ELITEHEALTH MEDICAL CENTERS
NEW PATIENT REGISTRATION PACKET

PLEASE PROVIDE A COPY OF INSURANCE CARD(S) & PHOTO ID OR DRIVERS LICENSE

Today's Date: _____ / _____ / _____

EliteHealth Office Location:

☐ Miami Beach ☐ Pembroke Pines ☐ Davie ☐ Sarasota ☐ Venice ☐ North Bay Village

1. PATIENT INFORMATION

Patient's First Name	Middle Name	Last Name	
Sex ☐ M ☐ F / Marital Status		Date of Birth (Age)	Social Security Number
Physical Address	City	State	Zip
Mailing Address (if different)	City	State	Zip
Home Phone	Mobile Phone	Email Address	Would you like to be Web App Enabled? ☐ YES ☐ NO

DEMOGRAPHICS

RACE:

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White or Caucasian

☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other

ETHNICITY:

☐ Hispanic or Latino ☐ Not Hispanic ☐ Unknown

PREFERRED LANGUAGE:

☐ English ☐ Spanish ☐ Creole ☐ Other

PREFERRED NOTIFICATION METHOD:

☐ E-mail ☐ Call ☐ Text

PATIENT EMPLOYER / SCHOOL INFORMATION

Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip

EMERGENCY CONTACT INFORMATION

In case of an emergency, whom should we notify?

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

PRIMARY CARE / REFERRING PHYSICIAN INFORMATION

Did a Physician Refer you? ☐ YES ☐ NO	Referring Physicians Name:	
Who is your Primary Care Physician?		
PCP Change Requested? ☐ YES ☐ NO	Reference #:	Effective On:

PHARMACY INFORMATION

Preferred Pharmacy Name:		Home Phone	
Physical Address	City	State	Zip

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2. BILLING AND INSURANCE INFORMATION

Primary Health Insurance	
Insurance Company	Insurance Plan
Member ID	Group Number
Secondary Health Insurance	
Insurance Company	Insurance Plan
Member ID	Group Number
If you are not the Primary Covered, please complete below.	

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number	
Insured's Address (If it's different from the physical or mailing address)	City	State	Zip

3. HOW DID YOU HEAR ABOUT US?

☐ In-office Event	☐ Community Event	☐Marketing Sales Rep	☐ Insurance Agent	☐ Insurance Directory	☐ ZocDoc
☐ Physician *(name):*			☐ Family or Friend *(name):*		
☐ Social Media Website *(which one?):*			☐ Other *(please specify):*		

4. HIPAA - DISCLOSURES OF MEDICAL INFORMATION TO FAMILY MEMBERS AND FRIENDS

I hereby give my permission to disclose personal medical information about my treatment to the following individuals:

Name:	Relation:
Name:	Relation:
☐ Same as Emergency Contact	☐ I do **NOT** give permission to disclose personal medical information about my treatment to family members or friends

May we leave personal information on your Answering Machine or Voicemail? ☐ YES ☐ NO

5. CONSENT OF MEDICAL RECORDS RELEASE TO INSURANCE AND PUBLICATION TO PRIVATE PATIENT PORTAL

I, _____, (Date of Birth) _____, give my permission to Elite Health Medical Group to provide my medical records to my insurance company, so they can better assess and understand all my conditions.

In addition, I give authorization to pubish my records to the patient portal, which is a secure website, in which only I can access and view my medical information. I understand that this isn't public information or accessible by anyone but myself.

Patient Name:	**Date:**
***Patient Signature:**	

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6. HEALTHCARE SURROGATE DESIGNATION

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures I wish to designate as my surrogate for health care decisions:

Name		Date:	
Street Address	City	State	Zip

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name		Date:	
Street Address	City	State	Zip

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility. Additional Instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name	Name

***Patient Signature:**	**Date:**
Witness Name:	***Witness Signature:**

(Medical Assistant or Office Representative can sign as a witness)

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7. FINANCIAL AGREEMENT

The undersigned agrees he/she is hereby obligated and agrees to pay the referenced Doctor (s)/Elite Health Medical charges for services rendered by said Doctors. I further agree that the payment is due upon receipt of invoice/statement. I understand that unpaid accounts will be considered default after (60) days. After which time interest will be imposed at the rate of 1-1/2% per month on unpaid balances (Annual Percentage Rate of 18%) or legal interest rate, whichever is lower. In the event a legal suit is necessary to enforce payment of this account, I agree to pay such attorney fees and court costs as may deem reasonable. The patient/guarantor waives venue jurisdiction, and submits itself to the jurisdiction and venue of the State Courts of Dade or Broward County, Florida.

Initials _____

8. ASSIGNMENTS OF INSURANCE BENEFITS

I hereby authorize payments to be made directly to the referenced Doctor(s)/Elite Health Medical Group of all benefits, which may be due and payable under insurance coverage for the above named patient. Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under the Title XVIII or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made payable on my behalf to the referenced Doctor(s)/Elite Health Medical Group. I authorize utilization of the application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I remain financially responsible to the Doctor(s)/Elite Health Medical Group.

Initials _____

9. AUTHORIZATION OF RELEASE MEDICAL RECORDS

Elite Health Medical Group is /are hereby authorized to disclose all or any part of the medical record on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment to services rendered by the referenced Doctor(s). This authorization is given with full acknowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Doctor(s).

Initials _____

10. DISCLOSURE TO ELITEHEALTH MEDICAL GROUP DOCTORS

Elite Health Medical Group is/are hereby authorized to disclose all or any part of the medical record on the above named patient, to such insurance companies, organizations or agencies as may be responsible for payment to services rendered by the referenced Doctor'(s). This authorization is given with full acknowledgement that such disclosure may contain information of confidential nature and may results in a denial of insurance coverage for services rendered by said Doctor(s).

Initials _____

11. MEDICAL MALPRACTICE INSURANCE

Under Florida Law physicians are generally required to carry medical malpractice insurance or demonstrate financial responsibility to cover potential claims for medical malpractice. WE HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law under certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Initials _____

12. MEDICARE AUTHORIZATION (FOR MEDICARE PATIENTS ONLY)

I request that payment for Medicare Benefits be made on my behalf to EliteHealth for any services provided to me by its Providers. I authorize EliteHealth to release to CMS and its agents any information needed to determine these benefits payables for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare benefits apply.

MEDICARE IS NOT ALWAYS THE PRIMARY INSURANCE. FEDERAL REGULATIONS REQUIRE THAT WE OBTAIN INFORMATION TO DETERMINE IF ANOTHER INSURER MAY BE PRIMARY TO MEDICARE:

Medicare Advantage Plan Provider:	**Member ID:**

***Patient Signature/Responsible Party:**	**Date:**
Witness Name:	***Witness Signature:**

(Medical Assistant or Office Representative can sign as a witness)