CAMBRIDGE medical group

NEW PATIENT REGISTRATION

Patient's last name:	First name:	Middle name:	Previous name:

Street address:	Apartment/ Suite	City:	State:	ZIP code:

Home phone: ( ) -	Cell phone: ( ) -	Work phone: ( ) - Ext:	Email address:

Patient Date of Birth: / /	Patient Sex: ☐ M ☐ F	Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ other

Social Security no.: - -	Employer Name and Address:

Employment Status: ☐ full time ☐ part time ☐ not employed ☐ retired ☐ military ☐ student- ft ☐ student- pt

EMERGENCY CONTACT

Name of emergency contact person:	Relationship to patient:	Home phone no.: ( ) -	Work phone no.: ( ) -

Mailing address:	City:	State:	ZIP code:

RESPONSIBLE PARTY (GUARANTOR)

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip this section

Guarantor's last name:	Guarantor's first name:	Guarantor's middle name:

Guarantor's date of birth: / /	Guarantor's Social Security No.: - -	Guarantor's phone number: ( ) -

Guarantor's mailing address:	City:	State:	ZIP code:

Patient's relationship to guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:

INSURANCE INFORMATION

Name of primary insurance:	Subscriber number:	Policy insured's name, if not patient:	Group name / number

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:

Name of secondary insurance:	Subscriber number:	Policy insured's name, if not patient:	Group name / number

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:

OTHER INFORMATION

Have you signed an Advanced Healthcare Directive? ☐ Yes ☐No

Your preferred pharmacy:	Pharmacy address:	Pharmacy telephone: ( ) -

May we leave appointment, test and medication info with family/household members and on your home voice mail? ☐ Yes ☐No

May we send you information regarding Cambridge events, health news updates and insurer/HMO announcements? ☐ Yes ☐No

If you answered "Yes" to the question above, where should we send these? ☐ home address ☐ email address ☐ both

How did you hear about our office, or who referred you to us?

_____ _____

Signature of Patient or Patient's guardian/representative Date

CAMBRIDGE medical group

FINANCIAL POLICY, ASSIGNMENT INFORMATION, AND RELEASE OF INFORMATION

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guardian or representative. I authorize (assign) any insurance or Medicare benefits to be paid directly to Cambridge Medical Group or its assignees. I agree that I am responsible for any non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my insurance plan works, and have requested medical services for this office. This acceptance and assignment will be in force for all future services by practitioners from this office.

I understand that diagnosis or treatment of me by Cambridge Medical Group may be conditioned upon my consent as evidenced by my signature on this document.

I agree to provide 24 hours advance notice should I need to cancel or reschedule an appointment. I understand and agree that a $25 fee will be charged for any broken appointment for which I do not provide 24 hours advance notice.

_____ _____

Signature of Patient or Patient's guardian/representative Date

_____

Printed name of person signing above

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my health care, Cambridge Medical Group originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality.

I understand that Cambridge Medical Group maintains a *Notice of Privacy Practices* that provides a more complete description of protected health information uses and disclosures. The most recent version of this Notice is available from the receptionist. I understand that Cambridge Medical Group reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this Notice at any time.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed.
- The right to revoke my consent to use or disclosure of my protected health information by notifying Cambridge Medical Group, in writing, of such revocation.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of Cambridge Medical Group.

_____ _____

Signature of Patient or Patient's guardian/representative Date

_____

Printed name of person signing above

CAMBRIDGE
medical group

CONSENT FOR TREATMENT

I, _____, HEREBY AUTHORIZE **Cambridge Medical Group of West Boynton**, the attending Clinician, or the Clinician designated by him/her and other Practice employees; to examine and treat me. I also authorize such treatment and procedures, as deemed necessary by the Clinician, including but not limited to, the taking of x-rays, medications, blood samples, urine samples and other therapies as deemed necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment.

I hereby certify that I understand the above authorization.

_____ WITNESS

_____ PATIENT SIGNATURE

_____ DATE & TIME

_____ PATIENT OR PERSON AUTHORIZED CONSENT

_____ RELATIONSHIP TO PATIENT

10817 S. Jog Road, Suite 230, Boynton Beach, FL 33437
Office: 561-634-8888 Fax: 561-634-8998

Cambridge Medical Group

Consent for Release of Protected Health Information

I, _____, consent to the release of protected health information that is required to carry out treatment, payment of healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that Cambridge Medical Group is not required to agree with my requested restrictions. I also understand that once Cambridge Medical Group agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
- I understand that Cambridge Medical Group must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- Cambridge Medical Group has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly; and we will inform you of any revisions by posting the information in the waiting room and the receptionist will hand out a copy of such revision.
- I hereby acknowledge that I have received a copy of Cambridge Medical Group Notice of Privacy Practices.
- For Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Cambridge Medical Group.

