Chance T. Kaplan, M.D.

1754 E. Commercial Blvd., Ft. Lauderdale, FL 33334 - Tel.: (954) 772-1069 Fax: (954) 772-9813

Patient Information Form

First Name: ______________________Middle ________________Last:______________________

Phone #: _____________________________ Alternate Phone#: ____________________________

Social Security #: ________________________________Date of Birth: ________________________

Address: ____

City: _________________________ State: _________ Zip Code: ___________ Gender: M___ F____

E-mail Address: ___________________________________Marital Status: ______________________

Primary Care or Referring Physician Name & Phone #: ____________________________________

Whom may we thank for referring you to us? ____

Whom may we contact in the case of emergency? ____________________ Phone: _____________

Relationship to you?____________________

Did you sustain an injury at work? Yes___No___ Are your injuries accident related? Yes__No__

Are you covered under an employer or union policy? Yes____ No____

Are you currently employed? Yes____ No____ Employer: ____________________________

Have you ever served in the military? Yes____ No____

Who is responsible for this bill? ____

Primary Insurance Name: _________________________________ ID#: ________________________

Secondary Insurance Name: ______________________________ ID#: ________________________

I have read all of the information on this form and have completed the above answers. I certify that the above information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered to me by Dr. Kaplan.

Signature ____ Date ____________________________

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PATIENT MEDICAL HISTORY

Patient Name: ____ Date of Birth: _________________

INSTRUCTIONS:

Please supply the following information in order to enable us to give you the best care appropriate to your problems. Please fill this out as completely as possible. If there are any areas that you are unclear of, or wish to discuss with the doctor, please do so at the time of your exam.

What is the nature of your visit today? ____

Have you seen any other physicians regarding this condition? ___Yes ___No If yes, please provide their name/s and phone numbers/s: ____

Please list all medications and dosages that you are currently taking: ________________________

____

Are you allergic to any medications? Please list: ____

What is your current height? _______________ Weight: ______________ Race: _______________

Do you smoke? ___Yes ___ No If Yes, how many packs a day and for how many years?_______

____

Do you drink alcohol? ___Yes ___No If Yes, please state how much, how often and what kind?

____

MEDICAL HISTORY:

Please list all current illnesses: ____

____

____

Please list all previous illnesses: ____

____

____

Please list all prior surgical procedures or hospitalizations: _________________________________

____

____

I have filled out the medical history form to the best of my knowledge. I understand that if I omit pertinent medical information, the doctor will not be able to treat me in the best of his ability.

Patient Signature: ____ Date: __________________

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YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

Signature____ Date__________________________

Print Patient Name: ________________________________ Date of Birth: ___________________

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THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at the office of Chance T. Kaplan, M.D. is to serve our customers with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

During treatment, we may find it necessary to acquire a laboratory analysis.
For payment purposes, we may use the services of a billing service.
During healthcare operations, we may need a second opinion.

We are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law. If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer at (954) 772-1069.

I have read and understand the above Notice of Privacy Practices.

Print Patient Name: ____ Date of Birth: _____________

Signed____ Date_________________________
(Patient or Legal Guardian)

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FINANCIAL AGREEMENT AND ASSSIGNMENT OF BENEFITS (FOR INSURED AND NON-INSURED PATIENTS)

Patient Name: ______________________________________ Date: ______________________

Date of Birth: ___________________________

We thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patient's financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact us at (954) 772-1069.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients. Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff. We make payment as convenient as possible by accepting cash, checks, MasterCard, Visa, American Express, and Discover. A $35.00 service fee will be charged for all returned checks.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurances, and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances. If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier. If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated. For those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

I understand that services rendered to me by Chance T. Kaplan, M.D. are my financial responsibility and that the Provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Chance T. Kaplan, M.D. and I understand that I will be fully responsible for any outstanding balance on my account.

I have been given the opportunity to pay my estimated co-payment, deductible, and/or co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company. I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Chance T. Kaplan, M.D. within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process, I will be responsible for any cost incurred by the office to retrieve their monies.

I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

I have read and understand the above financial policy and assignment of benefits. I agree to assign insurance benefits to Chance T. Kaplan, M.D. whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

____ Date: ___________________

Patient/Guardian Signature

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PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

PATIENT NAME: _________________________________ DATE: ________________

I consent to have medical photographs taken of me or of the person for whom I am the legal guardian. I understand that the photographs may be used in medical records, for purposes of insurance authorizations and/or claims, for purposes of medical/patient education, or for publication on the practice website as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will not affect the medical care I will receive unless photographic documentation is required by my medical insurance company for claims or authorizations processing. Questions or written requests to withdraw consent will be directed to Chance T. Kaplan, M.D., 1754 E. Commercial Blvd., Fort Lauderdale, FL 33334.

By signing this form below, I confirm that I understand this consent form and any questions I have pertaining to this form have been answered to my satisfaction in terms that I understand.

1. I consent for photographs to be used for **purposes of education of medical personnel or patients**. I understand that images may be seen by members of the general public. Although photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.
   SIGNATURE: _______________________________________

2. I agree for photographs to be used for **purposes of insurance authorizations and/or claims**. I understand that photographs must be submitted with identifying information for proper insurance processing. I understand that if I refuse this portion of consent and such documentation is required for claims processing, that I may become financially responsible for any denied claim resulting from such refusal.
   SIGNATURE: _______________________________________

3. I agree for photographs to be used for **purposes of patient/public education on the practice website** of Chance T. Kaplan, M.D. I understand that images may be seen by members of the general public. Although photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. **SIGNATURE:** _______________________________________

4. I agree for photographs to be used **for my medical records ONLY**. No publication is permitted. Authorization to forward photographs to any person, provider, or entity will be submitted by me in writing to Chance T. Kaplan, M.D., 1754 E. Commercial Blvd., Fort Lauderdale, FL 33334
   SIGNATURE: _______________________________________