PLATINUM
PRIMARY CARE

New Patient Registration Form

Date: _____

Last name:_____

First name:_____ Middle Initial:_____

Maiden name:_____

Date of Birth:_____

Gender: _____

Social Security #_____

Email:_____

Address:_____ Apt/Unit#:_____

City:_____ State:_____ Zip:_____

Home phone (_____)_____ Work phone: (_____)_____

Cell Phone: (_____)_____

Marital Status: (please circle) Single Married Divorced Other

Race (optional): (please circle) Black White Asian Hispanic Other

Employer:_____

Occupation:_____

Emergency Contact

Name:_____

Relationship:_____

Home phone: (____)_____ Work phone: (_____)_____

Cell phone: (_____)_____

Insurance Information

Primary Insurance Company:_____

Phone #: (_____)_____

Insured Name (if other than self):_____

Relationship:_____ Date of Birth:_____

Policy/Member #:_____

Group #:_____

Employer Providing Insurance:_____

Secondary Insurance Company:_____

Insured Name (if other than self):_____

Relationship:_____ Date of Birth:_____

Policy/Member #:_____

Group #: _____

Employer Providing Insurance: _____

Pharmacy

Name/Street:_____

Phone:_____

PLATINUM
PRIMARY CARE

Insurance Authorization Release and Assignment of Benefits

I hereby authorize Platinum Primary Care PLLC to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Platinum Primary Care PLLC on behalf of myself and/or my dependents and I understand by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, private insurance and any other health/medical plan to issue payment directly to Platinum Primary Care PLLC for medical services rendered to myself and/or my dependents.

Date:_____

Patient Name:_____

Signature:_____

Legal Representative (if applicable):_____

Relationship to patient:_____

Signature:_____

PLATINUM
PRIMARY CARE

Consent to Treat

I,_____, am voluntarily seeking healthcare and hereby
(Patient's name)

consent to medical treatment, procedures, laboratory tests and other health care services. I understand that I have the right to refuse specific treatments or procedures. However, by signing below, I agree in general , to permit laboratory and diagnostic tests, routine medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency procedures as necessary, and hospital services performed at the request of the attending physician or other physicians assisting in my care.

The consent given shall be valid and binding and the physician(s) can rely on this authorization and accept any consent given by the patient until such time as physician receives written notice that the authorization is revoked.

_____ _____

Patient name (please print) Date of Birth

_____ _____

Signature of patient or legal representative Relationship

_____

Date

PLATINUM
PRIMARY ✦ CARE

Financial Policy

Welcome to Platinum Primary Care PLLC! We are pleased that you have chosen us as your health care provider. Our mission is to provide you with the highest level of professional medical care with the highest degree of patient satisfaction. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require that all patients sign our Authorization and Consent for Treatment Form before receiving medical services. This form confirms that you understand that the services provided are necessary and appropriate, and advises you of your financial responsibility with respect to services received.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. Some insurance plans tell us exactly what you will owe at the time of your visit; in that case, we may request full payment for your share when you check in or out. Other insurance plans do not provide immediate information regarding patient responsibility; in that case, you will be asked to save a credit card on file to settle your account or pay a deposit when you check in or out.

If you save a credit card on file, we will charge your card for the balance due when your insurance company notifies us of your patient responsibility. When you make a deposit, you will pay an estimate of the expected patient responsibility; when your insurance company notifies us of your patient responsibility, we will either send you a statement for the balance due or issue a refund.

If you have an Annual Wellness Visit or Physical Exam but need additional services, we may bill you for those additional services. If you demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, payment plans may be available.

TYPES OF PAYMENTS

1. **Co-payments.** Insurance carriers require that we collect your co-payment at the time of your visit. If you are not prepared to make your co- payment, you may reschedule your appointment.

2. **Deductibles.** Most insurance plans require you to pay a predetermined amount (the “deductible”) before insurance will cover certain charges. Our technology allows us to view your remaining deductible and help you understand what you will owe for your visit so we can collect the amount due at the time of your visit.

3. **Co-insurance.** Some insurance plans require that you pay a certain percentage (for example, 20%) of the allowable charge amount. Our technology allows us to view the details of your insurance plan, including your coinsurance amount, and calculate the expected out-of-pocket cost for you. If we can determine the amount, we will ask that you pay your co-insurance at the time of your visit.

