Michele J. Moraes M.D., P.A.

Patient Registration Form

Patient Name:_____ **Date of Birth:**_____
First Middle Last

Legal Guardian/Parent Name (If Applicable) :_____

Cell Phone #:_____ **Home Phone:**_____

Email:_____ **Social Security Number:**_____

Would you like to receive emails about our office news, events and special offers? Yes___ No___

Preferred method to receive appointment reminders?(circle): Text to Cell Phone Email
(You must either provide an email address or a cell phone number that receives texts for these 2 options.)

Address:_____ Mailing Address _____
_____ (If different) _____
_____ _____

Marital Status: Married Single Widowed Divorced

Preferred Language: _____ **Race:** _____ **Ethnicity:** Non-Hispanic Hispanic

Place of Employment:_____ **Phone:**_____

Emergency Contact(s):_____ _____
Name/Phone Number/Relation to Patient Name/Phone Number/Relation to Patient

Do we have permission to:
Leave messages on your answering machine? Yes___ No___
Discuss your medical condition with any member of your household? Yes___ No___
If Yes, Whom?_____ Relationship:_____

Primary Care Physician:_____ Phone:_____ Fax:_____
Referring Physician (If applicable):_____ Phone:_____
Preferred Pharmacy Name and Phone Number: _____

Reason for today's visit?:_____

Financial Agreement

Please be aware, payment is expected from you at the time of service for your part of the charges (copay and deductible). Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the physician to release such medical information necessary to process your insurance claims (if any). I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related insurance/medicare claim (if applicable). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare and Commercial assignments of benefits apply. You hereby authorize payment of medical benefits to the doctor when an assigned claim is filed.

Patient or Guardian Signature: _____ **Date:** _____

Acknowledgment of receipt of Notice of Privacy Practices
I hereby acknowledge that I have received a copy of the Privacy Notice of Dr. Michele J. Moraes' practice and had an opportunity to ask any questions of concern at this time:
Patient or Guardian Signature_____ **Date:** _____

Michele J. Moraes M.D.. P.A.

Patient Name: _____ **Date:**_____

Past Medical History (Circle all that apply)

Anxiety	COPD	Hearing Loss	Hypothyroidism
Arthritis	Coronary Artery Disease	Hepatitis	Leukemia
Asthma	Depression	High Blood Pressure	Lung Cancer
Atrial Fibrillation	Diabetes	High Cholesterol	Lymphoma
Bone Marrow Transplantation	End Stage Renal Disease	HIV / AIDS	Prostate Cancer
Breast Cancer	GERD	Hyperthyroidism	Seizures
Colon Cancer			Stroke

NONE OF THE ABOVE APPLIES

Other Disease or Condition: _____

Are You Pregnant: Yes No **Are you planning a pregnancy**: Yes No

Past Surgical History (Circle and include dates)

Appendix Removed	Biological Valve Replacement	Ovaries Removed: Ovarian Cancer
Bladder Removed	Heart Transplant	Prostate Biopsy / Removal: Prostate Cancer
Mastectomy (Right, Left, Bilateral)	Knee Replacement (Right, Left, Bilateral)	TURP (Prostate Removal)
Lumpectomy (Right, Left, Bilateral)	Hip Replacement (Right, Left, Bilateral)	Spleen Removed
Colectomy: Colon Cancer Resection	Joint Replacement within last 2 years	Testicles Removed (Right, Left, Bilateral)
Colectomy: Diverticulitis	Kidney Removed (Right, Left)	Hysterectomy: Fibroids
Colectomy: IBD	Kidney Stone Removal	Hysterectomy: Uterine Cancer
Gallbladder Removed	Kidney Transplant	NONE OF THE CHOICES APPLY
Coronary Artery Bypass	Ovaries Removed: Endometriosis	

List any surgical procedures in the last 2 years: _____

Other:_____

Are you currently taking any blood thinners: Yes No

Do you have: Pacemaker Defibrillator Stents

Skin Disease History

Acne	Basal Cell Carcinoma	Dry Skin	Flaky scalp
Dysplastic Nevus	Eczema MRSA	Melanoma	
Psoriasis	Squamous Cell Carcinoma	None of the above	

Do you wear sunscreen: Yes No What SPF: _____

Family history of melanoma: Yes No If yes, which relative(s):_____

Allergy to: Latex Lidocaine Bacitracin Adhesives

Any problems with: (circle) Bleeding Healing Scarring

Please list all your Medications (prescription and OTC) with dosages and number of times taken daily:

_____

_____

_____

_____

_____

_____

Please list any allergies, especially allergies to medications:

_____

Social History

Cigarette Smoking

Current Smoker How many packs a day: ____ for how many years ____

Former Smoker How many packs a day: ____ for how many years ____

Never Smoked

Alcohol Use

None

Less than a drink per day

1 to 2 drinks a day

3 or more drinks a day

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

Have you received a pneumonia vaccine?: _____ if yes, when? _____

Have you received a flu vaccine in the last 12 months?: _____ if yes, when? _____

Advanced Directives

Advanced directives are designed to respect your autonomy and determine your wishes about future life sustaining medical treatment if you are unable to indicate your wishes. Key intervention and treatment decisions are resuscitation procedures such as Cardiopulmonary Resuscitation (CPR) and mechanical respiration (breathing tube).

Which statement(s) best reflect your wishes on advanced care recommendations?

☐ I want full cardiopulmonary resuscitation efforts to be made. (Full Code)

☐ I do not wish to have a breathing tube, even if it is necessary to save my life. (Do Not Intubate)

☐ If my heart were to stop, I do not wish to have chest compression or an automated external defibrillator to restart my heart, even if necessary to save my life. (Do Not Resuscitate)

☐ I have a living will which is administered by_____and contact information is_____.

☐ I have a health care proxy/decision maker whose name is _____ and contact information is _____.

Patient Signature:_____ Date: _____

Michele J. Moraes, M.D.,P.A.

Cancellation Policy

Cancellations without prior notification are not only discourteous to our staff but also prevent another patient in need from being seen. Patients who have a scheduled appointment and do not notify this office of a cancellation prior to 24 hours of the appointment will be charged a $25 fee. Patients who do not give at least 48 hours notice of a cancellation before a cosmetic procedure will also lose their initial deposit. Please be aware that patients can contact our answering service after hours to inform them of any cancellations.

While our office makes every effort to give each patient a courtesy call to remind them of their upcoming appointment, it is the patient's responsibility to keep track of all appointment dates and time. It is also the patient's responsibility to inform our office of any telephone number changes in order for us to give you a courtesy call.

We hope that these measures will help our office run more efficiently in proving the best possible care for our patients.

_____ _____

Patient (Print and Sign) Date

Michele J. Moraes, M.D., P.A.

FINANCIAL POLICY

Thank you for choosing the office of Michele J. Moraes, M.D., P.A. as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy. **All patients (or parent/guardian) must read and sign this form prior to receiving services.**

It is your responsibility to provide us with your most current insurance information.

- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, **you will be financially responsible for services rendered.**
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company.

You are financially responsible for services not covered by your insurance company.

- Before receiving services, **you must verify that we are participating providers for your insurance company.**
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Copayments, coinsurance and/or deductibles are due at the time of visit. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – **regardless of our estimation.**
- If your insurance plan requires a referral, this **must** be obtained from your primary care physician prior to coming in to the office. It is **your responsibility** to know if a referral is required for your visit and to obtain this referral.

It is your responsibility to provide us with your most current billing information.

- You must provide your most current billing address, correct telephone numbers and any other important contact and demographic information. You are responsible to notify us of changes to your address or contact information. If for any reason we fail to collect the due amount at the time of visit we will send a statement notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement, you can call **(561) 883-7770.**
- Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts will be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account will be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- If your account is assigned to a collection agency, you will no longer be able to receive services from our office.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add a $35.00 fee to your original balance. In addition, we may seek all additional legal remedies provided to us under Florida law.
- We will charge a "No Show" fee of $25 if you fail to cancel or reschedule your appointment without 24 hours prior notice.
- **FAILURE TO PAY PAST DUE BALANCES MAY REQUIRE US TO CANCEL OR RESCHEDULE YOUR APPOINTMENT.** Full payment is due at the time of service. We accept cash and most credit cards.
- Non-medical services such as providing medical records or physician claim statements will incur a fee which must be paid in advance. Cosmetic procedures will require a payment of at least half the amount of the total cost as a deposit at the time the appointment is made. Payment of the full balance must be made before the cosmetic procedure is performed. Payment on the same date as the cosmetic procedure must be cash or credit card only, no checks please.

I have read and understand this Financial Policy.

Name of Responsible Party (Print)_____

Signature of Responsible Party _____ Date_____