LAWRENCE BERGMAN, MD, LLC

Patient's Last Name: _____ Patient's First Name: _____Middle Name:_____

Address: _____City: _____State: _____ Zip:_____

Sex: ☐MALE ☐FEMALE Date of Birth _____ Birth Weight _____ Type of Delivery _____ Term: Yes or No

Race (check one) ☐1-American Indian/Alaska Native ☐2-Asian ☐3-Black/African American ☐4-White ☐5-Pacific Islander ☐6-Refuse

Ethnicity (check one) ☐1-Hispanic or Latino or Spanish origin ☐2-Non Hispanic or Latino or Spanish origin ☐3-Refuse

Preferred Language:_____ Parents Marital Status: ☐Married ☐Divorced ☐Separated ☐Single

Home Phone: _____ Cell Phone (Mom) _____ Cell Phone (Dad) _____

Email Address: _____ Sibling (first, last name, DOB) _____

Pharmacy Name: _____ Sibling (first, last name, DOB) _____

Pharmacy Phone Number: _____ Sibling (first, last name, DOB) _____

Who referred you to Lawrence Bergman, MD, LLC? _____

What is the name and phone number of your previous physician? _____

_

PRIMARY CONTACT PERSON FOR FAMILY (this primary contact will be the preferred contact person for Reminder calls)

Circle one: Mother / Father Social Security #: _____

Check one: ☐Biological ☐Step ☐Adoptive ☐Foster ☐Legal Guardian ☐Other: _____

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ Work Phone: _____ Email: _____

City: _____ State: _____ Zip: _____Date of Birth: _____

Do you live with patient? ☐Yes ☐No Name of Employer: _____

Check preferred means of contact for messages: ☐Home ☐Cell ☐Work ☐Email

Check preferred means of contact for Appointment Reminders: ☐Home ☐Cell ☐Work ☐Email

SECONDARY CONTACT PERSON FOR FAMILY

Circle one: Mother / Father Social Security #: _____

Check one: ☐Biological ☐Step ☐Adoptive ☐Foster ☐Legal Guardian ☐Other: _____

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ Work Phone: _____Email: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Do you live with patient? ☐Yes ☐No Name of Employer: _____

WHO HAS PRIMARY PHYSICAL CUSTODY? (if applicable) _____

(If either biological parent has NO parental rights per a SIGNED COURT ORDER, a copy of that Court Order is required to be on file.)

EMERGENCY CONTACT PERSON (other than either the parent(s) or contact(s) listed above)

Name: _____ Relationship to Patient: _____ Phone: _____

FINANCIAL GUARANTOR: _____Relationship to Patient: _____

Insurance Company name: _____ Primary Insured name: _____

ID # or Member # _____ Group # _____

PERSONS AUTHORIZED TO BRING CHILD IN FOR APPOINTMENTS - OTHER THAN PARENTS - (must be 18 years or older)

Name: _____Relationship to Patient: _____DOB: _____ Phone: _____

Name: _____Relationship to Patient: _____DOB: _____ Phone: _____

Name: _____Relationship to Patient: _____DOB: _____ Phone: _____

Name: _____Relationship to Patient: _____DOB: _____ Phone: _____

LAWRENCE BERGMAN, MD, LLC

Patient's Name: _____ Patient's DOB: _____

PAST MEDICAL HISTORY (Please check YES or NO. Write an explanation of YES answers on the line)

☐Yes ☐No Serious illness or medical condition (ex. asthma, allergies, diabetes, ADHD)_____

☐Yes ☐No Serious injury or accident _____

☐Yes ☐No Surgery _____

☐Yes ☐No Hospitalization _____

☐Yes ☐No Serious Behavior/Mental Problems/Developmental Delay _____

☐Yes ☐No Receiving medical care from a specialist - who?_____

☐Yes ☐No Taking medication _____

☐Yes ☐No Delayed or missing immunizations _____

☐Yes ☐No Recurrent medical problem (ex. ear infection, UTI, strep throat) _____

☐Yes ☐No Medication Allergies _____

Other _____

Biological Mother: _____ Date of Birth: _____

Biological Father: _____ Date of Birth: _____

FAMILY MEDICAL HISTORY (Please check all that apply for BIOLOGICAL family members) ***PLEASE INDICATE WHO: EX. AUNT, UNCLE, COUSIN***

