NEW PATIENT REGISTRATION			
Patient's last name:	First name:	Middle name:	Previous name:

Street address:	Apartment/ Suite	City:	State:	ZIP code:

Home phone: ( ) -	Cell phone: ( ) -	Work phone: ( ) - Ext:	Email address:

Patient Date of Birth: / /	Patient Sex: M F	Marital Status: single married divorced widowed other

Social Security no.: - -	Employer Name and Address:

Employment Status:	full time	part time	not employed	retired	military	student- ft	student- pt

EMERGENCY CONTACT			
Name of emergency contact person:	Relationship to patient:	Home phone no.: ( ) -	Work phone no.: ( ) -

Mailing address:	City:	State:	ZIP code:

INSURANCE INFORMATION			
Name of primary insurance:	Subscriber number:	Policy insured's name, if not patient:	Group name / number
Patient's relationship to insured:	Self Spouse Child	Other, please specify:	
Name of secondary insurance:	Subscriber number:	Policy insured's name, if not patient:	Group name / number
Patient's relationship to insured:	Self Spouse Child	Other, please specify:	

OTHER INFORMATION
Have you signed an Advanced Healthcare Directive? Yes No

Your preferred pharmacy:	Pharmacy address:	Pharmacy telephone: ( ) -
May we leave appointment, test and medication info with family/household members and on your home voice mail? Yes No		
May we send you information regarding Boynton Physicians events, health news updates and insurer/HMO announcements? Yes No		
If you answered “Yes” to the question above, where should we send these? home address email address both How did you hear about our office, or who referred you to us?		

______________________________________ ____________________

Signature of Patient or Patient’s guardian/representative Date

CONSENT FOR TREATMENT

I, ____, hereby authorize **Boynton Physicians Group,** the attending physician, or the physician designated by him and other center employees; to examine and treat me. I also authorize such treatment and procedures, as deemed necessary by the physician, including but not limited to, the taking of x-rays, medications, blood samples, urines samples and other therapies as deemed necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been 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

____
PATIENT OR PERSON
AUTHORIZED CONSENT

____
RELATIONSHIP TO PATIENT

FINANCIAL POLICY, ASSIGNMENT INFORMATION, AND RELEASE OF INFORMATION

I authorize 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 whose account I am acting as guardian or representative. I authorize (assign) any insurance or Medicare benefits to be paid directly to Boynton Physicians Group or its assignees. I agree that I am responsible for any non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my insurance plan works, and have requested medical services for this office. This acceptance and assignment will be in force for all future services by practitioners from this office.

I understand that diagnosis or treatment of me by Boynton Physicians Group may be conditioned upon my consent as evidenced by my signature on 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.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Boynton Physicians Group LLC

I understand that as part of my health care, Boynton Physicians Group originates and maintains paper and/or 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 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, and
- A tool for routine healthcare operations such as assessing quality.

I understand that Boynton Physicians Group maintains a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. The most recent version of this Notice is available from the receptionist. I understand that Boynton Physicians 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, and
- The right to request restrictions as to how my health information may be used or disclosed.
- The right to revoke my consent to use or disclosure of my protected health information by notifying Boynton Physicians Group, in writing, of such revocation.

I have had an opportunity to receive and review the Notice of Privacy Practices of Boynton Physicians Group.

Signature of Patient or Patient's guardian/representative   Date

____   _______________

Medical Information Release Form

Name: ____________________________________
Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse_______________________________________
Child(ren)____________________________________
Other____

[ ] Information is not to be released to anyone.

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

Messages

Please call [ ] my home [ ] my work [ ] my cell number:_________________

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] ____

The best time to reach me is:
(day)___________________between(time)_________

Signed: ____________________________________ Date: ____/____/_____

Authorization to Obtain, Release or Review Protected Health Information (PHI)

I, ____
(Print Name) (DOB)

hereby authorize Boynton Physicians Group, LLC.

Please check one:
[?] to obtain from Dr. ______________
[?] to release to Dr. _______________
[?] to release to me

- [?] All medical information and reports
- [?] Prenatal medical records
- [?] Physical examination reports
- [?] Laboratory reports
- [?] Immunizations
- [?] Radiology reports and images
- [?] Sexually transmitted disease reports
- [?] Psychiatric/Psychological reports
- [?] HIV/AIDS test results
- [?] Other (please specify) ______________________________

Please specify anything that you do NOT want to be released:
____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/ drug abuse and/or HIV/AIDS test results. I expressly consent to the release of information as designated above. I understand this authorization will remain in effect for one year unless otherwise specified.

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I understand that after signing this form, there is a processing period of **7–10 business days.**

____ ____________

Signature of Patient or Patient's guardian/representative Date

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substances 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 ability to work. Because 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 the 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

¨ 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 purposes of maintaining accountability. This includes a copy of this contract.

