BROWARD INTERNAL MEDICINE, P.A.
DR. SOLING LI, D.O., M.P.H.
8890 W. Oakland Park Boulevard, Suite 203
Sunrise, FL 33351-7224
(P) 954.746.5678
(F) 954.746.5555

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information **(Please Print).** All information will be strictly confidential.

Last Name 姓	First Name 名	Middle Name
Date of Birth Mon Date Year	Sex 性別 ☐M 男 ☐ F 女	Soc. Sec 工咭號碼 #
Race 種族 ☐Unknown 不知道 ☐White ☐African American ☐American ☐Asian 亞洲人 ☐Other 其他 ☐Hispanic		
Ethnicity 種族☐Unknown 不知道 ☐Hispanic or Latino 西班牙人或拉丁美洲人☐Not Hispanic or Latino 非西班牙人或拉丁美洲人		
☐ Single 單身 ☐ Married 已婚 ☐ Separated 分居 ☐ Widowed 寡 ☐ Minor 未成年 ☐ Divorced 離婚 ☐ Partnered for 同居_____years		
Home 住 ☎	Cell 手機 ☎	Office 辦公室☎
Email Address 電 郵		☐ Home ☐ Office Fax 傳真☎
Address 住	City 城市	State 卅 Zip 區號
Patient Employer/School 僱主/學校名稱		Employer/School 僱主/學校☎
Employer/School Address 僱主/學校地址	City 城市	State 卅 Zip 區號
Occupation 職業	How Long at current Employer? 工作/就讀	年 月
Person financially responsible for this account 費用負責人		
Relation to Patient 與病人之關係	Date of Birth 出生日期	Soc. Sec 工咭號碼 #
Responsible Party Drivers License Number 駕駛執照號碼		State 卅
Home 住☎	Cell 手機☎	Office 辦公室☎
Address 住址 (If different from patient's)	City 城市	State 卅 Zip 區號
Email Address 電郵		
Whom may we thank for referring you? 介紹人		Phone ☎ :
In case of emergency who should be notified? 緊急情況聯絡人		Relationship to patient 與病人之關係
Home 住☎	Cell 手機☎	Office 辦公室☎
Medicare #	Effective Date	Retire Date
Medicaid #	Effective Date	
Primary insurance company		Is insurance through your employer? ☐Yes ☐No
Subscriber's Name		Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ other _____
ID#	Group #	Soc. Sec# Date of Birth
Secondary insurance company		ID #
Secondary insurance company Address		Group #
Motor Vehicle Accident? ☐Yes ☐No Name of carrier		Carrier ☎
Date of accident: Mon Date Year	Claim #	Treatment authorized by

☐ **Private Insurance Authorization for Assignment of Benefits/Information Release:**

I certify that I, and/or my dependent(s), have insurance coverage with my primary insurance company and /or additional insurance company(ies) and assign directly to Dr. Soling Li 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 authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

☐ **Medicare/Medigap Authorization (Lifetime Signature on File):**

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to Dr. Soling Li for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ **Date**_____

Signature of Patient, Parent, Guardian (if child is under 18 years old) or Personal Representative

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FINANCIAL & OFFICE POLICY

- For your convenience we accept cash, Visa, Master Card, American Express, and money orders.
- All no show appointments or appointments that are not cancelled / rescheduled **24 hours** prior to the appointment will be charged **$25.00**.
- If we accept your insurance, you must pay your estimated co-pay and/or your coinsurance/deductible if applicable, at time of service.
- All fees are due prior to seeing the physician.
- There is a charge of $10.00 for blood draws in office for all uninsured patients and certain HMO patients (please check with staff for which HMO).
- There is a charge for copies of medical records ($1.00 per page for the first 25 pages and 25 cents per page after that, plus postage if applicable). This is according to the Rule 64B8-10.003 from the Florida Administrative Code.
- There is a $30.00 fee for any form to be filled out by the Physician or staff of Broward Internal Medicine, P.A., unless otherwise specified. (Insurance, Physical, School, Work, Disability, etc.)
- All patients must provide valid photo identification upon request.
- All patients who are going to be late must call to see if we are able to accommodate them.
- All patients more than 15 minutes late will be rescheduled unless we are able to accommodate them.
- Patients who come early for an appointment are required to wait until the patients with appointments prior to them are seen.
- For requesting a referral, an appointment might be acquired upon the nature of the referral. You will be informed if an appointment is needed. All referrals may take up to ten business days to complete.
- All refill requests must be called into the pharmacy, by the patient, so they can fax us a request form.
- All messages that are not urgent may not be returned the same day.

I have read the above and understand this is the Financial & Office Policy of Broward Internal Medicine, P.A.

Patient Name _____

Patient Signature _____

Date _____

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Practice has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

I, _____, give this office permission to leave a message on my
□ home, □ cell phone, □ office answering machine/voice mail or to a family member related to my personal health information in regards to confirming appointments and / or relaying lab or other test results.

Patient Name (Print): _____

Patient's/Guardian signature _____ Date: _____

Relationship to Patient (if other than patient): _____

Name of person designated to receive messages: _____

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PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should have any questions regarding these policies please do not hesitate to ask our privacy officer who can be reached at (954) 746-5678

INFORMATION WE COLLECT ON YOU

We collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide to us. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

HOW YOUR INFORMATION IS USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian. **Broward Internal Medicine, P.A.,** does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. **Broward Internal Medicine, P.A.,** maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with **Broward Internal Medicine, P.A.**

CHANGE TO OUR PRIVACY POLICY

All new patients will receive a copy of our privacy policy **Broward Internal Medicine, P.A.,** occasionally reviews the privacy policy and reserves the right to amend it. Notification of changes will be posted on our office and copies available at the front desk prior to the effective date of any changes.

YOUR RIGHT TO RESTRICT USE OF INFORMATION

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Signature _____ **Date** _____

B.I.M.P.A.

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Convenience Fee Acknowledgement

Dear Patient,

As a convenience, we can draw your blood in our office for a **small fee of $10.00**. Or, you may have your blood drawn at the lab assigned by your insurance carrier.

I, _____ have read the above acknowledgement and understand that if I elect to have my blood drawn at the office, I will be responsible for the $10.00 convenience fee, and this is not a covered benefit by my insurance carrier.

Signature: _____ Date: _____