PRINCETON
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New Patient Registration

Last Name: _____ **First Name**: _____ MI _____

Street Address:_____ **Apt/Suite #:** _____

City/State/Zip_____

Date of Birth: _____ **Sex:** Male / Female **Social Security**: _____

Cell Phone: _____ **Home Phone**: _____ **Email:** _____

Employer Name: _____ **Work Phone:** _____

Employment Status**: [ ] Full Time [ ] Part Time [ ] Unemployed [ ] Retired [ ] Military [ ] Student**

Marital Status**: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other**_____

Emergency Contact Information

Name of Emergency Contact: _____**Contact Number:** _____
Relationship to Patient: _____

Insurance Information

Primary Insurance: _____ **Member ID**:_____
Secondary Insurance: _____ **Member ID**:_____

Pharmacy

Preferred Pharmacy: _____ **Pharmacy Phone**: _____
Pharmacy Address: _____

Other Information

Have you signed an Advance Healthcare Directive? **[ ] Yes [ ] No** (Please ask front staff about the "Five Wishes" Sample Form for your care planning)
May we send you information regarding **Princeton Medical Group** events, health news updates and insurance announcements? **[ ] Yes [ ] No**

How did you hear about us? _____
Who referred you to us? (Please provide name and number)

_____

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Consent for Treatment

I, _____, HEREBY AUTHORIZE, **Princeton Medical Group,** the attending Clinician, or the Clinician designated by him/her and other Practice employees; to examine and treat me. I also authorize such treatment and procedures, as deemed necessary by the Clinician including but not limited to, the taking of x-rays, medications, blood samples, urine samples and other therapies. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has be made or implied to me as to the results that may be obtained by examination and treatment.

I hereby certify that I understand the above authorization.

_____ _____

Patient Signature Date

_____

Person Authorized Consent

_____

Relationship to Patient

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Financial Policy/Assignment Information/Release of Information

By signing below, I authorize the release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person who account I am acting as guardian or representative. I authorize (assign) any insurance or Medicare benefits to be paid directly to Princeton Medical Group, LLC or its assignees. I agree that I am responsible for any **non-covered services, supplies, co-payments or deductibles.** I agree that **I** am responsible for **knowing how my insurance plan works,** and have requested medical services for this office. I understand that diagnosis or treatment of me by Princeton Medical Group, LLC may be conditioned upon my consent as evidenced by my signature of this document. I agree to provide **24 hours** advance notice should I need to cancel or reschedule an appointment. I understand and agree that a **$25** fee will be charged for any broken appointment for which I do not provide 24 hours advance notice.

The acceptance and assignment will be in force for all future services by practitioners from this office.

Acknowledgement of Notice of Privacy Practices

By signing below, I understand that as part of my health care, Princeton Medical Group, LLC originates and maintains paper and electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality

I understand that Princeton Medical Group, LLC has given me a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures (Page 4 – 6). I understand that Princeton Medical Group reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this notice at any time.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclose
- The right to revoke my consent to use or the disclosure of my protected health information by notifying Princeton Medical Group, LLC in writing of such revocation

I have had an opportunity to receive and review the Notice of Privacy Practices of Princeton Medical Group, LLC.

Signature of Patient or Guardian/Representative: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE READ IT CAREFULLY.

Law requires this office to protect the privacy of your health information, give you a Notice of our office legal duties and privacy practices, and follow the current Notice. It will be followed by all employees, students, and volunteers of the health care components of this office, which include, but are not limited to, our administrative and operations administrative staff.

1. Uses and Disclosures of Your Health Information: The following categories describe some of the ways that this office may use and disclose your health information.

Treatment: This office will use your health information to provide you with medical treatment/services and for treatment activities of other health care providers. *Example:* Your health information may be used by others involved in your care.

Payment: This office may use your health information for payment activities, such as to determine plan coverage, to bill/collect, or to help another health care provider with payment activities. *Example:* Your health information may be released to an insurance company to get pre-approval of or payment for services.

Operations: This office may use your health information for uses necessary to run its healthcare businesses, such as to conduct quality assessment activities, train, or arrange for legal services. *Example:* this office may use your health information to conduct internal audits to verify proper billing procedures.

