PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION **DATE:_____**

mm/dd/yyyy

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ AGE _____ SEX: _____ CHILDREN:_____

ETHNICITY:_____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

OCCUPATION: _____ SPOUSE/PARTNER NAME: _____

MARITAL STATUS: ◯SINGLE ◯MARRIED ◯PARTNER ◯ DIVORCED ◯WIDOWED

☐PREGNANT (check if aplicable) ☐ NURSING (check if applicable)

REFERRED TO CLINIC BY? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT. _____

CEL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT PHONE NUMBER: _____

Primary Insurance _____ ID# _____ Group# _____

Insurance Name: Relation To Patient _____ DOB: _____ SS# _____

Secondary Insurance _____ ID# _____ Group#

Insurance Name: _____ Relation To Patient _____

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY ADDRESS: _____City _____State__ Zip _____

Your lnsurance Card and Photo ID are requlred at the time of your visit
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____

Date of Birth: _____

Name:

Patient History Form

Please describe your reason for today's visit:_____

What are you hoping to get out of today's visit?_____

How long has this been going on?_____

Does anything make your condition worse: No ○ Yes ○ Please describe_____

Does anything in particular help with your condition: No ○ Yes ○ Please describe_____

Past Medical History **Please check any problem you have had or you are being treated for.**

Please check this box if NO current medical problems.

Blood Problems
- ☐ Anemia
- ☐ Blood clots (DVT/ Embolism)
- ☐ Bleeding disorder
- ☐ Clotting disorder
- ☐ HIV positive

Cardiac Vascular
- ☐ Angina (chest pain)
- ☐ Arrhythmia (heart rhythm problems)
- ☐ Atrial fibrillation
- ☐ Heart failure
- ☐ Hyperlipidemia: (high cholesterol)
- ☐ Hypertension: (high blood pressure)
- ☐ Malignant hyperthermia
- ☐ Past heart attack
- ☐ Peripheral vascular disease: (Blood vessel problems in legs)

Cancer
- ☐ Anal cancer
- ☐ Bladder cancer
- ☐ Breast Cancer
- ☐ Cervical cancer
- ☐ Colon cancer
- ☐ Kidney cancer
- ☐ Ovarian cancer
- ☐ Penile cancer
- ☐ Prostate cancer
- ☐ Rectal cancer
- ☐ Small bowel cancer
- ☐ Stomach cancer
- ☐ Urinary tract cancer
- ☐ Uterine (endometrial) cancer
- ☐ Vulva cancer
- ☐ Other Cancer: _____

Eyes
- ☐ Glaucoma
- ☐ Vision loss

Endocrine
- ☐ Adrenal disease
- ☐ Diabetes
- ☐ Hyperthyroidism (high thyroid disease)
- ☐ Hypothyroidism low thyroid disease

Gastrointestinal
- ☐ Accidental bowel leakage
- ☐ Anal/Rectal trauma/injury
- ☐ Celiac disease (gluten sensitivity)
- ☐ Colon/Rectal polyps
- ☐ Crohn s disease
- ☐ IBS (Irritable bowel syndrome)
- ☐ Ulcerative colitis

Infection
- ☐ Hepatitis
- ☐ MRSA
- ☐ VRE

Kidney/Urinary
- ☐ Poor kidney function
- ☐ Renal failure
- ☐ Urinary incontinence (leakage of urine)

Mental Health
- ☐ Anxiety
- ☐ Depression

Musculoskeletal
- ☐ Arthritis
- ☐ Back problems
- ☐ Gout
- ☐ Pelvic fracture

STD'S
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Gonorrhea

Neurological
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Seizures
- ☐ Spinal cord injury
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar
  - ☐ Sacral
  - ☐ Unknown
- ☐ Stroke (Cerebrovascular accident)
- ☐ Brief stroke (Transient ischemic attack - TIA)

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Respiratory Tuberculosis
- ☐ Sleep apnea
- ☐ Other:_____

Female specific:
- ☐ Abnormal pap smears
  - ☐ Anus
  - ☐ Cervix
  - ☐ Vaginal
- ☐ Genital warts

Male specific:
- ☐ Abnormal pap smear anus
- ☐ Enlarged Prostate
- ☐ Genital warts

Other:
- ☐ Anesthetics adverse reaction
- ☐ Post Op Bleeding
- ☐ _____ (other problems not listed above)

