Patient Registration

Joshua A. Halpern, M.D., P.A.

Name: _____ _____ _____ Date: _____
Last Middle Initial First

Address: _____ City: _____

State: _____ Zip: _____ Age: _____ Date of Birth: _____
Mo/Day/Year

Cell Phone #: _____ May we leave detailed messages on your phone? ☐ Yes ☐ No

Home Phone #: _____

Email address: _____ Social Security #: _____ - _____ - _____

Occupation: _____ Employer: _____

Ethnicity: Caucasian / African American / Hispanic / Asian / Other: _____

Marital Status: S / M / W Name of significant other: _____

Pharmacy Name: _____ Phone #: _____

Name of emergency contact: _____

Relationship to you: _____ Phone #: _____

May we contact you through email? ☐ Yes ☐ No May we text you? ☐ Yes ☐ No

May we send mail to your home? ☐ Yes ☐ No If no, where would you like mail sent? _____

_____

Would you like to receive emails on specials or updates? ☐ Yes ☐ No

Please tell us how you heard about us: _____

_____

What would you like to discuss with the Doctor today? _____

_____

_____

Our Clinical Aesthetician and ARNP offer non-surgical procedures; is there anything else we can help you with today?

_____

I HEREBY STATE ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT

_____ _____

PATIENT'S SIGNATURE DATE

Employee Initials: _____

4214 N. Habana Ave Tampa, FL 33607 813-872-2696

HIPAA & Patient Rights

Patient Consent for the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care. In addition, it may become necessary to disclose health information to other healthcare providers, laboratories, insurance companies and/or other individuals or agents as permitted or required by state or federal law.

Notice of Patient Acknowledgment of Receipt of HIPAA and Privacy Practice

The Health Insurance Portability & Accountability Act (HIPAA) protects individual's identifiable health information and gives patient's rights with respect to that information. Privacy Practice describes the personal information (including obtaining photographs for medical records) we collect, and how and when we use or disclose "Protected Health Information" (PHI).

Each time you visit our office, a record of your visit is made. This information serves as:

- A basis for planning your care and treatment;
- A means of communication between medical professionals who contribute to your care;
- A legal document describing care you have received;
- A source of information for applying your diagnosis and treatment information to your bill, for payment purposes, so the third-party payer can verify that services billed were provided;
- A tool in educating health care professionals;
- A source of data for medical research;
- A source for planning and marketing, with your authorization.

Please note: This practice is committed to training and using (PHI) about you responsibly. As a responsible practice, we are required to:

- Maintain the privacy of your health information;
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Although your health record is the physical property of this practice, you have certain rights you need to be aware of:

- The right to read "Patient Health Information Privacy Protection Act" & " Patient Bill of Rights and Responsibilities" prior to signing this consent;
- The right to request a copy of "Patient Health Information Privacy Protection Act"
- The right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or healthcare operations

Information about my treatment/care at The Center of Dr. Joshua Halpern may be released to the following individuals:

Name & Relationship: _____ Phone #: _____
Name & Relationship: _____ Phone #: _____
Name & Relationship: _____ Phone #: _____

Consent Form

By signing this form, you are acknowledging that you understand the "Health Insurance Portability & Accountability Act" (HIPPA) & Privacy Practices providing a more complete description of health information uses and disclosures, and that you have read Patient's Bill of Rights and Responsibilities and are fully aware of your patient rights.

I UNDERSTAND, ACKNOWLEDGE AND ACCEPT THIS CONSENT

PRINT NAME _____ SIGNATURE _____ DATE _____

***Our office does NOT file any insurance claims. ***

Our office does not accept insurance as a form of payment for services provided. Payment for those services is to be paid directly to Joshua A. Halpern M.D., P.A.

I AGREE TO BE FULLY RESPONSIBLE FOR ALL PAYMENTS

PRINT NAME _____ SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

___Consent form reviewed by _____ _____
EMPLOYEE SIGNATURE DATE

___ Patient refused to sign consent _____
REASON FOR REFUSAL

Patient Medical History

Joshua A. Halpern, M.D., P.A.

Patient Demographics

Name: _____ _____ Today's Date: _____
Last First MO/Day/Year

Age: _____ Sex: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Phone # _____

Primary Care Physician's address: _____

Social History

Do you consume alcohol? ☐ Yes ☐ No If yes, how many per week? _____
Do you smoke? ☐ Yes ☐ No ☐ Occasionally If yes, how many per day? _____ For how many years? _____
*** You must quit smoking two weeks prior to any surgical procedure***

Do you diet? ☐ Yes ☐ No ☐ Occasionally Explain Diet: _____
Do you exercise? ☐ Yes ☐ No ☐ Occasionally What type of exercise: _____

Allergies, Medications and Supplements

Do you have any drug allergies? ☐ Yes ☐ No If yes, please list below:

Medication/Substance	Reaction

Please list all the medications and supplements/herbals you are currently taking below:
Please attach list for more than 5 medications

- Do you take any blood thinners? ☐ Yes ☐ No If yes, ☐ Coumadin ☐ Aspirin ☐ Other: _____

Name of Medication	Dose and Frequency	Reason for taking

Medical History

Which of the following have you been diagnosed with? (Check all that apply):