Business Associates: This office may disclose your health information to other entities that provide a service to this office or on this office's behalf that requires the release of your health information, such as billing service, but only if this office has received satisfactory assurance that the other entity will protect your health information.

Individuals Involved in Your Care or Payment for Your Care: This office may release your health information to a friend, family member, or legal guardian who is involved in your care or who helps pay for your care.

Directory: This office may include your name, location, general condition, and religious affiliation in a directory if you are staying overnight. Your religious affiliation may be given to a clergy member, even if you are not asked for by name, and your other information may be released to people who ask for you by name. *If you do not want to be in the directory,* notify us when you register at the facility and complete an "opt out" form.

Research: This office may use and disclose your health information to researchers for research. Your health information may be disclosed for research without your authorization if the authorization requirement has been waived or revised by a committee charged with making sure the disclosure will not pose a great risk to your privacy or that steps are being taken to protect your health information, to researchers to prepare for research under certain conditions, and to researchers who have signed an agreement promising to protect the information. Health information regarding deceased individuals can be released without authorization under certain circumstances.

Organ and Tissue Donation: If you are an organ donor, this office may release health information to organ donation banks or organizations that handle organ or tissue procurement or transplantation.

Fundraising/Marketing: This office may use (or release to an office-related foundation) certain information such as your name, address, department of service, and treatment dates for fundraising. If you do not want to be contacted for fundraising efforts, notify this office's Privacy Official.

De-Identification: We may also create and distribute health information by removing all reference to individually identifiable health information**.**

Contact: We may contact you by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications that may be of interest to you

2. Uses and Disclosures of Health Information Required/Permitted by Law: The following categories describe some of the ways that this office may be allowed or required to use or disclose your health information.

Required by Law/Law Enforcement: This office may use and disclose your health information if required by federal, state, or local law, such as for workers' compensation, and if requested by law enforcement officials for purposes such as responding to a court order.

Public Health and Safety: This office may use and disclose your health information to prevent a serious threat to the health and safety of you, others, or the public and for public health activities, such as to prevent injury. *Example:* Florida law requires this office to report birth defects and cases of communicable disease.

Food & Drug Administration (FDA) and Health Oversight Agencies: This office may disclose health information about incidents related to food, supplements, product defects, or post-marketing surveillance to the FDA and manufacturers to enable product recalls, repairs, or replacements; and to health oversight agencies for activities authorized by law, such as audits.

Lawsuits/Disputes: If you are involved in a lawsuit/dispute and have not waived the physician-client privilege, this office may disclose your health information under a court/administrative order, subpoena, or discovery request after attempting to inform you of the request.

Coroners, Medical Examiners, and Funeral Directors: This office may release your health information to coroners, medical examiners, or funeral directors to enable them to carry out their duties.

National Security/Intelligence Activities and Protective Services: This office may release your health information to authorized national security agencies for the protection of certain persons or to conduct special investigations.

Military/Veterans: This office may disclose your health information to military authorities if you are an armed forces or reserve member.

Inmates: If you are an inmate of a correctional facility or are in the custody of law enforcement, this office may release your health information to a correctional facility or law enforcement official, so they may provide your health care or protect the health and safety of you or others.

Florida law requires that this office inform you that health information used or disclosed may indicate the presence of a communicable or non-communicable disease. It may also include information related to mental health.

3. Your Rights Regarding Your Health Information: You have the rights described below regarding the health information that this office maintains about you. You must submit a written request to exercise any of these rights. Forms for this purpose are available at any of the locations where this office provides medical services.

Right to Inspect/Copy: You have the right to inspect and get a copy of health information maintained by this office and used in decisions about your care. This right does not apply to psychotherapy notes and certain other information. By law, this office may charge in advance $1.00 for the first page, $.50 for additional pages, up to $5.00 per x-ray, image, or slide, and $.12 cents per digital page, plus postage, payable prior to the release of the requested records (or those amounts permitted by current law). This office may deny your request in certain circumstances. You may request a licensed health care professional chosen by this office to review a denial based on medical reasons; this office will comply with this decision.

