SKYLAKE MEDICAL ASSOCIATES

1380 NE MIAMI GARDENS DR STE 280
NORTH MIAMI BEACH, FL. 33179
T: 305.735.2022

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: ____________________ First Name: ____________________ MI: ______ Social Security #: ________________

Address: ________________________________ City: ____________________ State: ________ Zip: ______________

Email: ____ Occupation: ______________________________

Date of Birth: __________ **Sex:** M F **Marital Status:** Married Single Divorced Widowed **Preferred Language:** ________

Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Unknown/Declined to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined to answer

Home phone: (_______)____________ cell phone: (_______)____________ work phone: (_______)____________

Best daytime number to reach you: ☐ home ☐ work ☐ cell Is it ok to leave a message at any of the numbers? ☐ Yes ☐ No

If no, please designate which ones, if any: ____

Primary Care Physician's Name (if applicable): ____________________ How did you hear about us? ____________________

Spouse's Name: __________________________ Date of Birth: ______________ Spouse's SS#: ________________

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section) ______________

Last Name: ________________________________ First Name: ________________________ MI: ______

Social Security Number: ____________________ Birth date (mm/dd/yyyy): ______________ Sex: ☐ Male ☐ Female

Address: ________________________________ City: ____________________ State: ______ Zip: __________

Home phone: (_____)______________ Cell phone: (_____)________________ Work phone: (_____)________________

INSURANCE INFORMATION

Primary Insurance Coverage: ____ Copay: $__________

Policy effective date: ____________ Deductible: $__________ Met? ☐ Yes ☐ No If no, amount met: $ ____________

Address: ________________________________ City: ____________________ State: ________ Zip: __________

Policy Number: ________________________ Group Number: ____________ Subscriber: __________________________

Subscriber's DOB: ________________________ Subscriber's SS #: ____

Secondary Insurance Coverage: ____ ______________

Address: ________________________________ City: ____________________ State: ________ Zip: __________

Policy Number: ________________________ Group Number: ____________ Subscriber: __________________________

Subscriber's DOB: ________________________ Subscriber's SS #: ____

☐ **Verified Patient Information** Staff Initials: ____________

DISCLOSURE TO FAMILIES AND LOVED ONES (Emergency Contacts)

I authorize Skylake Medical Associates, to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Skylake Medical Associates to disclose my personal health information to the following people:

Name: ______________________________ Relationship: ______________ Phone: (_____)______________

Name: ______________________________ Relationship: ______________ Phone: (_____)______________

Name: ______________________________ Relationship: ______________ Phone: (_____)______________

CONSENT TO TREATMENT FOR ALL PATIENTS

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all of my medication history including medications prescribed by other providers.

____
Patient initials

PHOTO DOCUMENTATION

I hereby grant authorization for the clerical staff to make a copy of my photo identification to be included in my confidential record as well as take a digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any injury or procedure that they feel is medically necessary to include in my confidential medical record.

____
Patient initials

NOTICE OF PRIVACY PRACTICES

I received a copy of the Skylake Medical Associates "Notice of Privacy Practices" today and agree with these privacy policies.

____
Patient initials

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize the offices of Skylake Medical Associates, to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to Skylake Medical Associates from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for the office visit, such as labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by Skylake Medical Associates providers.

____
Patient initials

______________________________ ______________________________

Date **Signature of Patient or Guardian if patient is Minor**

Emergency Contact Information Form

Please be sure to sign and date this form

Name: ____
Last First MI

Phone:

Home: ____________________ **Cell:** ____________________

Home Email Address: ________________________________

Address: ____
Street City State Zip Code

Primary Emergency Contact Name : ______________________________
Last First

Relationship: ____________________

Phone:
Home: ______________ **Cell:** ______________ **Work:** ______________

Secondary Emergency Contact Name: ______________________________
Last First

Relationship: ____________________

Phone:
Home: ______________ **Cell:** ______________ **Work:** ______________

Preferred Local Hospital: ________________________________

Insurance Information:

Company: ________________________ **Policy #:** ________________

Comments *(include any special medical or personal information you would want an emergency care provider to know – or special contact information:*

Signature: ____________________________ **Date:** ______________

SKYLAKE MEDICAL ASSOCIATES

Medical History Form

Directions: Please answer the following questions to the best of your knowledge.

