REBECCA FARINAS, M.D.

PATIENT REGISTRATION FORM

Patient Name (please print):_____ DOB:_____

If you are a parent completing this form for your child, please complete this section with your information and not your child's. All other sections should be completed with the child's information.

DEMOGRAPHIC INFORMATION

Name:	SSN:	Date of Birth:
Street Address:		
City, State, ZIP:		
Daytime Phone:	Marital Status:	Children:
Employer:	Work Phone:	
Insurance Company:	ID #:	Group#:
Subscriber Name:	Subscriber SSN:	Subscriber DOB:
May we contact you at home? □ YES □ NO	May we contact you at work? □ YES □ NO	

PLEASE COMPLETE IF PATIENT IS A MINOR

Name of Child:	Date of Birth:	Age:
Address:		
City, State, ZIP:	Social Security Number:	
Daytime Phone:		
Are you the primary custodian of the child? □ YES □ NO	School/Grade:	
Comment:		

EMERGENCY CONTACT INFORMATION

Relationship:	Daytime Phone #:
Name:	Evening Phone #:
Address:	Cell Phone #:
City, State, ZIP:	

MILITARY AND EDUCATION

Have you served or are you serving in the U.S. Military? □ YES □ NO	Education:
If Active Duty, what Branch?	College Degree:
Have you been discharged from the U.S. Military?	High School Diploma:
Discharge type:	Highest level of education?

MEDICAL HISTORY

Are you currently taking any supplements or over-the-counter medications (herbs or vitamins)? □ YES □ NO

If yes, please describe: _____

_____

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Patient Name (please print):_____ DOB:_____

Do you smoke cigarettes or tobacco products? □ YES □ NO (if "yes," how much and for how long) _____

Did you smoke cigarettes or use tobacco products in the past? □ YES □ NO (if "yes," how much and for how long) _____

Do you drink coffee or caffeinated beverages? □ YES □ NO (if "yes" which and how much) _____

Do you drink alcohol? □ YES □ NO (if "yes," how much and how often) _____

Drug use? (Marijuana, Cocaine, Pain Pills, etc.) Please list: _____

Are you allergic to or have you ever had an adverse reaction to any medication or other substances? □ YES □ NO Are you allergic to any food? □ YES □ NO

Please list all known allergies or sensitivities: _____

_____

Are you currently taking any prescription medication(s)? □ YES □ NO (if "yes" please list below)

Medication Name	Dosage	Date Prescribed	Reason Prescribed	Prescribed By	Tolerance/Adverse Reactions

Have you ever been prescribed medication(s) for emotional reasons and did you take it? □ YES □ NO (if "yes" please list below)

Medication Name	Dosage	Date Prescribed	Reason Prescribed	Prescribed By	Tolerance/Adverse Reactions

Have you ever had any psychiatric hospitalization or had any emotional or substance abuse treatment? □ YES □ NO (if "yes" please describe below)

Treatment Date(s)	Facility	Reason for Treatment	Duration	Outcome and Follow-Up Care

Do you have any other medical condition(s) (Diabetes, High Cholesterol, Obesity, etc.)? □ YES □ NO (if "yes" please describe below)

Past	Current	Medical Condition/Diagnosis	Diagnosed When?	Medication Prescribed	Results
□	□				
□	□				
□	□				
□	□				

Have you ever had any surgeries or hospitalization(s)? □ YES □ NO (if "yes" please describe below)

Surgery/Hospitalization Date	Reason for Treatment	Outcome and Follow-Up Care

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Patient Name (please print):_____ DOB:_____

Referring Physician: _____ Primary Care Physician: _____

Other treating physicians: _____

Presenting Complaint (Describe, in detail, what is bothering you, when started, treatments, tests performed, severity, and other symptoms):

_____
_____
_____
_____
_____

Past Psychiatric History (Please Elaborate) _____

_____
_____
_____
_____

Family Psychiatric History (Please be specific):_____

_____
_____
_____
_____

Family History:

.	Alive/Deceased	Age	Health Problems/Cause of Death
Father			
Mother			
Brothers/Sisters			

Please circle any symptoms/problems you have and explain below:

General Recent change in appetite, weight gain, or weight loss. Fevers, chills, or sweats.