Females Only: Your Obstetric History (OBGYN Detail)

Are you currently pregnant? ◯ **No** ◯ **Yes** ◯ **Possible** **Number of pregnancies: _____G**

Number of live births: _____P Number of C-Sections: _____ Number of vaginal deliveries: _____

Did you have a tear/laceration during delivery? ◯ No ◯ Yes Which Pregnancy?____

Did you have an episiotomy during any delivery? ◯ No ◯ Yes Which Pregnancy?____

Was forcep extraction used for any delivery? ◯ No ◯ Yes Which Pregnancy?____

Was vacuum extraction used for any delivery? ◯ No ◯ Yes Which Pregnancy?____

Did you experience Accidental Bowel Leakage (ABL) after any delivery? ◯ No ◯ Yes Which Pregnancy?____

If yes, how long ? _____

If yes, did your accidental bowel leakage (ABL) resolve (stop)? ◯ No ◯ Yes

Did you notice the passage of gas through your vagina after any delivery? ◯ No ◯ Yes Which Pregnancy?____

Surgery/Procedures - Please check all that apply and indicate the year the surgery was performed.

Please check this box if NO past surgeries.

Abdominal Surgery

- ☐ Appendectomy (appendix) Year_____
- ☐ Cholecystectomy (gallbladder) Year_____
- ☐ Hernia repair Year_____
- ☐ Gastric bypass Year_____
- ☐ Abdominoplasty (tummy tuck) Year_____

Bowel Surgery

- ☐ Colectomy (Removal of a portion of large intestine/colon) Year_____
- ☐ Small bowel resection (Removal of a portion of small intestine) Year_____
- ☐ Colostomy Year_____
- ☐ Ileostomy stoma Year_____
- ☐ Closure of ileostomy or Colostomy Year_____
- ☐ Parks pouch (Ileoanal Reservoir) Year_____
- ☐ Rectal prolapse repair (Abdominal) Year_____
- ☐ Rectal prolapse repair (Anorectal) Year_____

Bowel Incontinence Surgery

- ☐ Anal sphincter repair Year_____
- ☐ Sacral nerve stimulation Year_____
- ☐ Other__ Year_____

_____

Anal or Rectal Surgery Year_____

- ☐ Sphincterotomy (fissure surgery) Year_____
- ☐ Fistula surgery Year_____
- ☐ Rectovaginal fistula repair Year_____
- ☐ Hemorrhoid surgery Pilonidal Year_____
- ☐ Drainageÿofÿabscesscystÿsurgery Year_____

Cardiac (heart)/Vascular (blood vessels)

- ☐ Aortic aneurysm repair/bypass Year_____
- ☐ Cardiac pacemaker Year_____
- ☐ Defibrillator Year_____
- ☐ Heart stents Year_____
- ☐ Heart valve placement Year_____
- ☐ Coronary bypass (CABG) Year_____

Transplant Surgery

- ☐ Heart Year_____
- ☐ Lung Year_____
- ☐ Kidney Year_____
- ☐ Liver Year_____

Orthopedic Surgery

- ☐ Hip replacement Year_____
- ☐ Knee replacement Year_____
- ☐ Back surgery
  - ☐ Cervical Year_____
  - ☐ Lumbar Year_____
  - ☐ Thoracic Year_____

Female Specific Surgery

- ☐ Breast augmentation Year_____
- ☐ Mastectomy Year_____
- ☐ Cervical procedure (LEEP/CONE) Year_____
- ☐ C-section Year_____
- ☐ Hysterectomy Abdominal Year_____
- ☐ Hysterectomy Vaginal Year_____
- ☐ Removal of tubes and ovaries Year_____
- ☐ Infertility surgery Year_____
- ☐ Rectocele / Enterocele repair Year_____
- ☐ Urinary incontinence procedures Year_____
- ☐ Bladder repair / Cystocele repair Year_____
- ☐ Sling Year_____
- ☐ Vaginal prolapse repair Year_____

Male Specific Surgery

- ☐ Removal of prostate Year_____
- ☐ Prostate radiation Year_____

Miscellaneous Surgery

- ☐ Dental / Oral surgery Year_____
- ☐ Tonsillectomy Year_____
- ☐ Other_____ Year_____