¨ I will use **only one pharmacy** for all my prescription refills. I will register the name and phone number of this pharmacy with my physician.

¨ I know that telephone refills are **not allowed**. **Calls or faxes 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

¨ 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 in 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 MEDICATIONS

¨ **Will be made** only during regular office hours Monday through Friday, in person. This will be done either monthly, bi-monthly, tri-monthly during a scheduled office visit. Refills will not be made after hours, on weekends, or on holidays.

¨ **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.

¨ **Will not be made** as an “emergency” such as on 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

RISKS OF THE 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 may 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 Boynton Physicians 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 the 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 used 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 Boynton Physicians 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.

Date________________ Patient_______________________________ DOB______________

Signature ____

Witness________________________

▫ Copy given to pt. ▫ Pt refused copy.

PATIENT HISTORY FORM

Patient's Name: _______________________________ Today's Date: _____________

Social Security Number: _________________________ Date of Birth: _____________

244 N. Congress Ave., Boynton Beach, FL 33426 Phone# 561-734-4535 Fax# 561-734-7530

Boynton Physicians Group LLC

Previous Physician's name: ________________________ Date of last exam: ____________

Which of the following conditions are **you currently being treated or have been treated** for in the past (please check)

□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
□Eye disorder / Glaucoma	□Seasonal Allergies	□Headaches / Migraines	□Anemia or blood problems	□Cancer
□Diabetes	□High cholesterol	□Tonsillitis	□Seizures	□Stroke
□Kidney / Bladder problems	□Neurological problems	□Ulcers/colitis	□Swollen ankles	□Ear problems
□Heartburn(reflux)	□Arthritis	Other:		

Have you ever been tested for hepatitis A, B or C? □Yes □No Which hepatitis virus? _______________
Have you been vaccinated for hepatitis B? □Yes □No If yes, date vaccine series completed ___________
Have you been vaccinated for hepatitis A? □Yes □No If yes, date vaccine series completed ___________
Last Tuberculosis (TB) Screening? ____________________ Result of TB screening: □Positive □Negative
If positive TB screen, date of last chest x-ray: ______________ Result of chest x-ray: □Positive □Negative
Have you had a sexually transmitted disease? □Yes □No Diagnosis: ______________________________

Please describe any current or past medical treatment not listed above:
____
____
Have you ever been hospitalized? □Yes □No If yes, what for? ___________________________________

Please list your past surgeries: (MONTH/YEAR) **NAME OF SURGERY**

/	
/	
/	
/	

Past Medical History-Females: Gynecological History

How many times have you been pregnant? ___________ Date of last Pap Smear: _________________
Have you had an abnormal Pap Smear? □Yes □No Diagnosis: __________ Follow up: ____________
Date of last mammogram: ______/___________ Mammogram results: ________________________

Boynton Physicians Group LLC

Medications Please list:

NAME	STRENGTH	DOSAGE

Allergies

Are you allergic to penicillin or any other drugs? □Yes □No Please list:

Medication	Reaction

Social History

Influenza Vaccine	□Yes □No	If yes, Date /
Pneumonia Vaccine	□Yes □No	
Colorectal screening	□Yes □No	
Mammogram	□Yes □No	
Echo	□Yes □No	
EKG	□Yes □No	
Chest X-ray	□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 packs per day? ________________________
Do you drink alcohol, beer, or wine? □Yes □No, Have you in the past? □Yes □No
How many drinks per week? ________________________
Do you currently drink coffee and/or tea? □Yes □No if yes, how many cups per day?_____________
Do you use seatbelts while driving? □Yes □No Do you wear a helmet while riding a bike? □Yes □No

Boynton Physicians Group LLC

Family History

FATHER	□Alive □Deceased	**AGE:**	**DIABETES** □Yes □No	**HYPERTENSION** □Yes □No	**HEART** □Yes □No	**MENTAL** □Yes □No	**CANCER** □Yes □No	**UNKNOWN**
MOTHER	□Alive □Deceased	**AGE:**	**DIABETES** □Yes □No	**HYPERTENSION** □Yes □No	**HEART** □Yes □No	**MENTAL** □Yes □No	**CANCER** □Yes □No	**UNKNOWN**
SIBILINGS	□Alive □Deceased	**AGE:**	**DIABETES** □Yes □No	**HYPERTENSION** □Yes □No	**HEART** □Yes □No	**MENTAL** □Yes □No	**CANCER** □Yes □No	**UNKNOWN**

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

Patient/Legal Guardian Signature ____ Date __________

244 N. Congress Ave., Boynton Beach, FL 33426 Phone# 561-734-4535 Fax# 561-734-7530