Head Occasional mild headaches, migraines, recent trauma or concussion

Eyes Recent visual changes or double visional. Presbyopia (need bifocals), Cataracts, or Glaucoma

Ears Ringing, Infection, drainage, or pain. Mild Hearing Loss, Hearing Impaired, or use hearing aid

Nose/Throat Frequent nose bleeds, bleeding gums, sores in mouth or lips, difficulty swallowing, or hoarseness.

Lungs Wheezing, chronic cough, emphysema, or COP, coughing up blood. TB or positive skin test, sleep apnea, or use CPAP, Pulmonary Embolism, or Asthma

Heart Chest pain or angina, heart skips, rapid heart rate, exertional or nocturnal shortness of breath. Cardia testing within the last year (EKG, stress test, cardiac catheterization, or echo) Heart attack, Atrial fibrillation, Pacemaker, Mitral valve prolapse, Hypertension

Breast Current breast mass, nipple discharge, personal history of breast cancer, Breast Augmentation, Current abnormal mammogram or sonogram, Last mammogram _____(month and year), Overdue for mammogram

Digestive Abdominal pain, nausea, vomiting, bloating, heartburn, or GERD, diarrhea, constipation, Cirrhosis, jaundice, Gallstones, Black stools, blood in stool, hemorrhoid problems, History of cancer, Crohn's disease ulcerative colitis, diverticulitis, or irritable bowel disease

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Patient Name (please print):_____ DOB:_____

Gento-urinary	MEN Difficulty urinating, difficulty holding urine, frequent urination at night, Prostate cancer, Blood in Urine, kidney stones, herpes, discharge from penis WOMEN Difficulty urinating, difficulty holding urine, frequent urination at night, Menopause at age ____, Hysterectomy at age _____, Were ovaries removed? _____, Blood in urine, kidney stones, Genital Herpes, Last menstrual period _____
Musculoskeletal	Pain in joints, pain in muscles, muscle weakness, fibromyalgia, arthritis under treatment, Chronic back problems, swollen ankles, varicose veins
Neurological	Dizziness, loss of consciousness, transient loss of function, stroke, seizures
Skin	Rash, psoriasis, non-healing lesions, history of skin cancers or melanoma
Emotional	Anxiety, Depression, psychiatric therapy. Current treatment for depression or anxiety
Endocrine	Thyroid disorder, masses, heat or cold intolerance, or taking thyroid medication. Diabetes under Treatment, excessive thirst, hunger, or urination. Adrenal or pituitary disorder.
Hematologic	Anemia, bruise easily, excessive bleeding, swollen glands, leukemia, lymphoma, transfusions, Blood clots, phlebitis, deep venous thrombosis, anticoagulated with Coumadin, sickle cell
Infections	HIV positive, history of hepatitis (type _____), staph infections, MRSA, or ORSA

CONSENT TO TREAT

I hereby consent to examination and treatment by a psychiatrist at the Medical Office of Rebecca Farinas, M.D. I hereby affirm that I am of legal age and otherwise competent to consent to medical treatment. If not, the person signing below represents that such persons the parent, legal guardian or person otherwise allowed by law to consent to the examination and treatment of the patient and by their signature hereto consents.

Patient's Signature (Responsible Party if Minor): _____**Date:**_____

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Patient Name (please print):_____ DOB:_____

FINANCIAL AGREEMENT

We strongly agree that all patients deserve the best behavioral health care that we can provide. Further, your understanding of our Financial Policy is important to our professional relationship and we feel that everyone benefits when clear financial policies are outlined and agreed upon.

Our professional services are rendered to you, not the insurance company. Therefore, payment for services is your responsibility.

I understand that I am directly and fully responsible for charges not covered by my insurance company, such as co-payments, deductibles, and sometimes balances for non-covered services.

I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I might recover said fee.

I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 60 days, it is my responsibility to pay for services rendered.

I further understand and agree that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees, as well as, attorney's fees.

I understand there will be a $50 charge on all returned checks.

