Glades Medical
GROUP

Date: _____SS#: _____

Name: _____ DOB: _____

Address: _____

_____

Phone: _____ Cell: _____ Work: _____

Email Address: _____

Marital Status: _____Language: _____ Sex: _____ Race: _____

Ethnicity: (Hispanic/ Non-Hispanic/ Refused) _____

Responsible Party Name: _____

DOB: _____ SS#: _____ Relation: _____

Occupation: _____ Bus. #: _____

Employer: _____

Address: _____

Name of Spouse or Next of Kin: _____

Relationship: _____ Phone: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Local Pharmacy Name: _____Phone: _____

Mail Order Pharmacy: _____ Phone: _____

Advanced Directive: • Yes • No If YES please bring a copy with you to your next visit.

_____ I attest that the information above is correct to the best of my knowledge.
_____ I authorize the release of any medical information necessary to process insurance claims.
_____ I authorize payment of benefits to be sent directly to the attending provider.

Patient's Signature: _____ Date: _____

Glades Medical
GROUP

Date/La Fecha: _____ SS#: _____

Name/Nombre: _____DOB/La fecha de nacimiento: _____

Address/ Su dirección: _____

Phone/ teléfono : _____Cell: _____ Work: _____

Email Address/la dirección de correo electrónico: _____

Marital Status/ Estado civil: _____ Language/ Lengua: _____ Sex/ El sexo: _____ Race/ La Raza:_____

Ethnicity/ origen étnico: (Hispanic/ Non-Hispanic/ Refused)_____

Responsible Party Name/ La parte responsible:_____

DOB/: La fecha de nacimiento _____SS#: _____Relation/ relación: _____

Occupation/ La ocupación : _____ Bus. #: _____

Employer/ Empleador: _____

Address/ La dirección : _____

Name of Spouse/ La cónyuge or Next of Kin/ Parientes cercanos: _____

Relationship/ relación:: _____Phone: _____

Emergency Contact/ Contacto de emergencia: _____
_

Relationship/ relación:: _____ Phone/ teléfono: _____

Local Pharmacy Name/ La farmacia preferida: _____ Phone/ teléfono /: _____

Mail Order Pharmacy: _____ Phone/ teléfono: _____

Advanced Directive/ Directiva avanzada: • Yes/ Si • No If YES please bring a copy with you to your next visit.

LIFETIME SIGNATURE AUTHORIZATION

_____ I attest that the information above is correct to the best of my knowledge.
Doy fe que esta información es correcta para mi leal saber y entendimiento.

_____ I authorize the release of any medical information necessary to process insurance claims.
Autorizo la divulgación de cualquier información médica necesaria para procesar las reclamaciones de seguros.

_____ I authorize payment of benefits to be sent directly to the attending provider.
Autorizo que se envíe el pago de las prestaciones al proveedor.

Patient's Signature/ Firma del paciente_____ Date/ fecha _____

Glades Medical
GROUP

OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to the quality of your care. Please understand that payment of your bill is considered a part of your medical treatment. The following is a statement of our financial policy, which we require that you read and sign PRIOR to any treatment.

All patients must complete our registration form in full before seeing the doctor. Payment is due at the time of service. We accept cash, checks, and credit cards.

If you have insurance which we are providers of, and which we can verify, we still require that you pay all copayments, deductibles, coinsurance and charges for non-covered services at the time of service. Your doctors may order tests/procedures that are medically necessary but may not be covered by your insurance company. The financial responsibility for these non covered tests belongs to the patient. If this is a concern, please check with your insurance company by calling before proceeding with these tests/procedures.

If you have any questions regarding your bill, you may speak with our billing department at 561-394- 3088.

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.

_____ _____

Signature of Responsible Party Date

_____ _____

Signature of Co-Responsible Party Date

Glades Medical
GROUP

3848 FAU BOULEVARD, SUITE 210
BOCA RATON, Fl,.. 33431
561-394-3088

PAYMENT AUTHORIZATION

This form authorizes the Practice to maintain the Patient's credit card Information in a secure manner and authorizes the Practice to charge this credit card for any deductible, copayment, coinsurance, non covered service, or other outstanding balance. The amount you will be charged is strictly limited to the contractually obligated amount your Insurance requires you to pay. If the card is not valid or charges are contested, Patient agrees to pay any and all fees, including chargeback fees. Patients will receive an invoice so that alternative payment may be made prior to credit card authorization. Thank you for your cooperation.

PRINT NAME _____

SIGNATURE _____DATE _____

Glades Medical
GROUP

Consent for use and disclosure of health information

Section A: Patient Consent

Name:_____

Address:_____

Telephone:_____

Social Security:_____

Section B: To the Patient (Please read carefully)

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected he information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice.

You may obtain a copy of our Notice of Privacy Practices by contacting the office at the above address or asking the front desk.

Right to Revoke. You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation for this Consent will not affect any action that we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, _____,have had full opportunity to read and consider the content of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment and healthcare operations.

Signed: _____ Date: _____

Glades Medical
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Medical Information Release Form
(HIPPA Release Form)

Patient Name: _____ **Date of Birth:** ___/___/____

☐ I authorize the release of information, including but not limited to the diagnosis, treatment, medical records, claims information and financial records. This information may be released to or discussed with the following person(s)

Name: _____ **Relationship:** _____ **Phone: ( )** _____

Name: _____ **Relationship:** _____ **Phone: ( )** _____

Name: _____ **Relationship:** _____ **Phone: ( )** _____

Tel #: ( ) _____

☐ I DO NOT Authorize information to be released to anyone.
This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: Phone #: ( ) _____ ☐ **home** ☐ **work** ☐ **cell**

If you are unable to reach me:

☐ You may leave a detailed message.

☐ Please leave a message asking me to return your call.

The best time to reach me is (day) _____ **between (times)** _____

Signed: _____ **Date:** _____

Glades Medical
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3848 FAU Boulevard, Suite 210, Boca Raton, FL 33431
Phone: 561-394-3088 Fax: 561-394-3077

Medical Records Release Form

Date: _____

Previous or Specialist Physician Name: _____

Phone: _____ **Fax:** _____

Special Request For: ONE YEAR OF MEDICAL RECORDS ONLY
Please include H&P, progress notes, lab's, EKG's, Xray reports, problem list, and all vaccines.

David B. Hevert, M.D.
Paul C. Diamond, D.O.
Jorge Montalvan, M.D.
Sherman Steven, M.D.
Janice Plaxe, D.O.

Stephanie Oyen, M.D.
Michelle Beck, APRN
Donna Colligan, APRN
Mia Abraham, APRN
Basya Nachlas, APRN

May Rosenzweig, APRN, Phd
Lauren Cohen, APRN
Andrea Erickson, PA
Karrah Barrett, APRN
Sherri English, M.D.

Print Patient's Name: _____

Patient's Signature: _____

Date of Birth: _____

Glades Medical
GROUP

3848 FAU BOULEVARD, SUITE 210
BOCA RATON, FL 33431
561-394-3088

Credit Card Authorization Form

CARDHOLDER INFORMATION

Name:_____

Billing Street Address: _____

_____

City:_____ State:_____ ZIP Code:_____

Country:_____Email:_____

Telephone #: _____

❑ I authorize a one-time charge against my credit card for the following amount

$ _____

Payment Info: _____

CREDIT CARD INFORMATION

Credit Card Type: ❑ MasterCard ❑ Visa ❑ American Express ❑Discover Card

Name on Card: _____

Card Number:_____

Expiration Date: _____

Cardholder Signature X _____Date _____

Security Code: _____

Glades Medical
GROUP

Thank you for choosing Glades Medical Group. We take our role as your healthcare partner seriously and we are making changes to our practice to better serve you. We've set forth our practice policies and procedures below. These guidelines help us maintain a safe and efficient environment for everyone. Please read and review with your nurse or provider. A signed copy will be retained by our office and a copy provided to you, for your records.

Appointment Scheduling

We strive for fast, efficient scheduling of visits. You may contact our scheduling department as follows:

1. You may call our scheduling department at 561-394-3088, between 8am – 5pm Monday through Friday.

2. Text your scheduling request to 561-367-5410 and a scheduling team member will respond back to you within 24 hours.

3. Email your scheduling request to Scheduling@gladesmedical.com

Once scheduled, we will call and/or text you to confirm the appointment within 24-36 hrs prior to the appointment time. If you need to cancel or reschedule an appointment, please notify our office at least 24 hours in advance. We are very understanding of your busy schedule. However, when patients do not show up for a scheduled appointment it causes serious issues for our Clinic and other patients. In order to maintain our business, we must enforce a fee if the appointment isn't canceled at least 24 hrs in advance. We do not schedule appointments without your acknowledgement, and we will do our part to inform you of the upcoming visit. We ask that you help us by promptly informing us of any scheduled appointment timing issues.

Arrival and Check-In

Please arrive 5-10 minutes ahead of your scheduled appointment time to avoid delays and ensure adequate time for your visit. Upon arrival, please check in at the front desk and provide any necessary updates to your contact information and insurance details. It is our priority to make your experience fast and efficient.

Prescription Refills

Contact our office in advance for prescription refills. Please allow at least 48 hours for us to process your request. If you are on routine medications, we require an office visit or telehealth visit at minimum every 6 months, and more frequently for controlled substances. We require all patients on controlled substances to sign our Controlled Substances Contract annually, and adhere to our office visit protocols.

During these visits, the healthcare provider assesses the patient's response to treatment, monitors for any adverse effects, reviews medication usage, and adjusts the treatment plan as necessary.

We encourage you to keep track of your medication supply and request refills before running out to prevent any lapses in therapy.

Communication

Feel free to ask questions or seek clarification regarding your care. Our goal is to return calls within 48 hours. We recommend using our Patient Portal for communicating directly with your care team.

Lab and diagnostic testing

Labs and diagnostic testing will be ordered by your provider when medically necessary and with your consent.

Follow-up Policies

Routine lab and diagnostic test results will be communicated by our Care Team by phone. Please do not call the office for lab or diagnostic results within 5 days after the date of testing.

Preventative Care and Care Management

We take your healthcare seriously and we've invested substantial resources into our care management teams to make Glades Medical Group your trusted partner in your health. A few important things to know about our process:

1. If you have two or more chronic conditions, we must engage our Care Management Team to better serve you. If you are enrolled in Medicare or Medicare Advantage, our policy is to obtain your consent to engage our Chronic Care Management team. We strongly encourage you to participate in our care management program.
2. Our Care Teams will be actively managing your care plan. Your provider will review the care plan with you, and you are entitled to receive a copy.
3. Our Care Teams may contact you directly, via email, text or phone, during your choice of hours. Our typical work week is M-F 9am – 6pm.
4. You will be provided with a direct communication line for your Care Team.
5. Health insurance carriers, including Medicare, require physicians to manage patient health and outcomes. We are financially dependent on our ability to ensure our patients preventative services are met. We require our patients to comply with our Preventative Care guidelines, which will be provided on a per-patient basis.

Visit Reason:

We allow specific time depending on the nature of the visit reason. To stay on schedule, we ask that no more that two medical concerns are addressed per visit. We will expedite scheduling of a subsequent visit if additional time is needed.

Payment and Insurance:

We are committed to providing quality healthcare services to our patients. To ensure transparency and clarity regarding payment responsibilities, we have established the following patient payment policy. We kindly request that you review and understand these guidelines prior to your appointment.

1. **Insurance Coverage:**

a. Verification: It is the patient's responsibility to provide accurate and up-to-date insurance information during the registration process. We will make every effort to verify your insurance coverage before your appointment. However, it is essential for you to confirm the specifics of your coverage with your insurance provider.

b. Copayments and Deductibles: If your insurance plan requires copayments or deductibles, they will be collected at the time of service. We accept various payment methods, including cash, credit/debit cards, and personal checks.

c. Coverage Changes: If there are any changes in your insurance coverage, please inform our staff promptly to ensure accurate billing. Failure to provide updated insurance information may result in you being responsible for the full payment of services rendered.

2. **Self-Pay Patients:**

a. Full Payment: For patients without insurance coverage or for services not covered by their insurance plan, full payment is due at the time of service. Our staff will provide you with an estimate of charges upon request.

b. Payment Options: We accept cash, credit/debit cards, and personal checks for self-pay patients. Payment plans may be available on a case-by-case basis, subject to approval by our billing department.

3. **Outstanding Balances:**

a. Statements: In the event that you have an outstanding balance after insurance processing, we will send you a statement indicating the amount due. It is your responsibility to review the statement and promptly address any outstanding balances.

b. Payment Due Date: Payment for the outstanding balance is expected within 30 days of receiving the statement. Late payments may be subject to additional charges and may impact future appointments.

c. Collection Efforts: In the event of non-payment, we reserve the right to pursue collection efforts, which may include reporting to credit bureaus or engaging with a collection agency. We strive to avoid such measures and encourage open communication to resolve any payment issues.

4. **Financial Assistance:**

a. Eligibility: We understand that medical expenses can create financial challenges for some patients. If you require financial assistance, please contact our billing department to discuss available options. We are committed to working with you to find a suitable solution.

b. Payment Plans: Payment plans may be available for qualified individuals based on their financial circumstances. Our billing department will determine eligibility and establish a mutually agreed-upon payment plan.

Please note that this patient payment policy is subject to change, and updates will be communicated as necessary. We are committed to addressing any questions or concerns you may have regarding your financial responsibilities.

Compliance with Instructions:

Follow the instructions provided by our healthcare providers regarding medications, treatments, and lifestyle modifications. Adhering to these recommendations is vital for your health and well-being. If you

are not engaging in your healthcare process, we reserve the right to discontinue services, in accordance with state law.

Respectful Behavior:

Please treat our staff, fellow patients, and providers with respect and courtesy at all times. We strive to create a welcoming and inclusive atmosphere for everyone.
Refrain from using offensive language, engaging in disruptive behavior, or causing any disturbances that may interfere with the care of others.

We appreciate your cooperation in following these practice rules, as they contribute to a positive experience for all patients. If you have any questions or need further information, please don't hesitate to contact our office.

Thank you for entrusting us with your healthcare needs. We look forward to continuing to provide you with excellent care.

Sincerely,

By signing below, you acknowledge that you have read and understood the patient policy of Glades Medical Group and agree to comply with its terms.

Patient Name: _____ Date: _____

Signature: _____

Glades Medical
GROUP

Medical Appointment Cancellation/No-Show Policy

Effective July 1, 2023

Due to the financial disruption caused, it is the Policy of Glades Medical Group to enforce a Cancellation/ No-Show fee for a patient that fails to notify our office at least 24 hours in advance of the scheduled appointment. Patients shall be responsible for a charge of **$25.00** for office visits, **$10.00** for lab visits, **$50.00** for Ultrasounds or Echos, and **$100.00** for cognitive testing and immigration visits.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office manager, who may waive the fee if found to be acceptable and non-repeat behavior. Should you need to cancel after regular business hours, or are unable to reach our call center, you may contact us via text or email with our listed contact information:

Office: 561-394-3088

Email: Scheduling@gladesmedical.com

Text: 561-367-5410

Thank you for your understanding and cooperation.

Glades Medical Group

Glades Medical
GROUP

Dear Patient,

We value your health and want to ensure your healthcare experience is as seamless as possible. As part of our commitment to transparency and cost-effective care, we recommend that you consider checking the costs of laboratory tests prior to obtaining them, whether through insurance or directly with the lab company.

By being proactive and informed about the potential expenses involved, you can make better decisions about your healthcare and budget accordingly. While we strive to work with insurance providers and labs to offer competitive rates, understanding the costs upfront can help you avoid any unexpected financial burdens.

Before scheduling any laboratory tests, we encourage you to take the following steps:

Contact your insurance provider: Reach out to your insurance company to verify coverage for the specific lab tests recommended by your healthcare provider. Inquire about any co-pays, deductibles, or out-of-pocket expenses that may apply.

Inquire with the lab company: If you plan to pay for the lab tests directly, contact the lab company to obtain a price quote for the tests you need. Some labs offer cash-pay discounts or lower rates than what insurance may cover.

Ask your healthcare provider: If you have any questions about the necessity of specific tests or alternatives, feel free to discuss them with your healthcare provider. They can provide valuable insights into the medical necessity and potential cost-saving options.

Review your budget: Consider your financial situation and healthcare needs when deciding whether to proceed with the recommended tests.

At our practice, we are committed to offering high-quality healthcare with your best interests in mind. We believe that informed patients make empowered decisions for their well-being.

If you have any concerns or require assistance in navigating the cost of laboratory tests, please don't hesitate to reach out to our office staff. Together, we can work to ensure your healthcare experience is both beneficial and financially manageable.

Thank you for entrusting us with your health.

Sincerely,
Glades Medical Group

Glades Medical
GROUP

New Patient Medical History Questionnaire

Today's date: _____

Please complete the following questionnaire prior to your appointment with the physician. This information is very important to us for your care so please answer all the sections as accurately as possible If you have brought medical records to your appointment your nurse/doctor will make copies for our records

Name: _____ **Date of Birth:** _____ **Age:** _____

Past Medical History

Please review the following list. If you have any of these conditions check ☑ Yes or No and the approximate year of diagnosis If you have other conditions not listed, please write them down in the space provided.

Condition / Disease	Yes	No	Year	Condition / Disease	Yes	No	Year
Alcoholism / Cirrhosis				Heart attack (MI)			
Anemia				Hepatitis / Jaundice / Liver			
Arthritis				High blood pressure			
Asthma / Emphysema				HIV positive / AIDS			
Bleeding / Blood Disorders / Clots				Lung disease			
Bone or Spine				Prostate disease			
Cancer (past)				Seizures / epilepsy			
Leukemia				Stroke (s)			
Lymphoma				Thyroid disease			
Cataracts				Tuberculosis			
Crohn's disease / colitis				Ulcers / stomach pain			
Diabetes (high blood sugar)				Other: Significant illness for			
Gallbladder disease / stones				Which you have taken medicine			
Glaucoma				And/or seen a physician.			
Heart Disease							

Please list all hospitalizations and surgeries with the approximate date

Hospitalization and/or sugery	Date	Hospitalization and/or sugery	Date