

Patient Registration Form (11-12-07)

Janis Black, D.O.

PATIENT INFORMATION <small>(Person seeing the Doctor today)</small>				Family Health Center at Port St. John 3740 Curtis Blvd, Suite 108 Cocoa, FL 32927 (321)633-5500	
Last Name	First Name	Middle Initial			
Home Address <small>(Street, Apt #)</small>		City		State	Zip
Mailing Address <small>(if different from home)</small>		City		State	Zip
Home Phone Number	Cell Phone Number		Social Security Number		
Date of Birth	Gender (M-F)	Emergency Contact <small>(Name of Person to call)</small>		Emergency Phone Number	
Patient Employer <small>(Company Name)</small>	Work Address <small>(Complete: street, city, state, zip)</small>			Work Phone Number	
Referring Doctor <small>(Doctor who referred you to us. If not referred, please write "none" or your Primary Care Physician)</small>				Patient Marital Status	
BILLING INFORMATION <small>(Person responsible for any balances not covered by insurance; also called "Guarantor")</small>					
Name of Person responsible for bill	Home Address <small>(Complete: street, city, state, zip)</small>			Home Phone Number	
INSURANCE INFORMATION <small>(Person whose insurance is used for today's Doctor visit; also called "Subscriber")</small>					
Name of First (Primary) Insurance Company	Address of First (Primary) Insurance Company <small>(back of ins card)</small>			Insurance Company Phone Number	
Group Number	Policy Number or Insured Person ID Number			Relationship to Patient	
Subscriber Name <small>(Policy holder of insurance)</small>	Subscriber's Home Address <small>(Complete: street, city, state, zip)</small>			Subscriber's Home Phone Number	
Subscriber Date of Birth	Gender (M-F)	Social Security Number		Name of Company where Subscriber works	
Name of Second Insurance Company	Address of Second Insurance Company			Insurance Company Phone Number	
Group Number	Policy Number or Insured Person ID Number			Relationship to Patient	
Subscriber Name <small>(Policy holder of Insurance)</small>	Subscriber Home Address <small>(Complete: street, city, state, zip)</small>			Subscriber Home Phone Number	
Subscriber Date of Birth	Gender (M-F)	Social Security Number		Name of Company where Subscriber works	

*** Please note: We do not file liability insurance; visits related to accidental injuries must be paid in full. You will be given a receipt to file the liability claims with the insurance for reimbursement.

*** List any person with legal Power of Attorney for you. A copy of the Power of Attorney must be provided for your chart. _____
(Name of Person with Power of Attorney)

*** I give Dr Black permission to submit and view my prescriptions electronically. (Please Sign) _____

AUTHORIZATION: I certify that the information given by me in applying for payment under my insurance contract (including Title XVIII of the Social Security Act) is correct. I authorize release to my insurance carrier, employer and referring physician any information needed including diagnosis and records of any treatment or examination rendered to me to process this claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable or authorize Dr Janis Black to submit a claim to my insurance, including Medicare, for payment on my account. I understand that I will receive monthly statements reflecting my balance and that the FINAL PAYMENT of these accounts remains my responsibility.

(Patient / Legal Guardian's Signature)

(Date)

Patient Information Form

Please fill out form completely (check no or does not apply), please do not leave questions blank, unless indicated. The more information you provide enables the physician to provide better care.

Name: _____ Today's Date: _____ Age: _____ Marital Status: _____

Email Address: _____ May we email you with Appt reminders? _____

Occupation: _____ Retired? _____

Birth date: _____ Birthplace: _____ Lived outside of US?: _____

Who referred you to see the doctor today? _____

What is the reason for today's visit? _____

Past Medical History

Allergies Do you have any food or drug allergies? If so, please list below and describe.

Have you had any reactions to IVP dye used for X-ray studies? ___yes ___no

Medications For any additional medications please continue on back of form.

Name of Medication	Dose	Instructions	Prescribing Physician
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Herbs, supplements, vitamins:

Hospitalizations/Surgeries: continue on back if needed.

Year	Reason for Hospitalization	Hospital	Doctor

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Patient Name: _____ **Date:** _____

Have you ever been advised to have a surgical operation that was not done? Yes No
 If yes, explain. _____

Have you ever had radiation or chemotherapy? Yes No If yes, please explain.

