

Patient Name \_\_\_\_\_ Male  Female

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Married  Single  Other \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Can we leave a message on your preferred phone?  Yes  No

Patient e-mail address is  
Required for Patient Portal access \_\_\_\_\_

Race:  American Indian  Black or  Native Hawaiian  
 or Alaskan Native  Asian  African American  or Pacific Islander  White  Other  Decline

Preferred language \_\_\_\_\_ Ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Primary Care Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

Person Financially Responsible for account \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_

How did you learn about Medi-Station?  
 Driving By  Friend/Family  Doctor Referral  Am Existing Patient  
 Internet  Insurance Company  Other \_\_\_\_\_

Today's Payment How will you be paying for today's bill?  
 Patient Pay I will be paying the full bill today using  
 Cash  Debit Card  Credit Card  
 Insurance  Auto Insurance (accident)  Worker's Compensation Claim

Insurance Information Primary Policy Holder \_\_\_\_\_

SS# \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to subscriber  Self  Spouse  Child  Other \_\_\_\_\_

Employer of Insured Person \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Member ID \_\_\_\_\_ Group # \_\_\_\_\_

Do You Have Insurance with more than one Health Plan?  Yes  No  
If Yes, Please present both ID cards and Drivers License at check-in

I hereby authorize direct payment of medical benefits to Medi-Station for activities rendered by the employees. I understand that I am financially responsible for any balance not covered by insurance. I certify that all information is correct and authorize Medi-Station to release any information for either medical care or in processing applications for financial benefits.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Office Policies

## Financial Policy

This is an agreement between Medi-Partners of South Florida, dba Medi-Station, as creditor, and the Patient/Guarantor named on this form. By executing this agreement, you are agreeing to pay for all services that are received.

### Payment options if you have NO insurance or insurance companies we do NOT accept:

You choose to pay by \_\_cash, \_\_debit Card , or \_\_credit card on the day that treatment is rendered.

### Payment options if you have insurance:

You are responsible to pay your co-pay, deductible, and any out-of-pocket portions at the time services are rendered by \_\_cash, \_\_debit card , or \_\_credit card.

You are responsible for any coinsurance or amount stated per your insurance explanation of benefits.

**Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill primary and secondary contracted insurance companies only. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. We are not a Medicaid provider, we cannot send billing to the Department of Job and Family Services on your behalf. If you are a Medicaid recipient, you will be financially responsible for your services today.

**Returned checks:** There is a fee (currently \$40) for any checks returned by the bank.

**Workers Compensation:** We require you to notify us at the time of visit that this is due to a work related situation. Failure to do so will make you financially responsible for this bill. If your claim is denied, you will be responsible for payment in full.

**OUTSIDE LAB SERVICES:** If you need more comprehensive lab work, some tests may not be covered by your insurance carrier. In that case, you may receive an additional bill/statement for these services from the outside laboratory. Medi-Station will make every attempt to advise you of the costs prior to testing.

Patient's name: \_\_\_\_\_

Responsible party  
(if not the patient): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notice of Privacy Practices:** I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information. If you have any questions regarding the information in Medi-Station's Notice of Privacy Practices, you may contact the Privacy Officer for Medi-Station at 305-603-7650.

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Responsible party  
(if not the patient): \_\_\_\_\_

## Medical Record Release:

I, \_\_\_\_\_, hereby authorize release of my medical record information to my primary care Physician. I understand that this authorization may be revoked at any time.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Medical Release for a Minor Child:

I, \_\_\_\_\_, Parent or Legal Guardian of \_\_\_\_\_, (Name of Minor Child), hereby authorize Medi-Station to perform any Medical or Surgical treatment which may be necessary for the well being of the above mentioned minor. I agree to hold Medi-Station and the physician harmless for rendering such care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_