Date:

Witness:

_____ _____

Printed Name of Patient *Printed Name*

_____ _____

Signature *Signature*

CAMBRIDGE medical group

10817 South Jog Road, Suite 230
Boynton Beach FL 33437
Phone: (561) 634-8888 Fax: (561) 634-8998
Cmgfl.com

Are you transitioning from another primary care provider or specialist? Cambridge Medical Group is happy to provide you with excellent healthcare.

When transitioning between healthcare providers it is important to keep CMG up to date with your medical records. This information enables us to know your medical history and to individualize your healthcare plan.

Please see our front desk staff or your Welcome Packet for the *Transition of Care Form* giving our Medical Records Staff permission to obtain your medical records from your current provider(s). If you have any questions, please let the front desk or your clinical team know and we will be happy to answer them.

We encourage you to have an active role in your healthcare. Examples of ways to be more involved include but are not limited to, the following: open discussions about health, personal and social issues, keeping up to date on immunizations, behavioral health issues, health condition and management, functional independence, managing obstacles to care, health insurance, work plans, independent living issues and taking advantage of community services available to you.

To help us know you and your health better, please complete the following information: (**Print Please**)

Name: _____ Date of Birth: _____
Current Provider(s): _____Phone Number: _____
Specialist(s): _____Phone Number: _____
Primary Diagnosis: _____ Secondary Diagnosis: _____
Current Medication(s) with dosage: _____
_____

Main Concern	**Related Current Information (Hospitalizations, Surgeries, Procedures/Tests)**	**Current Plans / Interventions**	**Date – Initials**	**Review Date**

Topics to Review during Office Visit:

Health Promotion	Health Insurance	Immunizations	Independent Living Issues
Health Condition	Functional Independence	Work Plans	Community Inclusion
Management	Obstacles to Care	Retirement Plans	Other

If you have any questions, please ask your provider or any member of the CMG staff.

CAMBRIDGE MEDICAL GROUP

Health History

(Confidential)

Name_____ Today's Date_____

Age_____ Birth Date_____ Date of Last Physical Examination_____

What is the reason for your visit? _____

Symptoms: (Please put an "X" on the line next to any symptoms you currently have or have had in the past year.)

General

__Chills
__Depression
__Dizziness
__Fainting
__Fever
__Forgetfulness
__Headache
__Loss of Sleep
__Loss of Weight
__Nervousness
__Numbness
__Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:
__Arms __Hips
__Back __Legs
__Feet __Neck
__Hands __Shoulders

Genito-Urinary

__Blood in Urine
__Frequent Urination
__Lack of Bladder Control
__Painful Urination

Gastrointestinal

__Appetite Poor
__Bloating
__Bowel Changes
__Constipation
__Diarrhea
__Excessive Hunger
__Excessive Thirst
__Gas
__Hemorrhoids
__Indigestion
__Nausea
__Rectal Bleeding
__Stomach Pain
__Vomiting
__Vomiting Blood

Cardiovascular

__Chest Pain
__High Blood Pressure
__Irregular Heart Beat
__Low Blood Pressure
__Poor Circulation
__Rapid Heart Beat
__Swelling of Ankles
__Varicose Veins

Eye, Ear, Nose, Throat

__Bleeding Gums
__Blurred Vision
__Crossed Eyes
__Difficulty Swallowing
__Double Vision
__Earache
__Ear Discharge
__Hay Fever
__Hoarseness
__Loss of Hearing
__Nosebleed
__Persistent Cough
__Ringing in Ears
__Sinus Problems
__Vision-Flashes
__Vision-Halos

Skin

__Bruise Easily
__Hives
__Itching
__Change in Moles
__Rash
__Scars
__Sore that won't Heal

Men Only

__Breast Lump
__Erection Difficulties
__Lump in Testicles
__Penis Discharge
__Sore on Penis
__Other

Women Only

__Abnormal Pap Smear
__Bleeding Between Periods
__Breast Lump
__Extreme Menstrual Pain
__Hot Flashes
__Nipple Discharge
__Painful Intercourse
__Vaginal Discharge
__Other

Date of Last Menstrual Period:
_____
Date of Last Pap Smear:
_____
Have you had a Mammogram?
Y/N If yes, Date: _____
Are you Pregnant? Y/N
Number of Children_____

Conditions: (Please put an "X" on the line next to any conditions you currently have or have had in the past.)