4. **Uninsured Patients / Self-Pay.** If you do not have insurance or if the services provided are not covered by your insurance, payment for all services is due at the time of your visit. A prompt pay discount is available if you pay in full at the time of service.

5. **Out-of-Network.** We participate with most major insurance plans. You can contact your insurance company to confirm if your provider is in network prior to making your appointment. If we do not participate with your insurance plan, you will be required to pay for your visit at the time of service. We may send a courtesy bill to your insurance company. If the total charge amount is not available at the time of check out, you may be required to pay a deposit as described above.

6. **Non-Covered Services.** It is your responsibility to contact your insurance plan to determine whether a particular service is covered. If we provide you non-covered services, you are expected to pay for the services at the time of your visit. We will assist you in attempting to resolve any appeals.

If you are a Medicare patient, we will inform you of any non-covered services prior to your treatment. Your provider will review options with you and document your decision and acceptance of financial responsibility using the Centers for Medicare and Medicaid Services (CMS) form CMS-R-131 (03/08), Advance Beneficiary Notice (ABN).

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). If you provide your insurance card(s) at a later time, we may be able to retroactively bill the services to your insurer depending on the insurance plan's requirements. We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Our fees are for physician services only; you may receive additional bills from laboratory, radiology, or other diagnostic related providers.

You are responsible to:

Know if a referral or authorization is necessary for office visits (If it is required and you do not have the appropriate referral or authorization. you may be billed as an uninsured patient).

- Check with your insurance plan to determine if prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)
- Check with your insurance plan to review the schedule of benefits and whether a co-payment or deductible applies.
- File any appeals with your insurance plan, if needed.
- Coordinate benefits if you have more than one insurance plan. You may be required to contact your insurance company to clarify which plan is primary or to correct any demographic or other issues.
- Arrive for appointments with all required documentation.

Insurance Verification. We will attempt to verify your insurance eligibility two (2) business days prior to your visit. If we are unable to confirm active insurance coverage, we will contact you about your insurance eligibility. If you are unable to present an alternative form of active insurance coverage prior to the visit, you will be required to either pay at the time of your visit or reschedule your appointment. For same day appointments, we will check eligibility when the appointment is made.

Outstanding Balances. After your visit, we will send you a statement for any outstanding balances. All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. We do not accept cash – only checks and credit card.

We generally send statements every twenty-eight (28) days, beginning when the balance becomes patient responsibility. If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a $20 collection fee in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and you may not be allowed to schedule any additional services unless special arrangements have been made.

LATE ARRIVALS, CANCELLATIONS AND NO-SHOWS

Late arrivals. If you arrive late for a scheduled appointment, you may be asked to reschedule your appointment or wait for an open appointment time on that day's schedule.

Cancellations. If you are unable to keep a scheduled appointment, you must call at least one (1) business day in advance or we may consider you a "no-show."

No-shows. If you miss your appointment, you may be charged $25.00 fee for a missed appointment. This fee will need to be paid prior to rescheduling. This fee cannot be billed to insurance. As permitted by state law, you may be discharged as a patient following three (3) no- shows in a one-year period (365 days).

CARD-ON-FILE PROCESS

When you check into a hotel or rent a car, you are required to provide a credit card to cover the cost of any incidental charges and/or pay your bill. This process benefits both you and the hotel or rental company by making the checkout process easier, faster, and more efficient.

We have implemented a similar process at Platinum Primary Care PLLC. You will be requested to provide a credit card when you check-in for your visit and we will scan the card into our system. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that the remaining balance owed will be charged to your credit card. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

The “Card-on-File” program simplifies payment for you and eases the administrative burden on your provider’s office. This reduces paperwork and ultimately helps lower the cost of healthcare. Your statements will be made available and we are here to answer any questions about the balance due.

If you have any questions about the card-on-file payment method, please let us know.

It is understandable that temporary financial problems may affect timely payment of your account. If this situation should arise, please contact us promptly for assistance with management of your account. If you have any questions about the above information, please feel free to reach out to us.

Thank you for helping us run a better practice!

I have read and understand the above Financial Policy and agree to meet all financial obligations.

Patient Name:_____

Signature:_____

Date:_____

Legal representative (if applicable)

Name:_____ Relationship:_____

Signature:_____

Date:_____

PLATINUM
PRIMARY CARE

Designation of Health Care Representative

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person(s) as your "personal representative." You may revoke this designation at any time by signing and dating the revocation section of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I,_____ _____

Patient name Date of birth

hereby appoint the following person(s) to act as my personal representative(s) with respect to decisions involving the use and/or disclosure of health information that pertains to me.

