

EISENMAN & EISENMAN, M.D., LLC
Patient Registration Form

PATIENT INFORMATION				
Patient's Last Name:		First Name:		Middle Name:
Mailing Address:			City:	State: Zip Code:
Home Phone: ()	Cell Phone: ()	Work Phone: ()	Email Address:	
Patient's Date of Birth: / /	Patient Age:	Patient Sex: M F	Marital Status: Single Married Divorced Widowed Other	
Social Security #:	Employer Name and Address:			
If patient is a minor, please give parent/guardian names and specify relation to patient:				
What is your primary language? : English Spanish Other: _____				
Primary Care Physician/Referring Physician:				

IN CASE OF EMERGENCY			
Name of Emergency Contact Person:	Relationship to Patient:	Home Phone: ()	Work Phone: ()

INSURANCE INFORMATION		
Name of Primary Insurance:	Policy Subscriber's Name, if Not Patient:	Policy Subscriber's Date of Birth: / /
Patient's Relationship to Subscriber:	Self Spouse Child Other, please specify:	
Name of Secondary Insurance (if applicable):	Policy Subscriber's Name, if Not Patient:	Policy Subscriber's Date of Birth: / /
Patient's Relationship to Subscriber:	Self Spouse Child Other, please specify:	

OTHER INFORMATION		
Pharmacy Name:	Pharmacy Location:	Pharmacy Phone: ()

I authorize the release of any of my medical information necessary for insurance/prescription certification or to process insurance claims. I also authorize the release of my medical records to any doctor, hospital, or ancillary care center participating in my care and treatment. Only medically necessary information will be released when requested. I understand that this information will either be faxed or mailed to the party requesting the information.

I hereby assign all medical benefits to include major medical benefits to which I am entitled to Dr.'s Jesse, Richard Eisenman and/or Dr. Cathia Rene. This assignment will remain in effect until revoked by me in writing. I further agree to be solely responsible for any balances that my insurance does not pay. I understand this to include, but not limited to any charges deemed above "reasonable and customary" by said insurance company. I further understand that I am responsible for any collection and/or legal fees incurred as a result of non-payment on my account.

A photocopy of these authorizations are to be considered legally valid as is the original.

PATIENT SIGNATURE: _____ DATE: _____

MEDICAL RELEASE AUTHORITY
 TO: _____ ADDRESS: _____

I, _____ (Patient's name or guardian) hereby request that you release a report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from: _____ to _____: to Dr.'s Jesse and/or Richard Eisenman, 5065 South State Road 7 Lake Worth, FL 33449 (561) 753-7487 FAX (561) 753-8161.

Patient's Signature: _____ Date of Request: _____

Witness: _____ Date: _____

Eisenman & Eisenman, M.D.

5065 SR 7 – Suite 201

Lake Worth, FL 33449

Phone: 561-753-7487 Fax: 561-753-8161

Jesse H. Eisenman, M.D. Richard E. Eisenman, M.D. Cathia M. Rene, M.D.

HIPAA PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge receipt of:

- HIPAA “Privacy Notice”

The person or persons completing my registration process have explained to me that:

I need to read the information contained in these documents, and ask my healthcare staff if I need assistance in understanding my rights, or if I would like them to explain these materials to me in more detail.

I have been told:

- That these materials are to inform me of my privacy rights as a patient
- That the HIPAA “Privacy Notice” I have been given states that my personal “protected health information” (PHI) will be used and disclosed by my doctor and his staff in the routine activities of treatment, payment and healthcare operations.
- Before any other use or disclosure of my personal protected health information is made I will be asked for my written authorization.

I have been told that I have the right:

- To CONFIDENTIAL COMMUNICATIONS
- To REQUEST RESTRICTIONS on Uses and Disclosures of my PHL
- To REQUEST ACCESS to my personal protected health information
- To REQUEST AMENDMENTS to my personal protected health information
- To have an ACCOUNTING of any DISCLOSURES for purposes other than of treatment, payment and healthcare operations.

_____ I am requesting restrictions on uses and disclosures as noted below:

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PATIENT/REPRESENTATIVE SIGNATURE: _____ DATE: _____

PRINT PATIENT NAME: _____

RELATIONSHIP: _____ SELF _____ OTHER: _____

THIS ACKNOWLEDGEMENT EXPIRES SEVEN YEARS FROM THE DATE OF THE SIGNATURE ABOVE

5065 S State Rd 7
Lake Worth, Florida 33449

Phone: 561-753-7487
Fax: 561-753-8161

Patient Financial Policy

The following is a statement of our financial policy. We require that you read and sign this document prior to your treatment. In addition, we ask that you complete our Patient Registration form, including insurance billing information, before you are seen.

1. New patients who have insurance are expected to pay their coinsurance or co-pay responsibility the date they are seen. If their deductible has not been met, they are expected to pay in full up to the amount of their deductible at the time of service.
2. If you are a member of an HMO or PPO with which we participate, your co-pay or coinsurance is payable at time of treatment. If you belong to an HMO, you must have a referral before we can provide any services to you. **It is your responsibility to obtain that referral from your Primary Care Physician.** If you do not have a valid referral at the time of your appointment, you will have to be rescheduled.
3. Established patients with outstanding balances are expected to pay their balance in full before they are seen or treated for any routine services. No elective diagnostic or treatment procedure will be done for patients whose balance exceeds \$100.00. **Arrangements can always be made for financial hardships.**
4. Patients who were originally seen by one of our physicians in the hospital, and who came to our office for follow up services are expected to provide accurate insurance information, and responsible for referrals, co-payments, and coinsurance at the time of your appointment.
5. Patients may pay by: **cash, check, MasterCard, American Express, Visa, or Discover.** Patients whose checks are returned to us for non-sufficient funds will be fined a \$25 returned check fee and will have to pay the balance due by cash, credit card, or money order.
6. Patients who do not pay their balance or establish a pattern of steady payments within 90 days of the date they were first billed, or after the receipt of 3 statements from our office, may be sent to a collection agency on our behalf.
7. Patients whose accounts have been sent to a collection agency will be discharged from our practice and will no longer be able to be seen. Exceptions will only be made if collection balance is paid.
8. Co-pays and/or coinsurance will apply to your follow up appointments.

Signature

Date

Print Name

Social Security #