PATIENT INFORMATION				
Last Name	**First Name**	**Middle**	**Primary Language**	**Social Security No.**
Street Address	**City**	**State** **Zip**	**OK to Send Letter?** ☐ Yes ☐ No	**Sex:** ☐ Male ☐ Female
Home Phone	**OK to Call?** ☐ Yes ☐ No	**Work Phone**	**OK to Call?** ☐ Yes ☐ No	**If No, How can you be reached?**
Date of Birth	**Marital Status:** ☐ Single without partner ☐Single with partner Length of Time: ______________ ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Sexual Orientation ☐ Heterosexual ☐ Homosexual ☐ Bisexual				
Children: ☐ Yes ☐ No How Many?		**Number of Persons Living in Your Home?**		**Race/ Ethnicity**
Emergency Contact Person		**Phone Number**	**Relationship**	

PRIMARY PHYSICIAN(S)		
Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

Medication Allergies? ☐ Yes ☐ No
If yes, what medication(s) ___________________________

Substance or Food Allergies? ☐ Yes ☐ No
If yes, what substance(s) _____________________________________

FAMILY HISTORY: Please check the box if your family has a history of:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Attack, Heart Disease ☐ Blood Clots or Stroke ☐ Tuberculosis
☐ Cancer ☐ Alzheimer's ☐ Family History Unknown ☐ Mental Illness ☐ Epilepsy/Seizure

Any other major conditions?____

____

____

If you answered Yes to any of the above, please explain: ____

____

Are you currently being treated for medical conditions? ☐ Yes ☐ No If yes, please list: _______________________________

____

MEDICATIONS **(List more on separate page if necessary)**					
Current Medications	**For what condition?**	**Dosage**	**Frequency**	**Date started**	**Comments / Problems / Concerns**

Past Medications / For what condition? (List sedatives, pain medications, sleeping pills, antidepressants, etc)			

Social/Sexual Risk History	
☐ Yes ☐ No	Do you smoke? If yes, how many cigarettes per day?
☐ Yes ☐ No	Do you use alcohol? If yes, how often, how much?
☐ Yes ☐ No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
☐ Yes ☐ No	Have you ever had or would you like help now with an alcohol or drug problem?
☐ Yes ☐ No	Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?
☐ Yes ☐ No	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

Patient Name: ______________________________

REVIEW OF SYSTEMS: Please check the box if you currently have or have ever had the following			
1. General			
Productive cough (3 weeks or more)	☐ Current ☐ Past	Unusual discharge (vaginal or from penis)	☐ Current ☐ Past
Dry, unproductive cough (3 wks or more)	☐ Current ☐ Past	Bloody or painful urination	☐ Current ☐ Past
Shortness of breath	☐ Current ☐ Past	Dark, bloody or painful bowel movements	☐ Current ☐ Past
Chest pain	☐ Current ☐ Past	Hepatitis A	☐ Current ☐ Past
Recurrent night sweats, chills, fevers	☐ Current ☐ Past	Hepatitis B	☐ Current ☐ Past
Swollen glands (neck, armpits or groin)	☐ Current ☐ Past	Hepatitis C	☐ Current ☐ Past
Persistent weight loss without dieting	☐ Current ☐ Past	Chronic Fatigue	☐ Current ☐ Past
Weight problem/eating disorder	☐ Current ☐ Past	Cancer	☐ Current ☐ Past

Tuberculosis: Ever Tested? ☐ Yes ☐ No Date and result of last test: ________________ If Positive, did you have a chest x-ray? ________

