1855 Veterans Park Dr. Suite 304 Naples, Florida 34109 Phone: (239)676-0656 Fax: (239)533-9735

Confidential Patient Registration

Date: ___/___/____

Last Name: ______________________________ First Name: ______________________ MI:____

Home Phone: __________________ Cell Phone: _________________ Work Phone: ______________________

Permanent Address: (Main residence)

Street Address: ____

City: ____ State: ________ Zip:_____________

Extended Address: (Other)

Street Address: ____

City: ____ State: ________ Zip:_____________

Gender: Male___ Female___ SSN: ______ - _____ - _______ Birth-date: ____/____/______

Circle One: Married - Single - Partnered – Widowed Name of Spouse/Significant Other ______________________

Patient Employed by: ____

Occupation: ____________________________________

Policy Holder/Guarantor of Account (if other than patient):

Name: ____

Relationship: _________________ Birth-date: ____/____/_______

Home Phone: __________________ Cell Phone: _________________ Work Phone: ______________________

Permanent Address:

____

SSN: _____-_____-_______

Name of Primary Insurance: ______________________________ ID #: ___________________________ Group #: __________

Subscriber's Name: ____ Birth-date: ____/____/____

Name of Secondary Insurance: ______________________________ ID # ___________________________ Group # __________

Subscriber's Name: ____ Birth-date: ____/____/____

PLEASE HAVE YOUR INSURANCE CARD(S) AVAILABLE

In case of an emergency, who should be notified? ____

Relationship: ____ Phone: ______________________________

Preferred Pharmacy: ____ Phone: ____

Address: ____

How did you hear about us? __________________________

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I ____

(Name of Insured)

hereby assign my insurance benefits to be paid directly to Prestige Primary Care, LLC. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Prestige Primary Care, LLC will be credited to my account, in accordance with the above said assignment.

____ ______________________________

(Authorized Signature of Subscriber) (Date)

Consent for Treatment

I (or my legal guardian) authorize Prestige Primary Care, LLC to provide medical care reasonable by today's standards.

____ ______________________________

Signature of Patient/Legal Guardian Date

Medicare Authorization

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to Prestige Primary Care, LLC for any services furnished to me by Prestige Primary Care, LLC. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize 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 or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the health care provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

____________________________ Signature of Beneficiary

________________________ Date

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Prestige Primary Care, LLC Financial Policy

Thank you for choosing Prestige Primary Care, LLC for your medical care. It is our commitment to provide to you the very best healthcare. In effort to better serve you we have adopted the following payment policy. We thank you in advance for your understanding. Please review and let us know should you have any additional questions.

1. **Insurance**- We participate in assignment of payment with many insurance plans, please first verify if you are in network with us. If you however are insured by a plan that we are NOT in network with, payment will be expected at the time of service. Please be aware we will be verifying coverage and ask that you bring your card at each visit. All patients are required to complete and sign our patient registration form prior to seeing the provider. We must obtain a copy of your driver's license and current insurance card(s) to provide proof and for filing purposes. Knowing your insurance benefits, including out of pocket requirements is your responsibility. We advise that you contact your insurance company for any questions regarding coverage.

2. **Non-Coverage Services**- Please be advised that some services you receive may be considered not necessary by insurers or be non-covered. Your are required to pay in full for non-covered services

3. **Co-payments**- All co-payments must be paid on the day of service as required per the contract with your insurance company.

4. **Self-pay payments**- All self-pay payments must be paid in full at the time of service.

5. **Payment**- We accept cash, check, American Express, Visa, Discover, Master Card and Debit card.

6. **Bounced checks**- Please be advised that a $25.00 charge will be applied for each check that is returned by your bank.

7. **Claims**- We will submit your claim to your insurance company for you and will assist in any way we reasonably can to get your claims paid. We cannot guarantee coverage of any specific tests or procedures. It is your responsibility to verify your coverage and benefits with your insurance company and any "special conditions" required by your insurance agency for payment. The balance of your claim is your personal responsibility, regardless of insurance

coverage. Your personal insurance benefit is a contract between you, your employer and your insurance company.

8. **Missed appointments**- Please be aware that your appointment time has been set aside for you to meet your individual health care needs. As a courtesy to our patients, a reminder phone call will be made one business day prior to the scheduled appointment. It is your responsibility to ensure we have updated contact information to reach you. Failure to show up for a scheduled appointment on the day of service without prior day notice, you may be charged $25.00 no show fee. We understand that there are occasions when a patient may miss an appointment and ask that you notify the office promptly of such circumstances.

Please sign below to acknowledge that you have read and understand the policy and agree to abide by the above guidelines.

