PREMIER
FAMILY MEDICINE - URGENT CARE - WELLNESS

PATIENT INFORMATION

First Name	Middle Name	Last Name	Gender ☐ Male ☐ Female
Street Address	City, State, Zip	E-mail Address (Required)	
Date of Birth / /	SSN - -	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Widowed	
Home Phone	Cell Phone	May we web enable the patient portal? (required) ☐ Yes ☐ No	
What is your preferred method of contact? ☐ Home Phone ☐ Cell Phone ☐ E-Mail ☐ Mail			
Employer ☐ Check here if Retired	Occupation	Referred by	
Emergency Contact	Contact Phone	Relationship to Patient ☐ Spouse ☐ Child ☐ Sibling ☐ Parent ☐ Friend	
Race ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ Pacific Islander ☐ American Indian ☐ Other Race: _____ ☐ Unreported/Refused to Report			
Preferred Language	Ethnicity ☐Hispanic ☐Non-Hispanic ☐Unreported/Refused to Report		
Do you have an Advanced Directive or Living Will? ☐ Yes (Please provide a copy for office records.) ☐ No			
Name Financially Responsible Party	SSN of Insured - -	Date of Birth / /	
Relationship of Financial Party to Patient: ☐ Self ☐ Spouse ☐Parent ☐Guardian			

CONSENT FOR TREATMENT

_____ (initials) I hereby voluntarily consent to the rendering of care, including treatment, administration of anesthesia and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of **PREMIER FAMILY HEALTH, PA**, ("PREMIER") through its subsidiaries, "**PREMIER FAMILY HEALTH & WELLNESS**", "**PREMIER URGENT CARE**", "**REGENAISSANCE**", and /or "**PREMIER ANCILLARY CENTER.**" and it is the responsibility of the staff to carry out instruction of its physicians/providers.

_____ _____
Patient Signature or Authorized Party Date

CONSENT FOR TREATMENT OF A MINOR

_____ (initials) I understand that the patient named above may be suffering from a condition that requires diagnosis and medical treatment which may require further testing and clinical evaluation. With full understanding of all the forgoing, I do hereby consent to and authorize the performance upon the patient of clinical evaluation and diagnostic procedure as ordered by **PREMIER** through its subsidiaries, "**PREMIER FAMILY HEALTH & WELLNESS**", "**PREMIER URGENT CARE**", "**REGENAISSANCE**", and /or "**PREMIER ANCILLARY CENTER.**"
☐ Yes ☐ No I authorize my child to be seen without a parent/guardian present at time of clinic visit. (required)

_____ _____
Patient Signature or Authorized Party Date

Parent/ Guardian Full Name	Parent/Guardian SSN - -	Parent/ Guardian Date of Birth / /

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By initialing this CONTRACT, you confirm your responsibilities and your understanding of our Practice Policies

ACCESS TO CARE

_____(initials) The practice hours for Primary care are Monday through Friday from 7:30am to 5:00pm. For Urgent Care appointments, the practice hours are Monday through Friday 8:00am to 8:00pm and on Saturday from 9:00am to 4:00pm. No appointment is needed for minor emergencies and urgent care.

AFTER-HOURS ACCESS

_____(initials) Patients have after-hours access to a healthcare provider in the urgent care center from 5:00pm to 8:00pm, Monday through Friday, and on Saturday from 9:00am to 4:00pm. For emergencies, please call 911 or go to the nearest emergency room. To reach the on-call provider after operating hours, please call 561-798-3030 and follow the telephone prompts. Please note that the on-call service is available for urgent matters only and is not for medication refills or routine questions. Messages sent electronically or left on the office voicemails will not be checked until the next business day.

PATIENT-CENTERED HEALTHCARE

_____(initials) Our goal is to be your partner in healthcare and offer you quality and evidence-based care. We value continuity of care and want you to be able to identify one of our providers as your personal healthcare provider. It is our goal to coordinate your healthcare across all of the settings in which you may receive care. In order for us to create a patient-centered-medical home we need you to take an active role in your healthcare. It is your responsibility to provide a complete medical history as well as any information about care you receive outside of our practice. Please keep your provider informed of new medicines, allergies, hospitalizations, specialty visits, test results, and vaccines.