PRINT Name of Personal Representative(s)	**PRINT Relationship to Patient**
_____	_____
_____	_____
_____	_____

The Authority of this person when serving as my "personal representative" is restricted to the following functions:

☐This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.

☐This person is restricted to the following information about my health care:

_____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Platinum Primary Care PLLC.

I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____ _____

Signature Date

REVOCATION SECTION:

I hereby revoke the designation of _____ as my personal representative.

_____

Patient Signature

PLATINUM
PRIMARY CARE

NOTICE OF PRIVACY PRACTICES

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 are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses And Disclosures We May Make Without Written Authorization**. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. **Disclosures We May Make Unless You Object.** Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

- We participate in one or more **Health Information Exchanges (HIE)** which allows disclosure of your electronic health record via electronic transfer to other facilities and providers for your treatment purposes. Your health information and basic identifying information regarding your visits to our facilities may be shared with the HIEs for the purposes of diagnosis and treatment.

This includes health information for your continuing care, as well as care you may seek at other locations. Other providers participating in these HIEs may access this information as part of your treatment.

3. **Uses and Disclosures With Your Written Authorization**. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. **Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to Platinum Primary Care PLLC**.**

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e- mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. **Changes To This Notice.** We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception

area and on our website. You may obtain a copy of the operative Notice from our front desk staff.

6. **Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. **Contact Information.** If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer:	Dr. Asha Tota-Maharaj
Phone:	407 974 7856
Address:	320 N Edinburgh Drive, Ste B Winter Park, FL, 32792

8. **Effective Date.** This Notice is effective October 1, 2020.

I acknowledge I have received a copy of the Platinum Primary Care PLLC Notice of Privacy Practices. I have read and understand all of the above and agree to comply.

Patient name:_____

Signature:_____

Date:_____

Legal representative(if applicable) :_____

Relationship:_____

Signature:_____

PLATINUM PRIMARY CARE

PATIENT INFORMATION SHEET

NAME: _____ GENDER: _____ DOB: _____ DATE: _____

Allergies: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____

_____

_____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	Other:
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Other medical problems not listed above:

_____

Cancer Screening:

Colonoscopy: ☐Yes ☐No Repeat year:_____

Mammogram: ☐Yes ☐No Repeat year:_____

Bone dexa: ☐Yes ☐No Repeat year:_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐Elementary ☐High School ☐ Vocational ☐ College ☐Graduate / Professional

Are there any vision problems that affect your communication? (circle) Yes No

Are there any hearing problems that affect your communication?(circle) Yes No

Are there any limitations to understanding or following instructions (either written or verbal)?
☐Yes ☐No

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ NeverType:_____Amount/day:
_____Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐No

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age ____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age ____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Please circle any symptoms below that you have been experiencing for the past 2 weeks.

Constitutional	**Negative Weight loss Weight gain Fever Fatigue Other:**
Eyes	**Negative Vision change Loss of vision Pain Tearing Other:**
ENT/Mouth	**Negative Ulcers Sinusitis Tinnitus Headache Hearing loss Hoarseness Other:**
Cardiovascular	**Negative Orthopnea Chest pain Shortness of breath with activity Swollen feet Palpitation Other:**
Respiratory	**Negative Wheezing Hemoptysis Shortness of breath Cough Other:**
Gastrointestinal	**Negative Diarrhea Bloody stool Nausea Vomiting Constipation Flatulence Other:**
Genitourinary	**Negative Hematuria Painful urination Urgency Frequent urination Incomplete emptying Loss of urine wih cough/laughter Incontinent Abnormal bleeding Pain with intercourse Other:**
Musculoskeletal	**Negative Muscke Weakness Joint pain Joint swelling**
Skin/Breast	**Negative Mastalgia Discharge Masses Rash Ulcers Hair changes Other:**
Neurological	**Negative Syncope Seizures Numbness Trouble walking Other:**
Psychiatric	**Negative Depression Anxiety Suicidal ideation**
Endocrine	**Negative Diabetes Feeling abnormally hot or cold Hypothyroid Hyperthyroid Hot flashes Other:**
Heme/Lymph	**Negative Bruises Bleeding Adenopathy Other:**
Allergies	**Negative Hives Reaction to – Medication Food Animals**

Patient Name:_____

Patient Signature:_____

Date:_____