PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number:_-_____-_____Phone number: _____
Address:_____
City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____
Phone number:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address_____
City, State:_____ZIP: _____
Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

FINANCIAL POLICY

As your physician, we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy.

We ask that all services be paid at time of service. If you have insurance, please present your insurance card for verification. If your insurance changes, please notify us immediately.

MEDICARE: We are participating Medicare providers, and we will file Medicare for you. Any service routinely not covered by Medicare (i.e., Preventative/Routine Exams) we will request that the services be paid at time of service. We request payment for the 20% of the allowable Medicare charges and any deductible (if applicable) that has not been met at the time of your visit.

PARTICIPATING PLANS: As providers on certain insurance plans, we ask that the co-pay and deductibles (if applicable) be paid in full at the time of your visit. We accept assignment for services covered and will bill the insurance. Any balance outstanding following payment from insurance will be billed to you. **It is your responsibility to verify that we are participating with your plan.**

NON-PARTICIPATING PLANS: We are **NOT** providers on some plans. If you choose to see us as your physician, please be prepared to pay for any out-of-network or deductibles that may apply to your visit. Please verify **BEFORE** your appointment with your insurance company what your benefits will cover.

FINANCIAL AGREEMENT: We will be glad to discuss your proposed treatment and the cost of those services. If you have questions if your insurance will cover a medical service, we will be glad to try to find out if insurance will cover for those services. HOWEVER, please be aware that your insurance is a *contract between you, and your insurance company*. Unfortunately, not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g., yearly physicals)

We must emphasize that as your physicians, our relationship and concern is with you and your health, not with your insurance company. ALL CHARGES FOR SERVICES ARE YOUR RESPONSIBILITY AT THE TIME THE SERVICES ARE RENDERED. On any balance on your account after 120 days, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our insurance office at 561-548-3520 for assistance in the management of your account.

If you have any questions regarding the above, or any uncertainty regarding insurance coverage or request for payment, please do not hesitate to ask. We are here to help you.

I have understood and agreed to the financial policy for Broward Neurosurgeons LLC

_____ _____

Signature **Patient Name/Date**

Medication List

Patient Name: _____ DOB: _____

Date List Started: _____ Page: _____ of _____

Pharmacy Name _____ Phone: _____

A Current Medication List Helps Prevent Errors.

RX Date	Medication Name & Strength To include over the counter meds such as vitamins, herbs, diet supplements	Dosage (mg, ml, etc)	How & When to Use (Daily, at bedtime, etc)	Stop Date

ALWAYS KEEP THIS FORM WITH YOU – Take it with you to all healthcare visits.
USE THIS FORM TO DOCUMENT ALL CHANGES MADE TO YOUR MEDICATIONS – Taking an active role in your healthcare can help prevent medication errors and **KEEP YOU SAFE!**