New Patient Information

Personal information							
Last Name	First Name		MI	Previous Name	Date of Birth	Social Security #	
Primary Address		Line2	City		State	Zip	Country
Secondary Address		Line2	City		State	Zip	Country
Home Phone Cell Phone Work Phone		Email					Preferred Contact Method ☐ Home Phone ☐ Cell phone ☐ Email ☐ Text Message
Sex ☐ Male ☐ Female	Marital Status			Employer			Student Status ☐ Full time ☐ Part time ☐ Not student

Race, Ethnicity, Language			
☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific ☐ Black of African American ☐ unreported / Refuse to answer	☐ White ☐ Hispanic ☐ Other Race ☐ Other Pacific Islander	Hispanic or Latin American? ☐ Yes ☐ No ☐ Unreported / Refuse to answer	Primary Language Translator Required?

Responsible Party (if other than self)					
Last name	First name	MI	Date of Birth	Sex ☐ Male ☐ Female	Relationship

Emergency Contact						
Last Name	First Name		MI	Date of Birth	Relationship	Phone Number
Address		Line2	City	State	Zip	Country

Insurance Information	
Primary Insurance Company	Primary Insurance ID
Secondary Insurance Company	Secondary Insurance ID

Referred By

Preferred Pharmacy

1770 E Hallandale Beach Blvd
Hallandale Beach, FL, 33009
Tel. 954-458-2572

5355 Lyons Road,
Coconut Creek, FL 33073
Tel. 954-570-9595

106 N.E 2nd Street
Boca Raton, FL, 33432
Tel. 561-391-8086

Name:________________________________ D.O.B. ________________

PAYMENT OF BENEFITS
I authorize payments as determined by the CLSC, directly to CLSC. I understand that I may still be responsible for any amounts not paid by my insurance Company.

_________________________________ ______________
Signature Date

MEDICAL RELEASE AUTHORIZATION
I authorize any insurance Company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regards to processing my claims. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_________________________________ ______________
Signature Date

PRESCRIPTION MEDICATION HISTORY CONSENT
By signing this consent form you are agreeing that CLSC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.
Understanding all of the above; I hereby provide informed consent to CLSC to enroll me in the eprescribe progam. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_________________________________ ______________
Signature Date

1770 E Hallandale Beach Blvd Hallandale Beach, FL, 33009 Tel. 954-458-2572	5355 Lyons Road, Coconut Creek, FL 33073 Tel. 954-570-9595	106 N.E 2nd Street Boca Raton, FL, 33432 Tel. 561-391-8086

ADVANCE DIRECTIVES

A document called a Living Will advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare.

Have you prepared a living will? Yes ___________________No _______

The foregoing recommendations are for healthy individuals without symptoms of illness. Special conditions may change the frequency and the type of tests you desire.

Please sign below to acknowledge that you have read and understand this information.

_________________________ _________________________ ________

Signature Print Name Date

Notice of Privacy Practices – Short Form

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule. A federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA's regulations.

What is HIPAA and how does the Privacy Rule affect you?
When the Health Insurance Portability and Accountability Act HIPAA was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is the individually Health Information (IIHI)?
Any health information you provide our practice, including your mailing address. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?
Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI.

If you have any questions regarding this notice or our health information privacy policies, please contact one of the following:

CLSC Inc **5355 Lyons Road** **Coconut Creek, FL 33073**	**C.L.S.C, Inc** **106 NE 2nd Street** **Boca Raton, FL 33432**	**C.L.S.C, Inc.** **1770 Hallandale Bch Blvd** **Hallandale, FL 33009**

I have read the short notice provided by CLSC, Inc. 's practice and have been informed of how to obtain more information regarding our Notice to Privacy.

Signature **PRINT NAME OF PATIENT**

_________________________________ _________________________________

1770 E Hallandale Beach Blvd
Hallandale Beach, FL 33009
954-458-2572

5355 Lyons Road,
Coconut Creek FL 33073
954-570-9595

106 N.E 2nd Street
Boca Raton FL 33432
561-391-8086

Patient Name: ______________________________

DOB: ____________________

Acknowledgement of Receipt of Notice of Patient Bill of Rights

I,__________________________ acknowledge that I have received a copy of the
(Name of Patient)
CLSC, Inc. Notice of Bill of Rights.
This notice describes the patient's rights under the laws of Florida.

____
(Signature of Patient, or Parent or Personal Representative) (Date)
__________________________________ (Relationship to Patient)

Consent for treatment:
This is to authorize and consent to any necessary or routine medical treatment including comprehensive physical examination, injection(s), immunizations and /or diagnostic procedures, including X-ray and laboratory analysis. I understand that myself and those listed below will have authority to authorize treatment.

____
Name Relationship