__AIDS
__Alcoholism
__Anemia
__Anorexia
__Appendicitis
__Arthritis
__Asthma
__Bleeding Disorders
__Breast Lump
__Bronchitis
__Bulimia
__Cancer
__Cataracts
__Chemical Dependency
__Chicken Pox
__Diabetes
__Emphysema
__Epilepsy
__Glaucoma
__Goiter
__Gonorrhea
__Gout
__Heart Disease
__Hepatitis
__Hernia
__Herpes
__High Cholesterol
__HIV Positive
__Kidney Disease
__Liver Disease
__Measles
__Migraine Headaches
__Miscarriage
__Mononucleosis
__Multiple Sclerosis
__Mumps
__Pacemaker
__Pneumonia
__Polio
__Prostate Problem
__Psychiatric Care
__Rheumatic Fever
__Scarlet Fever
__Stroke
__Suicide Attempt
__Thyroid Problems
__Tonsillitis
__Tuberculosis
__Typhoid Fever
__Ulcers
__Vaginal Infections
__Venereal Disease

Medications: (List medications you are currently taking. ***Include Med Name, Strength, frequency taken***)

_____

_____

_____

Pharmacy Name/Phone Number:

Allergies: (To medications or substances.)

( ) NONE

_____

_____

_____

Family History: (Fill in information about your family.)

Relation	Age	State of Health	Age at Death	Cause of Death
Father	___	_____	_____	_____
Mother	___	_____	_____	_____
Brother(s)	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____
Sister(s)	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____

Please put an "X" on the line if your blood relatives had any of the following:

Disease	Relationship to you:
__Arthritis, Gout	_____
__Asthma, Hay Fever	_____
__Cancer	_____
__Chemical Dependency	_____
__Diabetes	_____
__Heart Disease, Strokes	_____
__Kidney Disease	_____
__Tuberculosis	_____
Other:	

Hospitalizations/Surgical History: ( ) None

Year: Hospital: Reason for Hospitalization and Outcome:_____

_____

_____

_____

Health Habits: Please put an "X" next to the substances you use and describe how much you use:

__Caffeine__(NO) (YES) _____HOW MANY CUPS DAILY _____

__Tobacco__(NO) (YES) _____HOW MANY DAILY _____ __ VAPING (NO) (YES) HOW OFTEN_____

Other:_____

__Drugs_____

Serious Illness/Injuries: Date/Outcome ( ) NONE

_____

_____

_____

Occupational Concerns:

Please put an "X" if your work exposes you to the following:

__Stress
__Hazardous Substances
__Heavy Lifting
Other: _____

Your Occupation:

IMMUNIZATION HISTORY ( ) NONE			
FLU VACCINE – TYPE	DATE		
PHEUMONIA VACCINE – TYPE	DATE		
SHINGLES	DATE		
COVID – TYPE	DATE 1ST SHOT	DATE 2ND SHOT	DATE - BOOSTER
OTHER -			

I certify that the above information is correct to the best of my knowledge. I will not hold Cambridge Medical Group or any members of their staff responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE: DATE

CAMBRIDGE medical group

A Primus Health Company

Patient Responsibility Agreement for Controlled Substance Prescriptions

Controlled substance medications (i.e. narcotics, tranquilizers, benzodiazepines, and barbiturates) are very useful for controlling both acute and chronic pain but have a high potential for misuse and are therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving quality of life, function and/or the ability to work. If my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions.

Treatment Goals

I understand that the main treatment goal is to reduce pain to a bearable level and improve the quality of my life. This includes the ability to function and/or work. I understand that in many cases the pain may not be completely eliminated. In consideration of this goal, and because of the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits. These include increase in activity and exercise, weight control, and avoidance of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

Patients' Responsibility

[ ] I am responsible for the controlled substance medications prescribed to me. If my prescription is **lost, misplaced, or stolen or if I "run out early",** I understand that it will **NOT** be replaced.

[ ] I give permission for my physician to discuss all my diagnostic and treatment details with other physicians providing my medical care and with my pharmacists for purposed of maintaining accountability. This includes a copy of this contract.

[ ] I will use **ONLY one pharmacy** for all my prescription refill. I will register the name and phone number of this pharmacy with my physician.

[ ] I am aware that telephone refills are **NOT allowed**. Calls or faxed from pharmacies to refill medications will not be authorized.

[ ] I agree to **bring the bottles of all the medications prescribed by pain management** to each visit. Medications will be **counted and number of refills checked.**

[ ] I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is **my** responsibility to comply with the laws of the State while taking the prescribed medications.

Initials_____

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Controlled Substance Agreement Cont.

[ ] At any time while I am receiving controlled substance medications, it may be deemed necessary by my doctor that I see a medication-use specialist. I understand that if I do not attend such an appointment, my medications will be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction); my medications may be tapered to completion.

[ ] I will comply with random **PILL COUNTS.** These will be performed during regular office hours. The purpose of the PILL COUNT is to monitor medication usage. The number of pills missing from the bottle must correlate to the number of days since the prescription has been filled. A discrepancy in the number of pills missing is to be considered a breach of this contract and thus grounds for termination. Patients who fail to show for random pill counts will be immediately terminated from the practice. The pill counts will be randomly scheduled by the pain staff.

