Palm Beach Internal Medicine

Rupesh R. Dharia, M.D. Michael F. Ambrose, M.D.
Brianne Gupta, APRN Melissa Dail, APRN Joanna Job, APRN
Katie Kuretski, DNP, APRN, FNP-C Kaymie Poldo, APRN

3502 Kyoto Gardens Dr. Suite A, Palm Beach Gardens, FL 33410
Phone: 561-776-8891 Fax: 866-436-2183

Due to government regulation, we will need a copy of your insurance card and photo ID to protect your identity.

LAST NAME____________________FIRST NAME__________________ MIDDLE INITIAL _____

HOME PHONE_________________WORK PHONE________________CELL_________________

HOME ADDRESS____

CITY___________________________________STATE__________________ZIP_____________

DATE OF BIRTH ______/______/______ SOCIAL SECURITY # __________-________-_________

SEX: F____ M____ MARITAL STATUS: S______ M_____ D_____ Legally Separated _____ WIDOWED_____

EMERGENCY CONTACT __________________RELATIONSHIP___________PHONE___________
(Different than yours)

ETHNICITY: African American _______ Asian _______ Caucasian _______ Hispanic _______ Other _______

EMAIL ADDRESS: __________________________________@ ______________.COM

PHARMACY NAME/LOCATION____

PHARMACY PHONE____________________________FAX_________________________________

EMPLOYER_________________________________OCCUPATION________________________

EMPLOYER ADDRESS____

How were you referred to our office?

◯ **Relative:** ____________________________
Family Member Name

◯ **Coworker/Friend:** ________________________
Coworker/Friend Name

◯ **Another Physician:** ________________________
Physicians Name

◯ **Website:** ____________________________
Please List Website Name

◯ **OTHER:** ____
Please list how you were referred to our office

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BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn patient's balance over to a collection agency for non-payment after 120 days, then the patient is responsible for the entire balance, accrued interest, collection service fees and attorney fee.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment or treatment to my insurance company in writing or by fax.

Signature ______________________________ Date ____________________

Patient or Parent/Guardian

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PATIENT NAME: ____

DATE OF BIRTH: ________/__________/_________

I have received a written Notice of Privacy of this Practice in plain language. The Notice of Practice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect of my information.

I understand that this practice reserves the right to change the forms of its Notice of Privacy, and to make the changes regarding all protected health information residing at or controlled of this practice. I understand I can obtain a copy of the current Notice of Privacy on request.

Signature: ________________________________ Date: ___________________________

Relationship to Patient____

If signed by a personal representative of Patient

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CONSENT TO DISCUSS OR RELEASE INFORMATION
&
ACKNOWLEDGEMENT RECEIPT OF PRIVACY PRACTICES

I, ________________________________ D.O.B. __________________ hereby Give consent to **Palm Beach Internal Medicine** to Discuss or release my private Health care information to ____
First and Last name

( ) who is related to me. ( ) is my caregiver, unrelated to me.

I fully understand and accept the terms of this consent. I have been informed of my rights according to **HIPAA** regulations, reviewed, and have had the opportunity to receive a copy of **The Notice of Privacy of Palm Beach Internal Medicine.**

Signature: _________________________ Date: _____________________

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Cancellation/No Show Policy

Here at Palm Beach Internal Medicine, we understand appointments may be missed due to emergencies or other obligations with work/or family. If you are not able to keep your scheduled appointment you or an authorized representative must call 24 hours in advance to cancel or reschedule your appointment. Without doing so, this may be preventing another patient from getting much needed treatment. If you fail to cancel in advance, you will be charged a $50.00 no show fee. The patient is responsible for the $50.00 no show fee and it is not covered by your insurance company. If you have five or more no show appointments within a year time, you will be discharged from the facility.

****No show appointments scheduled with Dr. Dharia will be charged $75****

I authorize that I have read and understand these terms.

____
Date

____________________________   ____________________________
Patient Signature   Patient Printed Name

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We would like to inform you that an EKG might be part of your visits; however, it may not be covered in full by your insurance. Therefore, you will be responsible to pay the balance, which is usually between $10 and $20. If you normally receive EKG's from your cardiologist, please inform your medical assistant and be sure your cardiologist is sending the results to us to keep in your chart.

By signing below, I acknowledge that I have read and understand the above statement.

________________________ ________________

Print Name Date

____

Patient Signature

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We would like to inform you that while your insurance company may cover yearly wellness physicals at 100%, please keep in mind that you may only discuss items related to your wellness visit. If you are changing medications or dosages, starting new medications, and/or discussing any other medical issues not related to the wellness exam, per insurance guidelines, it will incur a regular office visit charge in addition to the wellness. Your regular copay/co-insurance or deductible will be collected at checkout.

I have read and understand these conditions:

____
Patient Printed Name

________________________________ ____________________
Patient Signature Date