable bowel syndrome
❑ Jaundice/liver disease
❑ Kidney disease
❑ Migraines/headache
❑ Osteopenia
❑ Osteoporosis
❑ Pneumonia
❑ Prostate problems
❑ Rheumatic fever
❑ Seizures/epilepsy
❑ Stroke
❑ Syphilis
❑ TB/lung disease
❑ Thyroid disease
❑ Ulcers
❑ Urinary incontinence
❑ Other Conditions:
_____
_____

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HEALTH INFORMATION QUESTIONAIRE

Allergies- Do you have any known allergies to medications or food? ❑ Yes ❑ No
If yes, please list:_____

OB/GYN History (females only):

Age of menses: _____ Age of menopause: _____ Method of birth control:_____

How many pregnancies: _____ How many children: _____Vaginal or C-section _____

Hospitalizations and Surgeries - List any hospitalizations, surgeries or procedures you have had performed.

What	Date	What	Date

Family History- Please indicate if your blood relative(s) have had/currently have the following by placing an X in appropriate column:

Family Member	Health Problem(s)	General Health
Mother (age_____)		
Father (age_____)		
Brother(s) (age_____)		
Sister(s) (age_____)		
Grandparents (age_____)		

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HEALTH INFORMATION QUESTIONAIRE

Social History

Smoking/ Tobacco Use? ❑ Current ❑ Past ❑ Never
If you answered yes, answer these additional questions:
Type:_____ Amount/day:_____ How long(years):_____

Alcohol Use? ❑ Current ❑ Past ❑ Never
If you answered yes, how many drinks/week:_____

Recreational Drug Use? ❑ Current ❑ Past ❑ Never
If you answered yes, type:_____

Are there any personal problems or concerns at home, work or school you would like to discuss? ❑ Yes ❑ No
If you answered yes, type:_____

Do you have any personal health goals? ❑ Yes ❑ No
If you answered yes, please list:_____
_____

Occupation: _____❑ Full-time ❑ Part-time
If retired, what was your former occupation: _____

Health Screening Tests History- Please answer what screening tests you have had, the date of the last test and the results.

Screening Test	Yes/No/Date	Results
FLU Shot	❑ Yes ❑ No Date:_____	❑ Normal ❑ Abnormal
Dexa Scan	❑ Yes ❑ No Date:_____	❑ Normal ❑ Abnormal
Colonoscopy	❑ Yes ❑ No Date:_____	❑ Normal ❑ Abnormal
EKG	❑ Yes ❑ No Date:_____	❑ Normal ❑ Abnormal
Fecal Test	❑ Yes ❑ No Date:_____	❑ Normal ❑ Abnormal
Mammogram	❑ Yes ❑ No Date:_____	❑ Normal ❑ Abnormal
Pap Smear-Females Only	❑ Yes ❑ No Date:_____	❑ Normal ❑ Abnormal
Prostate-specific Antigen- PSA- Males only	❑ Yes ❑ No Date:_____	❑ Normal ❑ Abnormal
Spirometry	❑ Yes ❑ No Date:_____	❑ Normal ❑ Abnormal

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MEDICAL INFORMATION RELEASE FORM- (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse: _____

[ ] Child(ren): _____

[ ] Other: _____

[ ] Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call: [ ] my home [ ] my work [ ] my cell number

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

The best time to reach me is : (day)_____ Between (time) _____

RELEASE OF MEDICAL INFORMATION: I acknowledge that "protected health information" pertains to my diagnosis and/or treatment at Accord Medical Group including, but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases. I acknowledge that the "Notice of Privacy Practices" provides information about how this facility may use and/or disclose protected health information about me for treatment, payment, health care operations and as otherwise allowed by law. I understand that Accord Medical Group cannot be responsible for use or re-disclosure of information by third-parties.

Signed: _____ Date:_____

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Medical Records Release/Request Form

Patient Authorization for Use or Disclosure of Protected Health Information
As required by the Health Portability and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your identifiable health information without your authorization except as provided in our Notice of Privacy. Your Completion of this form means that you give permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

Your Name (Print)_____ Date of Birth _____

Address _____ City_____State _____ Zip _____

Telephone _____

☐Date(s) of Service For Release_____ OR ☐ the entire Medical Record

I hereby authorize this medical practice, _____ to release my health information to:

___ Accord Medical Group | 5112 N. Habana Avenue, Tampa, FL 33614 | T: 813-374-2406 | F: 813-374-2407

OR ___ Other practice (include name, address, phone number): _____

_____

Reason for release: _____
Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purpose identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law.
I understand that any medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse. Initial all requested exclusions:
EXCLUSION(S):
Alcohol/Drug _____ Behavior/Mental/Psychiatric _____ Sexually Transmitted Disease _____
HIV/AIDS _____ Other _____ specify other exclusion_____.

I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan. This authorization is effective _____ through _____ (dates must be specified).

Signature _____ Date: _____

Guardian: _____ Parent: _____

Patient Representative and Relationship: _____

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Awareness of Controlled Medication

Patient's Name: _____ Date of Birth:_____

The following is to make awareness of controlled medication requirements. All controlled medications will not be called in to your pharmacy and will not be written without a face-to-face visit. All controlled substances are required to be followed up by a primary care physician. If you are in need of a controlled substance, you must contact our office at 813-374-2406 and schedule an appointment for further treatment.

By signing this form, you are giving acknowledgement to the above-mentioned statement.

_____ _____

Patient Signature Date