Start Date End Date

Month	Year	Month	Year	Area Treated	Hospital	Doctor

Blood Transfusions Yes No When _____

Trauma/Fractures: _____

Illnesses (rheumatic fever, polio, TB, hepatitis, meningitis, malaria) _____

Do you see a Specialist (Cardiologist, OBGYN, Pulmonologist, Urologist, etc.)

Specialty	Doctor's name	Phone/fax	City, State	Last visit

Family History

Relation	Age	High Blood Pressure	Diabetes	Cancer	Lung Disease	Seizures	Mental Illness	Rheum.	Other	Age at
		High Cholesterol		(What kind and age at Diagnosis)	COPD Emphysema	Neurological Disorders	Suicide Depression Alcoholism	Arthritis Lupus	Medical Concern	Death
M Grandfather										
M Grandmother										
P Grandfather										
P Grandmother										

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Patient Name: _____ **Date:** _____

Relation	Age	High Blood Pressure High Cholesterol Heart Disease/Stroke Heart Attack	Diabetes	Cancer (What kind and age at Diagnosis)	Lung Disease COPD Emphysema	Seizures Neurological Disorders	Mental Illness Suicide Depression Alcoholism	Rheum. Arthritis Lupus	Other Medical Concern	Age at Death
Father										
Mother										
Spouse										
Brothers										
Sisters										
Children										
Other Relatives										

Personal History

Circle One:

Single Married Separated Divorced Widowed

Do you have a support system? Circle all that apply.

Significant Other Friends Family Children Church None

Religious Preference (optional) _____

Personal History

Do you use any medical devices? Check all that apply. ___glasses ___ hearing aids
 ___walker ___wheelchair ___oxygen ___Cpap ___Other_____

What medical equipment company do you use? _____

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Patient Name:_____ **Date:**_____

Occupation

What is your current occupation? _____

What other jobs have you held for a significant period of time? _____

During any of these jobs did you have a significant exposure to: ___asbestos ___fumes
___radiation ___chemicals ___smoke ___Other _____

Smoking:

Do you currently smoke cigarettes? ___Yes ___No If not, did you previously? ___Yes ___No

If you stopped, when was it? _____ How many years have you smoked? _____

During the entire time, what is the average number of packs per day smoked? _____

Do you smoke a pipe or cigars? ___Yes ___No. If yes, how long? _____

Do you or did you use snuff/chewing tobacco? ___Never ___Past ___Current-How Long _____

Alcohol:

Do you drink any alcoholic beverages? ___Current ___Former What kind? _____

How much? ___1-2 ___2-3 ___4+ How often? _____ Daily, Weekly, Weekends, Rarely.

Has it ever interfered with your personal or professional life? ___Yes ___No If yes, explain _____

Have you ever been treated for this? _____

Drug Use:

Have you ever used illegal/recreational drugs? ___Current ___Past ___Never

If yes, what kind? _____ how often? _____

Have you ever had formal treatment for this? _____

Have you ever been addicted to or abused prescription medication? _____

Psychosocial:

Does anyone else live with you? _____

Do you have reliable transportation to get to your medical appointments? _____

Do you have insurance coverage for prescription medication? _____

Women only:

Last Menstrual Period : _____ Might you be pregnant? Yes___ No___ Unsure___

Contraceptive Method None___ Pills___ Condoms___ Surgical___ Menopause___ Other___

Number of times pregnant: _____ # of Deliveries: _____ # of Children _____

Last Pap Smear: _____ Performed By Dr: _____ Results: _____

Prior abnormal Pap? _____ When? _____ Last Mammo? : _____

Action taken for abnormal pap? Repeat exam___ Cryotherapy___ Cone___ LEEP___ Other___

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Patient Name: _____ **Date:** _____

Testing:

Colonoscopy or Other Bowel or Digestive Studies? (Why, When, Results, When to Repeat?) _____

Stress Test/Cardiac Cath/EKG/Heart Studies? (Why, When, Results, Actions Taken/Advised?) _____

When was your last Tetanus shot? _____ Flu Shot? _____ Pneumonia Shot? _____

When was your last visit with your Dentist? _____ Your Last Eye Exam? _____

What Three things would you like to discuss with Dr. Black today?