Other Surgery

- ☐ Other_____ Year_____

Personal Habits / Social History

Have you ever used tobacco? ◯ No/never ◯ Yes ◯ Formerly -- Age Quit:_____

Smoking Tobacco Use (former and current):

Cigarette	_____ cigarettes/packs per day (circle one)
Cigarillo	_____ per day
Cigar	_____ per day
Pipe	_____ per day

Non-Smoking Tobacco Use (former and current):

Chewing	_____ units per day
E-cig	_____ units per day
Snuff	_____ units per day

Do you consume alcohol? ◯ No/Never ◯ Yes ◯ Formerly (in the past) **Type:** ☐ Beer ☐ Wine ☐ Liquor

How many drinks at a time? ◯ 1-2 ◯ 3-5 ◯ 6-9 ◯ 10+ **How often?** _____

Are you currently employed? ◯ No ◯ Yes **Occupation:** _____

Have you ever used drugs? ◯ No ◯ Yes ◯ Formerly (in the past)

Have you ever had anal sex? ◯ No ◯ Yes

HIV Status: Negative ◯ Positive ◯ Not Tested ◯

Please tell us the race that best describes you: _____ **Ethnic background - Hispanic or Latino?** Y ◯ N ◯

Why do we ask this? Some research has shown that some patients may benefit from early or more frequent colorectal cancer screening. Collection of this information helps us make an informed recommendation on screening/tests.

Please tell us your birth sex: _____ **Please tell us what gender you identify with:** _____

Sexual History

What is/are the sex and gender of your partner(s)? Male, ◯ Female ◯ Other ◯

How many partners have you had in the last 12 months?_____

When was the last time you got tested for STIs? _____

What type of sexual activity do you have: oral ☐ anal ☐ vaginal ☐ use of sex toys ☐ other?_____

Your Family History **For any of your family members, please check all that apply.**
Please check this box if NO relevant family history.

If yes, please indicate the family member and if that member was maternal (mother s side) or paternal (father s side).

	Family Member	Maternal or Paternal	Age Diagnosed	Age Deceased
Colon Cancer				
Rectal Cancer				
Celiac Disease				
Colon Polyps				
Crohn s Disease				
Ulcerative Colitis				

Cancer:

☐ Bile Duct /Gallbladder Cancer_____

☐ Bladder Cancer _____

☐ Brain Cancer_____

☐ Breast Cancer _____

☐ Endometrial Cancer _____

☐ Gastric (Stomach) Cancer_____

☐ Kidney Cancer _____

☐ Ovarian Cancer _____

☐ Small Intestine/ Small Bowel Cancer _____

☐ Uterine Cancer _____

☐ Other Cancer Type _____

Factor V Leiden Deficiency _____

Hemophilia _____

Malignant Hyperthemia_____

Von Willebrand s Disease_____

Diagnostic Studies **Please check all that apply and indicate location and date study was performed.**

Please check this box if NO diagnostic studies have ever been performed.

☐	Colonoscopy	Location/Facility:_____	Date:_____
☐	Virtual Colonoscopy; CT Colon Imaging	Location/Facility:_____	Date:_____
☐	Flexible Sigmoidoscopy	Location/Facility:_____	Date:_____
☐	Stool Testing for Blood (FOBT)	Location/Facility:_____	Date:_____
☐	Stool Testing for DNA (Cologuard)	Location/Facility:_____	Date:_____
☐	CT of Abdomen/Pelvis	Location/Facility:_____	Date:_____
☐	CT-PET	Location/Facility:_____	Date:_____
☐	Transit Time Study	Location/Facility:_____	Date:_____
☐	Anal Pap (cytology)	Location/Facility:_____	Date:_____

Medications/Allergies **Please document any medications you are currently taking.**

Please check if NO current medications

	Name	***Dose (Strength)***	***How Many?***	***How Often?***
Example:	*Aspirin*	*81mg*	*1 tablet*	*Daily*

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

Do you take aspirin? ☐ No ☐ Yes **If yes, please enter above**

Do you take other blood thinners? ☐ No ☐ Yes **If yes, please enter above**

Have you taken any steroids (i.e. prednisone or cortisone) within the last 6 months? ☐ No ☐ Yes

If yes, what kind of steroid? Name: _____ Dose: _____ For how long? _____

When was the last dose?_____

Do you have any medication allergies? ☐ No ☐ Yes If yes, please list below:

1. _____ **What type of reaction?** _____

2. _____ **What type of reaction?** _____

Are you allergic to latex? ☐ No ☐ Yes **What type of reaction?** _____

Review of Systems Please check any symptoms you are currently experiencing.
Please check this box if you are not experiencing any of these symptoms.

