Bonnie R. Saks M.D. & Associates, LLC

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ Provider________________________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Preferred Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Employer	Work Phone No. ( )	Mobile Phone No. ( )

Referred to Practice by (Please check one box) ❑ Dr. ____________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Phone Book ❑ Other ____________

Other Family Members Seen Here ________________________________

Can messages be left on phone numbers listed above (please check one box) ☐ Yes ☐ No

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Aetna ❑ BC/ BS ❑ Cigna ❑ Humana ❑ Medicare

❑ Tricare, Standard or Prime? ❑ United Healthcare ❑ Value Options ❑ Other ____________

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )

The above information is true to the best of my knowledge. I give my consent for Bonnie Saks & Associates to provide treatment using psychotherapy and or medication. I authorize my insurance benefits be paid directly to the physician. I also authorize Bonnie Saks & Assoc. or insurance company to release any information required to process my claims.

X ____

PATIENT/GUARDIAN SIGNATURE DATE

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, the undersigned patient, hereby give permission to ***Bonnie Saks MD & Associates*** of 3333 West Kennedy Blvd. Suite 106, Tampa, FL 33609, **TO RELEASE/OBTAIN** information including medical, psychiatric, psychological and substance abuse treatment contained in my medical records to the following person, agency or organization:

1. ____

____

____

2. ____

____

____

3. ____

____

____

(if you need more room or need to be more specific, please see receptionist for separate form)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have read or been given a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health information. I understand that the office of Dr. Bonnie Saks & Associates has the right to change its *Notice of Privacy Practices* from time to time. I may contact this office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights of privacy regarding the protection of my health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and/ or indirectly.

* Obtain payment from third-party payers.

* Conduct normal healthcare operations, such as quality assessments and physical certifications.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that this office is not required to agree to my requested restrictions, but once agreed upon, this office is bound to abide by such restrictions.

Patient Name (printed):____

Patient Signature: ____Date:_____________

OFFICIAL USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _______________ Initials: _____________ Reason: _____________________________

Patient's Presenting Problem:

What brings you to the office?

____
____
____
____
____
____

How has this affected your family or job?

____
____
____
____
____
____

Have there been any legal problems? _______ Yes _______ No Please explain:

____
____
____
____
____
____

Are you experiencing any of the following?

□ Weight gain- how much ________
□ Weight loss- how much ________
□ Changes in appetite
□ Sleep disturbances
□ Other ____

Do you consider your general health to be ___ excellent ___ good ___ fair ___ poor

Please list Current medications:

____
____
____
____
____
____
____

Any allergies to medication? ________ If so, what? __________________________

Past Psychiatric Treatment:

______ Inpatient ______ Outpatient ______ None

Physician/ Therapist____

Have you ever taken anti-depressant/ anti-anxiety medication? ____ yes ____no

Medication	Dosage	Effective?	Side Effects

Was psychological testing done? _____yes _____no, if so, when______________

Pertinent Family History (medical/psychiatric):

____
____
____
____

Alcohol/ drug use (past or present) Amount / Frequency Periods of past use

____
____
____
____

Do you feel that your drug/alcohol use is causing problems for you or your family?

____
____
____

Patients Social History: With whom do you live?____________________________

Relationship with significant others? ____ good ____ bad Please Explain:

____
____
____

To whom do you turn for support, and how do they help you?

____
____
____

Do you have a spiritual orientation or belief system? _____ yes _____ no

Please check the types of treatment you are interested in receiving:

☐ Individual ☐ Couples Therapy ☐ Medication Management

☐ Group Therapy ☐ Sex Therapy ☐ Psychological Testing

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW CAREFULLY.**

The Health Insurance Portability Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information. As required by “HIPAA”, we offer this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be a psychological exam, the results of which are shared with a primary care doctor. *In the course of treatment, clinicians are obligated by law to report child abuse, elder abuse, and danger to self or others.*
- Payment means such activities as obtaining reimbursements for services, confirming coverage, billing or collections activities and utilization review. An example of this would be submitting a claim to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer services. An example would be medical review, legal services and auditing functions.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorizations in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Office Manager (Privacy Officer):

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means, or alternative locations
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We cannot be responsible for computer, cell phone or text message violation by unauthorized third party.

This notice is effective as of April 14th, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Heath and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint: The U.S. Department of Health Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201

Updated 11/29/2013

(202) 619-0257 or toll free: 1-877-696-6775

CANCELATION/NO SHOW POLICY:

PLEASE BE ADVISED THAT THIS OFFICE REQUIRES 48 HOUR NOTICE (BUSINESS DAYS) TO CANCEL OR RESCHEDULE YOUR APPOINTMENT. IF YOU CALL OR LEAVE A MESSAGE WITH LESS THAN 48 HOUR NOTICE, WE RESERVE THE RIGHT TO CHARGE A **$40** ADMINISTRATIVE FEE.

THANK YOU,

BONNIE R. SAKS MD AND ASSOCIATES, LLC

SIGNATURE____DATE_______________

Financial Policy

This is an agreement between Bonnie R. Saks, MD, as creditor, and the Patient/Debtor named on this form.
In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Bonnie R. Saks, MD and Associates LLC. By executing this agreement, you are agreeing to pay for all services that are received.
Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of 30 days.

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 your primary insurance company as a courtesy to you. 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. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Billing Information: You understand that it is your responsibility to notify the office of any changes in address, phone number or insurance coverage, both primary and secondary.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned checks: There is a fee (currently $37) for any checks returned by the bank. This amount is subject to change without prior notification.

Missed appointment fee: Patients who do not show up on time for an appointment, or cancel with less than 48 hours notice will be charged a $40 administrative fee. Patients with three missed appointments will be asked to transfer their records to another doctor.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $1 per page) if you want to have copies of your records sent to another doctor or organization. This fee will be waived if records are being sent to your primary care physician (PCP). You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient should be aware that any medications prescribed have potential risk!

Patient's name:____

Responsible party
(If not the patient):____

Signature: ______________________________ Date: __________________

Payment options if you have no insurance coverage:

A. You choose to pay by cash, check, or credit card on the day that treatment is rendered. No checks for first visit.

Payment options: if you have insurance:

A. In network, you choose to pay your co-payment, your deductible and any out-of-pocket portions at the time services are rendered by cash, check, or credit card Because this is an insurance requirement, we cannot bill you for these. Check payments are not allowed for initial appointments.

B. Out of network, you choose to pay the total cost of your treatment by cash, check, or credit card. Your insurance carrier will send their payment directly to you.