**NEW PATIENT INTAKE FORM**

Rowan Tree Medical, P.A.
3197 NE 18TH TERRACE
Oakland Park, FL 33306

**Today's Date: _____**
**Social Security Number: _____**
**Date Of Birth: _____**

**Legal Name**:_____
**Marital Status:_____ Race:_____**
**Age: _____**
**Preferred Language:_____ Ethnicity:_____**
**Home Address: _____**
**Mailing Address (if different):_____**
**Primary Telephone #:_____ Cell – Work – Home**
**Secondary Telephone #:_____ Cell – Work – Home**

**Country of Birth:_____Occupation: _____**
**Emergency Contact Name:_____**
**Emergency Contact Number: _____**
**Emergency Contact Relationship to you: _____**
**Email Address: _____**

**How did you hear about Rowan Tree Medical? _____**
**Primary Insurance Company**:_____
**Secondary Insurance Company: _____**

**What is the reason for your visit today?**

_____
_____
_____
_____

**How long have you had this condition?:**

_____
_____
_____

**What treatments have you tried? How did your condition change?:**

_____
_____
_____

**Family History:**

**Father:** Deceased? Y N Health issues:_____

**Mother:** Deceased? Y N Health issues: _____

**Siblings:** Deceased? Y N Health issues: _____

**Do you have any allergies? _____**

**Number of cigarettes per day:** _____ If NONE, have you ever smoked?_____
When did you quit? _____

**Number of drinks per week:**_____ If NONE, have you ever drank?_____
When did you quit? _____

**What Medications are you currently taking?**

_____
_____
_____
_____
_____
_____
_____

**Medical History**
Please check all that apply:

- ☐ Addiction _____
- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergic Rhinitis
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Balance issues
- ☐ Breast Lumps
- ☐ Breathing Problems
- ☐ Bronchitis
- ☐ Bursitis
- ☐ Cancer _____
- ☐ Candida
- ☐ Chest Pain
- ☐ Chicken Pox
- ☐ Chronic Fatigue
- ☐ Colitis/Bowel Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Disorders
- ☐ Ear Lavage
- ☐ Eating Disorders
- ☐ Elevated Liver Enzymes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever/Chills
- ☐ Fibromyalgia
- ☐ Gall Stones
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Hair Loss
- ☐ Heart Disease
- ☐ Hernia
- ☐ Hepatitis _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hypertension
- ☐ Kidney Stones
- ☐ Meningitis
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Nephritis
- ☐ Neuralgia
- ☐ Night Sweats
- ☐ Paralysis
- ☐ Prostate Problems
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sinus Congestion
- ☐ Stroke
- ☐ STD
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Problems

**Other Illnesses:** _____

_____

**Surgeries:** _____

Do you have **Advance Directives** or a **Living Will**? Yes ____ No ____
Does **Domestic Violence** affect your life? Yes ____ No ____

ROWAN TREE MEDICAL, P.A.
**2500 NE 15th Avenue**
**Wilton Manors, FL 33305**
**(954) 533-5382**

## ASSIGNMENT OF BENEFITS

**Financial Responsibility**
I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Rowan Tree Medical, P.A. and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Rowan Tree Medical, P.A. of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Rowan Tree Medical, P.A. and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

**Assignment of Benefits**
I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Rowan Tree Medical, P.A. for all covered medical services and supplies provided to me during all courses of treatment and care provided by Rowan Tree Medical, P.A. and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Rowan Tree Medical, P.A., and will constitute a continuing authorization, maintained on file with Rowan Tree Medical, P.A., which will authorize and allow for direct payment to Rowan Tree Medical, P.A. of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Rowan Tree Medical, P.A..

**Authorization to Release Information**
I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Rowan Tree Medical, P.A. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Rowan Tree Medical, P.A.. Patient/Insured (Printed Name)

**Missed Appointments**
I understand that if I am unable to make my scheduled appointment, it is my responsibility to contact Rowan Tree Medical 24 hours in advance. I understand that I will be responsible for a "NO SHOW" fee of $25.00 if I miss a scheduled appointment without notifying the office.

Patient/Insured (Name) Date of Birth

_____ _____

Patient/Insured (Signature) Date of Signature

_____

Witness (Signature) Date of Signature

_____

# ROWAN TREE MEDICAL, P.A.

## PATIENT CONSENT FORM

### CONSENT FOR TREATMENT

By signing this contract, I authorize the physician or their appointed staff to administer treatment, anesthetics, or perform such operations as deemed necessary or advisable for the diagnosis and treatment of my health care. This includes blood draws for laboratory studies which may include HIV/AIDS diagnosis and treatment studies.

### AUTHORIZATION FOR RELEASE OF INFORMATION

I understand as part of my health care, Rowan Tree Medical, P.A. originates and maintains health records describing my health history, symptoms, examination and test result, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and health information for billing purposes
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have received the Rowan Tree Medical, P.A.'s Notice of Privacy Practices which provides a more complete description of information uses and disclosures. I have the right to review this notice prior to signing this consent. I understand the organization reserves the right to change their notice and practices at any time and I may request a copy of any revised notice by contacting Rowan Tree Medical's Privacy Office at (954) 533-5382 x101.

