VICTOR ARBOLEDA MD PA
REGISTRATION FORM

(Please Print)

Today's date:	Previous PCP:

PATIENT INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Primary Language	(Former name):	Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone no.: ( )	Mobile phone no.: ( )
Apt/Unit: City:	State:	ZIP Code:
Street address 2:	Home phone no.: ( )	Mobile phone no.: ( )
Apt/Unit: City:	State:	ZIP Code:
Occupation: Employer:		Employer phone no.: ( ) Ext

Chose clinic because/Referred by:	❑ Family	❑ Friend	❑ Dr.	❑ Insurance Plan	❑ Hospital

Reason for your visit:	❑Work Related ❑Accident Related ❑Neither	Date of Accident:	/ /

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Self / Spouse / Parent / Other	Birth date: / /	Address (if different):	Home phone no.: ( )

Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes ❑ No	Primary Ins:	Secondary Ins:

Primary Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Secondary Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of person with whom we can discuss your medical condition:	Relationship:	Home phone no.: ( )	Work phone no.: ( )
Address:	City:	State:	Zip Code:

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Victor Arboleda MD deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Patient/Guardian signature *Date*

REQUEST NUMBER: 1 2 3 STAT

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of **Recipient** of Records)							
Name	VICTOR ARBOLEDA. MD PA				Phone	727-442-6068	
Address	525 S. HERCULES AVE STE 102				Fax	727-443-4894	
City/State Zip	City	CLEARWATER	State	FLORIDA		Zip	33764

RECORDS FROM: (Who is **Releasing** the Records)							
Name					Phone		
Address							
City/State Zip	City		State			Zip	

For the Following Purposes:

	Continued Medical Care		Personal Information		Legal Follow-up
	Disability Insurance		Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

	Please send the entire Medical Record (all information) to the above named recipient.				
	Office Notes and Reports		Diagnostic Reports		Billing Statements
	Rx History		Transcribed Hospital Reports		Laboratory Reports
	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_______ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases
_______ Mental Health Information and/or Records
_______ Domestic Violence
_______ Genetic Testing Information and/or records
_______ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

____

_______ Other: ____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): ____________________.

Print Patient's Name: ________________________________ Date: ________________________

Signature of Patient or Patient's Legal Representative: ____________________________________

Print Name of Legal Representative (if applicable): ____

Relationship to patient: ________________________

Patient Name ______________________ Date: ______________

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990, and Chapter 745, Florida Statutes, please answer the following questions:

Declaration to Decline Life-Prolonging Procedures (LIVING WILL)

- ☐ I have made such a declaration
- ☐ I have NOT made such a declaration

Health Care Surrogate

- ☐ I have designated a Health Care Surrogate
- ☐ I have NOT designated a Health Care Surrogate

Durable Power of Attorney

- ☐ I have appointed a Durable Power of Attorney for Health Care decisions
- ☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT.

______________________________ ______________________

Signature of Patient or Representative Date

YEARLY RECONFIRMATION I acknowledge that this information remains accurate			
Signature of Patient/Representative	Date	Signature of Patient/Representative	Date
Signature of Patient/Representative	Date	Signature of Patient/Representative	Date
Signature of Patient/Representative	Date	Signature of Patient/Representative	Date
Signature of Patient/Representative	Date	Signature of Patient/Representative	Date

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

______________________________ ______________________

Signature of Patient or Representative Date

VICTOR ARBOLEDA MD PA

Assignment of Benefits And Acknowledgement of Notice of Privacy Practices

☐ **If you have no insurance**

I agree to pay my medical expenses, in full, when I am seen by the doctor. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement

☐ **If you have HMO, PPO, commercial insurance, or Workers Compensation**

I agree to comply with the terms of my insurance coverage, including payment of my co-payment, co-insurance, deductible and/or non-covered services at the time of service rendered, and payment of any portion of charges that my insurance carrier determines to be my responsibility, upon receipt of my monthly statement. If my workers' compensation does not pay my account for any reason, I will be responsible for the payment in full.

☐ **If you have Medicare Insurance**

I request that payment of authorized Medicare benefits be made on my behalf to **Victor Arboleda MD PA** for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to pay any portion of my charges that my Medicare carrier determines is my responsibility.

☐ **If you have Medigap coverage**

I request that payment of authorized Medigap benefits be made either to me or on my behalf to **Victor Arboleda MD PA** for any services furnished me by that provider. I authorize the holder of medical information about me to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

Acknowledgement

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.

I acknowledge receipt of the **Notice of Privacy Practices for Protected Health Information** and have been given the opportunity to review that notice.

Consent to Access Prescription History

Our practice uses an electronic medical record that allows us to electronically send prescriptions directly to pharmacies. Our system also allows our physicians to access a list of prescriptions filled by their patients within the past 2 years. Reviewing this list helps to assure patient safety and avoid duplication of medications and/or drug interactions. Please select one of the following and sign below.

