ISAAC LEVY MD PA, 9937 Pines Boulevard Pembroke Pines, Florida 33024
Tel. (954) 450-1808 FAX (954) 450-4884

Personal Information

Date _____

First Name _____ Last Name _____

Address: _____City _____State _____ Zip _____

Birth date _____ Age _____ Social Security# _____-____-_____

Male/Female _____ Home Phone# _____ Cellular _____

Work# _____ Email _____

Emergency Contact _____ relation _____ Phone#_____

With whom are we authorized to discuss your medical care with? _____

Primary Care Doctor _____ Phone# _____

Referring Doctor for today visit? _____ Phone # _____

I authorize payment to Isaac Levy MD PA for services rendered.

S/_____ Date _____

Please Initial

_____ I understand there is a fee for cancelled appointments **on the same day or a no show fee.** Office visit $25.00.

MILLENNIUM ONCOLOGY
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_____ I am responsible to notify Isaac Levy MD PA office of any changes in my address, phone numbers and insurance immediately.

Patient Name (Please Print): _____

Financial Agreement:

The undersigned agrees he/she is hereby obligated and agrees to pay the referenced Doctor(s)/Isaac Levy MD PA charges for services rendered by said Doctors'. I further agree that payment is due upon receipt of invoice/statement. I understand that unpaid accounts will be considered in default after sixty (60) days, after which time interest will be imposed at the rate of 1-1/2% per month on unpaid balances (Annual Percentage Rate of 18%) or the legal interest rate, whichever is lower. In the event a legal suit is necessary to enforce payment of this account, I agree to pay such attorneys' fees and court costs as may be deemed reasonable. The patient/guarantor waives venue jurisdiction, and submits itself to the jurisdiction and venue of the State Courts of Dade or Broward County, Florida.

Assignment of Insurance Benefits:

I hereby authorize payments to be made directly to the referenced Doctor(s)/Isaac Levy MD PA of all benefits, which may be due and payable under insurance coverage for the above named patient. Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title VIII or XIX of the Social Security Act is correct, and request that said payment of authorized benefits be made payable on my behalf to the referenced Doctor(s) Isaac Levy MD PA. I authorized utilization of the application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to the Doctor(s)/ Isaac Levy MD PA.

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Authorization to Release Medical:

Isaac Levy MD PA is/are hereby authorized to disclose all or any part of the medical record on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment to services rendered by the referenced Doctor(s). This authorization is given with full acknowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Doctor(s).

Disclosure to Isaac Levy MD PA Doctors:

I hereby authorize Isaac Levy MD PA to furnish and disclose my medical information to its "Business Partners," as such term is defined in the Health Insurance Portability and Accountability Act of 1996, as amended as is necessary or advisable for Isaac Levy MD PA to efficiently operate its medical practice.

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Medical malpractice insurance:

Under Florida law physicians are generally required to carry medical malpractice insurance or demonstrate financial responsibility to cover potential claims for medical malpractice. WE HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law under certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

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With whom are we authorized to discuss your medical care with?

FULL NAME AND RELATION: _____

S/ _____ _____ _____

Signature of Patient or Responsible Party Date Signature of Witness

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests. To request confidential communications, you must make your request in writing to the Privacy Officer. Your request must specify how or when you wish to be contacted, by you are not required to explain your reason for making the request.

Right to a paper Copy of this copy: If you received this notice form from our website or by electronic mail, you have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our privacy officer.

Change to this notice: We reserve the right to change this notice and to make the revised or change notice effective for protected health information we already have about you as well as any information we receive in the future. In the event that we revise this notice, the new notice will be provided to you as described above.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with Isaac Levy MD PA, or with the Secretary of the Department of Health and Human Services. To file a complaint with Isaac Levy MD PA, contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

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Your authorization is required for other uses of information: Other uses and disclosure of protected health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose protected health information about you, you may revoke that authorization to use or disclose protected health information about you; you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that disclosures we may have already made with your authorization will not be affected. We will honor revocation of authorizations from the date Isaac Levy MD PA Privacy Officer receives it.

I HEREBY ACKNOWLEDGE THE RECEIPT OF ISAAC LEVY MD PA PRIVACY PRACTICE ON _____ _____, 2013.

S/_____ _____

Signature Print Name

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REQUEST FOR MEDICAL RECORDS

To: _____

I, _____D.O.B. _____, AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO DR. ISAAC LEVY.

PLEASE SEND COPIES OF:

_____ ALL RECORDS

_____ MOST RECENT

_____ OTHER

PATIENT SIGNATURE _____

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MEDICATION	DOSE