Right to Amend: If you believe health information this office created is inaccurate or incomplete, you may ask this office to amend it. This office cannot delete or destroy any information already included in your media record. You must provide a reason for your request. this office may deny your request if you ask to amend information that this office

did not create (unless the person or entity that created the information is not available to make the amendment); that is not part of the health information this office maintains; that is not part of the information law permits you to inspect and copy; or that is accurate and complete.

Right to Accounting of Disclosures: You have the right to ask for a (free) list of disclosures this office has made of your health information. This office is not required to list all disclosures, such as those you authorized. *You must state a time, which may not be longer than 6 years or include dates before April 14, 2003*. If you request more than one accounting in a 12-month period, this office may charge you for the cost of the list. This office will tell you the cost; you may withdraw or change your request before the copy is made.

Right to Request Restrictions: You have the right to request a restriction or limit on how this office uses or discloses your health information. You must be specific in your request for restriction. You may restrict disclosure of your health information to a health plan if you choose to pay out-of-pocket in full for the services at the time they are provided. This office is not required to agree to every request. If this office agrees or is required to comply, this office will comply with the request unless the information is required to be disclosed by law or is needed in case of emergency. *Example*: You may want to pay cash in advance for services rather than have your insurance billed.

Right to Request Confidential Contacts: You have the right to request that this office contact you about medical issues in a certain way, such as by mail. You must specify how or where you wish to be contacted; this office will try to accommodate reasonable requests.

Right to a Copy of This Notice: You have the right to a paper or electronic copy of this Notice, which is posted and available at each location where medical services are provided and is on this office's website or both.

Right to be Notified: This office will notify you if your unsecured health information is breached.

4. Changes to this Notice: This office reserves the right to change this Notice and to make the revised Notice effective for health information this office created or received about you prior to the revision, as well as to information it receives in the future. Revised Notices will be posted and available at each location where medical services are provided and on this office's website.

6. Complaints. If you believe your privacy rights have been violated, you may file a complaint with this office's Privacy Official or with the Secretary of the Department of Health and Human Services, Office of Civil Rights.

_____ _____
Signature Date

_____
Printed Name

☐ Copy given to patient ☐ Patient refused copy

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Patient Consent for Pelvic Examination

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I _____authorize and direct

(Print Patient's Name)

Princeton Medical Group, LLC and my treating health care provider, the employed and/or contracted medical personnel of **Princeton Medical Group, LLC** as deemed necessary by my treating physician, and the medical students and/or students receiving training as a health care provider who may be involved in my care, to perform a pelvic examination, including vaginal sonography, as described above. I understand that a pelvic examination may be needed while receiving medical care from **Princeton Medical Group, LLC** in the future, and I hereby agree and acknowledge that this written consent applies to any and all pelvic examinations conducted today, or in the future, by a health care provider, medical student, or student receiving training as a health care provider employed by and/or contracted with **Princeton Medical Group, LLC** unless I revoke this consent in writing by hand delivering a copy of the revocation to **Princeton Medical Group, LLC.** By my signature below I acknowledge that I have read or have read to me and understand the contents of this form.

_____	_____	_____
Patient/Legal Representative Signature	Printed Name	Date
_____	_____	_____
Witness Signature	Printed Name	Date
_____	_____	_____
Physician/Provider Signature	Printed Name	Date

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Patient History

Patient Full Name: _____ Patient DOB: _____

Social Security #: _____ Date of Last Exam: _____

Which of the following conditions are **you currently being treated/have been treated** for (Please check all that apply)?

[ ] Heart Disease/Murmur/Angina
[ ] High Blood Pressure/Low Blood Pressure
[ ] Depression/Anxiety
[ ] Thyroid Problems
[ ] Shortness of breath/Asthma
[ ] Lung Problems/Cough
[ ] Liver Problems/Hepatitis
[ ] Psychiatric Care
[ ] Sinus Problems/Allergies
[ ] Eye Disorder/Glaucoma
[ ] Neurological problems
[ ] Swollen Ankles
[ ] Headaches/Migraines
[ ] Anemia or Blood Problems
[ ] Cancer
[ ] Stroke
[ ] Seizures
[ ] Tonsillitis
[ ] High Cholesterol
[ ] Diabetes
[ ] Kidney/Bladder Problems
[ ] Heartburn(reflux)
[ ] Ulcers/Colitis
[ ] Ear Problems

Other: _____

Please answer the following questions to the best of your ability.