_______I grant _______ I do not grant Victor Arboleda MD PA permission to access my external prescription history.

Patient Name:____ Date of Birth:______________________

Signed:____ Date:_____________________________

VICTOR ARBOLEDA, MD, PA

PRESCRIPTION RENEWAL POLICY

Dr. Arboleda or his covering physician is available to emergencies twenty four hours a day. Prescription renewals, however, should not be considered medical emergencies. Prescription renewals should be discussed with your doctor during your office visit or by phone with the nurses during office hours, Monday through Friday. We will get back to you within twenty-four hours. By following this policy, we can assure you the highest quality medical care.

PATIENT EXAMINATION ROOM ESCORT POLICY

To ensure your comfort, at your request, you may have an escort present with you during your examination.

Escorts may be a friend or a family member or we can furnish a nurse from our staff to be present during your examinations.

At the physician's discretion, an escort may also be asked to be present at the time of examination.

MEDICAL RECORD COPY POLICY

According to 45 CFR 164.524, The Privacy Rule permits the covered entity to impose reasonable, cost-based fees for copying medical records. The fee may include only the cost of copying (including supplies and labor) and postage, if the patient requests that the copy be mailed.

According to the Florida Administrative Code 64B8-10.003, a healthcare provider required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records, which shall not be more than:
(a) For the first 25 pages, the cost shall be $1.00 per page.
(b) For each page in excess of 25 pages, the cost shall be 25 cents.

This office will copy and release your medical records to other healthcare providers as a courtesy only if we receive:

1. A written request for Protected Health Information by a healthcare provider, **and**
2. A signed authorization to release PHI by the patient.

If a patient requests copies of his/her medical records, s/he will be subject to the copy fee.

I completely understand and will comply with all the above policies.

___________________________________ _________________________

Patient Signature Date

Consent to Share My Health Information with BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange (**BayCare eHX**) is designed to improve your health care and make office visits easier and more convenient. Giving your consent allows all your doctors who participate in BayCare eHX to enroll you in BayCare eHX and to disclose your demographic, insurance and medical information (collectively your **"health information"**) to BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses and health professionals, and hospitals and other health care facilities. Only health care providers and authorized personnel who participate in BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of BayCare eHX, will be able to access your health information. BayCare eHX allows your providers access to your health information more quickly and accurately than paper charts.

You may use this consent form to note whether or not to allow BayCare eHX to see and obtain access to your health information in this way. This form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on BayCare eHX for your medical treatment.**

If you check the **"YES"** box below, you are saying "Yes, members of BayCare eHX may see and get access to all of my health information through BayCare eHX."

If you check the **"NO"** box below, you are saying "No, members of BayCare eHX may not see or get access to my health information through BayCare eHX for any purpose."

Read the information on the back of this form carefully before making your decision.

Your Consent Choices

- ☐ YES, I give consent for my doctors to enroll me in BayCare eHX and for the members of BayCare eHX to access ALL of my health information as set forth in this Consent Form.

- ☐ NO, I deny consent for my doctors to enroll me in BayCare eHX and for the members of BayCare eHX to access ALL of my health information as set forth in this Consent Form.

______________________________	______________________________	__________
Printed name of patient/representative	Signature of patient/representative	Date

Authority of Representative

I, ______________________________, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: ____

____

____

Relationship to patient: ______________________

Details About Your Health Information in BayCare eHX and the Consent Process

1. How Your Health Information Will Be Used

Your health information will be used by members of BayCare eHX **only:**

- To provide you with medical treatment and related services
- To check whether you have health insurance and what it covers
- To evaluate and improve the quality of medical care provided to all patients
- For administrative management of BayCare eHX

2. What Types of Health Information About You Are Included

If you give consent, members of BayCare eHX may access **ALL** of your health information available through BayCare eHX. This includes information created before and after the date of this consent form. Your health information available through BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries (such as diabetes or a broken bone), test results (such as X-rays or blood tests), and lists of medications you've taken. As part of this consent form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:

- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Psychiatric/mental health conditions
- Sexually transmitted diseases
- Substance abuse

3. Where Health Information Comes From

Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health information electronically.

4. Who May Access Information About You, If You Give Consent

Access to BayCare eHX will be limited to only those members of BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth in this consent form and who have agreed to the overall terms and conditions established for use and operation of BayCare eHX.

5. Improper Access to, or Use of, Your Information

If at any time you suspect that someone who should not have seen or received access to your health information has done so, contact the BayCare Privacy Department at (727) 820-8024.

6. Re-Disclosure of Information

Any electronic health information about you may be re-disclosed by members of BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in paper form. You understand that the protected health information disclosed pursuant to this consent form may not be protected by federal law once it is disclosed by your physician.

7. Effective Period

This consent form will remain in effect until the day you withdraw your consent.

8. Withdrawing Your Consent

You can withdraw your consent at any time by giving written notice to the Population Health Administrator (eHX) of BayCare Health System at 2995 Drew Street, Clearwater, FL 33759. **Organizations that access your health information through BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.**

9. Copy of Form

You are entitled to receive a signed copy of this consent form after you sign it.