PATIENT PORTAL

_____(initials) PREMIER offers you access to your own personal web portal where you can obtain your records and contact the office. The portal can be used to message your provider, request appointments or referrals, and to manage your prescriptions. The portal is not for urgent issues, messages sent through the portal will not be checked until the next business day. Please list your healthcare provider of choice:_____.

PRESCRIPTIONS

_____(initials) In order to keep your records accurate and avoid potentially harmful drug interactions, we may need to verify your medications through an external database or with your pharmacist. This will allow your provider to know what medications other doctors or hospitals may have prescribed for you.

LATE AND MISSED APPOINTMENTS

_____(initials) I agree to arrive timely to my appointment and/or provide a full 24 hour notice if I am unable to keep my appointment. Missed appointments for lab will result in cancellation of the corresponding follow-up. I understand that missed appointments with less than 24 hour notice may incur a fee of $25 for PREMIER and a fee of $50 for REGENAISSANCE.

LABORATORY AND TEST RESULTS

_____ (initials) Laboratory results drawn for an upcoming visit will be discussed with you at your appointment. If you are unable to keep your scheduled appointment you will be required to reschedule to discuss your results.
Labs or tests ordered at your visit may require an additional follow-up appointment with your provider to discuss results. Sensitive labs such as HIV testing will always require a follow-up with your provider.

PREMIER
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FEE FOR SERVICE

_____ (initials) I agree to pay my account at the time service is rendered or will make financial arrangements satisfactory to PREMIER for payment. If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefit of any type under any policy of insurance insuring the patient, or any party liable to the patient, is hereby assigned to PREMIER. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to PREMIER. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

NON-COVERED SERVICES

_____ (initials) I understand that PREMIER, contracts with health care service plans (i.e., HMOs, PPOs) which specifically state services which are "covered" by the health care services plan. Accordingly, the undersigned accepts full financial responsibility for all services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with PREMIER to obtain necessary health care service authorizations. I understand that not all services provided are considered medically covered services by my health plan and payment will be due at the time of service.

CREDIT CARD POLICIES FOR CO-PAYS, DEDUCTIBLES, CO-INSURANCE, AND OTHER BALANCES

_____ (initials) I understand I am responsible for payment of services at the time they are rendered and for any unpaid balances in the event of third party or insurance claims. We gladly accept cash, check, or credit card. An Updated and current insurance and credit card will be requested of you each time at check in. If you have an outstanding balance after your insurance claim has been processed, your credit card will be charged for the outstanding amount. You will receive a confirmation of the charge along with a billing statement explaining the reason for you remaining balance. I understand that this in no way will compromise my ability to dispute a charge or question my insurance company's determination of payment. I understand that failure to pay any outstanding balances may result in additional fees if sent to collections

ASSIGNMENT OF BENEFITS

_____ (initials) I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to PREMIER. I understand that PREMIER, contracts with multiple but not all health care service plans. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by PREMIER if I belong to a plan that does not contract with PREMIER.

MEDICARE ASSIGNMENT OF BENEFITS (MEDICARE PATIENTS ONLY)

_____ (initials) I request that payment of authorized Medicare benefits be made on behalf to PREMIER, for services furnished me by PREMIER. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. PREMIER accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

MEDIGAP (MEDICARE PATIENTS ONLY)

_____ (initials) I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to PREMIER, if possible or otherwise to me.

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FAMILY MEDICINE - URGENT CARE - WELLNESS

CONSENT TO LEAVE PHONE MESSAGES

I understand that as part of my health care, PREMIER may need to reach me by phone.

( ) I DO authorize PREMIER to leave a message on my □ home telephone, □ cell phone, and/or □ work phone regarding laboratory/test results and imaging studies. **However, I understand that sensitive information and/or results that will require medication follow-up or discussion will require that I make an appointment with the physician.**

( ) I DO NOT authorize PREMIER to leave message on my telephone (home, cell, or work) regarding any type of testing results. **I will accept the responsibility of making an appointment with the physician to obtain the results.**

( ) I hereby give consent to my health care provider to discuss or release my private health care information to (i.e. Spouse, parent, care-taker):

Name: _____ **Relationship to patient:** _____

Name: _____ **Relationship to patient:** _____

Patient's Signature or Authorized Party: _____

OTHER

_____ (initials) I hereby consent that I will not use any recording device of voice or image on the premise of PREMIER this includes items such as cameras, voice recorders, phones and google glasses.

_____ (initials) I hereby consent that I would like to receive information on services offered by PREMIER either by email, mail or other. PREMIER does not provide your information of third parties and will not provide this information to unrelated parities for their own marketing and will not use this information for telephone solicitation.

I have read and fully understand and accept the terms of PREMIER and the information contained in the Registration Packet

_____	_____	_____
Patient Name or Authorized Party (printed)	Patient Signature or Authorized Party	Date
_____	_____	_____
Witness Name (printed)	Witness Signature	Date

By my signature, I am giving PREMIER authorization to obtain medical records or any past records pertinent to my health care from any consulting physician or other health care facility treating me during the course my care at this facility. I hereby request that any specific records needed for my care be released to:

PREMIER FAMILY HEALTH, PA
1037 STATE ROAD 7, SUITE 215
WELLINGTON, FLORIDA 33414
OFFICE: (561) 798-3030 FAX: (561) 798-8242

_____	_____	_____
Patient's Full Name (Print)	Date of Birth	Social Security Number
_____	_____	
Patient's Signature or Authorized Party	Date	

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FAMILY MEDICINE - URGENT CARE - WELLNESS

Reason for Visit:

What are your Overall Top Health & Wellness Concerns:

1. _____
2. _____
3. _____

MEDICAL HISTORY: ☐ Check here if you have No Medical History

☐ Allergies/ Asthma	☐ Emphysema/COPD	☐ Hepatitis/ Liver Disease	☐ Pneumonia
☐ Anemia	☐ Epilepsy / Seizures	☐ High Blood Pressure	☐ Stroke/ Mini Stroke
☐ Anxiety/ Depression	☐ Gout	☐ High Cholesterol	☐ Thyroid Problems
☐ Arthritis	☐ Headache/ Migraine	☐ Kidney Problems	☐ Other:_____
☐ Cancer:_____	☐ Heart Disease or Attack	☐ Nerve Problems/Tingling	☐ Other:_____
☐ Diabetes (Type 1 or 2)	☐ Heartburn/ Ulcers	☐ Osteoporosis/ Fractures	☐ Other:_____

MEDICATIONS/SUPPLEMENTS/VITAMINS:

☐ Check here if not on Medications

1._____	4._____	7._____
2._____	5._____	8._____
3._____	6._____	9.

ALLERGIES: MEDICATION & NON MEDICATION ALLERGIES:

1._____
2._____
3._____

SURGERIES:

☐ Check here if no Surgery History

☐ Appendix Removal	☐ Hernia Repair _____
☐ Gallbladder Removal	☐ Hysterectomy (Total / Partial)
☐ Gastric Bypass / Banding	☐ Joint Surgery _____
☐ Tonsillectomy	☐ Other: _____
☐ C-Section #_____	☐ Other: _____

HOSPITALIZATIONS:

☐ Check here if no Hospital History

1. _____
2. _____
3. _____
4. _____

FAMILY HISTORY: ☐ Check here for unknown or adopted

Father:	☐ Diabetes	☐ Heart Attack	☐ Stroke	☐ Cancer	☐ Depression/Substance Abuse	☐ Other:
Mother:	☐ Diabetes	☐ Heart Attack	☐ Stroke	☐ Cancer	☐ Depression/Substance Abuse	☐ Other:
Siblings:	☐ Diabetes	☐ Heart Attack	☐ Stroke	☐ Cancer	☐ Depression/ Substance Abuse	☐ Other:

HEALTH HISTORY: Check all that apply

Alcohol Use:	☐ None	☐ Socially	☐ With Dinner	☐ Daily ___ #/day	☐ Quit date:
Tobacco Use:	☐ Never	☐ Socially	☐ Daily #packs/day		☐ Quit date:
Exercise:	☐ None	☐ Occasional	☐ Regular	☐ Daily	
Diet:	☐ Poor	☐ Moderate	☐ Healthy	☐ Frequent Eating Out	
Flu Vaccine:	☐ Never	☐ Date:			
Pneumonia Vaccine:	☐ Never	☐ Date:			
Mammogram:	☐ Never	☐ Date:	Location/Facility		
Bone Density	☐ Never	☐ Date:	Location/Facility:		
Colonoscopy:	☐ Never	☐ Date:	Location/Facility:		
Eye Exam:	☐ Never	☐ Date:	Location/Facility:		
Specialists:	☐ None	☐ Doctor:			