	MOTHER	FATHER	BROTHERS/SISTERS	MATERNAL GRANDPARENT	PATERNAL GRANDPARENT	MATERNAL SIBLING/FAMILY	PATERNAL SIBLING/FAMILY
ALLERGIES							
ASTHMA							
ECZEMA							
CANCER (TYPE)							
HEART DISEASE							
HIGH CHOLESTEROL							
HIGH BLOOD PRESSURE							
DIABETES							
OBESITY							
GASTROINTESTINAL PROBLEM							
THYROID DISEASE							
PSYCHOLOGICAL PROBLEMS							
ADHD							
MIGRAINES							
SEIZURE DISORDER							
EYE PROBLEMS							
BLEEDING PROBLEMS							
PROBLEMS WITH ANESTHESIA							
OTHER							

I understand copies of the **PATIENTS FINANCIAL RESPONSIBILITY DISCLOSURE, CONSENT FORM, NOTICE OF PRIVACY PRACTICES** and **VACCINE POLICY** are posted on the Lawrence Bergman, MD, LLC website and are available in the office. I understand that I am bound by the terms of the policies and failure to do so could result in dismissal.

Signature: _____ Relationship to Patient: _____

Printed Name: _____ Date: _____

Lawrence Bergman, MD, LLC

PATIENT'S FINANCIAL RESPONSIBILITY FORM

(Please Read Carefully)

Patient Name: _____Date of Birth: _____ Account_____

I hereby acknowledge that I am receiving or about to receive health care services at the office of Lawrence Bergman, MD, LLC. I authorize payment of benefits, as determined by the insurance company, to be made directly to my physician. I certify that I will make sure that Lawrence Bergman, MD, LLC is immediately updated by me of any changes in my insurance including but not limited to change in carrier, termination of insurance or lapse in coverage.

As a **courtesy**, Lawrence Bergman, MD, LLC has agreed to file a claim for services rendered with my insurance carrier. I am responsible and expected to pay Lawrence Bergman, MD, LLC for the following:

1) Any co-payment or co-insurance as set by my insurance carrier
2) Any unsatisfied deductible or termination of coverage
3) Any amount my insurance carrier deems my responsibility
4) Any amount considered non-covered by my insurance carrier.
5) Any amount not paid because of failure of patient to provide correct insurance information to Lawrence Bergman, MD, LLC in a timely fashion (within 30 days of date of service)

If Lawrence Bergman, MD, LLC has not received payment from my insurance carrier within 60 days from the date of service, I will be expected to pay my balance in full, even if this balance should be legitimately paid by my insurance plan. Should the office of Lawrence Bergman, MD, LLC not be a participating provider on my insurance plan, then all charges for services will be directly charged to me and I will be personally responsible for payment at the time services are rendered. I understand that if Dr. Bergman is not an in-network provider for my insurance plan then I agree to be responsible for the paying his standard fees. Lawrence Bergman, MD, LLC would not be obligated in any way to accept any reduced fees that are suggested by my insurance company as Dr. Bergman has no contractual relationship as an out of network provider.

Any fees that are determined to be due by the patient are due at the time of service and are not pending receipt of an explanation of benefit from my insurance company. I agree to pay for services on a current basis unless other arrangements have been made with the billing department in advance of treatment. I understand that if I do not have medical insurance that I am personally responsible for all charges at the time services are rendered.

I understand that I will be responsible for a "**No Show**" fee of $25 for not giving at 24(twenty-four) hour advance notice of cancellation for any appointment that I am unable to keep. This fee will be billed directly to me and not to my insurance company for payment. Three no shows may result in my being discharged from Lawrence Bergman, MD, LLC.

In all cases, should charges become delinquent, these charges will accrue interest at the current rate per month until the full balance is paid and I will be responsible for all costs of collection including but not limited to court costs, reasonable attorney fees, and interest. I further agree that once my account has been placed in collections then I (my child) may not be seen until the balance is paid in full by me or by my insurance. Outside Collections my result in discharge from Lawrence Bergman, MD, LLC.

I understand that payment is required at the time services are rendered unless other arrangements have been made with the Billing Department in advance. Lawrence Bergman, MD, LLC only accepts cash, bank checks or personal checks. There is a $35.00 service charge for returned checks.

I HAVE READ THE ABOVE INFORMATION AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY LAWRENCE BERGMAN, MD, LLC

_____ _____

Patient's name (Please Print) Patient's Signature / Date

As Parent/Guardian of the above referenced individual, I will continue to be responsible for all costs incurred for services up through the age of 21 years.

_____ _____ _____

Parent/Legal Guardian (Please Print) Parent/Legal Guardian Signature /Date Parent/Legal Guardian Social Security #

Lawrence Bergman, MD, LLC

10115 W. Forest Hill Boulevard

Suite 303

Wellington Florida 33414

561-798-5565

No Show Policy

Patient Name: _____ Account_____

In an effort to address this concern and continue to meet the needs of our patients, we have developed the following No Show Policy.