Constitutional

- Chills ☐
- Fatigue or Weakness ☐
- Fever ☐
- Recent weight gain of 10 or more lbs. ☐
- Recent unplanned weight loss of 10 or more lbs. ☐

Integumentary (Skin)

- Itching (pruritus) ☐
- Rash ☐

Hearing/Eyes/Vision (HEENT)

- Loss of hearing / Diminished hearing ☐
- Loss of vision / Change in vision ☐

Neurological

- Dizziness / Light headed ☐
- Extremity numbness / Tingling ☐
- Headaches ☐
- Memory loss ☐
- Seizures ☐

Respiratory

- Chronic or frequent coughing ☐
- Shortness of breath ☐

Psychiatric (Mental Health)

- Anxiety ☐
- Depression ☐

Cardiovascular

- Chest pain ☐
- Irregular heartbeat (palpitations) ☐

Metabolic/Endocrine

- Cold intolerance ☐
- Heat intolerance ☐
- Excessive thirst or urination (polydipsia) ☐

Gastrointestinal

- Abdominal pain ☐
- Blood in stools ☐
- Change in stools ☐
- Constipation ☐
- Diarrhea ☐
- Accidental Bowel Leakage (ABL) ☐
- Loss of appetite ☐
- Nausea ☐
- Vomiting ☐

Musculoskeletal

- Back pain ☐
- Joint pain ☐

Genitourinary

- Pain with urination (dysuria) ☐
- Blood in urine (hematuria) ☐
- Urinary incontinence (leakage of urine) ☐

Hematologic/Lymphatic (Bleeding)

- Easy bleeding ☐

Reproductive (Females)

- Painful intercourse (dyspareunia) ☐

Preferred pharmacy name: _____ **Pharmacy Phone:** _____

Pharmacy address: _____ CITY: _____ STATE: ___ ZIP: _____

In the event of a medical emergency, who may we contact? Name: _____

Relationship: _____ Phone:_____

REQUEST FOR WRITTEN CONSENT FOR PELVIC EXAMINATION

DOES THE PATIENT NEED OR WANT A TRANSLATOR, INTERPRETOR OR READER?

YES ◯ NO ◯

Section 456.51, Florida Statutes (F.S.), requires a health care practitioner, a medical student, or any other student receiving training as a health care practitioner may not perform a pelvic examination on a patient without the written consent of the patient or the patient's legal representative executed specific to, and expressly identifying the pelvic examination.

As a patient or the patient's legal representative, I understand I have the absolute right NOT to consent to this pelvic examination, I have been fully advised of the examination, and at this time hereby consent as follows:

(Type in the fields below your initials)

_____I understand the pelvic examination means the series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

_____I have read this informed consent (or it has been read to me) and I fully understand it and the consent I am providing by signing this written consent. By signing below, I certify that this form has been fully explained to me by my health care practitioner, a medical student, or any other student receiving training as a health care practitioner, and all questions have been answered.

_____I consent to allow a pelvic examination, including vaginal sonography, as described above. I understand that a pelvic examination may be needed while receiving medical care from FLMSA. Timothy R Goshen, D.O. I consent to a pelvic examination by Timothy R Goshen, DO.

_____ I consent to a pelvic examination by a medical student, or another student receiving training as a health care practitioner, YES_____ NO _____.

_____ On the basis of the above statements, I voluntarily consent and authorize this pelvic examination procedure(s) until I revoke this consent in writing and provided by hand delivery to FLMSA. Timothy R Goshen, D.O.

Patient Print Name: _____Patient Signature: _____

Date: _____ Time: _____

Witness Print Name: _____Witness Signature: _____

Date: _____ Time: _____

Physician Print Name: Timothy R Goshen D.O. Physician Signature: _____

Date: __/__/____ Time: _____

FLMSA

2301 WILTON DRIVE SUITE C-2
WILTON MANORS, FL 33305
PHONE (954)567-5898
FAX (954)567-0395

TIMOTHY R. GOSHEN, D.O

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

In order to continue to provide our patients with the quality healthcare they have been accustomed to, it is important that Dr. Timothy Goshen, receive payment promptly. Therefore we will be implementing the case flow management program available through the Broward County Medical Association and Amer-Assist, The Nations Largest Medical Collections Agency.

