SCOTT BERENSON, MD
9970 CENTRAL PARK BLVD, STE 404
BOCA RATON, FL 33428
561-483-1125

Health Insurance Portability and Accountability Act of 1996 (HIPPA)
In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to an address other than your home address.

At Dr. Berenson's office, we respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information, with that in mind, please indicate your preferences for the areas noted below.

I, _____, wish to be contacted in the following manner (check all that apply)

1. Home Phone _____ Cell Phone _____
   - □ Ok to leave message on machine
   - □ Leave a message with call back number only

2. Written Communication
   - □ OK to mail to my home address
   - □ OK to fax to this number _____

3. Other Individuals (family, friends, etc.) that we may speak with about your care:
   - □ My care or treatment
   - □ My bill

   Name: _____ Phone #: _____
   Relationship to patient: _____

   Name: _____ Phone #: _____
   Relationship to patient: _____

   Name: _____ Phone #: _____
   Relationship to patient: _____

_____ _____/_____/_____
PATIENT NAME DATE OF BIRTH

_____ _____/_____/_____
PATIENT SIGNATURE DATE

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PATIENT INFORMATION

NAME: _____

ADDRESS: _____APT#:_____

CITY: _____STATE: _____ ZIP: _____

PHONE #: _____ CELL #: _____ WORK #: _____

SSN#: _____-____-_____ SEX: M OR F RACE: _____ MARITAL STATUS: _____

DOB: ____/____/_____ AGE: _____

EMPLOYER: _____ OCCUPATION: _____

SPOUSE: _____ PHONE #: _____ DOB: ___/____/_____

ADDRESS: _____

COMPLETE ONLY IF PATIENT IS A CHILD OR STUDENT UNDER THE AGE OF 18

PARENTS NAME: _____ PHONE #: _____

PARENTS ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE #: _____

INSURANCE

DO YOU HAVE HEALTH INSURANCE? YES NO

PRIMARY INSURANCE: _____ ID#: _____

SECONDARY INSURANCE: _____ ID#: _____

GUARANTOR: _____

PERSON RESPONSIBLE FOR PAYMENT: _____ PHONE #: _____

REFERRAL

HOW DID YOU HEAR ABOUT US?

FRIEND/RELATIVE NAME: _____

DOCTOR NAME: _____

INSURANCE WEBSITE WEB SEARCH YELLOW PAGES OUR WEBSITE OTHER

RELEASE OF BENEFITS INFORMATION/SIGNATURE

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR. I UNDERSTAND THAT THE DOCTOR'S OFFICE WILL BILL MY INSURANCE AS A COURTESY AND THAT I AM RESPONSIBLE AT THE TIME OF SERVICE FOR ALL CO PAYMENTS, DEDUCTIBLES AND NON COVERED SERVICES. I AUTHORIZE THE RELEASE OF INFORMATION REQUIRED TO PROCESS MY CLAIMS IN THE EVENT THIS ACCOUNT BECOMES DELIQUENT, I AGREE TO PAY ALL COSTS IN THE COLLECTIONS OF THIS ACCOUNT.

SIGNATURE OF PATIENT/GUARANTOR _____ DATE: _____

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Patient's Name: _____ DOB: _____

Current Medication □ **NONE**

DRUG NAME	AMOUNT/SIZE	HOW MANY TIMES PER DAY?

Vitamin Use □ **NONE**

□ Daily Multivitamin	□ Vitamin C (amt _____/day)	□ Vitamin D (amt _____/day)
□ Iron (amt _____/day)	□ Calcium (amt _____/day)	□ CoQ10 (amt _____/day)
□ Fish oil (amt _____day)	□ Red yeast rice (amt ___/day)	□ Other _____

Allergies □ **NONE KNOWN**

□ Aspirin	□ Cortisone	□ Penicillin	□ Other _____
□ Adhesive Tape	□ Iodine/Betadine	□ Novocain	□ Other _____
□ Codeine	□ Latex	□ Sulfa	□ Other _____

Family and Medical History □ **NONE**

Hypertension □family □self	Diabetes □family □self	Neurological disease □family □self
Renal disease □family □self	Liver disease □family □self	Cancer □family □self
Heart disease □family □self	Pulmonary disease □family □self	Ulcers □family □self
Stroke □family □self	Aids □family □self	Hepatitis □family □self
Other □family □self		

Past Surgical History: All types □ **NONE**

TYPE	DATE	DOCTOR	FACILITY

Social History

Alcohol Usage: □ Non-Drinker □ Social Drinker □ Moderate Drinker □ Heavy Drinker

Tobacco: □ Non-Smoker
□ Smoker _____ Packs/day _____# Years
□ Former Smoker _____ How many years? _____ Date Quit

Caffeine: □ No Caffeine □ 1-2 Servings/day □ 3-5 Servings/day □ 6-11 Servings/day

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STATEMENT OF FINANCIAL RESPONSIBILITY: INITIAL: _____

I understand that I am responsible for the payment of this account and hereby assume and guarantee prompt payment of all incurred expenses. All copays/balances/deductibles/fees are due at time of service. If my account becomes overdue, there will be additional fees for any billing after one statement. Should the outstanding balance is to be turned over to collections, you will be responsible for all collection fees, including but not limited to, court costs, interest and legal fees.

NOTICE OF NON-COVERED SERVICES: INITIAL: _____

I am aware that some services performed by Scott Berenson, MD may be a "non-covered" service according to my insurance policy or Medicare. According to all insurance companies, any and all services are not a guarantee of coverage until the claims has been received by your insurance company and processed according to your policy. If you have any questions regarding what is not covered you must contact your insurance company. Therefore, I am responsible for payment of all services.

APPOINTMENTS/NO SHOW POLICY: INITIAL: _____

I understand that if I am unable to keep a scheduled appointment, I will contact the office with 24 hour advance notice of cancellation. A no show appointment will generate a $35 fee for first (1) missed routine visit, $50 for second (2) missed, $75 for third (3) missed and $150 for a complete physical or Pre OP examination. In the event that you have a special circumstance regarding your no show appointment, please contact the billing department. We understand that there may be issues beyond your control. After three (3) missed visits you will be discharged from the practice.

AUTHORIZATION FOR OUTSIDE LAB USE: INITIAL: _____

I hereby authorize Scott Berenson, MD to utilize the services of outside laboratories to obtain testing for the purpose of diagnosing, should my condition require it.

FILLING OUT FORMS AND LETTERS: INITIAL: _____

Due to decrease reimbursement from Medicare and various insurance companies in 2011, we are forces to institute certain changes in our office policies. Therefore, beginning January 1, 2011, we will be charging for completion of forms and letters for issues such as filling out disability forms, family medical leave forms, changes to airline reservations, etc. The fees will range from $25 to $75, depending on the time it takes for our staff to fill out either the form or to compose a letter. We are sorry to have to make these changes, but the current medical reimbursement climate give us no choice.

I understand all of the above statements and agree to them.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

**If this is a Worker's Compensation or Auto claim please notify the receptionist.