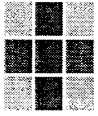
 Tenet Florida Physician Services

PATIENT INFORMATION

Last Name: ______________________________ First Name: __________________________ Middle Initial: __________

Previous Last Name: ______________________ Birth Date: ___________________________ Sex: □ Male □ Female

Billing Address: ____ State: _______ Zip: ___________

Country ____

Secondary Alternate Address: ____ State: _______ Zip: ___________

Country ____

Race: _________________________________ Language ______________________ Marital Status _______________

Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown

Home Phone: _______________________ Cell Phone: ____________________ Work Phone: ______________________

Email Address: ____

Preferred Contact Method: □ Home Phone □ Cell Phone □ Work Phone □ Email

Primary Care Physician: ____

How were you referred to our office? ____

If patient is a minor (under 18 yrs old): ________________________________ ______________________________

Father's Name Mother's Name

Emergency Contact Name: _______________ Phone Number: ___________________ Relation: _____________________

Employer: ___________________________________ Occupation: ____

Employer Address: ____ State: ________ Zip: ______________

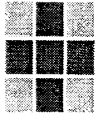
INSURANCE

Is your visit due to any of the following: □ Auto Accident □ Worker's Compensation Date of Accident? ____________

Are you personally responsible for payment of the fees for services provided by our office? □ Yes □ No

If no, who is? ____

Primary Insurance Plan Name: ___________________________ Policy Holder Name: ___________________________


Tenet Florida Physician Services

Policy Holder Date of Birth: ______________________

Policy # ______________________ Group# ______________________

Secondary Insurance Plan Name: ______________________ Policy Holder Name: ______________________

Policy Holder Date of Birth: ______________________

Policy # ______________________ Group# ______________________

PHARMACY

Name: ______________________ Address: ______________________ State: _____ Zip: ________

PATIENT HEALTH HISTORY

Reason for today's visit? ______________________

When did symptoms begin? ______________________

Location: ______________________ Onset: □ Gradual □ Sudden □ Other

Duration: ______________________ Severity: □ Mild □ Moderate □ Severe □ Incapacitating

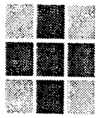
Context (when walking, sleeping, etc.) ______________________

Status: □ New Diagnosis □ Improving □ Stable □ Worsening □ Resolved

Aggravating Factors: ______________________ Relieved By: ______________________

Chronic Conditions (select those that apply)

Condition	Date of Onset	Condition	Date of Onset
Anemia		Eye Problems	
Angina		Cerebrovascular Accident	
Anxiety		Gastroesophageal Reflux	
Arthritis		Headaches	
Asthma		Crohn's Disease	
Atrial Fibrillation		Liver Disease	
Bladder Infections		Heart Attack (Myocardial Infarction)	
Cancer____________(type)		Hepatitis	
Constipation/Diarrhea		Insomnia	
COPD		Hypertension	
Coronary Artery Disease		Blood Clots	
Depression		Irritable Bowel Syndrome	
Diabetes Type I		Stroke	
Diabetes Type II		Thyroid Diseases	



Tenet Florida Physician Services

Gallbladder Disease		Osteoporosis	
Renal Disease		Seizure Disorder	

List any medications you are currently taking (including non-prescription or over the counter vitamins or supplements)

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.

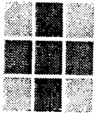
Do you have any current allergies (including medications, food, animal, plant or environmental)?

1.	2.
3.	4.
5.	6.

Please indicate any past surgical history

☐ Angioplasty	Year ____________	☐ Hernia Repair	Year ____________
☐ Angio w/ Stent	Year ____________	☐ Hip Replacement	Year ____________
☐ Appendectomy	Year ____________	☐ Knee Replacement	Year ____________
☐ Back Surgery	Year ____________	☐LASIK	Year ____________
☐ CABG	Year ____________	☐ Liver Biopsy	Year ____________
☐ Carpal Tunnel Release	Year ____________	☐ ORIF	Year ____________
☐ Cataract Extraction	Year ____________	☐ Pacemaker	Year ____________
☐ Cholecystectomy	Year ____________	☐Small Bowel Resection	Year ____________
☐ Colostomy	Year ____________	☐ Thyroidectomy	Year ____________
☐ Gastric Bypass	Year ____________	☐ Tonsillectomy	Year ____________

OTHER ____



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Family History

Relation	Alive & Well (Y/N)	Condition/Diagnosis	Age of Onset	Cause of Death (Y/N)
1.				
2.				
3.				
4.				
5.				
6.				

Social History – Tobacco Usage

Use Tobacco: □ Current □ Former □ Never □ Unknown

Type: □ Chewing □ Cigar □ Cigarettes □ Pipe □ Smokeless □ Snuff

Quantity per day: ________________ Year(s) Used: ________________ Have you ever tried to quit? (Y/N) _____

Year Quit ________________________

Social History – Alcohol

Yes/No/Former ______________________ If Yes, Type: ____________________ Frequency: ______________________

If former, when quit? _________________ Amount: ______________________ Last Drink: ______________________