1. We request at least 48 hours advanced notice when canceling your appointment.
2. There is a $25 fee for appointments cancelled with less than 24 hours' notice to cover administrative expenses. This includes appointments that are made and then cancelled within a 24-hour period (i.e. the same day).
3. Patients who do not reschedule within 30 days or have a history of repeatedly not showing may be subject to dismissal for "non-compliance."

We believe this policy will result in improved patient care and allow us to accommodate all of our patients in a timely fashion. We appreciate your understanding in this matter.

Signature of Responsible Party: _____

Printed Name of Responsible Party: _____

Date: _____

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Authorization To Consent For Treatment Of A Minor

Must be completed by biological parent(s) or legal guardian(s)

ID REQUIRED

Patient Name: _____ Account_____

It is important to remember that a child under 18 years of age who needs medical, dental, or hospital care cannot be treated without parental permission unless the situation threatens the child's life or limb. To ensure that your child receives the proper care in your absence, you can appoint anyone over 18 years of age to authorize your child's medical care and make medical decisions on your behalf. This includes the administration of any and all vaccines that might be recommended by Lawrence Bergman, MD, LLC. Please complete the information below and provide a copy of your Picture ID.

I, _____ authorize the following individual(s),
(Name of Parent or Legal Guardian)

Name: _____ Relationship to child: _____
(Photo ID Required)

Name: _____ Relationship to child: _____
(Photo ID Required)

Name: _____ Relationship to child: _____
(Photo ID Required)

This authorization expires on _____. If left blank, authorization expires a year from the date signed.

Signature of Responsible Party: _____

Printed Name of Responsible Party: _____

Date: _____

LAWRENCE BERGMAN, MD, LLC CONSENT FORM

Patient's Name_____ Record # _____

I consent to the use or disclosure of my child's protected health information by Lawrence Bergman, MD, LLC for the purpose of diagnosis or providing treatment, obtaining payment for health care bills or to conduct health care operations of Lawrence Bergman, MD, LLC. I understand that diagnosis and treatment of my child by Lawrence Bergman, MD, LLC may be conditioned upon my consent as evidenced by y signature on this document.

I understand that I have the right to request a restriction as to how my child's protected health information is used or disclosed to carry out treatment, payment or healthcare operation of the practice. Lawrence Bergman, MD, LLC is not required to agree to the restrictions that I may request. However, if Lawrence Bergman, MD, LLC agrees to a restriction that I request, the restriction is binding on Lawrence Bergman, MD, LLC and the physicians/providers.

I have the right to revoke this consent, in writing, at any time, except that Lawrence Bergman, MD, LLC has taken action in reliance on this consent.

My child's "protected health information" means health information, including my child's demographic information, collected from me and created or received by my physician/provider, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information related to my child's past, present, or future physical or mental health or condition and identifies my child, or there is a reasonable basis to believe the information may identify my child.

I understand that I have a right to review Lawrence Bergman, MD, LLC's Notice of Privacy Practices prior to signing this document. The Lawrence Bergman, MD, LLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my child's protected health information that will occur in my child's treatment, payment of my child's bills or in the performance of health care operation of Lawrence Bergman, MD. LLC. The Notice of Privacy Practices for Lawrence Bergman, MD, LLC is also displayed in the patient waiting room as well as on the practice website. The Notice of Privacy Practices also describes my rights and the duties of Lawrence Bergman, MD, LLC with respect to my protected health information.

I also authorize Lawrence Bergman, MD, LLC to leave reminders for appointments, statements that lab and/or diagnostic testing results were **normal** and messages to call the office on my home answering machine, cell phone, email or all of the above. These reminder and messages can also be in the form of an SMS text message, voice recording or email.

Lawrence Bergman, MD, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my child's next appointment. I can also print one from the practice website.

If I do not sign this consent, Lawrence Bergman, MD, LLC may decline to provide treatment to my child.

_____

Signature of Parent/ Personal Representative

_____

Name of Parent/ Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

_____

If refused, list reason below with signature of employee, time, date and cosigned by manager or physician onsite.

_____

Date/Time: _____ Employee Signature: _____ Manager's Signature: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____Date of Birth: _____ Account_____

I, _____, have received a copy of this Office's Notice of Privacy Practices. I understand that additional copies are posted in the patient waiting room as well as on the practice website.

_____ _____

Patient's name (Please Print) Patient's Signature / Date

If patient is less than 18 years of age and is a minor then sign below.

_____ _____ _____

Parent/Legal Guardian (Please Print) Parent/Legal Guardian Signature /Date Parent/Legal Guardian Social Security #

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐Individual refused to sign

☐Communication barriers prohibited obtaining the acknowledgement

☐An emergency situation prevented us from obtaining the acknowledgement

☐Other (Please Specify) _____

_____