Robert S. Tomchik, M.D., P.A.

3161 Dykes Road, Miramar, FL 33027

Phone: (954) 450-3550 Fax: (954) 450-3557 MiramarMedicine.com

Patient Information Sheet

PERSONAL INFORMATION:

Patient Name:_____
Last First Middle

Social Security #:_____ Birth Date:_____ Sex: ☐ M ☐ F

Address 1:_____ Address 2:_____

City:_____ Zip:_____ Email Address: _____

*Home Phone: (____)_____ *Cell Phone: (____)_____ *Work Phone: (____)_____
*At Least 2 Phone Numbers Please

Employed by:_____ Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name:_____
Last First Middle

Spouse's Birth Date:_____ Employed by:_____

Emergency Contact:_____ Phone Number: (_____)_____

How did you hear of us (optional):_____

If someone other than the patient is responsible for payment, please complete this section:

Name of Responsible Party:_____
Last First Middle

Relationship to Patient:_____ Social Security #:_____ Date of Birth:_____

Address 1:_____ Address 2:_____

City:_____ Zip:_____ Email Address: _____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Medical Authorization and direction to pay:

I do hereby authorize the doctors/providers of care to furnish you, my insurance company, with the above referred, concerning the examination, diagnosis, treatment, progress, etc., of myself in regard to the accident or illness for which I received treatment. I hereby authorize and direct you, my insurance company, to pay the said doctors/providers of care such sums as may be due and owing them for services rendered to me by reason of this accident or illness. Under no circumstances is this agreement revocable, nor can it be changed unless proof of payment in full of the bill is provided to him/her for services rendered to me. And, I further understand that such payment is not contingent on any insurance policy, settlement, judgment, or verdict by which I may eventually recover said fee. I hereby agree to pay for the services rendered, including attorney's fees, collection charges, and court costs necessary to affect payment of this account. I understand that interest charges of 1-1/2% per month may be charged should my account become delinquent. I will also pay you an additional fee for each dishonored check or similar instrument received by you in payment on this account. A photocopy of this is as valid as the original.

Patient Signature: _____ Date: _____

Patient's Name: _____

It is helpful to gather information about your medical history for the physician to use in your examination. Please complete this form completely for the physician's review

1. CONTITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

2. INTEGUMENTARY (skin, breast)

Rash of itching	No	Yes
Change in skin color	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

3. NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

4. HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

5. PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

6. ENDOCRINE

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes (insulin or non insulin – circle one)	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

7. Eyes, Ear, Nose, Mouth

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

8. CARDIOVASCULAR

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath while walking	No	Yes
Swelling of feet, ankles or hands	No	Yes

9. RESPIRATORY

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

10. MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes
Sports injury	No	Yes

11. GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

12. GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male – Testicle Pain	No	Yes
Female – Pain with period	No	Yes
Use douche	No	Yes
Irregular periods	No	Yes
Vaginal discharge	No	Yes
Age at the onset of menstruation	No	Yes
Number of days menstruation lasts	No	Yes
Date of last pap smear	No	Yes
Date of last menstrual period	No	Yes

List all pregnancies with dates, weights, and problems (Please include miscarriages, terminations, and pre-term):

_____

_____

_____

_____

_____

_____

_____

ALLERGIC/IMMUNOLOGIC

History of reaction to:
Medication No Yes

List:_____

Other No Yes
List:_____

Past Medical History

Previous Hospitalizations/Surgeries/Serious Injuries:	Medications:

Patient social history:

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Previously but quit ☐ Current packs per day:_____

Use of drugs: ☐ Never ☐ Type/Frequency:

Exposure to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Air-borne particles ☐ Noise

History of domestic violence:.....Verbal Physical Other:

Family medical history:

	Age	**Diseases**	**If Deceased, Cause of Death**
Father			
Mother			
Siblings			
Spouse			
Children			

Physician Reviewed:_____ Date:_____

Robert S. Tomchik, M.D., P.A.

3161 Dykes Road, Miramar, FL 33027

Phone: (954) 450-3550 Fax: (954) 450-3557 MiramarMedicine.com

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing our insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for payment of the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you need to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____

Signature of patient or responsible party Date

Robert S. Tomchik, M.D., P.A.

3161 Dykes, Miramar, FL 33027

Phone: (954) 450-3550 Fax: (954) 450-3557 MiramarMedicine.com

LIVING WILL

This Declaration is made this _____ day of _____, 20_____. I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at any I have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I direct that life prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medicine or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life prolonging procedures, I wish to designate, as my surrogate to carry out the provision of this declaration:

Name: _____

Address: _____

Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional instructions (optional):

_____

_____

_____
Signed

_____ _____
Witness Witness

_____ _____
Address Address

_____ _____
Phone Phone

Note 1: At least one of the above witnesses is neither a spouse nor a blood relative of the Declarant.
Note 2: It is the responsibility of the Declarant to provide for notification to his attending physician that this Declaration has been made.

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PIP) to carry out treatment, payment or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that related to your past, present, or future physical or mental health conditions and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed to your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician’s practice, and any other uses required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Or, for example, your protected health information may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of a medical student, licensing, and conducting or arranging for other activities. For example, we may disclose your protected health information to medical school students that are volunteering at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law: public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroner’s, funeral directors, organ donation, research, criminal activity, military activity and national security, worker’s compensation, inmates, required uses and disclosures. Under the law we must make disclosures to you, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other permitted and required uses and disclosures will be made only with only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following record: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask or request us not to use any part of your protected health information. For example, to not disclose to family members or friends who be involved in your care or for notification purposes as described in this Notice of Privacy Practice. Your request must state the specific restriction to apply.

Your Physician is not required to a restriction that you request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications for us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have accepted this notice alternatively, i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement for disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have had, if any, of your protected health information.

We receive the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain, to us or to the Secretary of Health and Human Services, if your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

The notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of individuals, and to provide them with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only an acknowledgment, that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature:_____ Date:_____

Robert S. Tomchik, M.D., P.A.

3161 Dykes, Miramar, FL 33027

Phone: (954) 450-3550 Fax: (954) 450-3557 MiramarMedicine.com

Patient Bill of Rights

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

Robert S. Tomchik, M.D., P.A.

3161 Dykes, Miramar, FL 33027

Phone: (954) 450-3550 Fax: (954) 450-3557 MiramarMedicine.com

Patient Bill of Rights

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Patient Signature:_____ Date:_____