Have you ever been tested for Hepatitis A, B, or C? **Yes / No** Which virus? **A / B / C**

Have you been vaccinated for Hepatitis A? **Yes / No** If yes, date vaccine series completed _____

Have you been vaccinated for Hepatitis B? **Yes / No** If yes, date vaccine series completed _____

Last **Tuberculosis (TB) Screening?** _____ Result of screening: **[ ] Positive [ ] Negative**

If **Positive** TB screening, date of last chest X-ray: _____ Result of X-Ray **Positive / Negative**

Have you had a Sexually Transmitted Disease? **Yes / No** If Yes, Diagnosis: _____

Have you ever been hospitalized? **Yes / No** If yes, what for? _____

Please describe any current or past medical treatment not listed above:

_____

_____

Past Medical Gynecological History (Females)

How many times have you been pregnant? _____ Date of last Pap Smear: _____

Have you had any abnormal Pap Smears? **Yes / No** If yes, Diagnosis? _____

Date of last Mammogram: _____ Mammogram Results _____

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Patient History Continued

Please list your Past Surgeries (Year/Surgery Type)

Please list your current Medications:

Please list any previous/current Allergies:

Are you allergic to penicillin or any other drugs? Y / N Please list others

Social History: Please **circle and date** if you have had any of the following:

Influenza Vaccine (Flu): **Yes / No** _____ Pneumonia Vaccine: **Yes / No** _____

Chest X-Ray: **Yes / No** _____ Colorectal Screening: **Yes / No** _____

Echocardiogram: **Yes / No** _____ EKG: **Yes / No** _____

Do you exercise daily/weekly? **Yes / No**

Do you currently smoke or chew tobacco? **Yes / No** Have you in the past? **Yes / No** How many per day? _____

Do you drink alcohol? **Yes / No** Have you in the past? **Yes / No** How many drinks per week?_____

Do you currently drink coffee and or tea? **Yes / No** How many per day? _____

Family History

Father	Alive / Deceased	Diabetes Yes / No	Hypertension Yes / No	Heart Disease Yes / No	Mental Illness Yes / No	Cancer Yes / No
Mother	Alive / Deceased	Diabetes Yes / No	Hypertension Yes / No	Heart Disease Yes / No	Mental Illness Yes / No	Cancer Yes / No
Siblings	Alive / Deceased	Diabetes Yes / No	Hypertension Yes / No	Heart Disease Yes / No	Mental Illness Yes / No	Cancer Yes / No

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is completed, true and accurate.

Patient/Legal Guardian Signature _____Date_____

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Controlled Substance Agreement

Patient Responsibility Agreement for Controlled Substance Prescriptions

Controlled substance medications (i.e. narcotics, tranquilizers, benzodiazepines, and barbiturates) are very useful for controlling both acute and chronic pain but have a high potential for misuse and are therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving quality of life, function and/or the ability to work. If my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions.

Treatment Goals

I understand that the main treatment goal is to reduce pain to a bearable level and improve the quality of my life. This includes the ability to function and/or work. I understand that in many cases the pain may not be completely eliminated. In consideration of this goal, and because of the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits. These include increase in activity and exercise, weight control, and avoidance of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

Patients' Responsibility

(Please check all)

- ☐ I am responsible for the controlled substance medications prescribed to me. If my prescription is **lost, misplaced, or stolen or if I "run out early",** I understand that it will **NOT** be replaced.
- ☐ I give permission for my physician to discuss all my diagnostic and treatment details with other physicians providing my medical care and with my pharmacists for purposed of maintaining accountability. This includes a copy of this contract.
- ☐ I will use **ONLY one pharmacy** for all my prescription refill. I will register the name and phone number of this pharmacy with my physician.
- ☐ I am aware that telephone refills are **NOT allowed**. Calls or faxed from pharmacies to refill medications will not be authorized.
- ☐ I agree to **bring the bottles of all the medications prescribed by pain management** to each visit. Medications will be **counted, and number of refills checked.**
- ☐ I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is **my** responsibility to comply with the laws of the State while taking the prescribed medications.