Patient's Signature (Responsible Party if Minor):_____**Date:**_____

NON-COVERED SERVICES AGREEMENT

Our staff will make every effort to assist you with your insurance company to make sure your treatment is authorized and you receive reimbursement to cover the cost of your treatment. In the event your insurance company refuses to authorize services as Medically Necessary, you will be responsible for all charges associated with your care.

Again, we will assist you in any way possible to obtain authorization prior to your treatment.

I understand that, if my insurance company refuses to authorize my care for any reason, I will be responsible for all charges and payments for services rendered.

Patient's Signature (Responsible Party if Minor):_____**Date:**_____

MEDICAL RECORDS FEES

Medical records may be requested and sent, if approved. Our fees are compliant with the Florida Statues and are $1 per page up to 25 pages, and $0.25 cents per page thereafter. Patient is responsible for fees if not paid by requesting party within 60 days.

Patient's Signature (Responsible Party if Minor):_____**Date:**_____

MEDICAL FORM FEES

In the event you need a letter from the doctor or forms completed, there will be a fee for these services. The fees vary and we will notify you of the exact cost depending on your specific needs (minimum of $50). These services may take up to 10 working days to complete due to the high volume of requests.

Patient's Signature (Responsible Party if Minor):_____**Date:**_____

APPOINTMENT CANCELLATION FEES

For our appointment cancellation or reschedule notice, and fees associated with these requests not being made in time required by our office, please see our Office Policies Form: No-Show and Late fees. Also, Office Policy Form can be downloaded from our website at http://www.rebeccafarinasmd.com/Patientresource.

Patient's Signature (Responsible Party if Minor):_____**Date:**_____

REBECCA FARINAS, M.D.

PATIENT REGISTRATION FORM

Patient Name (please print):_____ DOB:_____

ADMINISTRATIVE AGREEMENT

APPOINTMENT CONFIRMATION AGREEMENT

As a courtesy to our patients, we offer an appointment confirmation service. We will call you and remind you 2 business days in advance of your upcoming appointment with Dr. Farinas. Reminder calls are NOT placed on weekends. If, for any reason, our office fails to call you and notify you of your upcoming appointment, you are still responsible to keep the scheduled appointment. Failure to do so will result in appointment cancellation fees and you will be required to pay these fees. If you have any questions about our appointment confirmation system, please feel free to ask.

The cancellation fee will be charged in accordance with our Office Policy for No-Show and Late Fee schedule.

I hereby authorize Office of Dr. Farinas to confirm any future appointments:

Patient's Initials (Responsible Party if Minor):_____

I DO NOT want Office of Dr. Farinas to confirm any future appointments.

Patient's Initials (Responsible Party if Minor):_____

NOTICE OF PRIVACY PRACTICE

You may request a copy of the Privacy Practice Form as required by HIPPA at any time during your treatment, from our front desk. You can also download the notice of Privacy Practice Form from our website at www.rebeccafarinasmd.com/patientresources.

Patient's Initials (Responsible Party if Minor):_____

PRESCRIPTION POLICY

For our policy regarding all prescriptions and prescription refills, please see our Office Policy Form: Prescriptions and Medications. This form is available at the front desk and for download from our website at www.rebeccafarinasmd.com/patientresources.

Patient's Initials (Responsible Party if Minor):_____

AUTHORIZATION TO RELEASE OR RECEVIE MEDICAL INFORMATION

I authorize the Office of Dr. Farinas to release or receive any information necessary to process insurance claims.

Patient's Initials (Responsible Party if Minor):_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

For our patients, we created separate, detailed "**Authorization for Release of Medical Information**" form that outlines the duration of release and whom your medical information can be released, per your authorization.

This form encompasses both, the release of your medical information to another medical provider and the release of your medical information to a family member or other designated person, per your authorization. You can request this form at the front desk at any time or, you can download the form from our website at www.rebeccafarinasmd.com/patientresources.

Patient's Initials (Responsible Party if Minor):_____

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

I hereby authorize the Office of Dr. Farinas to bill my insurance company directly for services rendered. I authorize payment directly to this provider of any insurance benefits otherwise payable to me. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to the Office of Dr. Farinas for which fees are payable.

Patient's Initials (Responsible Party if Minor):_____