In the event that this account needs to be assigned to a collection agency or attorney, I am aware that I will be responsible for all attorney fees, collection fees, filing fees, finance charges, interest charges at 1.5% per month, and any other costs incurred.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that this organization is not required to agree to the restrictions requested. I understand I may revoke this consent by contacting Rowan Tree Medical, P.A.'s Privacy Officer and requesting a Revocation of Consent Form. I understand revoking my consent does not affect disclosures already made in reliance of my prior consent.

### CONSENT TO OBTAIN RECORDS

This consent is given freely with the understanding that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as authorized by law. A photocopy or fax of this consent is as valid as this original. This consent is valid for 10 years from the date of signing, and may be revoked upon written request.

Patient Name (Printed): _____ Date: _____

Patient Signature: _____ Patient DOB: _____

Witness Signature: _____ Witnessed Date: _____

# ROWAN TREE MEDICAL, P.A.

## NOTICE OF PRIVACY PRACTICES

**ROWAN TREE MEDICAL, P.A.**
**2500 NE 15th Avenue**
**Wilton Manors, FL 33305**
**(954) 533-5382**

**Privacy Officer:** **Thomas Mulligan**
**Effective Date:** **02-25-2009**
**Revision Date:** **01-17-2017**

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.***

We understand your medical information is private and we strive to protect the confidentiality of you medical records. Federal regulations require that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. The practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to the protected health information.
Prior to making important changes to our privacy practices, we will make available on request a revised Notice of Privacy Practices. This notice will be followed by any health care professional authorized to enter information in your medical record. All employees, staff and other personnel at this practice who may need access to your information must abide by this notice.
All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be used.

### *HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU*

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

**For Treatment:** We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you are allergic to specific drugs that could influence which medications we prescribe for the treatment purpose.

**For Payment:** We may use and disclose medical information about you so that treatment and services you receive from us may be billed and payment may be collected from your insurance, third party or you. Example: We may need to send your protected health information, such as your name, address, office visit date and codes identifying your diagnosis and treatment to your insurance company for payment.

**Health Care Operations:** We may use and disclose medical information about you for health care operations to assure that you received quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

**Other Uses of Disclosures That Can Be Made Without Consent or Authorization**

As required during an investigation by Law enforcement agencies
To avert a serious threat to public health and safety
As required by military command authorities for their medical records
To workers' compensation or similar programs for processing of claims
In response to legal proceeding
To a coroner or medical examiner for identification of body
If an inmate, to the correctional institution or law enforcement official
As required by the US Food and Drug Administration (FDA)

Other healthcare provider's treatment activities
Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
Uses and disclosures required by law
Uses and disclosures in domestic violence or neglect situations
Health Oversight activities
We may contact you to provide appointment reminders of information about treatment alternatives or other health related benefits and services that may be of interest to you

**Uses and Disclosures of Protected Health Information Requiring Your Written Authorization:**
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we're unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

## *Your Individual Right Regarding Your Medical Information*

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against of filing a complaint.

**Right to request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for your treatment, payment or healthcare operations or to someone who is involved with or in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions you must submit your request in writing to the Privacy Office at this practice. In your request, you must tell us what information you want limited.

**Right to request confidential Communications:** You have the right to request how we should send communications to you about medical matters, and where you would like those communication ns sent. To request confidential communications, you must make your request to the Privacy Office at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

**Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes; information compiled for use in a civil, criminal or administrative action or proceeding and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to a Paper Copy of this Notice:** You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Office at this practice.

**Right to Amend:** If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, you request must be made in writing and submitted to the Privacy Officer at this practice. In addition you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. We may

prepare a rebuttal to your statement and will provide you a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

**Changes to This Notice:** We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice, with the effective date in the upper right corner of the first page.

**Patient Acceptance of Notice of Privacy Practices**

I understand that, under the Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood the Notice of Privacy Practice.

The practice reserves the right to change the terms of this Notice of Privacy Practice. I understand the practice will provide current Notice of Privacy Practice on request.

Print Name: _____

Signature: _____

Witness: _____ Date: _____

**I was unable to obtain the patient's signature**

Date: _____ Name: _____

Reason: _____ ___

## NOTE: PAGES 1 AND 2 OF THIS DOCUMENT ARE TO BE GIVEN TO THE PATIENT. THIS PAGE (PAGE 3) REMAINS IN THE PATIENT FILE

**ROWAN TREE MEDICAL, PA**
**2500 NE 15TH AVE**
**Wilton Manors, FL 33305**
**954-533-5382**

# LATE/NO SHOW POLICIES

## LATE POLICY

Please be advised that this is an "appointment only" medical practice and each patient is given individual care. If you arrive greater than 15 minutes past your appointment time, you will need to be rescheduled. This policy is implemented to prevent delays in treatment for other patients. Depending on the sensitivity of the diagnoses of all patients, you may experience a delay between your appointment time and the actual time that you are seen by the physician. However, it is imperative that you arrive at your scheduled appointment time.

## NO SHOW POLICY

We ask that you have the courtesy of calling to cancel your appointments 24 hours in advance due to the fact that we schedule our office hours and staff to meet the needs of our patient population. Many patients are waiting to be scheduled. It is extremely important that you notify us so that we can schedule accordingly.

Please be advised that a $25 fee will be charged for all "NO SHOWS" who fail to call 24 hours in advance. This policy applies to "SAME DAY CANCELS" as well.

We greatly appreciate your understanding, patience and cooperation.

## ACKNOWLEDGEMENT

I have read and understand the statements above.

Name: _____ Date: _____