Initials_____

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Controlled Substance Agreement (continued 2)

(Please check all)

- ☐ At any time while I am receiving controlled substance medications, it may be deemed necessary by my doctor that I see a medication-use specialist. I understand that if I do not attend such an appointment, my medications will be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction); my medications may be tapered to completion.
- ☐ I will comply with random **PILL COUNTS.** These will be performed during regular office hours. The purpose of the PILL COUNT is to monitor medication usage. The number of pills missing from the bottle must correlate to the number of days since the prescription has been filled. A discrepancy in the number of pills missing is to be considered a breach of this contract and thus grounds for termination. Patients who fail to show for random pill counts will be immediately terminated from the practice. The pill counts will be randomly scheduled by the pain staff.
- ☐ I agree to undergo **random urine drug testing** at the discretion of the pain staff. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breach of this contract and therefore grounds for dismissal. Failure to comply with the test will be considered grounds for dismissal.
- ☐ **I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medications from pain management. I will not give, share or sell my medications to any other person.**
- ☐ **I also understand that I must maintain a primary care physician while being cared for pain management. He/She will be used to care for my other medical needs and in special cases used to write prescriptions if/when the pain management physician may be unavailable.**

Refills of Controlled Substance Medications

- ☐ Refills will be made **ONLY** during regular office hours Monday through Friday, in person. This will be done wither monthly, bi-monthly, tri-monthly during a scheduled office visit. Refills will not be made after hours, on weekends, or on holidays.
- ☐ Refills will **NOT** be made if I "run out early", or "lose a prescription", or "spill or misplace my medication", or "they are stolen". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location as to avoid their theft.
- ☐ Refills will **NOT** be made as an "emergency" such as on a Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least 24 hours in advance to schedule an appointment for refills.

Initials_____

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Controlled Substance Agreement (continued 3)

(Please check all)

Risks of Chronic Opioid Use

☐ I understand that **the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined.** My treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substance, and that my physician will advise me of any advances in this field and will make treatment changes deemed appropriate.

☐ I am aware that tolerance to analgesia means that I many require more medicine to get the same amount of pain relief. If this occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond to opioids may force my doctor to choose another form of treatment.

☐ (Female patients only) I am aware that if I plan to get pregnant or believe that I have become pregnant while taking these medications, I will immediately call my obstetric doctor to inform them. I am aware that there could be some adverse effects on my baby.

☐ I have been fully informed by **Princeton Medical Group, LLC** or the staff regarding the potential for psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to their medications, necessitating a dose increase to achieve he desired effect, and that there is a risk of becoming physically dependent on the medication. This can occur if I am on the medication even for a short period of time. Therefore, if and when I need to stop taking the medications, I must do so slowly and under the medical supervision or I may have withdrawal symptoms. I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. My doctor is not responsible for withdrawal syndrome if the medications are use inappropriately.

Termination of Care

☐ I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be **terminated immediately,** without a 30-day notice. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriated legal authorities. **I am responsible** for any withdrawal syndrome that may occur to do my misuse of the narcotic medications and/or termination of my care.

☐ I have read this contract and the same has been explained to me by **Princeton Medical Group, LLC**. All my questions have been answered to my satisfaction. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this agreement.

Patient Name _____ Patient Signature_____

Patient DOB _____Today's Date_____Witness _____

☐ Copy given to patient ☐ Patient refused copy

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Are you transitioning from another primary care provider or specialist?
Princeton Medical Group, LLC is happy to provide you with excellent healthcare.

When transitioning between healthcare providers it is important to keep **Princeton Medical Group** up-to-date with your medical records. This information enables us to know your medical history and to individualize your healthcare plan.

Please see next page in this *New Patient Registration Package* (Page 11) to obtain your medical records from your current provider(s) list (below). If you have any questions, please let front staff or your clinical team know and we will be happy to answer them.

