8260 W. FLAGLER ST STE 2-I
MIAMI FL, 33144
PHONE: 786-715-9183 FAX: 786-713-1115

PATIENT DEMOGRAPHICS

LAST NAME_________________________________ FIRSTNAME____________________________________

DATE OF BIRTH____

ADDRESS ____

CITY _____________________ STATE ___________________________ ZIP CODE ___________________

SOCIAL SECURITY NUMBER ___________________________________

PHONE NUMBER______________________________

EMAIL____

EMERGENCY CONTACT PERSON ____

TELEPHONE NUMBER ____

PREFERRED PHARMACY ____

TELEPHONE NUMBER ____

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ASSIGNMENT OF BENEFITS

PATIENT NAME:____

INSURANCE COMPANY:

- ☐ **FLORIDA MEDICARE**
- ☐ **GROUP INSURANCE**
- ☐ **FLORIDA MEDICAID**
- ☐ **PPO**
- ☐ **W/C COMP**
- ☐ **OTHER: _____________________**

I HEREBY AUTHORIZE AND REQUEST YOUR COMPANY TO PAY DIRECTLY TO NOVA MEDICAL SERVICES THE AMOUNT DUE BY ME IN ANY CLAIMS FOR MEDICAL, SURGICAL RENDERED TO ME BY NOVA MEDICAL SERVICES AND THEIR MEDICAL STAFFS.

SIGNATURE: _______________________________ DATE: ______________________________

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FINANCIAL AGREEMENT:

THE UNDERSIGNED AGREES WHETHER HE/SHE SIGNS AS GUARDIAN, AGENT OR AS A PATIENT, THAT IN CONSIDERATION OF THE SERVICES TO BE RENDERED TO PATIENT, HE/SHE HEREBY INDIVIDUALLY OBLIGATES HIM/HERSELF TO PAY ANY OUSTANDING BALANCE DUE TO NOVA MEDICAL SERVICES, SHOULD THE ACCOUNT BE REFERRED TO ANY ATTORNEY FOR COLLECTION, THE UNDERSIGNED SHALL PAY ANY ATTORNEY'S FEE AND COLLECTION EXPENSES.

SIGNATURE: ________________________________ DATE: ______________________________

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AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY GIVE MY PERMISSION TO: ____

TO RELEASE A COPY OF MY MEDICAL RECORDS

TO:

NOVA MEDICAL SERVICES
8260 W FLAGLER ST, STE 2-I
MIAMI, FL 33144
Phone: (786) 715 – 9183 Fax: (786) 713 - 1115

I HEREBY RELEASE THE FACILITY FROM ANY LIABILITY, WHICH MAY ARISE AS A RESULT OF THE USE OF THE INFORMATION CONTAINED IN THE RECORDS RELEASED.

NAME OF PATIENT: ____ DOB: ___________________

SIGNATURE OF PATIENT: _______________________________________ DATE: __________________

SIGNATURE OF GUARDIAN: _____________________________________ DATE: __________________

TO RECEIVING AGENCY: PROHIBITION OF REDISCLOSURE.

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED. ANY FUTHER REDISCLOSURE IS STRICTLY PROHIBITED UNLESS THE PATIENT PROVIDES SPECIFIC WRITTEN CONSENT FOR THE SUBSEQUENT DISCLOSURE OF THIS INFORMATION.

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NOTICE OF RECEIPT OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGE FORM

I___________________________________ certify that a copy of Notice of Patient Privacy Practices was given to me and was read by me.

THE SIGNATURE BELOW IS ONLY THE ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THIS NOTICE ABOUT PRIVACY PRACTICES.

_______________________________ ___________________________

PATIENT/PROXY SIGNATURE DATE

8260 W. FLAGLER ST STE 2-I
MIAMI FL, 33144
PHONE: 786-715-9183 FAX: 786-713-1115

PERMANENT LIFETIME SIGNATURE

FOR SERVICES STARTING DATE: ______________________________

I AUTHORIZE NOVA MEDICAL SERVICES, TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION, OR IT'S INTERMIDIARIES OR CARRIERS, ANY INFORMATION NEEDED FOR A RELATED MEDICARE / MEDICAID / INSURANCE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

_____________________________________ _____________________________________

PATIENT SIGNATURE (PRINT OR TYPE NAME)

_____________________________________ ______________________________

REASON IF PATIENT IS UNABLE TO SIGN RELATIONSHIP (IF OTHER THAN THE PATIENT)

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Consent for Evaluation and Treatment

Patient Name: **DOB:**

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

__________________________________ __________________

Signature of Patient or Representative **Date**

______________________________________ __________________

Printed Name of Patient or Representative **Relationship**