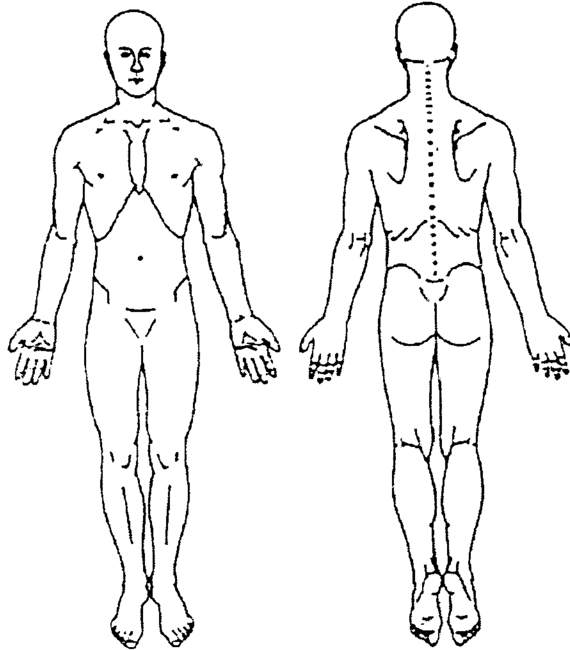
Social History – Caffeine

Use: □ Yes □ No Type: □ Chocolate □ Coffee □ Energy Drinks □ Soda □ Tablets □ Tea

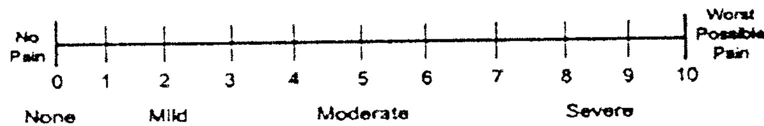
Quantity per day: ___________________

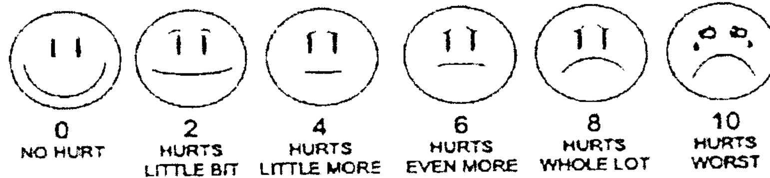
Body Diagram

Instructions:
On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition,



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.





Patient Signature_______________________________________ Date_______________

Dr. Jonathan Hersch Financial Policy and Authorizations

We are happy that you selected Dr. Jonathan Hersch for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

______________________________ ________________

Patient or Parent/Guardian if Minor Date

Dr. Jonathan Hersch

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: ______________________ Date of Birth: ________________

Signature: ______________________ Date: ______________________

***Minors or Users Requiring Caregivers – Acknowledgement of Consent to Contact**

Name: ______________________ Relationship to Patient: ____________

Signature: ______________________ Date: ______________________

Dr. Jonathan Hersch
6893 SW 18th Street, Suite F101
Boca Raton, FL 33433
P (561) 417-3339 F (561) 417-3409

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have received a copy of the "Notice of Privacy Practices" (Version 3 August 2013 dated 09/23/2013) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize Dr. Jonathan Hersch to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to Dr. Jonathan Hersch any information obtained in the adjudication of any claim for services furnished to me by Dr. Jonathan Hersch.
- I acknowledge that Dr. Jonathan Hersch, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

Name of Patient/ or Guardian (if Minor): ______________________________
Signature of Patient/or Guardian: ______________________________
Date: ____________

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care. This is to acknowledge that you authorize Dr. Jonathan Hersch to (check all that apply):

☐ Leave a detailed message on voice mail/machine

☐ Call my workplace phone number and leave a message

☐ Call my workplace phone number and speak only to me

☐ Transmit and Receive messages through Patient Portal (NextMD or Other) including secure email

☐ None of the above

I further authorize the disclosure of my PHI to the following individuals or family members:

Name: ______________________ Relationship to Patient: ______________

Name: ______________________ Relationship to Patient: ______________

Name: ______________________ Relationship to Patient: ______________

Signature of Patient/Guardian: ______________________ Date: ____________

Dr. Jonathan Hersch
6893 SW 18th Street Suite F-101, Boca Raton, FL 33433
Tel: 561-417-3339 Fax: 561-417-3409

CONTRACT FOR PRESCRIPTION CONTROLLED SUBSTANCE MEDICATION

Controlled substances (narcotics, tranquilizers and barbiturates) and all prescription medications can be very useful in the treatment of pain. Unfortunately, they also have a high potential for abuse and misuse and are closely supervised by the local, state and federal government.

I agree to enter into the following contract with Jonathan C. Hersch, M.D.:

1. I am responsible for my controlled substance and all prescription medications. If the prescription or medication is lost, misplaced, stolen, or I use sooner than prescribed, I understand that it will not replaced.

2. I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medications from Jonathan C. Hersch, M.D. The exception would be if I were hospitalized and under the care of another physician.

3. Refills of controlled substance and all prescription medication:

   A. Will be made during office hours only, 8:30am to 5:00pm, Monday through Friday. Refills will not be made at night, on holidays or weekends.

   B. Will not be made if "I run out early". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

   C. Will not be made as an "emergency". I will call at least 12 to 24 hours ahead if I need assistance with a controlled substance and prescription medication.

I understand that if I violate any of the above conditions, my relationship as a patient with Jonathan C. Hersch M.D. may be terminated. I understand that I may be reported to the Drug Enforcement Authorities, other physician and local medical facilities.

__________________________ Patient's Signature

__________________________ Printed Patient's Name

__________________________ Witness

__________________________ Date