GENERAL PRACTICE ASSOCIATES, P.A.

3301 Johnson Street, Hollywood, Florida 33021
Telephone: (954) 989-6650 • Fax: (954) 989-7783

PLEASE PRINT CLEARLY

Last Name:_____ First Name:_____

Do you go by a nickname:_____

Date of Birth:_____ Sex: **M / F**

Home Address:_____ Apt #_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work:_____ Mobile:_____

Email Address:_____

Marital Status: (**circle**) *Single Married Divorced Widowed* Name of Spouse:_____

Race: (**circle**) *White Asian Black/African American Hawaiian/Pacific Islander Hispanic Other*

Ethnicity: (**circle**) *Hispanic/Latino Not Hispanic/Latino* Language Spoken:_____

Responsible Party: **SELF** or _____ Relationship to Patient: _____

Emergency Contact: Name_____ Relationship to Patient_____

Phone #_____

Employer:_____ Phone #:_____ Occupation:_____

Health Plan Name:_____ HMO or PPO

Health Plan Member Number:_____ Group #_____

Pharmacy Name:_____ Pharmacy Phone #:_____

Is it ok to discuss your medical information with anyone else? Yes or No

If yes, with whom?_____ Relationship to Patient_____

AUTHORIZATION

I hereby authorize my insurance company to pay directly to General Practice Associates any and all medical and/or surgical benefits otherwise payable to me for his professional services.

I acknowledge that I am personally responsible and liable to General Practice Associates for any and all medical and/or surgical fees billed by them. Should General Practice Associates accept payment by direct assignment from Medicare or any other insurance company; I understand that I am responsible and liable for any and all deductible expenses and "co-insurance" not covered by Medicare or my primary insurance company. I understand that any overpayment on my part will be refunded to me promptly.

I acknowledge that I am personally responsible for full payment of all "non-covered" services, and I am responsible for all returned checks and I agree to pay a $50 per check per incident fee for each returned check. If I am placed into collections or if my account goes to litigations, I agree to be responsible for all collection and attorney's fees.
I hereby authorize release of all medical records to other physicians to whom I am referred for care, and to my insurance company or plan

LIFETIME SIGNATURE:_____ **DATE:**_____