INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.,

5535 GRAND BLVD., SUITE C, NEW PORT RICHEY, FL 34652

Phone (727) 841-0700

PATIENT REGISTRATION FORM

(Please Print Clearly)

Today's date:	**Email:**

PATIENT INFORMATION

Patient's last name:	**First:**	**M**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status** ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Widowed

Is this your legal name? ❑ Yes ❑ No		**Date of Birth:** / /	**Age:**	**Sex:** ❑ M ❑ F

Street address:	**Social Security #**	**Primary phone # Home /Cell** ( )

P.O. box:	**City:**	State:	ZIP Code:

Employer:	**Occupation**:	**Work phone #** ( )

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race: ❑ American Indian or Alaska Native ❑ Asian Indian
❑ Asian Other ❑ Black or African American ❑ Chinese ❑ Filipino
❑ Guamanian or Chamorro ❑ Hawaiian Native ❑ Japanese
❑ Korean ❑ Multiple ❑ Other ❑ Pacific Islander ❑ Samoan
❑ Unknown ❑ Vietnamese ❑ White

Primary Language:
❑ English ❑Spanish
❑Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist along with a Photo ID)

Policy Holder Name: **Relationship to Patient:** ❑Spouse ❑Mother ❑ Father ❑ Other	**Policy Holder's Date of Birth:** / /	**Policy Holder Address (if different than patient):**	**Policy Holder Phone #** ( )

Policy Holder ID:_____

Policy Holder Sex : ❑Male ❑ Female

Is this patient covered by insurance?
❑ Yes ❑ No

Please indicate primary insurance: ❑ **MEDICARE** ❑ **COMMERCIAL** ❑**SELF PAY** ❑ **OTHER (Please Specify)**

Preferred method of notification:
❑ Home Phone ❑ Cell Phone ❑ Email

Florenda L. Fortner, M.D.

Patient Name: **DOB:**

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Phone #** ( )	**Work phone #** ( )

I Authorize discussion and release of my health care conditions and diagnosis, including billing and medical records with the following individuals: (List any additional individuals on the back of this form)

Name:_____ **Phone number:** _____ **DOB:**_____ **Relationship:**_____

Name:_____ **Phone number:** _____ **DOB:**_____ **Relationship:**_____

Name:_____ **Phone number:** _____ **DOB:**_____ **Relationship:**_____

- The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.,**or insurance company to release any information required to process my claims. The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable by **INTERNAL MEDICAL & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.**
- I give **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.,** permission/ authorization to obtain medical information, pharmacy information, personal and billing information from other facilities, companies, physicians, etc. via Electronic, Email, Fax, Mail, Text Message, Phone/ Cell Phone.
- I authorize **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.** to collect Insurance benefits on my behalf, and to release any information in my medical chart to my Insurance Company.
- **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.** Collects All Patient Payments prior to seeing the physician on the day of your appointment. **All** Co-pays, deductibles, co-insurance, and prior balances must be collected via **Cash** or **Credit Card**.
- We no longer accept Personal Checks in our office. If you receive a Bill from our office, you may pay by check, but **All Returned Checks will be charged a $50.00 Returned Check Fee added to your total balance.**
- **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D**. will charge a **$25.00 NO SHOW FEE** for any No-Show Appointments. The patient must call our office and give us a 24 hour notice to cancel their appointments. This Fee is not billable to your insurance company, and will be the patient's responsibility to pay the no-show fee before being seen in our office. It is the patient's responsibility to provide our office with current and accurate billing information. Failure to provide the updated information will result in the patient being liable for all charges. **In the event that your account is placed with an outside Collection Agency, the patient / guarantor will be held responsible for ALL Incurred Fees.**
- **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D. charges $25.00 for work / disability forms**.
- **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.** also charges for other letters/ forms. These fees can be obtained by contacting our office.
- **I have received a copy of INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.'s Notice of Privacy Practices for Protected Health Information (HIPPA).**
- **I authorize INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D. to release my medical records and related information to authorized representatives of my third party payer or physicians / facilities related to my care.**
- **Permission for Treatment is granted to INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D to treat the patient as deemed medically necessary.**

_____ _____

Patient/Guardian signature ***Date***