Cardio Vascular System (HEART)
- ☐ High Blood Pressure
- ☐ Heart Attack /Heart Failure
- ☐ Angina (Chest pain)
- ☐ Arrhythmia(abnormal heartbeat)
- ☐ Heart Failure
- ☐ Blood clots (DVT or PE)
- ☐ Bleeding disorder
- ☐ Heart valve problems

If so, when? _____

Respiratory System (Lungs)
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Pulmonary Embolus

If so, when? _____

Gastrointestinal
- ☐ Peptic Ulcer Disease
- ☐ Hiatal / Umbilical Hernia
- ☐ Pancreatitis
- ☐ Gallbladder disease
- ☐ Inflammatory bowel disease
- ☐ Colonic problems

If so, when? _____

➢ Continues on next page

Medical History...Continued

Which of the following have you been diagnosed with? (Check all that apply):

Infectious Disease ☐ AIDS ☐ Hepatitis ☐ Herpes If so, when? _____ What type? _____	**Genitourinary** ☐ Urinary Tract Infections ☐ Prostate problem If so, when? _____	**Neurology** ☐ Bell's palsy ☐ Seizures ☐ Stokes/Mini strokes If so, when? _____
Skin ☐ Cold sores ☐ Shingles ☐ MRSA/Staph Infection If so, when? _____	**Cancer** ☐ Uterine ☐ Prostate ☐ Breast ☐ Skin If so, when? _____	**Endocrine** ☐ Diabetes/High blood sugar ☐ Thyroid problems If so, when? _____
Other Medical Conditions _____ _____	**Other Medical Conditions** _____ _____	**Other Medical Conditions** _____ _____

Surgical / Procedure History

Please list any other surgeries/procedures:

Surgery/Procedure:	Date:	Reason for surgery:

Acknowledgement

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: _____ DATE: _____

4214 N. Habana Ave Tampa, FL 33607 813-872-2696

COVID-19 INFORMED CONSENT AGREEMENT

Risk of Exposure. I, the undersigned individual, consent to an in-person consultation and/or to have my Doctor and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations and/or having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

Infection Control Procedures. I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

Testing. I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.

Symptoms. I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control here: https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf and printed on the reverse of this form, which information I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

My Consents. All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my in-person consultation and/or procedure until the COVID-19 pandemic is less prevalent, but I choose to have my in-person consultation and/or procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

_____ _____

Individual/Patient/Authorized Representative Signature and Initials Print Name & Date **[First encounter]**

_____ _____

Individual/Patient/Authorized Representative Signature and Initials Print Name & Date **[Day of procedure]**

The Aesthetic Society

Notice and Disclaimer. Medical information changes constantly. This COVID-19 Informed Consent Agreement sets forth the current recommendations of The Aesthetic Society, is provided for informational purposes only, and does not establish a new standard of care. June 2, 2020

JOSHUA HALPERN, M.D.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professional or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice message, text, email or with a household family member.

[ ] Please check here if you do not want us to leave message on your answering machine or with a household family member.

[ ] Please check here if you do not want us to leave a message on your mobile voice message/text.

[ ] **Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- If you choose, please list by name and relationship the person(s) with whom we may share your healthcare or payment information _____
  _____
- You may request a copy of and have the right to read our "*Notice of Patient Privacy Practices*" prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print): _____

_____	_____	_____
Signature	Print name of person signing if other than patient	Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP _____

FOR OFFICE USE ONLY

Patient refused to sign the form. Reason: _____ Date: _____

SUMMARY OF THE FLORIDA PATIENT'S BILLOF RIGHTS AND RESPONSIBILITIES

In order to promote the interests and well-being of our patients, we recognize your rights while you are receiving medical care. We trust that you will respect our right to expect certain behavior of your while you are a patient at our facility. The following is a summary of your rights and responsibilities in accordance with the Florida Patient's Bill of Rights and Federal Regulations.

Your Rights

You have the right to:

- be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- a prompt and reasonable response to questions and requests.
- know who is providing medical services and who is responsible for his or her care.
- know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- know what rules and regulations apply to his or her conduct.
- be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- refuse any treatment, except as otherwise provided by law.
  be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- (if eligible for Medicare) know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

Your Responsibilities

You are responsible for:

- providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- reporting unexpected changes in his or her condition to the health care provider.
- reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- following the treatment plan recommended by the health care provider.
- keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- your actions if he or she refuses treatment or does not follow the health care provider's instructions.
- assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- following health care facility rules and regulations affecting patient care and conduct.

For a copy of the full text of the Florida Patient's Bill of Rights and Responsibilities, please ask.

If you have any complaint against a hospital or ambulatory surgical center, call the Complaint Administration Unit at 888.419.3456 or write to Agency for Healthcare Administration Consumer Assistance Unit 2727 Mahan Drive Tallahassee, FL 32317-4000 www.fdhc.state.fl.us. If you have complaints against a doctor, call Medical Staff Services at 407.841.5139 or the Medical Quality Assurance, Consumer Service Office at 888.419.3456 or write to Healthcare Practitioners Medical Quality Assurance Consumer Services PO Bo 1400 Tallahassee, FL 32308-4000.