1. _____

2. _____

3. _____

Thank you for completing this information it will enable us to give you the best possible care.

Patient Name: _____ **Date:** _____

Dr. Janis Black

Family Health Center at Port St. John

3740 Curtis Boulevard, Suite 108

Port St. John, FL 32927

Phone: 321-633-5500

Fax: 321-633-5566

As your healthcare provider we may collect specimens that will need to be sent out to a laboratory for testing. We kindly ask that our patients be informed on which area laboratories participate with their insurance plan as we have a large volume of patients with many different types of insurance.

Your personal selection of a laboratory helps avoid error so that you are not left responsible for any charges due to your specimen being sent to the incorrect laboratory. If you are unsure about which laboratories accept your insurance please call the number listed on the back of your insurance card.

By signing below I am accepting that I understand it is my responsibility to know which laboratories are contracted with my insurance; it is also my responsibility to notify Dr. Black's office if this changes at any time. I have verified that the laboratory I have chosen below accepts my insurance and I understand that if it does not I will be responsible for any fees incurred from testing. As with all insurance, if my insurance company chooses not to pay for any tests performed I will be financially responsible.

The laboratory I wish for my specimens to be sent to is:

- Brevard Community Laboratory
- Health First
- I am self pay and have no preference for which laboratory my specimens are sent to
- I am self pay – however I do prefer the laboratory I have chosen
- Lab Corp
- Quest Diagnostics
- Wuesthoff
- Parrish Medical Center

Patient's Printed Name: _____

Patient's Signature: _____

Date: _____

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(321)633-5500 Fax(321)633-5566

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

The following information/records **WILL NOT** be disclosed without the patient's authorization or the patient's Power of Attorney or Healthcare Surrogate's Authorization:

- Acquire Immunodeficiency Syndrome (AIDS)
- Infection with Human Immunodeficiency Virus (HIV)
- Behavioral Health Services and/or Psychiatric Care
- Treatment for Alcohol and/or Drug Abuse

I authorize Dr. Black and her staff to share my personal medical information, such as appointment times, test results, medication issues, etc. and other details in relation to my care, with the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization in writing at any time. Unless revoked, this authorization will not expire. If I have questions about the disclosure or my health information, I can contact Dr. Black's office staff at: 321-633-5500.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Dr. Janis Black
Family Health Center at Port St. John
3740 Curtis Boulevard, Suite 108
Port St. John, FL 32927
Phone: 321-633-5500
Fax: 321-633-5566

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA
NOTICE OF PRIVACY PRACTICES

I have received a copy of Dr. Janis G. Black's HIPPA Notice of Privacy Practices ("Notice"). The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. In addition, I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by requesting one from Dr. Black or her staff.

Please initial below:

___ I am accepting a copy at this time.

___ I am refusing a copy, but I am aware that I can request a copy at anytime.

Print Name: _____

Signature: _____

Date: _____

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Drjanisblack.com

Payment and Office Policies

Thank you for choosing our office! We are committed to the success of your medical treatment and care. We realize that communication with our patients helps us provide the best care. We have taken the time to answer the most commonly asked questions regarding payment and insurance.

All patients must complete our ***Patient Information Form***. We believe that a good relationship is based on understanding and open communication. Our staff has been instructed to make every effort available to you to clarify any misunderstanding you have concerning your care or balance.

How may I pay?

We accept cash, check, VISA, and MasterCard. Returned checks are subject to a \$25 NSF fee or 5% of face value of the check and you may lose the privilege to write checks to this office in the future. For your convenience, you may call our office directly for any questions regarding your bill. Payment for services is due at the time of service unless prior arrangements have been made. If you are unable to pay your portion of your medical visit, you must speak with the office staff prior to making an appointment.

When is my account delinquent?

An account is considered past due 30 days following billing to the insurance company. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to our collections and will have a service fee/billing fee added.

How are my Medicine Refills handled?