Any Account 45 days past will incure reasonable collections and Attorney's fees. In addition, any account 45 days past due will also be charged 1 ½ % per month on the outstanding balance from the date of service. If you will require a payment plan request a confidential conference with the Office Mange prior to see Dr. Goshen.

By signing this you are acknowledging that you have read and understand the terms and agreements of your our Practice.

Patient Signature: _____ Date: _____

Thanks for your cooperation and understanding.

FLMSA

2301 WILTON DRIVE SUITE C-2
WILTON MANORS, FL 33305
PHONE (954)567-5898
FAX (954)567-0395

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____ **have received a copy of this office's Notice of privacy Practices.**

Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempt to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but attempt to acknowledgement could not be obtained because:

- ◯ **Individual refused to sign**
- ◯ **Communication barriers prohibited obtaining the acknowledgement.**
- ◯ **An Emergency situation prevented is from obtaining the acknowledgement.**
- ◯ **Other** _____

FLMSA

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MISSED APPOINTMENT FEE AGREEMENT

I agree that:

A time slot has been reserved exclusively for me and/ or my family members.
I understand that I am required to give twenty-four (24) hours notice of cancellation.
I understand that if I am more than 15 min late to an appointment that FLMSA reserves the right to reschedule my appointment slot to another time.

In the event that I do not provide 24 hours advance notice of cancellation to FLMSA, I understand that I will be charged a $60.00 office visit / $150.00 procedure visit "MISSED APPOINTMENT FEE" for the reserved appointment

I also understand that my insurance company is NOT responsible for fees that are incurred for missed appointments, and that it would be unethical or illegal for FLMSA to bill for the missed appointment.

Therefore, I understand and agree to pay the office visit missed appointment fee of $60.00 and or the procedure visit missed appointment fee of $150.00 unless I give at least 24 hour notice.

Patient Signature: _____ Date: _____

FLMSA

2301 WILTON DRIVE SUITE C-2
WILTON MANORS, FL 33305
PHONE (954)567-5898
FAX (954)567-0395

Dear Patient,

We ask that you read and sign this because it concerns every patient. Due to the many constant changes in insurance policies, it is no longer an easy task to interpret every individual policy. Although we try to stay on top of the changes, it is not always possible. So, we urge you as the patient, to check with your insurance company regarding your policy coverage. **It is your responsibility to know your individual coverage**. Failure to comply with this suggestion could result in you, as the patient, being responsible for all costs incurred during your visit with the doctor: Your insurance policy is between you and your insurance company, not the doctor and the insurance company.

Some of the tests and procedures that are performed in this office may be subjected to your insurance policy's yearly deductible to which you as the insurance holder (patient) will be responsible to pay at the time of the visit. Many insurance companies require referrals forms from your primary care physician or the insurance company, which you will need to have at the time of visit so you will not be responsible for the total price of the visit. Some insurance policies will not allow you to be seen out of the network. We cannot keep up with the changes and are often unaware of that until too late.

Patient Signature: _____ Date: _____

FLMSA

2301 WILTON DRIVE SUITE C-2
WILTON MANORS, FL 33305
PHONE (954)567-5898
FAX (954)567-0395

TRIAGE AND PHLEBOTOMY SERVICES
CONSENT FORM

I, _____ , do herewith grant my consent and permission to the medical staff to assess and /or monitor my vital signs including but not limited to, blood pressure (diastolic/systolic), Physical body temperature, respiratory rate and pulse. I understand that the purpose of evaluating my vital signs, along with my chief complaint, is for the sole use of preparing me for medical evaluations by the physicians (s).

I also consent to phlebotomy (blood draw) for the purpose of laboratory evaluation of certain physiologic markers as may be determined by the physician(s) after medical evaluations have been performed.

The original of this Consent Form for Triage and Phlebotomy Service will be contained in may official medical record and a copy of which will not be released to any individual, third party, or other requestors without my expressed written consent to release this information.