Ever Treated? ☐ Yes ☐ No Date(s) and type(s) of treatment: ____

HIV: Ever Tested? ☐ Yes ☐ No Would you like information regarding HIV/AIDS or testing sites? ☐ Yes ☐ No

REVIEW OF SYSTEMS: Please check the box if you currently have or have ever had the following:			
2. Skin		**7. Gastrointestinal**	
Allergies/Rash/Itching	☐ Current ☐ Past	Recurrent nausea/vomiting/diarrhea	☐ Current ☐ Past
Psoriasis / Eczema	☐ Current ☐ Past	Stomach/bowel problems	☐ Current ☐ Past
		Gall bladder disease	☐ Current ☐ Past
3. Eyes		Pancreatitis	☐ Current ☐ Past
Vision problems	☐ Current ☐ Past	Diabetes / hyperglycemia / hypoglycemia	☐ Current ☐ Past
Eye infections	☐ Current ☐ Past	Encopresis (incontinent of feces)	☐ Current ☐ Past
4. Ears, Nose, Throat, Lungs		**8. Genitourinary**	
Hearing problems	☐ Current ☐ Past	Bladder/kidney problems or infection	☐ Current ☐ Past
Teeth/gum problems or disease	☐ Current ☐ Past	Incontinence (unable to control bladder)	☐ Current ☐ Past
Frequent nosebleeds	☐ Current ☐ Past	Enuresis (bedwetting)	☐ Current ☐ Past
Recurrent sinusitis	☐ Current ☐ Past	Sexually transmitted diseases:	
Frequent sore throats	☐ Current ☐ Past	___Gonorrhea ____Syphilis ____Herpes	
Recurrent Pneumonia	☐ Current ☐ Past	___Chlamydia ____Trichomonas	
Asthma	☐ Current ☐ Past	___HPV or genital warts	
5. Cardiac		**Females:**	
Palpitations/arrhythmia	☐ Current ☐ Past	Menstrual Difficulties	☐ Current ☐ Past
Heart disease/murmur	☐ Current ☐ Past	Cycle: Regular ___ Irregular ___	
High blood pressure / Low blood pressure	☐ Current ☐ Past	Pre-Menopause ___ Menopause ___	
High cholesterol	☐ Current ☐ Past	Problems/infection of tubes/ovaries/uterus	☐ Current ☐ Past
Thrombophlebitis/blood clots	☐ Current ☐ Past	Abnormal Pap Smear(s)	☐ Current ☐ Past
		Number of pregnancies ______________	
6. Neurological		Number of births ______________	
Stroke	☐ Current ☐ Past	Problems with pregnancies/births (explain)	
Frequent Headaches or Migraines	☐ Current ☐ Past		
Seizures/Epilepsy	☐ Current ☐ Past	Breast disease / tumor / surgery (explain)	
Weakness/paralysis/unsteady walking	☐ Current ☐ Past		
Dizziness/confusion/wandering	☐ Current ☐ Past	**Miscellaneous:**	
Forgetfulness/memory lapse/memory loss	☐ Current ☐ Past	Anemia / blood disorder	☐ Current ☐ Past
		Arthritis	☐ Current ☐ Past
Other conditions / problems not listed:		Sleep disturbance	☐ Current ☐ Past

I certify that I have answered these questions to the best of my knowledge

Patient Name: ____

Patient Signature: ________________________________ Date: __________

CLINICIANS NOTES (CLARIFICATIONS / FOLLOW UP / ETC)

____

____

____

____

Reviewed by (Clinician): ______________________________ Date: ____________

Preventative Care History Sheet

Patient Name: ________________________________ Date: _________________

DOB: ______________ Allergies: ____

	DATE
When was your last Flu shot?	
When was your last Pneumonia shot?	
When was your last Tetanus shot?	
When was your last Pap Smear?	
When was your last Mammogram?	
When was your last Dexa Scan?	
When was your last Rectal Exam?	
When was your last Colonoscopy?	
When was your last Prostate/PSA check?	
When was your last Glaucoma Screening?	
When was your last Diabetic-Eye Exam?	
Who is your eye doctor? For diabetic patients only	
Who is your foot doctor? For diabetic patients only	
Do you have an OBGYN doctor? For females only	

Notice of Privacy Act

Patient Contact

We may contact you to provide appointment reminders, treatment information, billing and payment information, or for patient satisfaction surveys.

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to {Practice Name} all insurance benefits, if any, otherwise **payable to me for services** rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of my benefits. I authorize the use of this signature on all insurance claim submissions.

_______ (INITIALS)

Allowed Uses and Disclosures of Your Medical Information:

- Treatment – such as ordering diagnostic test
- Payment – such as submitting information to your insurance company
- Health Care Operations – such as quality assurance review, coordination of care, eligibility verification.

In addition to the above, your medication information may be used or disclosed for emergency treatment; when we are required by law to treat you, we attempt to obtain consent, and if we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under the circumstances or we created or received the information in treatment.

You have the right to:

- Request a restriction on certain uses and disclosures; however we are not required to agree to any requested restrictions.
- Receive confidential communication from us, upon written request.
- Inspect and request copies of your medical information.
- Request to amend copies of your incorrect or incomplete medical information.
- Receive an accounting of any disclosures made, upon written request.
- Receive a paper copy of the notice upon request.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice.
- Abiding by the terms of this notice.
- Providing written notice of any change to this notice.

_______ (INITIALS)

Medicare and Insurance Authorization

I request that payment of authorized Medicare or insurance benefits be made to me on my behalf to Beaton Podiatry Center Inc dba Advanced Podiatry and Wound Care for any service furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents; the information needed to determine these benefits or the benefits payable for any related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If 'other health insurance' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician, agency shown, or supplier agrees to accept the charge determination of the Medicare carrier as based upon the charge determination of the Medicare Carrier.

_______ (INITIALS)

Failure to Keep Scheduled Appointments

If you are unable to keep your scheduled appointment, we ask that you please notify our office; at least 24 hours prior to your appointment time. Should you fail to provide proper notice, you will be charged $50.00 for the time that was allotted to you. By not contacting our office to cancel or reschedule your appointment, those in need of a time slot are unfortunately unable to see us. Thank you for your cooperation. I have read the above policies and I understand and agree to these policies. _______ (INITIALS)

Printed Name ______________________________

Signature______________________________ Date ______________

OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you to sign prior to any treatment.

All patients must complete our information packet and produce all insurance cards and id prior to seeing the doctor.

CUSTOM MADE PRODUCTS (SHOES, INSERTS, ORTHOTICS, ETC.) ARE NON REFUNDABLE.

24 Hours notice is required in the event you cannot keep your appointment. If notice is not given in a timely manner there is a mandatory $50.00 no show fee.

ALL returned checks have a $25.00 processing fee applied to the account.

Non insurance patients (self pay) **full payment is due at time of service.** We accept cash, check, credit card, etc.

Regarding insurance

We may accept assignment of insurance benefits**. ALL co pays, coinsurance and deductibles are due at the time of service.** In the event that your insurance is not in network you will be considered self pay. **The balance is your responsibility whether your insurance company pays or not.** Your insurance policy is a contract between you and your insurance company. We are not a third party to that contract. Please be aware that some, perhaps all, of the services provided may be non covered services and not considered reasonable under your insurance program.

Usual and customary rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult patients

Adult patients are responsible for their portion of payment at the time of service depending of self pay or insurance coverage.

Minor patients

The accompanying parent or guardian is responsible for full payment. For non accompanying minors, non emergency treatment will be denied.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read the financial policy. I understand and agree to this financial policy:

Signed Name ____________________________________

Printed Name ____________________________________

Date ____________________________