Our policy is to refill all medications at the patient's office visit with the physician. We kindly ask that you do not have your pharmacy fax refill requests to the office. Our office is dedicated to providing the best healthcare for you and your family. This means that medications requiring a prescription require a follow up visit and some will require routine blood work. This is for your safety. Controlled medications (i.e. pain/sleep medications, ADD/ADHD medications, and other narcotics) will **NOT** be refilled over the phone for any reason, only at the time of the office visit with the physician. For your wellbeing, antibiotics and cough medication will not be refilled. If you are still not feeling well, an additional visit is necessary to ensure you receive the proper treatment for your illness.

Phone calls to the office

Our office staff is available to you Monday through Friday from 8am to 5pm. We close for lunch from noon to 1pm. If you are calling with a medical concern for the clinical staff please give them time to consult with the provider and return your call. Calls will be returned after the morning appointments and again after the afternoon appointments. Multiple calls and messages are not necessary and can actually delay a return call by needlessly causing your message to be pulled away from the Physician's desk for your repeated calls. Calls will be returned within 24 hours.

Phone calls to Doctors

Dr Black does not believe in telephone medicine; if you need to talk your doctor we will be happy to give you an appointment. We reserve several same day appointments for acute or sick visits for this reason. Calling the doctor after hours with non-emergent concerns (refills, appointments, and non-acute symptoms) will result in a charge of \$25, which most insurances do not pay, thus making you responsible.

Missed Appointments

We would appreciate your help and courtesy of a call if you are unable to keep an appointment. Please notify our office at least twenty-four (24) hours prior to the appointment time. **We reserve the right to charge you a missed appointment fee of \$25** and three (3) non cancelled missed appointments are grounds for patient discharge. A cancelation of less than 24 hours before the appointment is considered a missed appointment. Any patient that is more than 20 minutes late for an appointment, without calling, will have to be rescheduled or may be worked in at the discretion of the doctor. We realize that your time is valuable and will make every possible endeavor to stay on schedule. However, throughout the day, some patients do need unanticipated additional time. If the doctor is running more than thirty minutes behind schedule, you will be notified at check-in and may reschedule with no fee charged to you.

Do I Need A Referral?

If you have an HMO or Federally sponsored plan with which we are contracted, you will need to ensure that Dr Janis Black is listed as your Primary Care Physician; this can be done by contacting your insurance company. In order to see a specialist you will need a referral. If we refer you to a specialist we are more than happy to provide this service for you. If you make an appointment with a specialist and need a written referral or authorization from your insurance company we require an appointment within the last six months and 72 hours notice before the appointment with the specialist to gather the needed information that is required for the appointment. This is in addition to any delay by the insurance company in processing the referral, so please give our office enough time to ensure all is complete for your visit. (If you see a specialist, especially cardiology, you may need to have prior medical records or other information forwarded to this office to expedite your care.)

What Is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained in this paperwork. Claims that have not been paid in 45 days will be automatically billed to you and we can assist you in refilling your insurance at your request.

What if My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult (who consents to the treatment) is responsible for payment of the account, according to the policy outlined on the previous pages. A written note from a parent or legal guardian must accompany the child to any visit in which the parent/guardian will not be present. Our office will not be involved in separation/divorce disputes.

Legal Fees: Any patient sent to collections will be responsible for all collection fees. If a patient is taken to small claims court the patient will be responsible for all fees/charges.

Insurance

It is the responsibility of the patient or legal guardian to be familiar with your insurance plan. We are not familiar with each of your personal insurance plans/products and might need your assistance in order to get your claim paid. Most insurance companies are happy to send you an EOB (Explanation of Benefits) before they will send one to the office.

If the office is closed..

Our answering service may be reached at 1-800-570-0085. They will be happy to take your information and it will be forwarded to the physician. She will review the information and you will be contacted within three hours. If you require emergency medical attention please go to the Emergency Room located at:

Wuesthoff Health Systems
110 Longwood Ave
Rockledge, FL 32955
(321) 637-2600

For less urgent matters you can go to Royal Oaks Walk-In Clinic on US Hwy 1, in Port St John.

Assignment of Benefits

You need to assign benefits/payments for your insurance to Dr Janis Black.

I have read, understand, and agree to the above Office and Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Family Health Center at Port St John.

I authorize Family Health Center at Port St John to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Printed Name

Signature

Date: