Beth Freedland, D.O., FACOOG

7301A West Palmetto Park Road, Suite #301A

Boca Raton, FL 33433

*(P) 561-961-5456 * (F) 561-672-7953*

Patient Name _____
Last First Middle

SS# _____ Date of Birth _____ Marital Status S M W D

Home Address _____

_____

Home Phone _____ Cell Phone _____
Spouse Name _____ Contact Number _____
Spouse SS# _____ Spouse's DOB _____
Employer _____ Work Phone _____
E-mail _____

In case of emergency, please notify _____

Relationship _____ Phone Number _____

Primary Care Physician _____ Phone number _____
I was referred to Dr. Freedland by _____

Insurance Company _____ Policy Number _____
Insurance Co Phone Number _____

Pharmacy name:_____ Phone:_____

Address:_____

Assignment of Benefits

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Beth Freedland, DO, FACOOG

I understand that I am financially responsible for all charges whether or not paid by said insurance. I will be responsible for expenses associated with all collection, including reasonable attorney fees and court costs. Co-payments are due at the time of the visit. Self pay patients are responsible for payments at the time of their visit.

I authorize Beth Freedland, DO, FACOOG to release all information necessary to secure payment

Signed _____ Date _____

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PROTECTED HEALTH INFORMATION
PATIENT CONSENT

PATIENTS PLEASE NOTE: The practice is not required to agree to your request. Please see our notice of privacy practice for more information regarding such requests.

Patient Name _____ Date of Birth _____

Patient Address _____

_____

PATIENT CONTACT
All calls regarding your care, test results and appointments will be made to your home telephone number. If you would like us to contact you at an alternative phone number, please indicate that number below

Alternative Contact Number

_____ I hereby authorize this practice to contact me by telephone and if I am not present, they may leave a message on my answering machine or with the persons listed below.

OR

_____ I prefer that you ***DO NOT*** leave messages on my answering machine.

I, _____, authorize Beth Freedland, DO, FACOOG to release my Protected Health Information to the people I have listed below if I am not available. (Please include restrictions, if any, of your PHI to each individual.)

Individual/Relationship to Patient	Restrictions (If Applicable)
_____	_____
_____	_____
_____	_____
_____	_____

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize _____ to use and/or disclose the
(Name of Health Care Provider)

protected health information described below to _____.
(Name of Individual)

2. Authorization for Release of Information. Covering the period of health care from

☐ _____ to _____ **OR** ☐ all past, present and future periods:

☐ a. I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS and treatment of alcohol/drugs abuse).

OR

☐ b. I hereby authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. This authorization shall be in force and effect until _____, at which time this authorization expires.
(Date of Event)
5. I understand that I have the right to revoke this authorization, in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment or eligibility for benfits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient

Payment Policy

Please read and sign this form as it concerns you, the patient.

*****YOU ARE RESPONSIBLE FOR YOUR INSURANCE POLICY**

Due to the many changes in insurance policies, we cannot be responsible for interpreting each individual policy. **It is your responsibility to know your individual coverage and its limitations, as well as who is a provider for your plan.** We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient, being responsible for all costs incurred. **Please remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to know or find out, whether or not we are providers for your specific network.**

- **Referrals**

If you need a referral from your insurance company or from your primary care physician to be seen in this office, the referral must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you will need to reschedule your visit should a referral not be available. We welcome you to call your primary care physician and have your referral faxed to us.

- **Non-Participating Provider Policy**

If we are not a provider for your insurance company, we will collect our fee in full at the time of service.

- **Your Financial Responsibility**

You are responsible for payment of any co-payments, co-insurance, deductibles, etc. at the time of service. Because we are specialists, some diagnostic/invasive procedures are not considered part of your office visit co-payment and may be applied to your deductible and/or co-insurance. Please call your insurance company and learn about your coverage. It may save you a lot of confusion and out of pocket expense.

_____ _____

Patient Signature Date