We encourage you to have an active role in your healthcare. Examples of ways to be more involved include but are not limited to the following: open discussion about your health, personal and social issues, keeping up-to-date on immunizations, behavioral health issues, health condition and management, functional independence, managing obstacles to care, health insurance, work plans, independent living issues, and taking advantage of community services available to you

To help us know you and your health better, please complete the following information:

Patient Name: _____ **Date of Birth:** _____

Current/Previous Primary Care Provider(s):

_____ Phone: _____

_____ Phone: _____

Current/Previous Specialist(s):

Cardiologist: _____ Phone: _____

Dermatologist: _____ Phone: _____

Gastroenterologist: _____ Phone: _____

Gynecologist: _____ Phone: _____

Ophthalmologist: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Any current concern(s)?: _____

_____

_____

PRINCETON
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PATIENT AUTHORIZATION TO USE / DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION			
Name			
Last 4 SSN		Date of Birth	
Address			

By signing this form, I authorize the release of protected health information (e.g. medical records)

Release records FROM:
(The following information is required: Medical Provider Name, Address, Phone # & Fax #)

These records are required for emergency and continuing care of the above-named patient. Pursuant to Federal and State Law, records should be furnished as soon as possible, at no cost.

Failure to timely provide copies may subject the Patient's prior Provider to fines and sanctions from the Florida Board of Medicine and other Governmental Agencies.

Send records TO:

Princeton Medical Group, LLC
7301 W. Palmetto Park Rd, Suite 106
Boca Raton, FL 33433
Phone: **561-483-1125**
Fax : **877-460-1537**

Please select the type of information to be used or discussed (include dates where appropriate)

☐ Entire record	☐ Immunization records	☐ Notes from
☐ Medication List	☐ Most recent history & physical	
☐ Problem List	☐ Lab results	☐ Other
☐ List of allergies	☐ X-ray & imaging reports	

This authorization for release of information covers the period of healthcare services rendered from:

☐ _____ - _____	☐ All past, present and future periods

Unless revoked, this authorization will expire

☐ Expiration date: _____	☐ Automatic expiration after one year

I have the right to revoke this authorization at any time by contacting Family Practice & Internal Medicine of the Palm Beaches. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I understand signing this authorization is voluntary. I do not need to sign this form in order to receive treatment.

I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

If I have any questions about disclosure of my PHI I can contact **Princeton Medical Group** Medical Record Dept. at 877-460-1537.

Signature:	Date:
Print Name:	Signature by: ☐ Patient ☐ Legal Guardian ☐ Proxy

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HIPAA Release Form

Patient Name: _____ Date of Birth: _____

Please check one of the boxes below:

☐ I authorize the release of my information, including the diagnosis, records, examinations rendered to me and claim information. This information may be released to: (Please print names)

Spouse: _____ Phone: _____

Other: _____ Phone: _____

Relationship to Patient: _____

☐ Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by the patient in writing.

Communication

Please call my ☐Home ☐ Work ☐ Cell (Please make sure number is listed on the first page)

If unable to reach me, you may:

☐ Leave a detailed message

☐ Leave a message to return call

Signature: _____ **Date:** _____

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Patient Communication

Type of Reminders:	**VOICE**	**TEXT/SMS**
Select All	☐	☐
Appointments	☐	☐
Lab Results	☐	☐
Health Maintenance	☐	☐
Rx Confirmation	☐	☐
General Notification	☐	☐

Cell Phone # for Text/SMS: _____

Phone # for VOICE Messages (if different): _____

Preferred Phone # (if different from above): ☐ Cell ☐ Home ☐ Work ☐ _____

Preferred Language: ☐ English ☐ Spanish

Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening

EMAIL: _____

Patient opts out of all practice reminders: ☐

Patient Name (please print): _____ **Date:** _____

PRINCETON
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CONSENT FOR NON-SECURE COMMUNICATIONS

It may become useful during treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. These methods, in their typical form, are not confidential means of communication. If you use these methods to communicate, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with **Princeton Medical Group**
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want to access these communications, please talk with our Privacy and Security Official about ways to keep your communications safe and confidential.

We also offer the following, more secure means of communication. While it cannot be guaranteed that they will prevent 100% of confidentiality breaches, they are designed with the intention of supporting the confidentiality of clinical communications:

- Front desk pick-up at a designated time
- Delivery via Unites States Postal Service
- Secure E-Mail

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION
BY NON-SECURE MEANS

I consent to allow use of unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Other – Please specify:

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____

(Signature of Patient) Date

Thank you!