X____ ____________

(Signature of patient or responsible party) (Date)

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Health History Questionnaire:

I.Medications (please include vitamins/herbals/over-the counter-medications)

Name:	Dosage:	Directions:

II.Allergies

Allergy:	Reaction:

III.Medical History

Have you ever been treated for any of the following medical conditions? (check all that apply)

- ☐ Arthritis
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Heart problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Lung disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Seizure disorder
- ☐ Stroke/TIA
- ☐ Thyroid problems
- ☐ Urinary complaints

Please list any additional medical conditions:

____

____

IV.Surgical History

(Surgeries/date:)

____
____
____
____
____
____

V.Family History

□ Do not know family history- skip this section

Please list any known medical problems for the relatives listed below:

(Include: Alcoholism, Cancer, Diabetes, Heart Attack, Heart Disease, High Blood Pressure, High Cholesterol, Osteoporosis, Psychiatric disorder, Stroke)

Mother:____

Father:____

Brothers/Sisters:____

Children:____

VI.Social History

Alcohol Use: □ Yes □ No

Type:___________

Number of drinks:______

□ Day

□ Week

□ Month

Current Tobacco User: □ Yes □ No

Frequency:______Packs/Day

Number of years:______

Former smoker: : □ Yes □ No

Quit date:_______

Illicit Drug Use: □ Yes □ No

□ Marijuana

□ IV Drug Use

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Patient Authorization for Disclosure of Medical Information

I DO NOT want to name a patient representative at this time.

X_________________________________ X______________________________ ________

(Printed Name of Patient:) (Signature of Patient:) (Date:)

I DO direct Prestige Primary Care, LLC to disclose and release my protected health information described below with the following:

______________________________ ______________________________

(Name:) (Relationship:)

______________________________ ______________________________

(Name:) (Relationship:)

Health Information to be disclosed --- (select below):

A. Disclose my **complete** health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)___

B. Disclose my health record, as above, but DO NOT disclose the following-(check as appropriate):

Mental Health____ Alcohol/Drug abuse____ Communicable diseases(including STD's, HIV, AIDS____

Other (please specify): ______________________________

X_________________________________ X______________________________ ________

(Printed Name of Patient:) (Signature of Patient:) (Date:)

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers. This authorization ends one year from the date it was signed unless specified otherwise)

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HIPAA-Acknowledgment of Receipt

Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

I hereby acknowledge that I received Prestige Primary Care, LLC's Notice of Privacy Practices.

X ______________________________

(Printed name:)

X ______________________________

(Signature:)

____

(Date:)

Notice of Privacy Practices

Prestige Primary Care, LLC

1855 Veterans Park Dr. Suite 304 Naples, Fl 34109 Phone (239)676-0656

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office is required by law to provide you with this Notice of Privacy Practices so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact our HIPAA Compliance Officer.

Understanding Your Health Information

Your health record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan your care and treatment
- communicate with other health professionals involved in your care
- document the care you receive
- educate health professionals
- provide information for medical research
- provide information to public health officials
- evaluate and improve the care we provide
- obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- ensure it is accurate
- better understand who may access your health information
- make more informed decisions when authorizing disclosure to others

How We May Use and Disclose Protected Health Information About You

For Treatment

We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to office personnel who are involved in taking care of you at our office. We may also disclose health information about you to people outside the office who may be involved in your care.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at our office may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all patients receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols.

Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of the office including resolution of internal grievances and customer service.

Other Allowable Uses of Your Health Information

Business Associates

There may be some services provided in our office through contracts with business associates. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Treatment Alternatives

We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services and Reminders

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care.

Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care.

As Required by Law

We will disclose health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.

Organ and Tissue Donation

If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

Research

Under certain circumstances, we may use and disclose health information about you for research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process.

Workers' Compensation

We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Other Disclosures

Reporting Federal and state laws may require or permit the office to disclose certain health information related to the following:

Public Health Risks

We may disclose health information about you for public health purposes, including:

- Prevention or control of disease, injury or disability
- Reporting births and deaths
- Reporting child abuse or neglect
- Reporting reactions to medications or problems with products

Health Oversight Activities

We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose health information when requested by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the office; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Health Information Rights

The heath records we maintain are the property of the office. The information in it, however belongs to you. You have the following rights regarding your health information.

Right to Inspect and Copy

With some exceptions, you have the right to review and copy your health

information. You must submit your request in writing our HIPAA Compliance

Officer. We may charge a fee for the costs associated with your request.

Right to Amend

If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for the Facility.

You must submit your request in writing to our HIPAA Compliance

Officer. In addition, you must provide a reason for your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the Facility; or
- Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.

You must submit your request in writing to our HIPAA Compliance Officer. Your request must state a time period which may not be longer than six years from the date the request is submitted and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request

unless the information is needed to provide you emergency treatment.

You must submit your request in writing to our HIPAA Compliance Officer.

In your request, you must tell us:

1. what information you want to limit
2. whether you want to limit our use, disclosure or both
3. to whom you want the limits to apply, for example, disclosures to your spouse

Right to Request Alternate Communications

You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.

You must submit your request in writing to our HIPAA Compliance Officer.

We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the office. The Notice will specify the effective date. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the Facility administrator.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services.

To file a complaint with the office, contact our HIPAA Compliance Officer.

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Contact Us

If you wish to contact us regarding the terms in this Notice, please contact:
HIPAA Compliance Officer-Jessica Bartalino (239)676-0656