Patient Signature: _____ Date: _____

FLMSA

2301 WILTON DRIVE SUITE C-2
WILTON MANORS, FL 33305
PHONE (954)567-5898
FAX (954)567-0395

Authorization to Release Information:

I hereby authorize FLMSA to release to my insurance carrier(s) any information acquired in the course of my examination or treatment required for payment of any insurance claim.

Signed: _____ Dated: _____

Assignment of Benefits:

I hereby authorize payment directly to FLMSA for medical benefits. I understand that I am financially responsible for the charges not covered by the insurance company.

Signed: _____ Dated: _____

Electronic Privacy Waiver:

I understand that my medical récords may be transmitted electronically. Although every effort will be made to assure the records are sent/received by the appropriate third party, I absolve FLMSA/ Dr. Timothy R. Goshen from liability should they be received in error by a third party. I give my consent to fax my records for the purpose of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

Signed: _____ Dated: _____

Acknowledgement of Office Policies:

I am aware that I will be charged a $60.00 office visit/ $150.00 procedure visit FEE for missed appointments not canceled at least 24 hours in advance. I am also aware that $60.00 will be charged for the preparation of FMLSA/private disability forms at the time the forms are dropped off at the office. I am aware that I must return to the office for formal appointment with the doctor to go over these forms.

Signed: _____ Dated: _____

Permission to Share Medical Information:

You have my authorization to share my medical records and medical information with the following people:

Name:_____ **Relationship**:_____

Signed: _____ Dated: _____

Fort Lauderdale Medical Surgical Medical Associates, INC

2301 Wilton Drive SUITE C-2, Wilton Manors, FL 33305 P: (954)567-5898 F: (954)567-0395

Credit Card Payment Authorization Form

Fort Lauderdale Medical Surgical Associates has implemented a new credit card policy. Much like many other businesses such as a hotel or car rental agency, attorneys, etc. we now have a similar policy where we ask for a credit card which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service. At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement in which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card. Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

By signing this form, you give Fort Lauderdale Medical Surgical Medical Associates permission and authorization for the following:

I, _____ , (PRINT NAME) authorize Fort Lauderdale Medical Surgical Medical Associates to charge my credit card.

Card Type: Visa ◯ Mastercard ◯ Discover ◯ American Express ◯

Card Holder Name _____

Credit Card Number ____-____-____-____

Expiration Date ____ / ____ CVV Number _____

Billing Address _____ , _____ , _____ , _____

I agree to pay $ _____ every _____ weeks until my balance is paid full.
(FOR PAYMENT PLANS ONLY)

Print Name _____

Signature _____ Date _____

I authorize Fort Lauderdale Medical Surgical Medical Associates to charge my credit card. stated above on this authorization form according to the terms outlined above or below.

Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice? Yes. This is our policy and it is a growing trend in the healthcare industry. Insurance reimbursements are applying towards patient's deductibles and there has been a large increase in patíent balances. These factors are driving offices to either squeeze more patients into shorter periods of time to stop accepting insurance. We have decided to focus on becoming more efficient in our billing and collections processes ínstead.

How much and when will the money be taken from my account? The insurance companies on average take approximately 2 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. lt simply depends on your individual policy what you may owe. Once the insurance explanation of benefits is received and posted to your account, you will be sent a statement showing your portion. You will have 30 days to send an alternative form of payment If you prefer, if no alternative payment is received, your patient financial responsibílity will be processed in full.

How do you safeguard the credit information you keep on file? We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. This system stores the card information for future transactions using the same sort of technology that any online retailer would.

What are the benefits? lt saves you time and eliminates the need to write checks, buy stamps, or worry about delays in the mail. lt also drives our administrative costs down because our staff sends out fewer statements and spends less time, taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than us storing the information.

Why do I have to do this? The entire billing process is time consuming and wasteful, and the few patients that we do have to send to a collection agency end up casting a lot of money. Reducing unnecessary costs are essential to allowing us to continue to be an in-network provider with most insurance companies. Nothing is changing about how much you end up paying.

What if there is a payment discrepancy or I have other payment questions? Please contact our billing department directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or question your insurance company's explanation of benefíts.

Will I still receive a paper bill by mail or E-bill? Yes. You will receive one bill which will show what will be charged to your card in 30 days. lf you prefer to pay by an alternative method, you may do so during that period. If you do not wish to make any payment method changes, just hold onto the statement for your records and your card will be charged.

_____

Patient Signature