[ ] I agree to undergo **random urine drug testing** at the discretion of the pain staff. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breach of this contract and therefore grounds for dismissal. Failure to comply with the test will be considered grounds for dismissal.

[ ] **I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medications from pain management. I will not give, share or sell my medications to any other person.**

[ ] I also understand that I mist maintain a primary care physician while being care dfor in pain management. He/She will be used to care for my other medical needs and in special cases used to write prescriptions if/when the pain management physician may be unavailable.

Refills of Medications

[ ] Refills will be made **ONLY** during regular office hours Monday through Friday, in person. This will be done wither monthly, bi-monthly, tri-monthly during a scheduled office visit. Refills will not be made after hours, on weekends, or on holidays.

[ ] Refills will **NOT** be made if I “run out early”, or “lose a prescription”, or “spill or misplace my medication”, or “they are stolen”. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location as to avoid their theft.

[ ] Refills will **NOT** be made as an “emergency” such as on a Friday afternoon because I suddenly realize I will “run out tomorrow”. I will call at least 24 hours in advance to schedule an appointment for refills.

Initials_____

CAMBRIDGE medical group

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Risks of Chronic Opioid Use

[] I understand that **the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined.** My treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substance, and that my physician will advise me of any advances in this field and will make treatment changes deemed appropriate.

[] I am aware that tolerance to analgesia means that I many require more medicine to get the same amount of pain relief. If this occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond to opioids may force my doctor to choose another form of treatment.

[] (Female patients only) I am aware that if I plan to get pregnant or believe that I have become pregnant while taking these medications, I will immediately call my obstetric doctor to inform them. I am aware that there could be some adverse effects on my baby.

[] I have been fully informed by Cambridge Medical Group, LLC or the staff regarding the potential for psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to their medications, necessitating a dose increase to achieve he desired effect, and that there is a risk of becoming physically dependent on the medication. This can occur if I am on the medication even for a short period of time. Therefore, if and when I need to stop taking the medications, I must do so slowly and under the medical supervision or I may have withdrawal symptoms. I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. My doctor is not responsible for withdrawal syndrome if the medications are use inappropriately.

Termination of Care

[] I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be **terminated immediately,** without a 30-day notice. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriated legal authorities. **I am responsible** for any withdrawal syndrome that may occur to do my misuse of the narcotic medications and/or termination of my care.

[] I have read this contract and the same has been explained to me by Cambridge Medical Group, LLC. All my questions have been answered to my satisfaction. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this agreement.

Patient Name_____ Patient Signature_____
Patient DOB _____ Todays Date _____
Witness_____

[] Copy given to patient [] Patient refused copy

CAMBRIDGE medical group

PATIENT AUTHORIZATION TO USE / DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION			
Name			
Last 4 SSN		Date of Birth	
Address			

By signing this form, I authorize the release of protected health information (e.g. medical records)

Release records FROM:
(The following information is required: Medical Provider Name, Address, Phone # & Fax #)

These records are required for emergency and continuing care of the above named patient. Pursuant to Federal and State Law, records should be furnished as soon as possible, at no cost.

Failure to timely provide copies may subject the Patient's prior Provider to fines and sanctions from the Florida Board of Medicine and other Governmental Agencies.

Send records TO:

CAMBRIDGE MEDICAL GROUP
10817 S. Jog Road, Suite 230
Boynton Beach, FL 33437
Fax - 561-634-8998
E-mail -

Please select the type of information to be used or discussed (include dates where appropriate)

☐ Entire record	☐ Immunization records	☐ Notes from
☐ Medication List	☐ Most recent history & physical	
☐ Problem List	☐ Lab results	☐ Other
☐ List of allergies	☐ X-ray & imaging reports	

This authorization for release of information covers the period of healthcare services rendered from:

☐ _____ - _____	☐ All past, present and future periods

Unless revoked, this authorization will expire

☐ Expiration date: _____	☐ Automatic expiration after one year

I have the right to revoke this authorization at any time by contacting Cambridge Medical Group. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I understand signing this authorization is voluntary. I do not need to sign this form in order to receive treatment.

I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

If I have any questions about disclosure of my PHI I can contact Cambridge Medical Group's Medical Record Dept. at 561-634-8888.

Signature:	Date:
Print Name:	Signature by: ☐ Patient ☐ Legal Guardian ☐ Proxy

CAMBRIDGE medical group

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HIPAA Release Form

Name: _____ Date of Birth: _____

Please check one of the boxes below:

[] I authorize the release of my information, including the diagnosis, records, examinations rendered to me and claim information. This information may be released to: (Please print names)
Spouse _____
Child(ren)_____
Other _____

[] Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by the patient in writing.

Communication

Please call my [] Home [] Work [] Cell

If unable to reach me you may:

[] Leave a detailed message

[] Leave a message to return call

Signature: _____Date: _____